

# Commonwealth of Massachusetts

Request for a State Innovation Waiver to Stabilize  
Premiums Under Section 1332 of the Affordable Care Act



September 8, 2017

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## 1.0 Executive Summary

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 health coverage 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 of 2010 (Affordable Care Act or ACA). 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 competitive insurance markets in the country, and residents' access to the high-quality health coverage and care is strong.

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 federal government ceases reimbursement to insurance issuers for the reduced cost-sharing issuers are required to provide by law for eligible enrollees, Massachusetts issuers would lose an estimated \$36 million during the remainder of 2017 and—absent a rate increase—an additional \$146 million in 2018. Massachusetts would experience a significant decline in issuer participation and coverage disruptions for hundreds of thousands of residents.

Given these risks, Massachusetts will need to permit issuers to submit revised rates to account for this risk, as many other states have done in recent weeks. Regulatory guidance establishing the parameters for this supplementary rate filing will be announced on or about September 15, 2017. While this approach will mitigate some market disruption, it will remain highly disruptive to certain populations, particularly unsubsidized Exchange enrollees. As a further consequence of these premium rate increases, the Commonwealth and federal government will face increased aggregate liability for premium subsidies, including Advance Premium Tax Credits/Premium Tax Credits (APTC/PTCs).

To prevent this outcome, Massachusetts seeks a State Innovation Waiver under ACA Section 1332 to establish a Premium Stabilization Fund in lieu of CSR payments for 2018 and potentially beyond. Under the waiver, CSR payments will be waived, and in their place the Commonwealth will stabilize premiums via direct issuer reimbursement, an approach that would eliminate the need for a rate revision and any related consumer-facing changes to coverage costs. Federal APTC/PTC savings that accrue due to the stabilization program will be shared with the Commonwealth in the form of "pass-through" funding to help pay for the stabilization program. The Commonwealth's proposal would meet all Section 1332 "guardrails", including scope of coverage, comprehensiveness of coverage, cost of coverage, and deficit neutrality. The State Innovation Waiver would be effective January 1, 2018 for an initial period of at least one year, with a requested annual opportunity to renew at Massachusetts' option for a five year period, including reconciliation to account for actual enrollment and costs.

Recognizing the time-sensitivity of this request as 2018 plans are currently under review, Massachusetts respectfully requests review by the U.S. Departments of Treasury and Health and Human Services ("Departments") as soon as possible, given the need to implement 2018 premium rates by October 15, 2017 in time for Open Enrollment. While Massachusetts recognizes the Departments are within their rights to review over a longer time period, Massachusetts suggests that an expedited review may be

warranted given the urgent need for market stability. If the drivers of market instability are addressed within that time span—for example, through a Congressional appropriation of CSRs in September—Massachusetts would expect to update the Departments as to the continued need for its waiver request. Massachusetts appreciates federal consideration of this proposal, and looks forward to future collaboration on opportunities for state flexibility and innovation.

## 2.0 Assurances

The waiver will meet Section 1332 “guardrails” because the proposal will maintain equivalent coverage at no greater cost to enrollees, issuers, or the federal government. The direct impact of the waiver will be to reduce premiums in the Exchange marketplace back to levels anticipated without the uncertainty about CSR payments. The waiver will not impact other market segments. The Commonwealth of Massachusetts provides the following assurances:

- Comprehensiveness of coverage. The waiver will not change the comprehensiveness of benefits for Massachusetts residents or employers. Individuals and employers accessing insurance through the merged market will continue to receive the Essential Health Benefits and additional benefits required by state law.
- Affordability of coverage. The waiver will not increase premiums or cost-sharing for Massachusetts residents or employers.
- Scope of coverage. The waiver will not reduce the number of Massachusetts residents covered nor the number of Massachusetts employers offering coverage. Rather, the waiver will maintain an equivalent number of covered individuals by ensuring the same level of subsidization to eligible enrollees via the Premium Stabilization Fund and state subsidy program.
- Deficit neutrality. The waiver will not increase federal spending, net of federal revenues, in any one year or in total over the ten-year budget period. The proposal will not require any additional direct spending or administrative costs. The waiver is not expected to appreciably impact federal revenues from individual shared responsibility payments or other revenue sources.
- No impact on federally-facilitated marketplace. The waiver will not impact the federally-facilitated marketplace since the Commonwealth maintains a state-based marketplace for individuals and small groups and expects to continue to do so.
- No impact on other public programs. The waiver will not impact public coverage programs, such as Medicaid and the Children’s Health Insurance Program.
- Public input. A description of the waiver has been publicly posted, public hearings were held, and public comments were solicited in compliance with 31 CFR § 33.112 and 45 CFR § 155.1312. The Commonwealth provided equal access for individuals with limited English proficiency and disabilities to participate in its public notice-and-comment process. In addition, the Commonwealth has engaged in a separate consultation process with the federally-recognized tribes residing within its borders.

## 3.0 Characteristics of Massachusetts Market

### 3.1 Health Insurance Market Overview

Over the past two decades, Massachusetts has engaged in a series of state health insurance reforms that have 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 quality improvement. Key milestones in the commercial market are highlighted in Figure 1.<sup>1</sup>

**Figure 1. Milestones in Massachusetts Market Reform**

<b>1992 – 1996</b>
<ul style="list-style-type: none"><li>Massachusetts introduced consumer protections to the nongroup and small group market, including guaranteed issue and a state version of adjusted community rating rules.</li></ul>
<b>2006 – 2008</b>
<ul style="list-style-type: none"><li>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:<ul style="list-style-type: none"><li>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.</li><li>State shared responsibility requirements for individuals and employers.</li><li>The merger of the nongroup and small group markets into a single risk pool.</li></ul></li></ul>
<b>2010 – 2014</b>
<ul style="list-style-type: none"><li>Massachusetts prepared to implement the ACA, opting to retain its state-based marketplace and merged market structure.</li><li>Massachusetts enacted comprehensive cost-containment legislation.<sup>2</sup></li></ul>
<b>2014 – 2017</b>
<ul style="list-style-type: none"><li>Massachusetts retained its state-based marketplace, the Health Connector, and transitioned Commonwealth Care enrollees to ConnectorCare, a new program within the Exchange for residents with income up to 300% FPL that includes new federal APTCs and CSRs and maintains a federally-matched "state wrap" via a Medicaid Section 1115 waiver to meet a state affordability schedule that exceeds the federal affordability schedule. Residents between 300-400% FPL are also eligible for premium tax credits.</li><li>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.</li></ul>

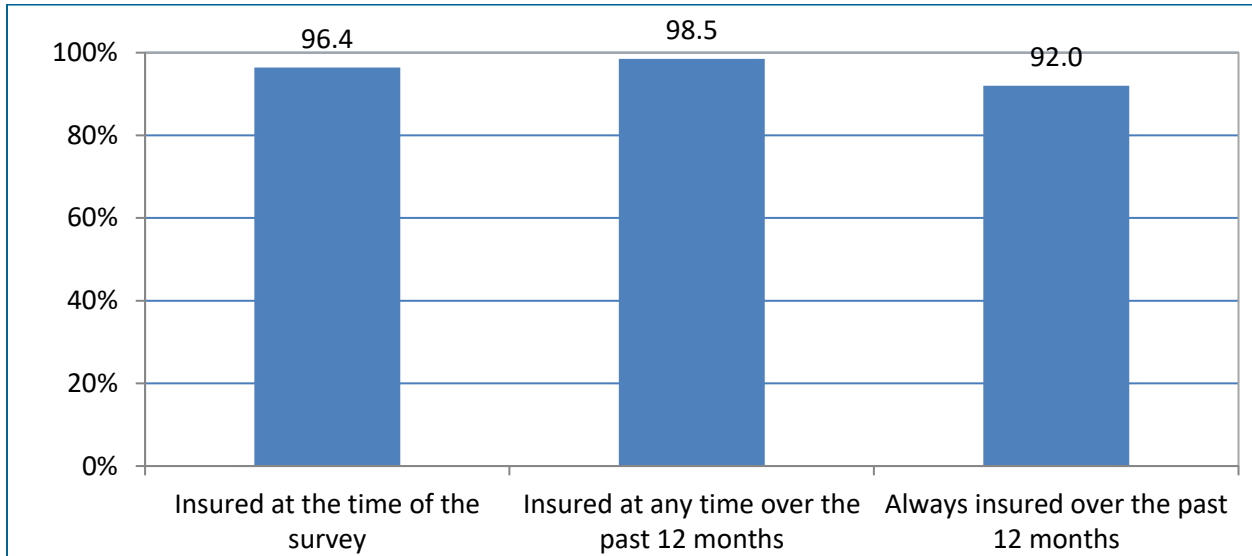
Until recent signs of distress, Massachusetts has had one of the most robust health insurance markets in the nation. Over 96 percent of Massachusetts residents are covered (*see Figure 2*), 89 percent of residents report regular access to health care, and the Commonwealth is beginning to make strides

<sup>1</sup> 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.

<sup>2</sup> Chapter 288 of the Acts of 2010 and Chapter 224 of the Acts of 2012.

toward better value in health care.<sup>3</sup> Roughly two-thirds of Massachusetts residents have commercial health coverage.<sup>4</sup> The commercial market has been competitive, with over a dozen companies actively marketing coverage throughout the Commonwealth.<sup>5</sup>

**Figure 2. Health Coverage Status in Massachusetts**



Source: CHIA, 2015 Massachusetts Health Insurance Survey

The Commonwealth’s insurance marketplace, the Commonwealth Health Insurance Connector Authority (Health Connector), has nine participating health insurance issuers and over 250,000 enrollees<sup>6</sup>, representing roughly 85 percent of nongroup covered lives.<sup>7</sup> Over three-quarters (77%) of Health Connector members report satisfaction with their experience.<sup>8</sup>

The Health Connector administers an innovative subsidized insurance program for enrollees earning up to 300% FPL, ConnectorCare, which wraps federal APTCs and CSRs to meet a state affordability schedule that exceeds the federal affordability schedule.<sup>9</sup> (See Figure 3). State funding for this program is held in a dedicated trust, the Commonwealth Care Trust Fund. State expenditures for this program receive federal financial participation (FFP) for eligible enrollees via a Medicaid 1115 waiver.

<sup>3</sup> 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>.

<sup>4</sup> Center for Health Information and Analysis, “Enrollment Trends Databook” (March 2017), available at: <http://www.chiamass.gov/enrollment-in-health-insurance/>.

<sup>5</sup> Center for Health Information and Analysis. (Sept. 2015) *2015 Annual Report: Performance of the Massachusetts Health Care System (report)*. Retrieved from [www.chiamass.gov/annual-report/](http://www.chiamass.gov/annual-report/).

<sup>6</sup> Health Connector Board Materials (July 13, 2017), available at: <https://www.mahealthconnector.org/about/leadership/board-meetings>.

<sup>7</sup> Center for Health Information and Analysis, “Enrollment Trends Databook” (March 2017), available at: <http://www.chiamass.gov/enrollment-in-health-insurance/>.

<sup>8</sup> Commonwealth Health Connector Member Experience Survey (Oct. 2016), Market Decisions Research, on file.

<sup>9</sup> Health Connector Board materials (April 13, 2017), available at: [www.mahealthconnector.org/wp-content/uploads/board\\_meetings/2017/04-13-2017/CY2018-Final-Affordability-Schedule-VOTE-041317.pdf](http://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/04-13-2017/CY2018-Final-Affordability-Schedule-VOTE-041317.pdf).

**Figure 3. Massachusetts Health Connector Affordability Schedule for Individuals, CY 2018**

Income Bracket				Monthly Dollar Amount	
% of FPL	Bottom	Top	Monthly Affordability Standard	Bottom	Top
0 - 150%	\$0	\$18,090	0%		
150.1 - 200%	\$18,091	\$24,120	2.90%	\$44	\$58
200.1 - 250%	\$24,121	\$30,150	4.20%	\$84	\$106
250.1 - 300%	\$30,151	\$36,180	5.00%	\$126	\$151
300.1 - 350%	\$36,181	\$42,210	7.45%	\$225	\$262
350.1 - 400%	\$42,211	\$48,240	7.60%	\$267	\$306
Above 400%	\$48,241		8.05%	\$324	

Source: Health Connector Board of Directors, April 2017 (note that similar schedules are set for couples and families)

Another unique feature of Massachusetts’ insurance market is its quasi-merged market for individuals and small employers with up to 50 employees.<sup>10</sup> Massachusetts merged its nongroup and small group markets in 2007, as part of the implementation of state health reform under Chapter 58. Over time, the merged market has evolved in Massachusetts to feature a blend of typical merged market characteristics and some remaining characteristics of a typical small group market. Products and rates are typically identical, with some exceptions, such as the fact that ConnectorCare is available only in the nongroup market. In August 2017, Massachusetts’ merged market included 471,692 enrollees in small group plans and 295,993 enrollees in non-group plans.<sup>11</sup>

### 3.2 Recent Market Deterioration

Under the ACA, CSRs are available to Exchange enrollees with incomes below 250% of the FPL and federally-recognized American Indian tribal members with incomes below 300% of the FPL. 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 state funds to meet state-specific affordability standards.

Exchange issuers participating in ConnectorCare 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

<sup>10</sup> See generally, M.G.L. ch. 176J.

<sup>11</sup> Center for Health Information and Analysis. (Aug. 2017) *Enrollment Trends (databook)*. Available at: [www.chiamass.gov/enrollment-in-health-insurance/](http://www.chiamass.gov/enrollment-in-health-insurance/).

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 of Representatives, 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.

In July 2017, Massachusetts issuers were required to submit rates for the 2018 plan year that assumed CSR payments would continue to be made.<sup>12</sup> However, 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.”<sup>13</sup>
- **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.”<sup>14</sup>
- **State Legislature:**<sup>15</sup> The State Senate passed an amendment in its 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.

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.

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 (DOI), and finds the concerns to be fully warranted for both issuers and their enrollees. (See Figure 4).

**Figure 4. Estimated Massachusetts Market Disruption Due to CSR Uncertainty, Absent State Mitigation**

Issuer Impact if MA Does Not Permit Mid-Year Revision of Rates	<ul style="list-style-type: none"> <li>• In CY 2017, Massachusetts issuers are expected to receive an estimated \$110 million in total federal CSRs, an amount that is expected to increase to \$146 million in 2018 due to enrollment and utilization projections.</li> </ul>
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<sup>12</sup> 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>.

<sup>13</sup> 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/>

<sup>14</sup> Letter from the Massachusetts Association of Health Plans to Governor Charlie Baker (May 24, 2017), available on file.

<sup>15</sup> Senate Bill 2076 (May 25, 2017), available at: <https://malegislature.gov/Budget/FY2018/SenateBudget>.



	<ul style="list-style-type: none"> <li>Based on current and projected enrollment, some issuers could face tens of millions of dollars in risk if CSRs are eliminated, accruing liability at a rate of approximately \$11 million per month during any market transition to new rates.</li> <li>Issuers with low risk-based capitals measures could potentially face solvency challenges. The Division of Insurance is actively monitoring all of the issuers' financial conditions, given market instability to date and the fact that one issuer, one of the few remaining ACA CO-OPs in the country, recently announced it will stop writing business as of January 1, 2018.<sup>16</sup></li> </ul>
Enrollee Impact if MA Does Not Permits Mid-Year Revision of Rates	<ul style="list-style-type: none"> <li>Over 155,000 low-income ConnectorCare enrollees receiving federal CSRs would have their coverage directly disrupted if CSRs are eliminated and issuers withdraw coverage.</li> <li>In addition, because of the integrated 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 could be impacted if CSRs are eliminated and issuers withdraw coverage.</li> </ul>
Impacts if MA Permits Mid-year Revision of Rates	<ul style="list-style-type: none"> <li>State agencies and issuers would face grave operational risks and costs as they transition coverage as quickly as possible to reflect the new rates and corresponding enrollment changes. Such a significant shift in enrollment would severely tax Exchange technology and operational systems.</li> <li>Hundreds of thousands of Massachusetts residents would face unexpected rate increases. Because Massachusetts has a merged insurance market, rate increases could potentially impact over 550,000 persons covered through small businesses<sup>17</sup> as well as nongroup enrollees, depending on the structure of the increase.</li> <li>Unsubsidized enrollees would face the full impact of the rate spike unless they transition to new coverage.</li> <li>Low-income residents in rural or remote regions of the state could be left without coverage if issuers withdraw.</li> </ul>

In light of the untenable risk to the Massachusetts insurance market that stems from CSR uncertainty, the Commonwealth has determined that requiring the use of rates submitted in July 2017 is not feasible. In addition, the Commonwealth has determined that rerating in the middle of 2018 in the event that CSR payments are not made would cause unacceptable operational and consumer disruption. As a result, the Commonwealth will permit issuers to revise their rate filings to account for the risk of CSR withdrawal prior to the start of the plan year. Absent an alternative, the Commonwealth expects to issue guidance to issuers instructing them of the supplemental rating approach on or about September

<sup>16</sup> Minuteman Health Inc. press release, "Minuteman Health, Inc. Management seeks to organize a new insurance company to begin writing business as of January 1, 2018; Minuteman Health, Inc. will stop writing business as of January 1" (June 23, 2017), available at: <https://www.minutemanhealth.org/about-us/Minuteman%20Health%20Newsroom/2017/20170623>.

<sup>17</sup> Center for Health Information and Analysis, "Enrollment Trends Databook" (March 2017), available at: <http://www.chiamass.gov/enrollment-in-health-insurance/>.

15, 2017. While this is not a preferred pathway—Massachusetts would greatly prefer for the issue to be resolved in a comprehensive, national fashion by federal partners— the prospect of ongoing uncertainty leaves the Commonwealth with no other reasonable choice absent a waiver.

## 4.0 Proposed Waiver

Facing the prospect that Massachusetts' once-thriving health insurance market could deteriorate further, Massachusetts seeks to waive ACA requirements associated with CSR payment, 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 resulting from these premium reductions could then be shared back with the state to fund the PSF via a pass-through, which in turn would support ongoing stability for issuers and enrollees.

### 4.1 Rationale for Waiver

Given the risk of CSR payment termination and in keeping with the approaches of many other states, the Massachusetts DOI will announce via a regulatory bulletin on or about September 15, 2017 that it is permitting ConnectorCare-participating issuers to revise the nongroup premium rates submitted for the silver tier Qualified Health Plans (QHPs) for Plan Year 2018 to reflect no CSR payments being made.

Under this approach, DOI anticipates that carriers will file to increase premium rates by an average of about 18% for these products as a result (in addition to any underlying rate changes for other reasons). This market-wide estimate draws from the analysis of Commonwealth actuaries based on 2016 actual blended total CSR reconciliation<sup>18</sup> and data collected in a special DOI data examination. This estimate is in line with national estimates of about 19 percent increase on average due to CSR payment uncertainty.<sup>19</sup>

While subsidized enrollees receiving coverage through the Health Connector will be insulated from the impacts of revised premium rates, the Commonwealth is concerned by three negative consequences of the rate revision:

- Unsubsidized member confusion

Unsubsidized enrollees in the nongroup market would face the full impact of the rate increase. While the Health Connector, DOI, and issuers can mitigate this impact by helping enrollees to transition to unaffected plans, this transition will cause enrollee disruption.

- Increased federal liability

There is analytical consensus that the federal government would face significant new liability for premium-based subsidies under the revised rate approach because these subsidies are designed to grow

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<sup>18</sup> Health Connector analysis of 2016 actual blended total CSR reconciliation, at 14.4% of actual premiums.

<sup>19</sup> 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, 2017), 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/>.

in proportion to premium growth.<sup>20</sup> Without the waiver, the upcoming revision to rates would impact the selection of the “applicable second lowest cost silver plan” available to enrollees, which, under Section 36B (b)(3)(B) of the Internal Revenue Code, sets the benchmark amount of APTC/PTC available to Exchange enrollees. To the extent that a revision of premium rates will result in an applicable second lowest cost silver plan which has higher premiums, the amount of federal liability for APTC/PTC will grow proportionally. With an estimated total 220,500 affected enrollees projected for 2018, this would increase federal APTC/PTC liability for subsidized enrollees by an estimated \$143M.

- Increased state liability

Specific to Massachusetts, the rate revision will also result in additional costs to the Commonwealth because the ConnectorCare program is designed to wrap any available APTC/PTC and CSR funding with state premium and cost-sharing subsidies to meet the state affordability schedule, which is linked to a state individual mandate. The affordability schedule is set in advance each year by the Health Connector Board of Directors, and has already been finalized for the 2018 plan year. As a result, the Health Connector must ensure that ConnectorCare enrollees receive access to a plan that corresponds to the affordability schedule for their income band and household structure. If the revision of premium rates takes effect, the state expects to incur an estimated \$11M in additional spending to ensure enrollees are held harmless for the portion of the premium increases that would not be absorbed by APTC/PTC increases. For example, if the premium for a particular enrollee is currently (without the re-rate) between the state expected contribution and the federal expected contribution, a premium increase could trigger an increase in the state premium wrap. Approximately 46% of these additional state costs for ConnectorCare would be eligible for federal matching under the state’s Medicaid 1115 waiver, so the federal government would also incur additional liability stemming from the ConnectorCare subsidy wrap.

Massachusetts seeks to avoid these harmful consequences through its waiver proposal, which would eliminate the market uncertainty stemming from CSRs while avoiding the enrollee disruption and the increased federal and state costs associated with a rate revision.

## 4.2 Provisions State Seeks to Waive

Under the proposed waiver, the Commonwealth seeks to remove the primary element that is causing destabilization in its insurance market: uncertainty about whether CSRs will continue to be available. Massachusetts seeks to waive any potential CSR payments for 2018 and potentially beyond, replacing them with a state-administered program that would make equivalent payments and thereby allow premiums to hold steady.

Specifically, the Commonwealth seeks to waive CSR payments under 42 USC § 18071(c)(3)(a), which requires that “[a]n 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

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<sup>20</sup> 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](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](https://aspe.hhs.gov/system/files/pdf/156571/ASPE_IB_CSRS.pdf).

issuer equal to the value of reductions.” The Commonwealth does not seek to waive other provisions related to CSR, such as the requirement for issuers to provide enriched plan designs.

### 4.3 Description of Proposed Waiver

Without flexibility from the Departments in the form of a waiver, the Commonwealth will permit issuers to file supplementary rates that include a load for CSR contingencies. This will increase federal APTC/PTC liability, as well as federal Medicaid waiver liability for the state “wrap”, and cause unsubsidized enrollee disruption and churn. The proposed waiver program will avoid this outcome as follows, and detailed in *Figure 5* below:

- CSR payments to Massachusetts issuers will be waived. This represents an estimated \$146M dollars saving in 2018 to the federal government if CSRs are paid for the entirety of 2018.
- The Commonwealth will create a Premium Stabilization Fund (PSF) to make payments to issuers equivalent to those that would be made under federal CSR program (an estimated \$146M). The Commonwealth will use its existing Commonwealth Care Trust Fund (CCTF) to make these payments directly to issuers participating in the Health Connector on a pro rata basis based on membership. Issuers will be required by contract with the Health Connector to reinvest these funds into enrollee coverage.
- The DOI will issue regulatory guidance, requiring issuers to maintain their 2018 premiums at July levels (as adjusted under rate review), saving the federal government an estimated \$148M (\$143M in APTC/PTC savings and \$5M in ConnectorCare matching payments under the Medicaid 1115 waiver). The DOI will require issuers to maintain product offerings with the same enrollee cost-sharing.
- The Commonwealth will receive pass-through funding reflecting APTC/PTC savings due to reduced premiums (\$143M) and the waiver of CSR payments (\$146M, if such payments are made for all of 2018), but capped at the amount needed to make CSR-equivalent payments (\$146M). Thus the pass-through funding will range between \$143M (if CSR payments are not made for any of 2018) and \$146M (if payments are made for all of 2018). The pass-through funding will be directed to the PSF, to be used solely for the distribution of funds to issuers to account for the costs of enrollee coverage through ConnectorCare. The Health Connector will issue guidance to issuers specifying how funds will be distributed. Enrollees will continue to receive coverage at the same CSR-enriched and state wrap-enriched level.
- Any excess pass-through funding beyond what is needed for the state PSF (such as waived CSR payments if CSR payments otherwise continue) will remain with the federal government. This will save the federal government about \$143M if CSR payments are in fact made, avoiding the risk of effectively double-paying that would occur without the waiver.
- Massachusetts requests an annual reconciliation as part of its annual renewal option to account for differences in projected versus actual enrollment and costs.

Because the PSF will ensure that carriers are compensated for providing CSR-enriched coverage to eligible enrollees, the Commonwealth will no longer need to permit carriers to increase their rates to account for this uncertainty. This will prevent the federal government from incurring additional APTC/PTC liability concurrent with the rate revision. Massachusetts requests authority to receive the

resulting savings in federal APTC/PTC liability as “pass-through” funding under 42 USC § 18052(a)(3), which would be used to further stabilize the insurance market and reduce costs for enrollees.<sup>21</sup>

Massachusetts seeks these changes effective for Plan Year 2018, starting January 1, 2018, for an initial period of at least one year. Massachusetts requests the opportunity to renew at its option for an additional four year period, to complete the full five year waiver period permitted under Section 1332.

Under the waiver, 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 PSF funds expected to account for no more than the cost of APTC/PTCs attributable to market uncertainty.

**Figure 5. Estimated Federal Liability for Plan Year 2018 Under the Baseline and the Waiver**

Federal Spending for Massachusetts <sup>22</sup>	Baseline Without Waiver: Use Sept. Rerate for Silver QHPs	With Waiver: Use July Initial Rates for Silver QHPs	Change in Federal Expenditures under Waiver	Proposed Pass-through Funding and Remaining Federal Savings Under Waiver
Plan Year 2018 Total				
Federal APTC/PTC Spending	\$632M	\$490M	(\$143M)	\$143M pass-through requested.
Federal CSR Spending	<i>Between \$0 and \$146M, based on if CSRs are paid</i>	\$0 M	<i>(Between \$0 and -\$146M, based on if CSRs are paid)</i>	If CSRs paid: \$3M in pass-through requested; \$143M in federal savings.
Federal share of “match” for ConnectorCare state funds (1115 authority) <sup>23</sup>	\$159M	\$154M	(\$5 M)	If CSRs paid: \$5M in federal savings.
<b>Total</b>	<b>\$791 - \$937 M</b>	<b>\$643 M</b>	<b>(\$148 M - \$294 M)</b>	<b>If CSRs paid: \$146M in pass-through requested; \$148M in federal savings. If CSRs not paid,</b>

<sup>21</sup> See Departments of the Treasury and Health and Human Services, “Waivers for State Innovation,” 80 FR 78131 (Dec. 16, 2015), available at: <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>.

<sup>22</sup> Projected costs use preliminary rate information available as of August 2017, without incorporating some information such as possible changes to the federal risk adjustment methodology. Massachusetts requests an opportunity to amend these estimates once rate information prior to submission of the 1332 waiver and/or when rates are finalized by the DOI.

<sup>23</sup> Estimates reflect that ConnectorCare enrollees’ contributions would be identical under all scenarios, based on its more generous affordability schedule (which is linked to the state’s individual mandate). The ConnectorCare wrap would incur an estimated \$11M in additional spending in 2018 without the waiver to account for the portion of the premium increases that would not be absorbed by APTC/PTC increases. These federal costs would not occur under the waiver. See Deficit Neutrality discussion for details.

				<b>\$143M in pass-through requested; \$5M in federal savings.</b>
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#### 4.4 Statutory Authority for Waiver

Ch. 119, Sec. 20 of the Acts of 2015 provides authority for the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.<sup>24</sup> 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.”

#### 4.5 Waiver Implementation Plan

The proposed waiver would not require extensive additional planning or resources, beyond current insurance market activities. While some planning would be required to implement the PSF, the Commonwealth expects this could be managed within existing resources, infrastructure, and statutory authority.

The responsibility to implement the proposed waiver would reside primarily with the DOI and the Health Connector, with support from the Baker-Polito Administration more broadly. The Commonwealth also expects waiver implementation support from market stakeholders that have indicated their support for the proposal, such as Health Connector participating insurance issuers.

- Regulatory Oversight from the Division of Insurance

The DOI administers the laws of the Commonwealth as they pertain to the protection of the insurance consumer through the regulation of the insurance industry. The DOI monitors financial solvency, licenses insurance companies and producers, reviews and approves rates and forms, and coordinates the takeover and liquidation of insolvent insurance companies and the rehabilitation of financially-troubled insurance issuers. The DOI also investigates and enforces state insurance laws and regulations, responds to consumer inquiries and complaints, and provides members of the public with information regarding various types of insurance.

Under the proposed waiver, DOI would continue its current role as the primary regulatory entity for the merged market, including supervision of issuers’ rating and enrollment practices. By state law, DOI has authority to review and approve nongroup and small group rates for health insurance products offered by insurance issuers, health maintenance organizations, non-profit hospital service corporations, and medical service corporations.<sup>25</sup>

<sup>24</sup> Ch. 119, Sec. 20 of the Acts of 2015. Retrieved from <https://malegislature.gov/Laws/SessionLaws/Acts/2015/Chapter119>.

<sup>25</sup> In the Commonwealth of Massachusetts, insurance companies are licensed and regulated by the Division of Insurance under M.G.L. ch. 175. Health maintenance organizations (HMOs) are licensed and regulated under M.G.L. ch. 176G and regulation 211

Given this general regulatory authority, DOI could act to supply regulatory guidance to issuers to support the waiver or otherwise enforce the waiver as needed.

- Implementation Support from the Health Connector

The Health Connector is an independent quasi-governmental authority that has helped residents and small employers compare and enroll in high-quality, affordable health plans since its inception in 2006.<sup>26</sup> In 2014, the Health Connector began serving as a designated state-based marketplace under the Affordable Care Act, refining its offerings to meet new federal requirements.

In addition to serving as a source of coverage, the Health Connector also serves as a policymaker and regulator regarding elements of state health reform, including the design of ConnectorCare via a Seal of Approval procurement/certification process and the state’s individual mandate and associated affordability schedule. Using this existing authority, the Health Connector could ensure that enrollees are held harmless under the waiver proposal, by requiring participating issuers to continue to offer plans that meet CSR-enriched levels via its Seal of Approval program and ConnectorCare subsidy design.

The Health Connector is the statutory recipient of dedicated revenue streams available under the Commonwealth Care Trust Fund (CCTF).<sup>27</sup> The Health Connector has statutory authority to seek and receive grant funding from the federal government.<sup>28</sup> The Health Connector could leverage this existing authority to support implementation of the PSF. Because the CCTF is used to reimburse issuers on a monthly and annual basis for state-based subsidies already, the Commonwealth could use the fund to distribute the PSF in an equitable fashion to account for each issuers’ premium stabilization needs.

- Implementation Timeline

The Commonwealth proposes the following implementation timeline for the waiver, subject to further refinement:

Implementation Activity	Timing	Entity	Specific Activity
Issue regulatory guidance for rerate	On or about Sept. 15, 2017	DOI	Release regulatory bulletin, instructing issuers that rating revisions will be permitted
Determine whether to implement revised rates	Prior to Oct. 15, 2017	DOI and CCA	Depending on whether the waiver has been approved or is imminently likely to be approved, implement revised rates.
<i>(Assumes waiver approval by October 15, 2017)</i>			
Notify public of waiver approval	October 2017	DOI	Release regulatory bulletin, instructing issuers that rating revisions will not be permitted

C.M.R. 43.00. Non-profit hospital service corporations (Blue Cross) and medical service corporations (Blue Shield) are organized and regulated under M.G.L. ch. 176A and M.G.L. ch. 176B respectively.

<sup>26</sup> M.G.L. ch. 176Q, §2(a), §2(b) and §2(c), available at: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176Q/Section2>.

<sup>27</sup> M.G.L. ch. 29, § 2000 *et. seq.*, available at <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleIII/Chapter29/Section2000>.

<sup>28</sup> M.G.L. ch. 176Q, §3(c), available at: <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176Q/Section3>.

		Health Connector	Release waiver approval document and other information describing the waiver via Section 1332 webpage and stakeholder distribution list
			Provide update to Board of Directors and stakeholders groups (e.g., Issuer Workgroup, Consumer Advisory Council, Employer Advisory Council, Broker Advisory Council)
Prepare for implementation of Premium Stabilization Fund	November – December 2017	Health Connector	With the support of the DOI and the state Executive Office of Administration and Finance, convene issuers to adjust mechanics of the Commonwealth Care Trust Fund funding receipt and expenditure mechanisms to facilitate the Premium Stabilization Fund. Issue implementation guidance as appropriate.
<i>(Waiver period begins January 1, 2018)</i>			
Premium Stabilization Fund Begins	January 2018 (and ongoing monthly)	Health Connector	Issuers begin to receive monthly payments from the Premium Stabilization Fund. Issuers do not receive federal CSRs.
Post-award public forum	Summer 2018	DOI and Health Connector	Hold public forum to solicit comments on the progress of the waiver (publishing the date, time, and location on the DOI and/or Health Connector websites, 30 days in advance)
Monitor market trends and seek ongoing public feedback	Annually	DOI and Health Connector	Following public release of premium rates each year, hold public forum to solicit comments on the progress of the waiver (publishing the date, time, and location on the DOI and/or Health Connector websites, 30 days in advance)
Determine whether to seek waiver renewal	Annually	DOI and Health Connector	Hold public forum to solicit comments

## 5.0 Public Waiver Development Process

The Commonwealth began first exploration of a possible Section 1332 waiver in fall 2015 at the direction of Governor Charlie Baker and the Massachusetts General Court.<sup>29</sup> The Health Connector was asked to lead a collaborative interagency effort to engage the public about potential opportunities available under Section 1332.

From October through December 2015, the Health Connector launched a series of public meetings to discuss possibilities under Section 1332. The Health Connector convened seven public meetings in the

<sup>29</sup> Ch. 119, Sec. 20 of the Acts of 2015, available at: <https://malegislature.gov/Laws/SessionLaws/Acts/2015/Chapter119>.



initial stakeholder series. The Health Connector included partners in the executive and legislative branches of the Commonwealth in the public meetings, including representatives from:

- The Office of the Governor;
- The Office of the Attorney General;
- General Court committees, including the Joint Committee on Health Care Financing and other committees related to health insurance;
- The Health Connector’s governing Board of Directors;
- The Executive Office of Housing and Economic Development and its Division of Insurance;
- The Executive Office for Administration and Finance;
- The Executive Office of Health and Human Services and its MassHealth Division;
- The Center for Health Information and Analysis;
- The Group Insurance Commission; and
- The Health Policy Commission.

Stakeholders attending the initial stakeholder meeting series included representatives from:

Stakeholders	
Consumer representatives	<ul style="list-style-type: none"> <li>• Community Catalyst</li> <li>• Health Care For All</li> <li>• Health Law Advocates</li> <li>• Massachusetts Law Reform Institute</li> </ul>
Health plan issuers	<ul style="list-style-type: none"> <li>• Blue Cross and Blue Shield of Massachusetts, Inc.</li> <li>• Boston Medical Center Health Plan, Inc.</li> <li>• CultiCare Health Plan of Massachusetts, Inc.</li> <li>• Dental Service of Massachusetts, Inc. (d/b/a Delta Dental of Massachusetts)</li> <li>• Fallon Community Health Plan, Inc.</li> <li>• Harvard Pilgrim Health Care, Inc.</li> <li>• The Guardian Life Insurance Company of America</li> <li>• Health New England, Inc.</li> <li>• Massachusetts Association of Health Plans</li> <li>• Metropolitan Life Insurance Company</li> <li>• Minuteman Health Plan of Massachusetts, Inc.</li> <li>• Neighborhood Health Plan, Inc.</li> <li>• Tufts Associated Health Maintenance Organization, Inc. (d/b/a Tufts Health Plan)</li> <li>• UnitedHealthcare Insurance Company</li> </ul>
Provider entities	<ul style="list-style-type: none"> <li>• Massachusetts Hospital Association</li> <li>• Massachusetts Council of Community Hospitals</li> <li>• Massachusetts League of Community Health Centers</li> <li>• Partners Health Care</li> <li>• Steward Health Care</li> </ul>
Business entities	<ul style="list-style-type: none"> <li>• Associated Industries of Massachusetts</li> <li>• Boston Chamber of Commerce</li> <li>• Massachusetts Business Roundtable</li> <li>• Massachusetts Food Association</li> </ul>

	<ul style="list-style-type: none"> <li>• Massachusetts Municipal Association</li> <li>• Massachusetts Retailers Association</li> </ul>
Agents & Brokers	<ul style="list-style-type: none"> <li>• Borislow Insurance</li> </ul>
Labor representatives	<ul style="list-style-type: none"> <li>• Massachusetts Coalition of Taft-Hartley Trust Funds</li> <li>• SEIU 1199 United Health Care Workers East</li> </ul>
Other	<ul style="list-style-type: none"> <li>• Blue Cross Blue Shield Foundation of Massachusetts</li> <li>• Massachusetts Budget and Policy Center</li> </ul>

While these stakeholder meetings yielded a number of fruitful ideas about the potential future of health reform in Massachusetts, stakeholders also expressed an overriding interest in market stability. As a result, the Health Connector decided not to pursue a full Section 1332 request at the time, and instead focused on more targeted flexibility requests related to maintaining its quasi-merged market status.

In May 2017, a similar set of stakeholders began to express concerns about the potential impact of CSR nonpayment on the stability of the Massachusetts market. Health insurance issuers wrote to the Baker-Polito Administration expressing grave concerns about the issue,<sup>30</sup> and the state Senate passed initial budget language directing the DOI and Health Connector to develop a contingency plan to address the risk.<sup>31</sup> Given these concerns, the Health Connector and/or DOI convened a number of stakeholder meetings at which the CSR issue was discussed, including:

Audience	Meeting Details
Health Connector Issuers	Thursday, June 1, 2017; Boston location and phone
Health Connector Issuers	Thursday, June 8, 2017; Boston location and phone
Health Connector Issuers	Thursday, June 22, 2017; Boston location and phone
Health Connector Issuers	Thursday, June 29, 2017; Boston location and phone
Health Connector Issuers	Thursday, July 6, 2017; Boston location and phone
Health Connector Board of Directors	Thursday, July 13, 2017; Boston location and phone
Health Connector Issuers	Thursday, July 20, 2017; Boston location and phone
Health Connector Consumer Advisory Council	Wednesday, July 26, 2017; Boston location and phone
Health Connector Employer Advisory Council	Wednesday, July 26, 2017; Boston location and phone
Health Connector Broker Advisory Council	Thursday, July 27, 2017; Boston location and phone
Health Connector Issuers	Thursday, August 3, 2017; Boston location and phone
Health Connector Issuers	Thursday, August 10, 2017; Boston location and phone
Health Connector Issuers	Thursday, August 31, 2017; Boston location and phone

Through these meetings, the Commonwealth developed its proposed waiver approach with the input of relevant stakeholders. At the conclusion of this preliminary stakeholder input period, on July 24, 2017,

<sup>30</sup> Letter from the Massachusetts Association of Health Plans to Governor Charlie Baker (May 24, 2017), available on file.

<sup>31</sup> Senate Bill 2076 (May 25, 2017), available at: <https://malegislature.gov/Budget/FY2018/SenateBudget>.

the Health Connector announced its intention to apply for a Section 1332 waiver, and made a description of the proposal available for public comment. The notice provided a summary description, a web link to access a description of the draft application and instructions to obtain paper copies, information about the public comment period and process, information about public hearings, and information about how to request language or disability accommodations. The notice was disseminated through the Health Connector’s dedicated distribution list and publicly available website. The application description was made available through the Health Connector’s distribution list and publicly available website for a public comment period of at least 30 days, from July 24, 2017 through August 25, 2017, and additional detail was posted as available. The Health Connector also held two public hearings during this time, held in a coordinated fashion with its sister agency MassHealth on a variety of policy topics (some not related to this waiver proposal) to encourage greater public participation:

Audience	Meeting Details
Public Hearing	Friday, August 4, 2017; Boston location and phone
Public Hearing	Wednesday, August 16, 2017; Chicopee (Western Massachusetts) location and phone

These meetings were announced publicly, via a dedicated e-mail distribution list and a dedicated webpage on the Health Connector’s website: <https://betterhealthconnector.com/about/policy-center/state-innovation-waiver>. The public was notified of the opportunity for language or disability accommodations for each meeting, and the dedicated webpage offers language and disability assistance options and meets applicable “Section 508” standards. The Health Connector encouraged public comment at each meeting, and kept a record of comments. Throughout the course of the public comment period, the Health Connector also accepted written public comment regarding possible Section 1332 waiver content.

While most comments were related to policy content not included in the scope of this waiver, the Health Connector received four oral comments and six written comments related to this request. The Health Connector has incorporated these comments into this application. *See Figure 6 and Appendix D.* Other comments not germane to this specific waiver request are appreciated and will be incorporated into other policy proposals separate from this application.

**Figure 6. Summary of Public Comments Received Related to Waiver Proposal**

Commenter	Summary of Comments	Comment Method	Comment Response
Health Care For All, Health Law Advocates, Massachusetts Law Reform Institute (Consumer representatives)	Supports goal of proposal. Requests inclusion of written assurances in the waiver application that enrollees will be held harmless from cost-sharing changes if CSRs are waived. Requests inclusion of written assurances in the waiver application that PSF funding will be used only to reimburse issuers for the costs of coverage for	Oral comment (HCFA only), written comment (jointly)	Application has been updated to provide requested detail.

	ConnectorCare enrollees. Requests opportunity to adjust PSF amount available under waiver based on actual enrollment.		
American Cancer Society of MA (Consumer representative)	Supports goal of proposal. Supportive of reinsurance-like model. Requests inclusion of written assurances in the waiver application that enrollees will be held harmless from cost-sharing changes if CSRs are waived. Requests inclusion of written assurances in the waiver application that PSF funding will be used only to reimburse issuers for the costs of coverage for ConnectorCare enrollees. Requests greater detail on PSF mechanics and timing.	Written comment	Application has been updated to provide requested detail.
MA Health & Hospital Association (Provider representative)	Supports goal of proposal. Requests inclusion of written assurances in the waiver application that PSF funding will be used only to reimburse issuers for the costs of coverage for ConnectorCare enrollees.	Written comment	Application has been updated to provide requested detail.
Blue Cross Blue Shield of MA (Issuer)	Supports goal of proposal.	Oral comment, written comment	Noted.
MA Association of Health Plans (Issuer representative)	Supports goal of proposal. Requests inclusion of written assurances in the waiver application that PSF funding will be used only to reimburse issuers for the costs of coverage for ConnectorCare enrollees. Requests withdrawal of application if there is federal certainty that CSRs will continue to be paid. Requests application only go into effect if CSRs are actually withdrawn.	Oral comment, written comment	Application has been updated to provide requested detail, with the exception of the suggestion that the waiver be contingent upon actual withdrawal of CSRs. The Commonwealth does not believe this timing would be operationally feasible.
Retailers Association of MA (Business representative)	Supports goal of proposal. If it is not successful, consider de-merging the market to protect small businesses from CSR uncertainty.	Oral comment (written comment on other topics)	Noted.

Associated Industries of MA (Business representative)	Supports goal of proposal.	Written comment	Noted.
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In addition to the general public process, the Health Connector engaged in a separate consultation with the sovereign federally-recognized tribes within Massachusetts borders. Together with MassHealth, the Health Connector engaged members of the agencies’ joint Tribal Workgroup through a separate outreach effort, including a tribal consultation meeting on Wednesday, August 9, 2017. Tribal members did not express any comments or concerns regarding the proposed waiver.

## 5.0 Estimated Waiver Impact

### 5.1 Affected Population

The Commonwealth expects that the proposed waiver will primarily impact individuals enrolled in non-group silver Qualified Health Plans offered by ConnectorCare participating issuers through the Health Connector, to the extent that this population would be affected by the premium rate revision if the waiver is not granted.

Under the parameters of the rate revision that will go into effect absent the waiver, the DOI will allow ConnectorCare issuers to submit revised rates for these products only, and only with respect to nongroup coverage. The proposed rerate is not expected to impact other products available to nongroup or small group enrollees. As a result, the waiver analysis focuses primarily on the impact to this population under a baseline and waiver scenario. *See Figure 7 for details.*

**Figure 7. Demographic Information of Population Affected by Waiver (as of July 2017)**

Health Connector Enrollment in Silver Tier Qualified Health Plans	
Enrollment Type	Number of Enrollees
Subsidized Nongroup, Enrolled Through Health Connector	196,195
Unsubsidized Nongroup, Enrolled through Health Connector	33,898
<b>Total</b>	<b>230,813</b>

Health Connector Silver Tier Enrollment by Gender			
Enrollment Type	Female	Male	Total
Subsidized Nongroup	109,955	89,690	196,915
Unsubsidized Nongroup	16,791	17,107	33,898
<b>Total</b>	<b>126,746</b>	<b>104,067</b>	<b>230,813</b>

Health Connector Silver Tier Enrollment by Age (In Years)							
Enrollment Type	0-9	10-19	20-26	27-44	45-64	65+	Total
Subsidized Nongroup	1,056	2,464	23,447	78,030	89,420	2,498	196,915
Unsubsidized Nongroup	2,014	2,667	2,658	12,347	13,734	478	33,898
<b>Total</b>	<b>3,070</b>	<b>5,131</b>	<b>26,105</b>	<b>90,377</b>	<b>103,154</b>	<b>2,976</b>	<b>230,813</b>

Health Connector Silver Tier Enrollment by FPL						
Enrollment Type	0-100%	100.01-200%	200.01-300%	300.01-400%	Above 400%	Total
Subsidized Nongroup	5,355	95,011	79,039	7,377	138	196,920
Unsubsidized Nongroup	14,772	1,435	1,699	6,666	9,327	33,899
<b>Total</b>	30,127	96,446	80,738	14,043	9,465	230,819

Source: Health Connector July 1, 2017 Reporting Data (FMS). The Health Connector does not have data on race, ethnicity, and language data with sufficient granularity and accuracy so as to be reliable for this purpose.

The Commonwealth does not expect the proposed waiver to impact large group (employers with over 50 employees) coverage. Since the Massachusetts DOI regulates the merged market under a different set of laws and procedures, the Commonwealth would not expect any aspect of the proposed waiver to impact the large group market.

Similarly, the Commonwealth does not expect the proposed waiver to appreciably impact public coverage, such as Medicaid and the Children’s Health Insurance Program. The Commonwealth does not anticipate any specific impact to coverage as a result of the proposed waiver for those enrolled in these programs.

## 5.2 Comprehensiveness of Coverage

The Commonwealth expects that the proposed waiver would have no impact on the comprehensiveness of coverage otherwise available to its residents under the Affordable Care Act. Under the proposed waiver, all enrollees in the merged market would continue to be guaranteed the Essential Health Benefits and applicable state-required benefits. *See Appendix C for additional details.*

## 5.3 Affordability of Coverage

The waiver will not increase the costs of health coverage for Massachusetts residents. As detailed in *Appendix C*, actuarial modeling shows that under the PSF proposal, premiums are expected to be about 18% lower under the waiver scenario for the affected population, and cost-sharing will remain the same for all populations under both the waiver and baseline scenarios because the Health Connector will continue to require compliance with existing actuarial value and plan design requirements. More specifically:

- Under either scenario, individuals who are eligible for APTC/PTC will see little change in premium affordability due to the fact that this federal subsidy increases proportionally as premium increases.
- However, the waiver will have an important impact on individuals with incomes above 400% FPL, who currently pay all premiums without any federal APTC/PTC and will experience premium reductions under the waiver.
- Actuarial modeling shows there may be a subset of the population in the 300-400% FPL range that will potentially experience higher premiums under the waiver because they would receive additional APTC/PTC under the baseline scenario while having access to plans that will not increase premiums. However, the impact on this population is relatively small, and the federal limits of affordability remain in place under the waiver. Under the ACA, the amount consumers are expected to

contribute to healthcare costs is limited to a percentage of their income. Massachusetts residents with incomes between 300-400% FPL would continue to be eligible for APTC/PTCs based on the second-lowest cost silver plan, and if they purchased a silver plan, they would pay premiums that the federal government deems affordable.

In addition to this overall consideration of affordability, the Commonwealth has considered potential impacts to affordability under the waiver for vulnerable populations, such as low-income populations, elderly populations, and those with serious health issues. Massachusetts also considered its proposal carefully to evaluate any potential impact to tribal populations, given the fact that certain American Indians and Alaska Natives are eligible for reduced cost-sharing under the ACA. As indicated above, Massachusetts does not expect any changes to premiums or cost-sharing for these populations because existing federal and state affordability and plan richness standards would continue to apply.

## 5.4 Scope of Coverage

As detailed in *Appendix C*, the waiver will not reduce the number of Massachusetts residents covered or the number of Massachusetts employers offering coverage. Rather, the waiver will maintain an equivalent number of covered individuals by ensuring the same level of subsidization to eligible enrollees via the Premium Stabilization Fund and state subsidy program. Though fewer unsubsidized enrollees and groups will “churn” under the waiver because it will prevent market disruption, Massachusetts expects to maintain an equivalent number of covered individuals under the waiver overall because the long-standing state individual mandate and availability of non-affected health plans will ensure coverage retention regardless of the outcome of the waiver.

## 5.5 Economic Analysis and Deficit Neutrality Over Waiver and Budget Period

Based on the findings of its actuarial analysis, which indicate premium savings but no changes to other variables such as insurance coverage take-up or enrollee movement to other markets such as Medicaid, the Commonwealth does not anticipate any increase in the federal deficit as a result of the proposed waiver, either over the waiver period or the ten-year budget period.

Since the waiver will not influence the number of individuals with employer or government-sponsored insurance or costs in those markets, there is not expected to be any impact on related costs and revenues, such as excise taxes on high cost employer-sponsored plans, small business tax credits, employer shared responsibility payments, tax exclusions related to employer-sponsored insurance, or changes in Medicaid spending (other than Medicaid spending directly related to the Exchange population, as described below). As a result, the Commonwealth’s economic analysis focuses on the possible deficit impacts related to the affected population of Health Connector enrollees under the waiver.

As detailed below, there are at least four primary ways the waiver could potentially impact the federal deficit, summarized in *Figure 8*. Massachusetts’ proposal will not require additional spending from the federal government. While it is possible the waiver may have a small impact on federal revenue collection via secondary effects, this will be vastly outweighed by other federal saving resulting from decreased APTC/PTC, CSR, and Medicaid 1115 waiver expenditures, resulting in an overall favorable deficit trajectory under the waiver. As such, as long as the pass-through funding is less than or equal to these figures, the proposed waiver will meet the deficit neutrality requirement.

**Figure 8. Overall Impact of Proposed Waiver on Deficit**

Federal Deficit Factor	Direction of Effect
APTC/PTC Savings	+
CSR Savings	+
Medicaid 1115 Savings	+
Individual Shared Responsibility Payments	N/A
<b>Overall Impact on Deficit</b>	<b>+</b>

Calendar Year	Total Estimated Savings (APTC/PTC, CSR, and 1115, Prior to Any Reduction for Health Insurance Providers Fee or Pass-through to State, in Millions)
2018	(\$294)
2019	(\$327)
2020	(\$364)
2021	(\$405)
2022	(\$451)
2023	(\$501)
2024	(\$558)
2025	(\$621)
2026	(\$692)
2027	(\$770)
2028	(\$857)
<b>Total</b>	<b>(\$5,840)</b>

- APTC/PTC, CSR Spending, and Medicaid 1115 Spending

Massachusetts’ waiver will not increase federal spending on the three sources of federal subsidies available to enrollees in the nongroup market: APTC/PTC payments, CSR payments, or Medicaid 1115 waiver federal financial participation. Rather, in each of these categories, the waiver is designed to generate savings to the federal government that can be passed-through to the state in a fashion that is always deficit neutral.

As described in the actuarial memorandum in *Appendix C*, the reduction in premium made possible by the waiver will also reduce the amount of APTC/PTC owed to Massachusetts under the waiver every year starting in 2018. Over the span of the waiver and a ten year budget period, this could generate pre-pass-through savings of approximately \$2.85 B cumulatively. The source of the savings is two-fold, stemming from both an increasing gap in premiums between the baseline and waiver scenarios, and an increasing number of APTC/PTC eligible individuals. *See Figure 9.*



**Figure 9. Estimated Federal Savings due to APTC/PTC Spending Reductions Over 10-Year Period**

CY	Projected Membership of APTC/PTC-Eligibles (in Thousands)			APTC/PTC (Annual Total, in Millions)		
	Baseline	Waiver	Difference	Baseline	Waiver	Difference Before Pass-through (Federal Savings)
2018	221	221	0	\$632	\$489	(\$143)
2019	227	227	0	\$727	\$567	(\$159)
2020	234	234	0	\$833	\$656	(\$177)
2021	241	241	0	\$952	\$755	(\$198)
2022	248	248	0	\$1,086	\$866	(\$220)
2023	256	256	0	\$1,236	\$991	(\$245)
2024	263	263	0	\$1,404	\$1,131	(\$273)
2025	271	271	0	\$1,591	\$1,287	(\$304)
2026	279	279	0	\$1,802	\$1,463	(\$339)
2027	288	288	0	\$2,037	\$1,660	(\$377)
2028	296	296	0	\$2,299	\$1,880	(\$420)
<b>Potential Total Savings Under Waiver</b>						<b>(\$2,854)</b>

Moreover, under the waiver, Massachusetts will forgo its CSR payment allotment, eliminating that element of federal spending. Over the span of the waiver and a ten year budget period, this could generate pre-pass through federal savings of approximately \$2.9 B cumulatively if CSRs continue to be paid. See Figure 10.

**Figure 10. Estimated Federal Savings due to Foregone CSR Payments over 10-Year Period**

CY	Projected Membership of CSR-Eligibles (in Thousands)			CSR Payments (Annual Total, in Millions)		
	Baseline	Waiver	Difference	Baseline	Waiver	Difference if CSRs Continue to be Paid
2018	175	175K	0	\$146	0	(\$146)
2019	180	175	0	\$163	0	(\$163)
2020	185	180	0	\$181	0	(\$181)
2021	191	185	0	\$201	0	(\$201)
2022	197	191	0	\$224	0	(\$224)
2023	203	197	0	\$249	0	(\$249)
2024	209	203	0	\$277	0	(\$277)
2025	215	209	0	\$308	0	(\$308)
2026	221	215	0	\$343	0	(\$343)

2027	228	221	0	\$382	0	(\$382)
2028	235	228	0	\$425	0	(\$425)
<b>Potential Total Savings Under Waiver</b>						<b>(2,900)</b>

In addition, unlike other states, Massachusetts has an additional source of federal subsidies available to its Exchange-eligible enrollees under the terms of its Medicaid 1115 demonstration waiver. Under this 1115 authority, state investments in additional premium and cost-sharing subsidies for a subset of the ConnectorCare population that meets federal Medicaid eligibility requirements are also eligible for Medicaid federal financial participation.

The Commonwealth has assumed that ConnectorCare enrollees' contributions would be identical under all scenarios, based on the state's more generous affordability schedule (which is linked to the state's individual mandate). As a result, the ConnectorCare wrap would incur additional spending under the baseline without the waiver to account for the portion of the premium increases that would not be absorbed by APTC/PTC increases. For example, if the premium for a particular enrollee is currently (without the rerate) between the state expected contribution and the federal expected contribution, a premium increase could trigger an increase in the state premium wrap. Approximately 46% of these additional state costs for ConnectorCare would be eligible for federal matching under the state's Medicaid 1115 waiver. These federal costs would not occur under the waiver.

While Massachusetts recognizes that these savings are not from Exchange subsidies and therefore are not directly eligible for pass-through funding, the Commonwealth notes that these savings affect the overall positive trajectory of the deficit neutrality calculation. See *Figure 11*.

**Figure 11. Estimated Federal Savings due to Medicaid Spending Reductions over 10-Year Period**

CY	Projected Membership of Medicaid FFP-Eligibles in ConnectorCare (in Thousands)			Medicaid 1115 Spending (Annual Total, in Millions)		
	Baseline	Waiver	Difference	Baseline	Waiver	Difference Before Pass-through (Federal Savings)
2018	210	210	0	\$70	\$65	(\$5)
2019	216	216	0	\$72	\$67	(\$5)
2020	223	223	0	\$75	\$69	(\$6)
2021	229	229	0	\$78	\$72	(\$6)
2022	236	236	0	\$81	\$75	(\$7)
2023	243	243	0	\$85	\$78	(\$7)
2024	251	251	0	\$89	\$81	(\$8)
2025	258	258	0	\$93	\$84	(\$9)
2026	266	266	0	\$98	\$88	(\$10)
2027	274	274	0	\$102	\$92	(\$11)
2028	282	282	0	\$108	\$96	(\$12)
<b>Potential Total Savings under Waiver</b>						<b>(\$85)</b>

- Other Federal Spending

The waiver proposal will not require any new investments, infrastructure, or administrative processes from the federal government. The proposed waiver does not require state-specific modifications of the Internal Revenue Code for administration of the waiver, as pass-through funds can be provided in a lump sum separately from the ordinary administration of APTC/PTC, which will continue under the waiver as it does today. If approved, Massachusetts government entities and issuers stand ready to implement the waiver in short order, without additional support.

- Federal Receipts

In considering the waiver, the Commonwealth closely examined the possibility that its waiver could influence additional factors in the federal budget, such as the shared responsibility payments.<sup>32</sup>

Under the federal shared responsibility provision, uninsured adults and children without an exemption pay a penalty, amounting on average to \$115 per uninsured in 2018.<sup>33</sup> If the actuarial analysis had projected a measurable shift in the market from Exchange coverage to uninsurance among the affected population, it could be possible that federal receipts would be diminished for this factor, since it is based on the number of uninsured. However, since the actuarial analysis determined that there would not be a measurable change in uninsurance status between the waiver and baseline – since churn in coverage would result in coverage gaps of only a month or two as individuals transition to plans not affected by the premium rerate under the baseline, and short coverage gaps are exempt from the federal penalty – there is no associated change in federal revenue collected under the federal shared responsibility penalty.

## 5.6 Access to Care Out-of-State

The Commonwealth does not expect any impact from the proposed waiver on Massachusetts residents' ability to access coverage or care out of state. Nothing in the proposed waiver will impact provider networks or other aspects of out-of-state care.

## 5.7 Administrative Burden

Massachusetts does not anticipate any substantial increase in administrative burden as a result of the proposed waiver. Rather, the proposed waiver is likely to decrease administrative burden because it will spare the Commonwealth, health plan issuers, agents and brokers, and consumers from the market impact of high premium rates that would occur without the waiver. Aside from the evaluation and reporting requirements associated with the waiver itself and the administration of the PSF, there will be no new requirements associated with the waiver proposal.

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<sup>32</sup> Massachusetts did not consider the impact of Exchange User Fees, as its enrollees are not subject to the fees because they enroll via the state-based Exchange.

<sup>33</sup> Congressional Budget Office, "Federal Subsidies for Health Insurance Coverage for People under Age 65: 2016-2026" (March 2016), available at: <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-healthinsurancebaselineonecol.pdf>.

- Health plan issuers and producers

The proposed waiver will save health plan issuers and related insurance professionals, such as agents and brokers, the significant burden of assisting consumers through a rate revision. Under the proposed waiver, there will be no need for issuers or brokers to educate their enrollees about the premium increase that will occur absent the waiver.

The waiver will result in some administrative requirements for issuers, as they will need to partner with the Health Connector and Division of Insurance to implement the initial mechanics of the PSF. This should not require a significant burden from the issuers, as they already receive monthly advance payments and reconcile annual payments of state subsidies provided via the Commonwealth Care Trust Fund, the entity that will serve as the PSF clearinghouse. Issuers will need to assist the Health Connector to test and ensure that the new PSF funding mechanism yields accurate per-enrollee payments, but otherwise will not need to perform new administrative duties.

- Consumers and employers

While Massachusetts residents would not be directly impacted, the waiver proposal will avert market confusion and congestion that could indirectly cause administrative burden for consumers. If the waiver is approved, individual and group enrollees will not notice any difference in their coverage from today (previous to the rating increase that is expected to go into effect absent the waiver). Their coverage will continue without disruption.

- Commonwealth of Massachusetts

The proposed waiver will add some duties to Commonwealth agencies involved in regulating and administering health insurance, such as the Health Connector and the DOI. These agencies will need to issue regulatory guidance to issuers and oversee the implementation and everyday administration of the PSF. However, because both of these agencies perform similar duties today, the Commonwealth expects that the additional burden could be absorbed within existing staffing, resources, and infrastructure.

- Federal agencies

The proposed waiver would not create any new administrative burdens or costs to the federal government. Federal agencies would not need to make any new changes or federal processes or submissions to accommodate the proposed waiver, aside from providing the PSF pass-through funds to the Commonwealth and reviewing waiver reporting.

## **5.8 Impact on ACA Sections Not Proposed to be Waived**

No other section of the ACA would be affected by the proposed waiver.

## **5.9 Fraud, Waste, and Abuse**

Massachusetts does not expect any impact on waste, fraud, and abuse as a result of the proposed waiver. Currently operating programs will continue to detect and prevent waste, fraud, and abuse in the merged market. For example:

- Health Connector

The Health Connector engages in a robust and continuous program integrity and oversight process that extends to all its business areas, including funding provided for programmatic and administrative purposes stemming from the Commonwealth Care Trust Fund. Per 45 C.F.R. §155.1200, the Health Connector engages an independent auditing entity which follows generally-accepted governmental auditing standards to perform an annual independent external programmatic audit. The Health Connector provides the results of this audit to HHS and publishes a public summary of the results. Similarly, the Health Connector engages an independent entity to provide a standard and “A-133” financial audit.

- Division of Insurance

DOI’s Financial Surveillance department plays a vital role in monitoring the solvency of health plan issuers chartered in Massachusetts. DOI’s staff financial examiners and external consultants conduct statutorily required on-site audits of issuers with domestic licenses, ensuring their financial solvency and ability to continue to meet reserve requirements and pay claims.

DOI’s Consumer Service department responds to inquiries and intervenes on behalf of consumers to resolve complaints against health plan issuers and other licensees. Consumer Service provides consumers with general insurance information and intervenes on behalf of consumers to resolve complaints, including consumer complaints involving fraud and abuse.

- Office of the Attorney General

The Attorney General’s Consumer Protection Division uses investigation and enforcement actions to protect consumers from fraud, deception, and other unfair business practices. The Attorney General’s Health Care Division enforces health care laws to protect the rights of Massachusetts’ consumers and to halt unfair or deceptive practices that may harm consumers. The Health Care Division also operates a health care hotline to help consumers understand their health care rights and to mediate consumer disputes with health care payers and providers.

In addition to these government resources, the Commonwealth expects to continue to rely on issuers and their internal systems to monitor and curb waste, fraud, and abuse under the proposed waiver.

## **6.0 Expected Evaluation and Reporting**

If the proposed waiver is approved, Massachusetts will hold public fora six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the Commonwealth Health Connector Authority and Division of Insurance websites and also be shared with known interested stakeholders, such as tribal representatives, health insurance issuers participating in the merged market, business associations, and consumer representatives. As with previous public meetings in the waiver process, these meetings will afford equal access to those with limited English proficiency or disabilities.

In compliance with 45 CFR § 155.1308(f)(4), the Health Connector will submit quarterly and annual reports to the Departments. In its reports, which will be made publicly available, Massachusetts proposes to include:

- Quarterly – Assessment of reporting targets for the scope of coverage, affordability, comprehensiveness, and deficit neutrality requirements.
- Annually – Evidence of compliance with public forum requirements, including date, time, place, description of attendees, the substance of public comment, and the Commonwealth’s response, if any;
- Annually – Progress on implementation, including information about any challenges the Commonwealth may face in implementing and sustaining the waiver program and its plan to address the challenges;
- Any other information applicable to the terms and conditions in the State’s approved waiver.

The Commonwealth will also cooperate fully with any independent evaluation conducted by the Departments.

## 7.0 State Contact Information

The Commonwealth wishes to acknowledge the array of partner agencies contributing to this application. Special thanks are due to partners at the Division of Insurance, Executive Office for Administration and Finance, Executive Office of Health and Human Services, and the Center for Health Information and Analysis. Inquiries regarding Section 1332 or this application can be directed to the Health Connector as follows.

<p><b>Waiver Application</b></p>	<p>Audrey Morse Gasteier            Chief of Policy and Strategy            Commonwealth Health Insurance Connector Authority            617-933-3094  <a href="mailto:audrey.gasteier@state.ma.us">audrey.gasteier@state.ma.us</a></p> <p>Emily Brice            Deputy Chief of Policy and Strategy            Commonwealth Health Insurance Connector Authority            617-933-3156  <a href="mailto:emily.brice@state.ma.us">emily.brice@state.ma.us</a></p>
<p><b>Permanent Contact</b></p>	<p>Commonwealth Health Insurance Connector Authority            100 City Hall Plaza            Boston, MA 02108            617-933-3030  <a href="mailto:StateInnovations@state.ma.us">StateInnovations@state.ma.us</a></p>

## 8.0 Appendices

### Appendix A: Frequently Used Abbreviations

ACA	Patient Protection and Affordable Care Act of 2010
APTC/PTC	Federal advance premium tax credits/premium tax credits
CBO	Congressional Budget Office
CCA or the Health Connector	Commonwealth Health Insurance Connector Authority
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CSR	Federal cost-sharing reduction payments
DOI	Massachusetts Office of Consumer Affairs and Business Regulation, Division of Insurance
FPL	Federal Poverty Level

### Appendix B: Text of State Enabling Legislation

Ch. 119, Sec. 20 of the Acts of 2015 ([HB 3829](#)) authorizes the Commonwealth Health Insurance Connector Authority to apply for and implement a Section 1332 waiver application.

Under the language therein, the 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.”

## Appendix C: Actuarial Analysis and Certification

September 7, 2017

Mr. Louis Gutiérrez  
Executive Director  
Massachusetts Health Connector  
100 City Hall Plaza  
Boston, MA 02108

### **Re: Actuarial Certification for Massachusetts' Request for a State Innovation Waiver to Stabilize Premiums under Section 1332 of the Affordable Care Act**

Dear Director Gutiérrez:

At your request, I have completed an actuarial analysis of the Commonwealth of Massachusetts' proposed State Innovation Waiver to Stabilize Premiums. The following analysis is intended to demonstrate that the State Innovation Waiver meets the following three guardrails required under Section 1332 of the ACA:

- **Comprehensiveness of coverage:** The coverage provided under this waiver will be at least as comprehensive as the coverage that would be available absent the Premium Stabilization Fund.
- **Affordability of coverage:** The coverage provided under this waiver will be at least as affordable as the coverage that would be available absent the Premium Stabilization Fund.
- **Scope of coverage:** This waiver will allow coverage to be provided to at least a comparable number of Massachusetts residents as would have been provided absent the Premium Stabilization Fund.

Each of three guardrails above were evaluated in the aggregate across all affected enrollees and for various relevant subpopulations. The fourth guardrail, related to federal deficit neutrality, is addressed in a different section of the waiver application and is not discussed here.

#### **I. Scope of Modeling and Analysis**

To evaluate the impact the Premium Stabilization Fund would have on Massachusetts residents and on Federal subsidies, two scenarios were modeled: the baseline and the waiver scenarios. The baseline scenario assumes that the rates for Silver Qualified Health Plans (QHPs) offered to individual business by the carriers participating in the ConnectorCare program are increased to reflect the transfer of claims liability related to Federal Cost-Sharing Reductions (CSR) from the Federal government to the carriers. This rate increase will be reflected in the premiums for these products available to Exchange enrollees at all incomes, before any available state or federal subsidies are applied. On the other hand, the waiver scenario assumes that carriers will continue to receive CSR-equivalent payments from a Premium Stabilization Fund that draws on federal pass-through funding available as a result of the waiver.

This analysis focuses on the Exchange individual population since Medicaid, Medicaid Expansion, Medicare, or the CHIP program are not impacted by the waiver. Premiums and cost-sharing for the small and large group markets as well as unsubsidized individual business sold off-Exchange are also not impacted by the waiver, since these market segments are not subject to either the increased rates under the baseline or the Premium Stabilization Fund under the waiver.



## II. Comprehensiveness of Coverage

In order to satisfy this requirement, the coverage provided to Massachusetts residents must be at least as comprehensive as it would be without the waiver. Comprehensiveness is measured by the Essential Health Benefits and other related benefit standards.

The proposed waiver would have no impact on the comprehensiveness of coverage otherwise available to its residents under the ACA because it does not make changes to benefits. Under the proposed waiver, all enrollees in the merged market would continue to be guaranteed the Essential Health Benefits and applicable state-required benefits.

Under the ACA, enrollees of non-grandfathered nongroup and small group plans are assured benefits that meet both applicable state requirements and the federal Essential Health Benefits, as defined in Section 1302(b) of the Affordable Care Act and further specified in 45 C.F.R. § 156.100. This benchmark package includes items and services in ten categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

Starting plan year 2017 and beyond, Massachusetts has selected the following base benchmark plan and supplemented the plan to meet the Essential Health Benefits requirements:

<b>Plan Type</b>	Small Group Market
<b>Issuer Name</b>	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
<b>Product Name</b>	HMO Blue With Deductible
<b>Plan Name</b>	HMO Blue New England \$2,000 Deductible
<b>Supplemented Categories</b>	Pediatric dental (CHIP); Pediatric vision (FEDVIP)

This plan also meets Massachusetts’s own “Minimum Creditable Coverage” standards, the level of coverage adult residents must carry in Massachusetts to meet the state-specific individual mandate. Further details about Massachusetts’ Essential Health Benefits benchmark and applicable state-required benefits are available at: [www.cms.gov/ccio/resources/data-resources/ehb.html#Massachusetts](http://www.cms.gov/ccio/resources/data-resources/ehb.html#Massachusetts).

Under the proposed waiver, enrollees would continue to be assured the same state-required benefits and Essential Health Benefits that would otherwise be required under the Affordable Care Act, including all ten categories of benefits. All residents currently receiving the Essential Health Benefits would continue to do so for each year of the proposed waiver. As such, there would not be any impact on particularly vulnerable residents, such as low-income individuals, elderly individuals, or those with serious health issues or who have a greater risk of developing serious health issues.

## III. Affordability of Coverage

In order to satisfy this requirement, the coverage provided to Massachusetts residents must be at least as affordable under this waiver as it would be without the waiver. The affordability of health coverage is measured by the ability of enrollees to pay for their out-of-pocket expenses according to their income. Out-of-pocket spending includes both claims cost-sharing and premium contribution.

## **Affordability Methodology**

The below analysis of affordability uses estimates produced by a model that includes all Exchange enrollees and their characteristics.

Projected premium PMPMs under the waiver scenario were calculated at the member level using their demographic information, benefit plan and the 2018 filed rates received from the carriers. Projected enrollee contributions, APTC/PTCs and State premium wrap subsidies were calculated using the projected 2018 premium rates, income at the household level, and the 2018 Massachusetts Affordability Schedule. The waiver scenario also includes an expectation that federal CSR payments will be waived, but a Premium Stabilization Fund will provide equivalent funding to hold enrollee coverage steady.

Figure 1 below explains the State Affordability Schedule and its interaction with ConnectorCare premium payment amounts for ConnectorCare enrollees earning up to 300% FPL.

### **Figure 1: Explanation of the State Affordability Schedule and ConnectorCare Premiums**

- The State Affordability Schedule is a component of the state individual mandate which is used by the Health Connector to establish premium affordability limits for residents with incomes of 300% of FPL or less that exceed the federal affordability schedule.
- The Health Connector designs its ConnectorCare program for these enrollees such that enrollees that choose the lowest cost silver plan offered in their region pay a maximum contribution according to the State Affordability Schedule. The Health Connector wraps the premiums and cost-sharing for these plans with additional federally-matched state subsidies available under its Medicaid 1115 waiver up to the State Affordability Schedule. The difference between the expected enrollee contribution under the schedule and what the enrollee is expected to contribute if only APTCs/PTCs were available is the amount of the state premium wrap subsidy.
- This ensures that eligible low-income residents can enroll in a QHP that is highly affordable – more so than under the federal maximum enrollee contribution schedule that would otherwise apply.
- Enrollees that choose a carrier other than the lowest cost carrier in their region need to pay a higher contribution, representing the contribution of the lowest cost plan plus the average difference between the premium of the benefit plan of their choosing and the premium of the lowest cost plan.
- There are no State premium wrap subsidies for enrollees with an income greater than 300% of FPL.

For the baseline scenario, an 18% load corresponding to the average load that carriers are expected to file in mid-September to reflect uncertainty related to Federal CSR was added to projected rates under the waiver scenario. This represents the baseline scenario that will take effect absent the waiver. This average load was calculated by projecting the 2016 claims subject to Federal CSR reimbursement. Claims were trended to 2018 using carriers' trend assumptions. According to comments made by carriers this load to pay for Federal CSR seems reasonable, and it is also in line with national estimates. If carriers' assumptions change, we will update this analysis using their most recent inputs.

## **General Discussion of Affordability of Coverage and Federal Spending**

As a consequence of the waiver, the average premium PMPM for Silver QHPs is significantly lower under the waiver scenario than it would be under the baseline scenario. Table 1 below shows the projected 2018 average premium PMPMs by income level for both the baseline and waiver scenarios based on projected individual enrollment on-Exchange, as well as the average enrollee contribution (after applying

relevant federal and state subsidies). Table 1a shows the 2018 average premium in the aggregate for both the baseline and waiver scenarios for the Exchange population. These tables demonstrate that overall, Massachusetts enrollees will face lower premiums and neutral-to-lower associated contributions under the waiver than under the baseline. The tables show enrollee premiums prior to any membership migration that may occur if enrollees choose to move to a different product to avoid high premium increases.

**Table 1: Projected premium and enrollee contribution by income level for CY 2018 (PMPM)**

% of FPL	Average Premium Rate PMPMs			Average Enrollee Contribution PMPMs		
	Baseline	Waiver	Difference	Baseline	Waiver	Difference
<= 300%	\$380	\$322	(\$58)	\$76	\$76	(\$0)
300% - 400%	\$457	\$405	(\$53)	\$292	\$297	\$5
>400%	\$455	\$420	(\$35)	\$455	\$420	(\$35)

**Table 1a: Projected premium rate by income level for CY 2018 (aggregate)**

% of FPL	Projected Average Membership	Projected Premium			Projected Enrollee Contribution		
		Baseline	Waiver	Difference	Baseline	Waiver	Difference
<= 300%	210K	\$958M	\$811M	\$146M	\$192M	\$192M	(\$0M)
300% - 400%	10.5K	\$58M	\$51M	\$7M	\$37M	\$37M	1M
>400%	55K	\$300M	\$277M	\$23M	\$300M	\$277M	(\$23M)

As an additional consequence of the waiver, the average federal expenditure for APTC/PTC is significantly lower under the waiver scenario than it would be under the baseline scenario since APTCs/PTCs increase when premium rates increase. APTCs/PTCs account for the total difference between the premium PMPMs and the enrollee contribution PMPMs for the 300% - 400% FPL population. Populations with incomes below this 300% FPL threshold receive state subsidies in addition to APTC/PTCs, so both of these subsidies contribute to the difference between the average premium rate PMPMs and the enrollee contribution PMPM for the lowest income population. Table 2 below shows the amount of APTCs/PTCs projected under both scenarios as well as the difference between them. As can be observed, the Federal government will be liable for a much higher APTC/PTC PMPM in the baseline scenario compared to the waiver scenario.

**Table 2: Projected APTC/PTC cost by scenario and projected federal savings for CY 2018**

% of FPL	APTC/PTC PMPMs			Projected Average Monthly Enrollment	Annualized APTC/PTC cost		
	Baseline	Waiver	Difference		Baseline	Waiver	Savings
<= 300%	\$242	\$189	(\$54)	210K	\$611M	\$476M	\$136M
300% - 400%	\$166	\$108	(\$58)	10.5K	\$21M	\$14M	\$7M
> 400%	No APTCs/PTCs available						
<b>TOTAL</b>				<b>222.5K</b>	\$632M	\$489M	<b>\$143M</b>

Using projected membership for calendar year 2018, it is expected that the Federal government will save \$143M in APTCs/PTCs for calendar year 2018 under the waiver scenario. As a comparison point, the Federal government spent \$378M and \$253M respectively for CY 2016 and YTD 2017.

Given the guardrail requirement to ensure affordability specifically for vulnerable populations as well as the broader Exchange enrollee population, the below analysis discusses potential affordability impact of the waiver for subpopulations by income level.

**Affordability of Coverage Impact for Enrollees with Incomes Under 300% FPL**

In Massachusetts, Exchange enrollees earning at or below 300% of FPL are enrolled in the ConnectorCare program available through the Health Connector. By state regulation, the premium these individuals pay is capped at the State Affordability Schedule for at least one plan in each region. As can be seen in Table 3 below, rates do vary by age but the enrollee contributions for this population do not vary by age.

As a result, under both the baseline and waiver scenarios, these individuals will always pay the same premium for at least one plan in each region. As mentioned above, when ConnectorCare enrollees choose a plan other than the lowest cost plan, they need to pay a higher contribution that represents the contribution for the lowest cost plan plus the average difference between the premium of the benefit plan of their choosing and the premium of the lowest cost plan. These differences should be higher under the baseline scenario, but since it is assumed that the state will absorb the difference in enrollee contributions that result from the higher rates in the baseline scenario, the same enrollee contribution schedule is used for both the baseline and the waiver scenarios.

Since the same enrollee contribution schedule is used under both scenarios, we would expect the difference in enrollee contributions to be \$0. However, in a few instances, the contribution actually paid by the enrollee is lower than the schedule. This happens when the difference between the premium and the APTC is less than the schedule. Since premiums are higher in the baseline scenario, this does not happen as frequently, which explains why the average contribution in the baseline scenario is sometimes slightly higher than in the waiver scenario.

**Table 3: Projected premium and enrollee contribution PMPMs by income level and age band for CY 2018**

		Average Premium Rate PMPMs			Average Enrollee Contribution PMPMs		
<b>Total Enrollee Population</b>							
% of FPL	Age Group	Baseline	Waiver	Difference	Baseline	Waiver	Difference
<b>0% - 100%</b>	TOTAL	\$360	\$305	<b>(\$55)</b>	\$7	\$7	<b>(\$0)</b>
	0-34	\$281	\$238	<b>(\$43)</b>	\$7	\$6	<b>(\$1)</b>
	35-39	\$327	\$277	<b>(\$50)</b>	\$8	\$8	<b>(\$0)</b>
	50+	\$485	\$411	<b>(\$74)</b>	\$7	\$7	<b>(\$0)</b>
<b>100% - 200%</b>	TOTAL	\$375	\$317	<b>(\$57)</b>	\$49	\$48	<b>(\$0)</b>
	0-34	\$280	\$237	<b>(\$43)</b>	\$44	\$44	<b>(\$0)</b>
	35-39	\$344	\$292	<b>(\$53)</b>	\$47	\$47	<b>(\$0)</b>
<b>200% - 300%</b>	50+	\$508	\$430	<b>(\$78)</b>	\$55	\$55	<b>(\$0)</b>
	TOTAL	\$390	\$331	<b>(\$60)</b>	\$123	\$123	<b>(\$0)</b>
	0-34	\$280	\$237	<b>(\$43)</b>	\$115	\$115	<b>(\$0)</b>
	35-39	\$352	\$298	<b>(\$54)</b>	\$122	\$122	<b>(\$0)</b>

	50+	\$521	\$441	(\$80)	\$131	\$131	(\$0)
<b>American Indian/Alaska Native Population</b>							
<b>0% - 100%</b>	<b>TOTAL</b>	\$288	\$244	(\$44)	\$8	\$8	(\$0)
	0-34	\$288	\$244	(\$44)	\$8	\$8	(\$0)
<b>100% - 200%</b>	<b>TOTAL</b>	\$362	\$307	(\$55)	\$51	\$51	(\$1)
	0-34	\$302	\$256	(\$46)	\$47	\$46	(\$1)
	35-39	\$357	\$303	(\$55)	\$61	\$61	(\$0)
	50+	\$489	\$415	(\$75)	\$47	\$47	(\$0)
<b>200% - 300%</b>	<b>TOTAL</b>	\$363	\$308	(\$56)	\$116	\$116	(\$0)
	0-34	\$289	\$245	(\$44)	\$114	\$114	(\$0)
	35-39	\$355	\$301	(\$54)	\$109	\$109	(\$0)
	50+	\$540	\$457	(\$82)	\$131	\$131	(\$0)

Because of the design of the ConnectorCare program, individuals under 300% FPL will also pay the same cost-sharing under both the baseline and waiver scenarios. Under ConnectorCare, benefit plans offered to Massachusetts residents with income of 300% of FPL or less are standardized. Massachusetts has its own cost-sharing subsidy program to make benefit plans richer than required by the ACA. Table 4 shows the actuarial values (AVs) of the benefit plans offered at each of the income levels, which will continue to apply under both the baseline and the waiver scenarios, even if CSR payments are waived under the waiver scenario:

**Table 4: Actuarial Values (AV) of ConnectorCare Plans**

<b>Plan designs</b>	<b>Income level</b>	<b>Actuarial Value</b>
<b>Plan Type 1</b>	0 – 100%	99.62%
<b>Plan Type 2</b>	100 – 200%	94.54%
<b>Plan Type 3</b>	200 – 300%	91.33%

Even if an enrollee switches to a different carrier, the benefit design remains the same since it is linked to the enrollee’s income level. Because benefit designs are standardized and they do not change with the level of the premium rates or with the enrollee contribution, cost sharing is the same under both the baseline and waiver scenarios. Therefore the coverage offered under the waiver scenario is at least as affordable under the waiver as it would be without the waiver for the lower income population.

**Affordability of Coverage Impact for Enrollees with Incomes between 300-400% FPL**

For the 300-400% population which receives only APTC/PTCs, we can divide this population into two:

- Enrolled in a Silver QHP that includes a load for the uncertainty of Federal CSR
- Enrolled in any other QHP

**Table 5: Projected premium and enrollee contribution by QHP category and age band**

300% - 400%		Average Premium Rate PMPMs			Average Enrollee Contribution PMPMs		
		Baseline	Waiver	Difference	Baseline	Waiver	Difference
<b>All QHPs</b>	TOTAL	\$457	\$405	(\$53)	\$292	\$297	\$5
	0- 34	\$314	\$276	(\$38)	\$215	\$220	(\$5)
	35-39	\$340	\$298	(\$42)	\$233	\$234	(\$1)
	50+	\$532	\$472	(\$60)	\$329	\$337	(\$7)
<b>Silver QHPs*</b>	TOTAL	\$433	\$367	(\$66)	\$268	\$260	(\$8)
	0-34	\$300	\$254	(\$46)	\$201	\$197	(\$4)
	35-39	\$327	\$277	(\$50)	\$220	\$214	(\$7)
	50+	\$506	\$429	(\$77)	\$303	\$293	(\$10)
<b>Other QHPs</b>	TOTAL	\$555	\$555	\$0	\$384	\$445	\$60
	0-34	\$376	\$376	\$0	\$279	\$322	\$43
	35-39	\$411	\$411	\$0	\$304	\$348	\$45
	50+	\$620	\$555	\$0	\$421	\$488	\$67

\*Silver QHPs that include a load for the uncertainty of Federal CSR under the baseline scenario.

About 80% of the current enrollees in this segment of the population have a Silver QHP that includes a load for the uncertainty of Federal CSR under the baseline scenario. Under the waiver scenario, there will not be any disruption to coverage, so we expect most of the enrollees in a Silver QHP to remain in their same plans because past experience with plan-switching behavior indicates the majority of enrollees remain in the plans into which they are auto-renewed if premiums remain relatively steady.

As can be seen in Table 5, under the baseline scenario, enrollees in a Silver QHP that includes a load will see an enrollee contribution similar to the one they would have under the waiver scenario if they remain in their current Silver QHP, since APTCs/PTCs increase with premium rates and insulate them from the higher premium increase. However, because the load for the loss of federal CSR affects the Silver metallic tier only, APTCs are higher in the baseline scenario, but the premium for all benefit plans not affected by the Federal CSR load are the same under both scenarios. As a result, plans that do not include a Federal CSR load may appear to offer better value to enrollees and many could take advantage of the higher APTC to move to a richer QHP or to save even more on their enrollee contribution by moving to a cheaper QHP. In these instances, the out-of-pocket cost could be lower in the baseline scenario.

However, the affordability of coverage guardrail is still met in this instance because the population is not considered vulnerable and the federal limits of affordability remain in place. Under the ACA, the amount consumers are expected to contribute to healthcare costs is limited to a percentage of their income. Massachusetts residents with incomes between 300-400% FPL would continue to be eligible for tax credits based on the second-lowest cost silver plan, and if they purchased a silver plan, they would pay premiums that the federal government deems affordable.

**Affordability of Coverage Impact for Enrollees with Incomes above 400% FPL**

For Exchange enrollees with income greater than 400% FPL, we can also divide this population into two:

- Enrolled in a Silver QHP that includes a load for the uncertainty of Federal CSR

- Enrolled in any other QHP

**Table 6: Projected premium rate and enrollee contribution by QHP category before migration**

>400% of FPL	Average Premium Rate PMPMs			Average Enrollee Contribution PMPMs		
	Baseline	Waiver	Difference	Baseline	Waiver	Difference
All QHPs	\$455	\$420	(\$35)	\$455	\$420	(\$35)
Silver QHPs*	\$396	\$335	(\$60)	\$396	\$335	(\$60)
Other QHPs	\$537	\$537	\$0	\$537	\$537	\$0

\*Silver QHPs that include a load for the uncertainty of Federal CSR under the baseline scenario.

Residents enrolled in a QHP that does not include a load related to the uncertainty of Federal CSR will not see any changes to their premium rates or cost sharing between the waiver and baseline scenarios.

For the enrollees in a Silver QHP that includes a load for Federal CSR uncertainty, the premium is lower in the waiver scenario and the waiver would avoid disrupting the more than 29K members that currently have one of these Silver QHPs. However, it is assumed that almost all, if not all, enrollees will be able to move to a very similar Silver QHP with very similar premium and cost sharing off-Exchange. A few enrollees may move to a Bronze or Gold QHP on-Exchange if the premium and cost sharing are relatively similar. For all these enrollees, we expect premium rates and cost sharing to be similar or lower under the waiver scenario. As a result, the coverage is at least as affordable under the waiver as it would be absent the waiver.

#### IV. Scope of Coverage

In order to satisfy this requirement, the number of Massachusetts residents having health coverage under the waiver scenario must be comparable to the number of residents having health coverage absent the waiver.

For the purpose of this component of the analysis, we focus on whether individuals who would be impacted by the Silver QHP premium load under the baseline scenario may be less likely to take up coverage, compared to the waiver scenario. Enrollment projections are based on recent historical trends of various events such as: voluntary terminations, terminations for non-payment of premium, residents joining outside of the open enrollment period, and Medicaid enrollees becoming eligible for ConnectorCare. The enrollment projections also include assumptions about the impact of future outreach effort and operational processes such as eligibility re-determination.

As described above, under the baseline scenario, some enrollees are expected to experience migration to other plans on or off the Exchange to mitigate the impacts of the rate increase. This is expected to cause significant member disruption under the baseline scenario. However, given the ongoing availability for federal subsidies for some of these enrollees, the state’s individual mandate that has contributed to a decade-long culture of coverage, and the ample availability of similar off-Exchange plans, it is expected that any coverage gaps would be limited to a month or two until enrollees take up alternative coverage. As a result, it is expected that the number of residents, it is expected that the number of residents covered will be similar under both the baseline and the waiver scenarios.

Table 7 shows the projected enrollment in both the baseline and the waiver scenarios for different income levels:

**Table 7: Projected On-Exchange Enrollment under the Baseline and Waiver Scenarios**

% of FPL	Projected Average Enrollment for CY 2018		
	Baseline	Waiver	Difference
<= 300%	210K	210K	0K
300% - 400%	10.5K	10.5K	0K
> 400%*	55K	55K	0K
<b>On-Exchange</b>	23K	55K	32K
<b>Off-Exchange</b>	32K	0K	-32K

\*Includes residents projected to enroll on-Exchange only if there were no additional premium rate increases due to the loss of CSR

**Scope of Coverage Impact for Enrollees with Incomes under 300% of FPL**

As explained above, because of Massachusetts’ State Affordability Schedule, all residents eligible for this program have the possibility of enrolling in a benefit plan with a highly affordable enrollee contribution. The State Affordability Schedule insulates enrollees from the actual premium rates charged by carriers, if they choose the lowest cost carriers. As a consequence, the number of covered residents is not very sensitive to the level of premium rates and we expect the number of covered residents for this income range to be comparable under both scenarios.

**Scope of Coverage Impact for Enrollees with Incomes between 300-400% FPL**

Since APTCs increase with premium rate increases, most enrollees in a Silver QHP that includes a load will see similar premium rates under the baseline and the waiver scenarios if they remain in their current QHPs. QHPs not needing the additional increase for the loss of Federal CSR will have the same rates under both scenarios but since APTCs will be higher in the baseline scenario, enrollees will benefit from lower enrollee contributions under the baseline scenario. Overall, even if the enrollee contributions is lower for QHPs not needing an additional increase, we expect a comparable number of Massachusetts residents to be covered under both scenarios. The level of the rates will not lead to additional terminations under the waiver scenario and with the current highly-saturated insurance rate in Massachusetts, it is not expected that the difference in enrollee contribution between the two scenarios will affect the number of new enrollees.

**Scope of Coverage Impact for Enrollees with Incomes above 400% FPL**

A significant number of unsubsidized individuals enrolled in a Silver QHP are projected to experience an overall rate increase greater than 20% under the baseline scenario. We expect a large proportion of these enrollees to move to a very similar plan off-Exchange with a very similar premium and coverage. Others may move to either a Bronze or Gold QHP on-Exchange. Under the waiver scenario, we expect most of the enrollees to remain in their current benefit plan, minimizing disruption. Since it is expected that all enrollees will be able to find a QHP similar to theirs with a similar premium rate and similar cost sharing either on or off-Exchange, the number of people covered under both scenarios is comparable.

**V. Considerations Related to Vulnerable Residents**



Waiver proposals are expected to take into account the effects on different groups of residents including vulnerable residents. Vulnerable residents include low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues.

As demonstrated above, the lowest-income populations affected by the waiver (those with incomes below 300% FPL) will receive access to the same benefits, cost-sharing, and enrollee contributions under both scenarios. Enrollee contributions do not vary by age or health status in the ConnectorCare program offered to residents with income of 300% or less. For the Silver 300%-400% population affected by the rate increase due to CSR load, enrollee contributions are lower for all age groups under the waiver scenario, with the largest difference for older people as can be seen in Table 5. Also for this population, enrollees with the highest claims expenses tend to choose QHPs with broader networks. These QHPs tend to have higher premiums than the second lowest cost plan. Therefore, these enrollees would also show larger negative differences.

## VI. Actuarial Certification

I, Edith Boucher Calvao, am a Fellow in the Society of Actuaries, and a member of the American Academy of Actuaries, and am qualified to provide the following certification. This actuarial certification applies to the Premium Stabilization Fund 1332 Waiver's application that requests that Massachusetts have the 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. In my opinion request complies with the following requirements:

- **Comprehensiveness of Coverage Requirement** – The coverage provided under this waiver will be at least as comprehensive as the coverage that would be available absent the Premium Stabilization Fund.
- **Affordability Requirement** - The coverage provided under this waiver will be at least as affordable as the coverage that would be available absent the Premium Stabilization Fund.
- **Scope of Coverage Requirement** – This waiver will allow coverage to be provided to at least a comparable number of Massachusetts residents as would have been provided without the Premium Stabilization Fund.

## VII. Caveats and Limitations

This actuarial certification has been prepared for the specific purpose of providing information necessary for the review of Massachusetts' Premium Stabilization Fund Section 1332 waiver application. This information is intended for the use of the Commonwealth of Massachusetts, as well as the Departments of Treasury and Health and Human Services in reviewing this waiver request. The information included in this document may not be appropriate for other purposes.

Please note that additional information, such as the second-lowest cost silver plan by rating region for a given enrollee, are available upon request of a federal regulatory entity but have not been provided in this analysis given the fact that rates have not yet been made public. These figures will be released publicly before October 15, 2017.

Please note that differences between the projections and the actual numbers depend on the extent to which assumptions used in this analysis deviate from future experience.

Should you have any questions, please feel free to contact me to discuss.

Sincerely,

Edith Boucher Calvao, F.S.A., M.A.A.A.  
Chief Actuary, Massachusetts Health Connector  
617-504-8180  
[Edith.Calvao@state.ma.us](mailto:Edith.Calvao@state.ma.us)

## **Appendix D: Public Notice and Comment Materials**

(See following pages)



# Massachusetts: Exploring the Future of Health Reform

Overview

Public Comment Opportunities and Meeting Materials

Announcements

Learn More about Federal Guidance

Get Involved

Public Comments Received

## Overview

Massachusetts led the nation in 2006 with a comprehensive health care reform law that established the Massachusetts Health Connector, a new marketplace designed to make affordable health insurance available to more people. National health reform built upon the successful example set by Massachusetts. Today, over 250,000 Massachusetts residents have health insurance through the Health Connector, and our state has the highest rate of health insurance coverage in the nation.

Even with this progress, Massachusetts continues to strive to improve its health care system. The Commonwealth is leading once again with its landmark law to contain health care costs, Chapter 224. Now the Commonwealth is exploring options under national health reform that would offer greater flexibility to improve health coverage and maintain market stability in Massachusetts.

### Public Comment Opportunities and Meeting Materials

Please notify us of any language or disability accommodations you may need to participate in our stakeholder process: [emily.brice@state.ma.us](mailto:emily.brice@state.ma.us).

Topic(s)	Meeting Details	Meeting Materials
Listening Session # 1	<p><b>Date:</b> Friday, August 4, 2017  <b>Time:</b> 9:00 a.m. – 11:00 a.m.  <b>Location:</b> 1 Ashburton Place, 21st Floor, Boston  <b>MAConference Line:</b> 1-888-822-7517  Participant Code: 163 4530#</p>	<ul style="list-style-type: none"> <li>Public Comment Draft of Massachusetts Request for Federal Flexibility to Support Commercial Market Reforms <i>Posted: 07/24/2017</i></li> <li>Public Notice of Opportunity to Comment <i>Posted: 07/24/2017</i></li> <li>Supplemental Material: Listening Session Presentation</li> </ul>

Topic(s)	Meeting Details	<ul style="list-style-type: none"> <li>Supplemental Meeting Materials</li> </ul>
<p><b>Listening Session # 2</b></p>	<p><b>Date:</b> August 16, 2017  <b>Time:</b> 10:00 a.m. – 12:00 p.m.  <b>Location:</b> Castle of Knights, 1599 Memorial Drive, Chicopee,  <b>MA Conference Line:</b> 1-888-822-7517                      Participant Code: 163 4530#</p>	<ul style="list-style-type: none"> <li>Premium Stabilization Fund Request</li> </ul>

## Announcements

June 24, 2017

**Massachusetts is pursuing requests for flexibility.** In order to ensure that the Massachusetts health insurance market remains stable, sustainable, and vigorous in the future, Massachusetts has identified opportunities to adjust or re-examine particular federal policies in areas that could further strengthen the employer-sponsored coverage and ensure stability in the commercial insurance market more broadly. Specifically, the Commonwealth seeks to:

- Promote Market Stability with a Premium Stabilization Fund in Lieu of Cost-Sharing Reductions;
- Revive State Employer Shared Responsibility Program in Lieu of Delayed and Less Comprehensive Federal Program;
- Revive Permissibility of Section 125 Plans for Non-Benefits Eligible Employees to Enhance Consumer Savings and Promote Private Coverage;
- Permission for Commonwealth to Administer the Federal Small Business Health Care Tax Credit;
- Allow for State Option to Continue to Use Select State-Based Rating Factors; and
- Commence a Process to Evaluate Future of Risk Adjustment in the Commonwealth

The Commonwealth will host two public meetings in various regions of the Commonwealth to seek input regarding its flexibility requests. The Commonwealth will consider comments received by August 25, 2017. Comments may be submitted by e-mail to: [StateInnovations@state.ma.us](mailto:StateInnovations@state.ma.us).

May 23, 2016

**Massachusetts announced a successful resolution to its initial request for flexibility.** Governor Baker **announced** that the Centers for Medicare and Medicaid Services (CMS) has authorized flexibility for Massachusetts to maintain its merged insurance market for non-group and small group commercial insurance. In response to a joint request from the Massachusetts Health Connector and the Division of Insurance, CMS agreed that Massachusetts can maintain rolling enrollment throughout the year for small businesses and quarterly small group premium rate refreshing within its merged market.

**This request** was formulated as a result of Massachusetts' exploration of a Section 1332 State Innovation Waiver. Background materials on this request included: (Note to Kirsten: I moved these materials down from where they used to live above)

- [Notice of Public Hearing and Opportunity to Comment](#)
- [Draft Waiver Application Narrative](#)
- [Draft Waiver Appendix – Actuarial Analysis](#)
- [Draft Waiver Appendix – Deficit Neutrality Worksheet \(XLS File\)](#)

During this exploration, stakeholders unanimously supported seeking flexibility to retain Massachusetts' unique "hybrid" merged market structure, which was created under state health reform in Chapter 58 of the Acts of 2006. This merged market structure has promoted affordability for individuals while maintaining familiar enrollment cycles for businesses. **CMS has determined** that the current market

structure provides appropriate consumer protections and will permit Massachusetts to continue its version of a merged market.

## Where to Learn More

### Federal Guidance

- [Department of Health and Human Services Hub](#)
- [ACA Sec. 1332](#)
- [Final federal rules](#)
- [Additional federal guidance](#)

## How to Get Involved

Sign up for the State Innovation Waiver distribution list to receive updates and meeting invitations:

**Email \***

**Name \***

First

Last

**Your Title**

**Organization Name**

**Organization Address**

Street Address

Address Line 2

City

State

ZIP Code

**Phone**

- Request an individual meeting or presentation with your group:  
**Audrey Morse Gasteier**  
Chief of Policy and Strategy

[audrey.gasteier@state.ma.us](mailto:audrey.gasteier@state.ma.us)

**Emily Brice**

Deputy Chief of Policy and Strategy

[emily.brice@state.ma.us](mailto:emily.brice@state.ma.us)

- Submit written comments with your priorities, suggestions, and data/support (note: written comments will be posted: [StateInnovations@massmail.state.ma.us](mailto:StateInnovations@massmail.state.ma.us))
- Join us at an upcoming stakeholder meeting or view archived materials from past meetings. [You can find this information here →](#)
- Notify us of any language or disability accommodations you may need to participate in our stakeholder process: [emily.brice@state.ma.us](mailto:emily.brice@state.ma.us)

## Public Comments Received

*Coming soon.*

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

CHARLIE BAKER  
Governor

KARYN POLITO  
Lieutenant Governor

MARYLOU SUDDERS  
Board Chair

LOUIS GUTIERREZ  
Executive Director

## **NOTICE OF PUBLIC HEARING AND OPPORTUNITY TO COMMENT**

July 24, 2017

Pursuant to its authority under St. 2015, ch. 119 § 20, the Commonwealth Health Insurance Connector Authority (Health Connector) announces its intent to submit a request for a State Innovation Waiver (Waiver Request) under Section 1332 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act) or other available federal flexibility pathways to the U.S. Department of Health and Human Services (HHS) and/or U.S. Department of Treasury on or after August 25, 2017.

### **1. Opportunities for Public Comment**

The Health Connector welcomes public comment on its Flexibility Requests, as detailed below.

#### Publicly Available Materials

Materials describing the Flexibility Requests may be obtained on the Health Connector's website: <https://betterhealthconnector.com/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 02018.

#### Open Public Meetings

The Health Connector will host two listening sessions on the proposed Waiver Request. All persons desiring to be heard on these matters should appear at the designated place and time. The meeting details are as follows:

- **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#  
Directions are available here:  
[http://www.mass.edu/meetings/documents/DirectionsandParking\\_OneAshburtonPlace.pdf](http://www.mass.edu/meetings/documents/DirectionsandParking_OneAshburtonPlace.pdf).
- **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#

Directions: <http://castleofknights.com/directions/>

Members of the public are encouraged to arrive at the beginning of the hearing to sign in. Members of the public are also encouraged to bring a written copy of their testimony for the record. For other rules regarding the conduct of the hearings, please see: <https://www.mahealthconnector.org/wp-content/uploads/rules-and-regulations/PublicHearingGuidelines.pdf>.

To request a reasonable accommodation in order to attend and/or participate in the public hearing, please contact: Emily Brice, Deputy Chief of Policy and Strategy: [StateInnovations@MassMail.State.MA.US](mailto:StateInnovations@MassMail.State.MA.US), 617-933-3156. If you need an interpreter or other assistive device, please provide at least two (2) business days advance notice to the Health Connector stating the type of accommodation needed.

### Written Public Comment Period

The Health Connector will accept public comments on the proposed Flexibility Requests through 5:00 PM EST on Friday, August 25, 2017. Comments must be received by this deadline in order to be considered. Written comments may be delivered by e-mail or mail. By e-mail, please send comments to: [StateInnovations@MassMail.State.MA.US](mailto:StateInnovations@MassMail.State.MA.US) and include "Comments for 1332 Waiver Request" in the subject line. By mail, please send comments to: Emily Brice, Commonwealth Health Insurance Connector Authority, 100 City Hall Plaza, 6th Floor, Boston, MA 02018.

## **2. Summary of Federal Flexibility Requests**

Massachusetts led the nation in 2006 with a comprehensive health care reform law that established the Massachusetts Health Connector, a new marketplace designed to make affordable health insurance available to more people. Even with this progress, Massachusetts continues to strive to improve its health care system. Now the Commonwealth is exploring options under national health reform that would offer greater flexibility to improve health coverage and maintain market stability in Massachusetts. In order to ensure that the Massachusetts health insurance market remains stable, sustainable, and vigorous in the future, Massachusetts has identified opportunities to adjust or re-examine particular federal policies in areas that could further strengthen the employer-sponsored coverage and ensure stability in the commercial insurance market more broadly. Specifically, the Commonwealth seeks flexibility to:

- Promote Market Stability with a Premium Stabilization Fund in Lieu of Cost-Sharing Reductions;
- Revive State Employer Shared Responsibility Program in Lieu of Delayed and Less Comprehensive Federal Program;
- Revive Permissibility of Section 125 Plans for Non-Benefits Eligible Employees to Enhance Consumer Savings and Promote Private Coverage;
- Permission for Commonwealth to Administer the Federal Small Business Health Care Tax Credit;
- Allow for State Option to Continue to Use Select State-Based Rating Factors; and
- Commence a Process to Evaluate Future of Risk Adjustment in the Commonwealth.

Additional details of Massachusetts' request are available at:

<https://betterhealthconnector.com/about/policy-center/state-innovation-waiver/>

To get this information in English **large print**, call 617-933-3156. **TTY: 1-877-623-7773.**

**Important!** This has important information about your health insurance. If you want the information translated into your own language, call **617-933-3156**.

**¡Importante!** Esto tiene información importante sobre su seguro de salud. Si usted quiere la información traducida a su propio idioma, llame al **617-933-3156**.

Spanish

**សំខាន់!** គួរ ដឹង រមែង ព័ត៌មាន សំខាន់ អំពី ធានារ៉ាប់រង សុខភាព របស់ អ្នក ។ បបសិ លេបី អ្នក ចង់ បា ព័ត៌មាន បែប កម្រិត ជា ភាសា របស់ អ្នក សូម ទូរស័ព្ទ មក លេខ **617-933-3156** ។ Cambodian

**重要提示：**該文件載有關於您的醫療保險的重要資訊。如果您想要將相關資訊翻譯為您的母語，請致電 **617-933-3156**。

Traditional Chinese

**重要提示：**该文件载有关于您的医疗保险的重要信息。如果您想要将相关信息翻译为您的母语，请致电 **617-933-3156**。

Simplified Chinese

**Enpòtan!** Sa a gen enfòmasyon enpòtan ou asirans sante ou. Si w vle nou tradwi enfòmasyon an nan pwòp lang ou rele **617-933-3156**.

Haitian Creole

**ສິ່ງສຳຄັນ!** ນີ້ມີຂໍ້ມູນທີ່ສຳຄັນກ່ຽວກັບການປະກັນໄພສຸຂະພາບຂອງທ່ານ. ຖ້າທ່ານກຳລັງຖາມ ຫຼື ມີຂໍ້ມູນຂ່າວສານເຂົ້າໃນການແປພາສາໂທຫາ **617-933-3156** ຂອງຕົນເອງຂອງທ່ານ. Laotian

**Importante!** Neste pacote há informações importantes sobre o seu seguro-saúde. Se quiser que as informações sejam traduzidas para o seu idioma, ligue para **617-933-3156**.

Brazilian Portuguese

**Importante!** Contém informações importantes sobre o seu seguro de saúde. Se desejar a tradução das informações para a sua língua, contacte-nos pelo telefone **617-933-3156**.

European Portuguese

**Важная информация!** Здесь содержится важная информация о Вашем медицинском страховании. Если Вы хотите, чтобы информация была переведена на Ваш родной язык, позвоните по номеру: **617-933-3156**.

Russian

**Lưu ý quan trọng!** Đây là thông tin quan trọng về bảo hiểm y tế của quý vị. Nếu quý vị muốn có bản dịch thông tin này bằng ngôn ngữ của quý vị, hãy gọi số **617-933-3156**.

Vietnamese

**هام!** يتضمن هذا معلومات مهمة عن تأمينك الصحي. إذا كنت تريد ترجمة المعلومات إلى لغتك فاتصل برقم **617-933-3156**.

Arabic



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# **Federal Flexibility Request Update**

August 4, 2017 and August 16, 2017

# Background and Overview of CCA-Driven Flexibility Requests



***The Health Connector is drafting a set of policy requests to federal partner agencies to help strengthen and stabilize the employer-sponsored insurance market in Massachusetts.***

- Massachusetts has a longstanding commitment to universal health care coverage, with an insurance rate of over 96% – the highest rate in the country
- Despite this progress, federal flexibility is needed for further reforms in the commercial insurance market and Medicaid that can help support long-term fiscal sustainability
- The Health Connector is seeking to propose some federal flexibilities using Affordable Care Act (ACA) Sections 1332, 1321(e), and other flexibility vehicles
- These requests will support a broader set of Baker-Polito Administration requests for discrete policy flexibilities that enable Massachusetts to take a state-specific approach to employers' shared responsibility to maintaining near universal coverage, stabilizing our commercial health insurance market, and ensuring financial sustainability
- Some of the changes being proposed that relate to the commercial insurance market and the Health Connector build on policy approaches that the Commonwealth implemented under Chapter 58 of the Acts of 2006

# Request 1: Flexibility on ACA Employer Mandate



***Massachusetts seeks to waive the federal employer mandate in favor of a Commonwealth-specific employer contribution policy.***

## Rationale & Background:

- Massachusetts seeks to implement a state-specific approach to employers' shared responsibility in lieu of the federal requirements and penalties: a 2-year approach to a state-based employer contribution policy that leverages the state's existing Employer Medical Assistance Contribution (EMAC) policy
- The ACA's employer mandate has experienced multiple delays and, as such, is not currently contributing to a shared responsibility model for employer participation in supporting universal coverage
- Massachusetts previously administered a set of state-based policies to promote shared employer responsibility for coverage, and seeks to restore the state-based approach

## Flexibilities needed:

- Transition relief under Treasury discretion; ACA § 1321(e) [42 USC § 18041(e)], an ACA provision that presumes compliance for state exchanges that operated prior to the ACA; and/or 1332 waiver of federal employer penalty provisions [26 USC § 4980H], [26 USC § 6056]

# Request 2: CSR Risk Mitigation Proposal Using APTC Pass-Through



***Massachusetts seeks opportunity to obtain “pass-through” APTC funding to use in a premium stabilization fund that could be accessed in the event that Cost Sharing Reduction (CSR) payments are withdrawn.***

## Rationale & Background:

- ConnectorCare plans for individuals <250% FPL feature federal CSRs
- If there is a continued threat of CSR withdrawal, carriers will need to file higher premium rates to account for the loss/possible loss of these funds
- The resulting spike in premiums would increase federal APTC liability, and would also significantly destabilize coverage for individuals as well as small employers, given Massachusetts’ merged market
- To prevent this outcome, Massachusetts would seek to receive an immediate pass-through of the APTC it otherwise would have received for its residents, to be deposited into a state market stabilization fund

## Flexibilities needed:

- 1332 waiver of requirements related to cost-sharing reduction payments [42 USC § 18071] and pass through of available funds to Massachusetts [permissible under 42 USC §18052(a)(3)]

# Request 3: Section 125 Plan Flexibility



***Massachusetts seeks to expand options for employers to connect non-benefits eligible employees to health insurance through Section 125 cafeteria plans.***

## Rationale & Background:

- Create options for employers to connect non-benefits eligible employees with private coverage
- Massachusetts had a Section 125 cafeteria plan program administered by CCA that had to be discontinued under the ACA. These vehicles can provide meaningful savings for non-benefits eligible employees who are not eligible for ESI or subsidized coverage
- Reinstating such plans would expand the number of options available for employers to offer support for health insurance and for employees to purchase insurance, and could be particularly useful in light of recent labor market trends (e.g., rise of part-time work force, contract-based work)

## Flexibility Needed:

- Discussion with IRS/Treasury/CMS on Section 125 cafeteria plans, or potentially flexible avenue via Health Connector for Business platform (*under exploration*)

# Request 4: State Administration of Small Business Tax Credits



***Massachusetts seeks option to administer ACA Small Business Tax Credits at a state level to make them more accessible to eligible small employers in the Commonwealth.***

## Rationale & Background:

- Federal small business tax credits are not currently being used for maximum impact - preliminary data indicates that uptake has been low
- These tax credits are designed to help the types of small employers data indicates are struggling most in the current employer-sponsored-insurance market: the smallest (<25 employees) and those with lower wage employees (average wages <\$50,000)
- With federal approval, Massachusetts would receive the federal funds currently available to eligible employers in Massachusetts and distribute them in a streamlined and administratively simplified manner in concert with the Health Connector's Wellness Track program

## Flexibilities needed:

- 1332 waiver of federal small business tax credit program [26 USC § 45R] and pass through of available funds to Massachusetts [permissible under 42 USC §18052(a)(3)]



# Request 5: Rating Factor Flexibility



***Massachusetts seeks the option to allow continued use of state-based rating factors at their current level.***

## Rationale & Background:

- The state-specific rating factors we have maintained include adjustments for industry code, group size, and cooperative usage. Massachusetts has existing approval to continue to use these factors at one-third of their original magnitude through the end of Plan Year 2018
- Massachusetts' current flexibility with respect to small group rating factors has contributed to the stability of our insurance market and the Commonwealth wishes to maintain this flexibility, at the state's option

## Flexibilities needed:

- Continued flexibility under ACA § 1321(e) [42 USC § 18041(e)], an ACA provision that presumes compliance for state exchanges that operated prior to the ACA

# Request 6: Request Opportunity to Reexamine Risk Adjustment



***Massachusetts seeks the opportunity to convene a state working group to explore possible changes to Risk Adjustment in the Commonwealth for Plan Year 2019 and beyond.***

## Rationale & Background:

- Massachusetts seeks to convene a set of stakeholders to explore whether Risk Adjustment (RA) should continue to be administered 'as is' in the Massachusetts market for plan years 2019 and beyond
- Evolving market conditions and several years of RA experience make this an appropriate time for the Commonwealth to consider how it wishes to proceed with the program, mindful that any changes would need to be made well in advance for effectiveness so that the market can adapt appropriately
- The Commonwealth wishes to ensure that its policy goals for its health care market are well served by the RA program

## Flexibility needed:

- Written comment through the Notice of Benefit and Payment Parameters (NBPP) rule making process

## Hogan, Kathy (CCA)

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**From:** Kirchgasser, Alison (EHS)  
**Sent:** Tuesday, August 15, 2017 1:16 PM  
**To:** Cfrye-Cromwell@mwtribe.com; WPocknett@mwtribe.com; kfrye@mwtribe.com; chairwoman@wampanoagtribe.net; richard@wampanoagtribe.net; durwood@wampanoagtribe.net; stephanie@wampanoagtribe.net; rmalonson@wampanoagtribe.net; cheron@wampanoagtribe.net; Janelle@nativelifelines.org; nena@nativelifelines.org; ella@nativelifelines.org; Rita.Gonsalves@ihs.gov; Lorraine.Reels@ihs.gov; DHill@mwtribe.com; HAndrews@USETINC.ORG; elizabeth@neptuneadvantage.com; Wendy Pocknett; Reels-Pearson, Lorraine (IHS/NAS/MSH); Kimberly Frye; Judith Graham-Robey  
**Cc:** State Plan Amendments (EHS); Conte, Niki (CCA); Brice, Emily (CCA); Goody, Michele (EHS); Ellwood, Malinda (EHS); Spicer, Kenneth (EHS); Chiev, Sokmeakara (EHS); Alsentzer, Dorothee (EHS)  
**Subject:** Follow up to 8/9/17 Tribal Consultation call  
**Attachments:** July2017\_MTF LS deck\_MH\_final\_7.19.pptx; Health Connector Federal Flexibilities Request Slides for Public Meetings.pdf; COMMBUYS One Care Announcement 063017.pdf

Good afternoon,

This is a follow up to the quarterly Tribal Consultation call on August 9, 2017. Below is a list of items that we discussed on the call. Please let me know if you have any advice, feedback, questions or concerns about any of these items.

### MassHealth Update

Please see the attached MA Health Care Learning Series PowerPoint for Massachusetts Healthcare Training Forum (MTF) for information on the MassHealth updates that Kara shared during the call. Please note that slides 28-36 provide information about HIX system updates and slides 37-50 provide information about MassHealth health plan updates.

### Health Connector Update

Please see attached Health Connector Federal Flexibilities Request slides for information about the Health Connector's request for Federal Flexibilities that has been posted for public comment. The Commonwealth is exploring options under national health reform that would offer greater flexibility to improve health coverage and maintain market stability in Massachusetts. 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 employer-sponsored coverage and ensure stability in the commercial insurance market more broadly. This includes requests to:

- Promote Market Stability with a Premium Stabilization Fund in Lieu of Cost-Sharing Reductions
- Revive State Employer Shared Responsibility Program in Lieu of Delayed and Less Comprehensive Federal Program
- Revive Permissibility of Section 125 Plans for Non-Benefits Eligible Employees to Enhance Consumer Savings and Promote Private Coverage
- Permit the Commonwealth to Administer the Federal Small Business Health Care Tax Credit
- Allow for State Option to Continue to Use Select State-Based Rating Factors
- Commence a Process to Evaluate Future of Risk Adjustment in the Commonwealth

Materials describing the flexibility requests are attached and may also be obtained on the Health Connector's website: <https://www.mahealthconnector.org/about/policy-center/state-innovation-waiver>. The Health Connector will accept comments provided by 5 p.m. on August 25<sup>th</sup>.

## **Updates on Major MassHealth Initiatives**

### **Home and Community Based Services (HCBS) Waivers**

MassHealth is developing applications to renew four of its HCBS waivers, including the two Acquired Brain Injury (ABI) waivers and two Money Follows the Person (MFP) waivers. HCBS waivers are typically approved for a five year period and then must be renewed. (MassHealth's other HCBS waivers are not due for renewal at this time.) Prior to submission to CMS, these waiver renewal applications will be posted for a 30-day public comment period during which there will be a public forum in order for the state to receive input. The public comment period is expected to begin in October 2017.

### **Money Follows the Person (MFP)**

MassHealth has ended transitions under the MFP Demonstration but will continue to utilize this grant through FY 2018 and possibly thereafter. We want to especially note that the MFP Waivers will continue to operate, and in fact, as noted above, will be renewed for an additional 5-year period.

We will also continue to have the HUD 811 Project Rental Assistance program available for individuals transitioning from facilities, and will continue to:

- Identify developers and housing for transitioning individuals;
- Provide up to 197 units of project-based housing, and
- 50 additional units through state-provided vouchers

### **One Care**

- **One Care Plan Procurement:** MassHealth has decided to move its timeline for releasing the One Care plan procurement to 2018 and anticipates having new One Care plans in place on January 1, 2020. The new timing of this procurement will allow:
  - Opportunities to align agency-wide long-term services and supports (LTSS) policies and timelines among the One Care, MCO, and ACO programs;
  - Interested parties to fully participate in the One Care procurement; and
  - MassHealth to conduct robust stakeholder engagement in developing the One Care procurement

MassHealth will post updates about the One Care procurement process on both COMMBUYS (<https://www.commbuys.com>) and on the Duals website (<http://www.mass.gov/masshealth/duals>) under "Information for Organizations Interested in Serving as One Care Plans." Please see attached for the full COMMBUYS announcement.

- **Passive Enrollment:** In late July, MassHealth sent 60 day notices to members who are being passively enrolled into a One Care plan for an October 1, 2017 enrollment effective date. As with the most recent round, we are including both newly eligible (folks whose first date of Medicare eligibility will be the same day as their OneCare enrollment effective date) and folks that already have both MassHealth and Medicare.

Members who receive a passive enrollment notice may choose to opt-out of passive enrollment at any time before their One Care enrollment effective date. As well, all members enrolled in One Care may disenroll at any time. Disenrollments (and enrollments) are effective the first day of the following month.

- **Implementation Council:** MassHealth is pleased to announce that thirteen individuals have been selected to serve on the new One Care Implementation Council for a term beginning June 2017. As previously, at least half of all Council members are MassHealth members with disabilities or family members or guardians of MassHealth members with disabilities.

The Implementation Council plays a key role for One Care in monitoring access to health care and compliance with the Americans with Disabilities Act (ADA), tracking quality of services, providing support and input to EOHHS, and promoting accountability and transparency.

More information about the Implementation Council, including current membership, upcoming meetings, and materials from previous meetings, can be found on the duals website at <http://www.mass.gov/masshealth/duals> under "Implementation Council."

### **MassHealth Innovations/1115 Demonstration Waiver Amendment requests**

On Friday 7/21, MassHealth posted for public notice, a request to amend our 1115 Demonstration waiver. The request outlines the specific authorities being requested from CMS to ensure the sustainability of the MassHealth program. Specifically, the Demonstration Amendment seeks authority to align coverage for non-disabled adults with commercial plans; adopt widely-used commercial tools to obtain lower drug prices and enhanced rebates; and improve care, reduce costs and achieve administrative efficiencies.

On August 4, 2017 we held the first of two listening sessions in Boston. Our second listening session will be Wednesday, August 16<sup>th</sup> at the Castle of Knights in Chicopee. As I noted in the email I sent to you on July 27, 2017, MassHealth will accept comments on the proposed Demonstration Amendment from tribal members through August 26, 2017. The proposed Amendment; details on upcoming public listening sessions; information on how to submit comments; and additional relevant information are available at: [www.mass.gov/hhs/masshealth-innovations/1115waiver](http://www.mass.gov/hhs/masshealth-innovations/1115waiver).

### **State Plan Amendments we plan to submit by September 30, 2017**

- a. An amendment to the Medicaid State Plan to allow the state to receive 1% increase in federal matching funds for preventive services.
- b. An amendment to the Medicaid State Plan to change copayments for medications used to directly treat addictions.
- c. An amendment to the Medicaid State Plan to update the payment methodologies for Personal Care Attendants (PCA).
- d. An amendment to the Medicaid State Plan to update the payment methodologies for Home Health Agency services.
- e. An amendment to the Medicaid State Plan to (1) update the payment methodologies for physicians and midlevel practitioners, and chiropractors; (2) update and clarify coverage pages related to physician and midlevel practitioner services; and (3) make conforming changes to the Standard and CarePlus Alternative Benefit Plan (ABP) State Plans, if necessary.
- f. An amendment to the Medicaid State Plan to update the payment methodology for nursing facilities.
- g. An amendment to the Medicaid State Plan to update the payment methodology for dental services.

h. An amendment to the Medicaid State Plan to update the payment methodology for prescribed drugs.

Please let me know if you have any advice, feedback, questions or concerns about any of these State Plan Amendments by August 29, 2017.

Alison Kirchgasser  
Massachusetts Office of Medicaid  
617-573-1741



via electronic communication

August 25, 2017

Audrey Morse Gasteier, Chief of Policy and Strategy  
Emily Brice, Deputy Chief of Policy and Strategy  
Massachusetts Health Connector  
100 City Hall Plaza, 6<sup>th</sup> Floor  
Boston, MA 02108

**Re: Comments for 1332 Waiver Request**

Requests for State Flexibility to Support Commercial Insurance Market Stability and Reforms (July 24, 2017)

Dear Ms. Gasteier and Ms. Brice:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on the Commonwealth of Massachusetts' Requests for State Flexibility to Support Commercial Insurance Market Stability and Reforms (Massachusetts' 1332 waiver request), released for public comment July 24, 2017. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Section 1332 of the Affordable Care Act (ACA) provides states with flexibility to respond to the unique characteristics of their insurance markets while still maintaining the underlying goal of the ACA to increase access to affordable, comprehensive, quality coverage. 1332 waivers are a valuable tool for enabling states to test marketplace innovations but we believe the waivers must never be used to avoid ACA requirements or to nullify patient protections. That is why ACS CAN strongly supports the requirements that any waiver provides coverage that: (1) is at least as comprehensive in covered benefits, (2) is at least as affordable, including premiums and cost-sharing, (3) covers at least a comparable number of state residents, and (4) does not increase the federal deficit.

ACS CAN looks forward to working with you and the Health Connector to continue to ensure that all patients, including cancer patients and survivors, have access to quality, comprehensive and affordable health insurance coverage. Following are our specific comments on sections 1-3 of the proposal.

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

Recognizing the serious instability being caused by the lack of permanent, guaranteed funding for cost-sharing reduction (CSR) plans, Massachusetts requests a "fast-track premium stabilization waiver." The waiver would "waive requirements associated with CSRs, and...replace these requirements with a state-

based Premium Stabilization Fund (PSF).” The proposal states that removing the uncertainty of CSR funding will reduce premiums, and the state proposes that the federal savings from these reduced premiums “could then be shared back with the state to fund the PSF,” “in keeping with the logic of the recently-approved Alaska State Innovation Waiver,” which established a reinsurance program. The proposal states that the plan would meet all 1332 waiver guardrails, as “Massachusetts residents would receive coverage that is at least as comprehensive and affordable as today.”

ACS CAN applauds Massachusetts for attempting to address the instability of CSR funding. We strongly support CSRs as a way to help low-income cancer patients and survivors afford their cost-sharing.<sup>1</sup> We also share the state’s grave concerns about the lack of permanent funding for CSRs, which has real costs and consequences for the millions of Americans who rely on subsidies to afford their health care coverage.<sup>2</sup>

In addition to CSRs, ACS CAN also supports creating state reinsurance programs. A well-designed reinsurance program can help to lower premiums and mitigate the plan risk associated with high-cost enrollees. Reduced premiums would not only benefit the federal government by reducing federal subsidy payments, but would also benefit consumers who enroll in coverage through the exchange and need assistance but are not eligible for subsidies. A reinsurance program may also encourage insurance carriers to continue or begin offering plans through the exchange. This maintenance or increase in plan competition may also help to keep premiums from rising. Premium savings could help cancer patients and survivors afford health insurance coverage, and may enable some individuals who previously could not afford coverage to enroll in a plan.

It appears that the intent of the Massachusetts proposal is to remove the instability caused by uncertainty regarding federal CSR payments, create a reinsurance program, and hold consumers harmless by not changing the generosity of benefits or patient protections available through the Health Connector. ACS CAN fully supports the intention of this proposal. However, it is unclear how the various mechanisms in this proposal will work together, and work with state law, to accomplish these goals.

Specifically, we are concerned that the proposal requests to “waive requirements associated with CSRs” without substituting state requirements or any other guarantees that low-income enrollees will receive similar subsidized cost-sharing. As stated above, ACS CAN strongly supports CSRs and opposes removing the subsidies without replacing them with similar subsidies or other cost-sharing reductions for low-income individuals. Reducing premiums is an important goal, but a cheaper premium will not help a cancer patient if the cost-sharing is so high the patient cannot afford to use the policy. Given the assurance in the proposal that “Massachusetts residents would receive coverage that is at least as comprehensive and affordable as today,” it is clear the proposal document is missing information on how low-income residents will continue to have similar coverage if CSR requirements are discontinued.

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<sup>1</sup> See American Cancer Society Cancer Action Network. “The Need to Fund Cost-Sharing Reduction (CSR) Subsidies.” June 5, 2017. Available at <https://www.acscan.org/policy-resources/need-fund-cost-sharing-reduction-csr-subsidies>

<sup>2</sup> American Cancer Society Cancer Action Network. Statement of Chris Hansen. “CBO: Health Insurance Premiums Would Spike 20 Percent Next Year Without Critical Cost-Sharing Payments.” August 15, 2017. Available at <https://www.acscan.org/releases/cbo-health-insurance-premiums-would-spike-20-percent-next-year-without-critical-cost>



ACS CAN urges Massachusetts to address the following questions in detail in its ultimate waiver request submission to the Centers for Medicare and Medicaid Services (CMS):

- Upon removal of the CSR requirements, how exactly will Massachusetts guarantee that low-income individuals who were previously CSR-eligible will continue to receive subsidized cost-sharing plans? If this will be addressed through a state requirement, is this requirement already implemented? If the state intends to address this through its ConnectorCare program, we urge them to include that information in detail. Would the CMS approval of the waiver and its future continuation be contingent upon such a state law being in place?
- The proposal states that the stabilization fund would be financed by the savings from reduced premiums gained by removing CSR requirements. But the proposal also references the Alaska reinsurance program as a model – that program is funded through a state tax as well as savings from reduced premiums gained by having the reinsurance program in place. Does Massachusetts plan to contribute funding to the PSF initially or continually? How will reduced premiums due to the presence of the reinsurance program factor in to its continued funding?
- Does Massachusetts intend this program to only become effective if the administration does NOT provide CSR funding? If so, what is the exact trigger for the program? One month of no funding? Multiple months? An announcement that the administration will stop making CSR payment indefinitely?
- If Massachusetts creates the PSF in this proposal, but the administration continues to make CSR payments, what happens to those payments in Massachusetts? Do they continue to flow to the issuers? Or are they captured by the state and put in to the PSF?
- What protections are in place to ensure that any federal funding passed through to the state under this waiver is used for the intent of the program, and not diverted to other state budget priorities?

ACS CAN encourages Massachusetts to provide answers to these questions in its waiver submission to CMS, and we stand ready to work with you in continuing to formulate this proposal.

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

Prior to passage and enactment of the ACA, Massachusetts maintained a mandate for certain employers in the state to provide employees with health insurance coverage (the Employer Medical Assistance Contribution, or EMAC). When the federal ACA employer mandate was implemented, the state discontinued EMAC. Massachusetts proposes to revive elements of EMAC in place of the current federal mandate, and has passed state legislation that enacts the revised EMAC program as of January 1, 2018.

ACS CAN supports policies that increase the number of individuals – especially cancer patients and survivors – who are able to enroll in quality health insurance coverage, and believe any waivers to ACA requirements should accomplish this goal while maintaining the patient protections in current law and following the requirements of Section 1332 of the ACA. We are supportive of this request for flexibility to the extent that it will reduce the number of uninsured in the state, and we encourage Massachusetts to carefully evaluate the effects this change has on enrollment if this request is approved. Furthermore, to the extent that this policy change requires individuals to transition from one type of health care coverage to another (from Medicaid to employer-sponsored insurance, for example), we encourage the

state to provide assistance and education to individuals in this transition – particularly because higher cost-sharing is likely to be required if an individual transitions off of Medicaid.

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

Prior to 2014, Massachusetts required employers with at least 11 employees to offer Section 125 “cafeteria” plans to those employees not eligible for benefits (mostly part-time and contract employees). This allowed the employee to pay insurance premiums pre-tax, which according to the proposal could save an individual up to 40 percent of their payroll deductions, and at least partially address problems with premium affordability.<sup>3</sup> Employers were allowed, but not required, to contribute money towards these premiums. Employers could establish such a plan directly with an issuer or broker, but the Massachusetts Health Connector also operated a “Voluntary Plan,” allowing employers to fulfill their requirement by offering Section 125 plans through the exchange. Federal requirements led to the state closing this program and suspending the Section 125 requirement in 2014.

Noting that approximately 80,000 individuals purchase nongroup insurance in the state without a contribution from an employer and without federal and/or state subsidies, Massachusetts proposes to explore the revival of these Section 125 plans and the accompanying employer requirement. The state proposes several ways HHS could give them this authority, and indicates a desire to discuss further details and options.

ACS CAN offers the following preliminary feedback based on the details available in the current proposal document, but our support is conditional upon receiving more details about the proposed program and HHS’ mechanism for granting authority for the program.

ACS CAN agrees that policymakers must find a way to help individuals who do not receive employer-sponsored insurance and who are not eligible for Medicaid or subsidies afford health insurance premiums. We believe the proposal to allow such individuals to pay premiums pre-tax will help at least some employed individuals better afford health insurance coverage. This type of policy could particularly benefit cancer patients. Many working cancer patients in active treatment must reduce their work hours because of their treatments or side effects, and this reduction in hours sometimes causes them to lose their employer-sponsored health insurance. While these patients are usually offered coverage through COBRA, that is often unaffordable. But if their income from part-time work is still too high to qualify them for subsidies, buying a plan through the Health Connector can also be unaffordable. Allowing these cancer patients to buy insurance through the Health Connector pre-tax is at least a good first step in helping them afford needed insurance coverage.

ACS CAN believes this proposal is worth exploring further, and would be supportive of such a proposal if the details ensure that (1) all individuals gaining coverage through this program are enrolling in comprehensive, quality coverage that includes the patient protections required by the ACA; and (2) the program will not harm the individual or small group markets by segmenting risk. The best way to meet these criteria is to make the Health Connector’s Voluntary Plan a requirement instead – e.g. require employers to offer Section 125 plans only through the Health Connector. This would ensure that all eligible individuals are using their pre-tax dollars to purchase quality insurance coverage that covers the

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<sup>3</sup> See pg. 25 of Requests for State Flexibility to Support Commercial Insurance Market Stability and Reforms.

Essential Health Benefits, meets other important standards and incorporates key patient protections. Such a requirement would also give these individual employees the choice of several plans, where available, so they can choose a plan that best meets their needs. Lastly, this requirement would also avoid market segmentation and help to continue to balance the risk pool in Health Connector plans.

Additionally, ACS CAN notes that this proposal does not address affordability problems for all of the approximately 80,000 individuals who purchase nongroup health insurance without subsidies in the state. ACS CAN encourages Massachusetts to work on proposals that address affordability for individuals who are unemployed, have employers who do not have to meet Section 125 requirements, or otherwise are not eligible for any other subsidy or financial help.

**Conclusion**

On behalf of the American Cancer Society Cancer Action Network Massachusetts we thank you for the opportunity to comment on the flexibility requests. We stand ready to work with you and other stakeholders to ensure that this and future Massachusetts 1332 waivers are designed in a manner that provides the long-term viability of the individual market while also maintaining patient protections crucial to cancer patients and survivors. If you have any questions, please feel free to contact me at [marc.hymovitz@cancer.org](mailto:marc.hymovitz@cancer.org) or 781.361.9661

Sincerely,

A handwritten signature in black ink, appearing to read "Marc Hymovitz", with a stylized flourish at the end.

Marc Hymovitz  
Government Relations Director  
Massachusetts American Cancer Society Cancer Action Network



August 25, 2017

Audrey Morse Gasteier, Chief of Policy and Strategy  
Emily Brice, Deputy Chief of Policy and Strategy  
Massachusetts Health Connector  
100 City Hall Plaza, 6<sup>th</sup> Floor  
Boston, MA 02108

*Submitted by email to [StateInnovations@MassMail.State.MA.US](mailto:StateInnovations@MassMail.State.MA.US)*

Re: Comments on 1332 Waiver Request

Dear Ms. Gasteier and Ms. Brice:

On behalf of Health Care For All, Health Law Advocates, and the Massachusetts Law Reform Institute, thank you for the opportunity comment on the Commonwealth's proposed Waiver for State Innovation under Section 1332 of the Affordable Care Act (ACA), released on July 24, 2017. We share the Health Connector's commitment to maintaining access to affordable health coverage for Massachusetts residents, and believe that the 1332 waiver request largely aims to further this goal. Our comments focus on ensuring that the appropriate protections are in place for low and moderate income Massachusetts residents eligible for subsidized health coverage.

### **1332 Waiver Request: Premium Stabilization Fund in Lieu of Cost-Sharing Reductions**

Cost-sharing reductions (CSRs), along with Advanced Premium Tax Credits (APTCs), are the key mechanisms in the ACA that make coverage more affordable for low and moderate income individuals and families. CSR payments are made to health insurers with members below 250% of the federal poverty level (FPL) who purchase Silver-level plans through the Marketplace, as health insurers are required to increase the actuarial value, thereby reducing cost-sharing, for these enrollees.<sup>1</sup> Massachusetts leverages CSRs and APTCs, and invests additional state dollars, to provide even more affordable coverage than federal CSRs and APTCs alone through the ConnectorCare program.

Recent uncertainty about whether the federal government will continue to make CSR payments has introduced significant risk for both insurers and consumers in the Massachusetts health insurance market. Failure to make CSR payments would result in fewer insurers participating in Marketplaces, including the Health Connector; coverage disruptions for consumers; and significant premium increases. In turn, the premium increases would increase federal and state liability for APTCs and supplemental subsidies. The Health Connector estimates that Massachusetts carriers would need to increase their premium rates by 16% to 20% due to CSR uncertainty alone.<sup>2</sup> Similarly, the Congressional Budget Office and Joint Committee on Taxation recently reported that ending CSRs would lead to gross premium increases of 20% for Silver-level

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<sup>1</sup> 42 USC § 18071.

<sup>2</sup> Massachusetts Health Connector, *Requests for State Flexibility to Support Commercial Insurance Market Stability and Reforms*, July 24, 2017. Available at: <https://www.mahealthconnector.org/about/policy-center/state-innovation-waiver>.

plans as well as increase federal APTC obligations, and thereby the federal deficit by \$194 million from 2017 through 2026.<sup>3</sup>

The instability caused by the federal government's failure to make CSR payments would lead to increases in the uninsurance rate as premiums increase for these plans.<sup>4</sup> To address uncertainty around the CSR payments, and thus the market as a whole, the Health Connector proposes to establish a Premium Stabilization Fund in lieu of CSRs. The Commonwealth would receive federal APTC savings, which will accrue through moderation of premium increases for Silver-level plans, in the form of a "pass-through," to be deposited into the Commonwealth Care Trust Fund.

HCFA supports the Health Connector's efforts to ensure continued affordability and continuity of coverage for consumers purchasing coverage through the Health Connector. We understand that with this proposal the Health Connector intends to hold consumers harmless by keeping premiums and cost-sharing stable for ConnectorCare members. As such, we request that the Health Connector clarify this intent by providing specific language in the 1332 waiver request, and including a written analysis of how the Commonwealth will continue to meet the ACA guardrails requiring that coverage be as affordable and comprehensive as coverage absent the waiver.<sup>5</sup>

We also ask the Health Connector to consider language in state law or regulation to ensure that the pass-through funding is used as intended – to shield consumers from increased costs and to reimburse insurers for meeting their obligations under the ACA and ConnectorCare with regards to cost-sharing levels. This is especially important as the Commonwealth's past several General Appropriations Acts have allowed a substantial transfer from the Commonwealth Care Trust Fund to the General Fund.<sup>6</sup> In addition, should the Commonwealth implement the proposed transition of 140,000 non-disabled adults from MassHealth to ConnectorCare, the Commonwealth must ensure that there is enough funding to at least maintain – and potentially improve – affordability of ConnectorCare premiums and cost-sharing.

### **1115 Waiver Amendment Request: Health Connector-Related Provisions**

MassHealth released their 1115 waiver proposal on a parallel track with the 1332 waiver request. We ask you to also consider HCFA's comments on the Health Connector-related provisions in the MassHealth proposal.

### **MassHealth Eligibility Changes for Non-Disabled Adults**

MassHealth proposes to shift coverage for non-disabled adults ages 21 to 64 with incomes over 100% FPL to ConnectorCare as of January 1, 2019. This transition would impact 100,000 parent and caretakers currently eligible for MassHealth Standard and 40,000 childless adults enrolled in MassHealth CarePlus.<sup>7</sup>

ConnectorCare is a valuable program, integral to Massachusetts' health coverage system, as it offers more affordable coverage than even the federal APTCs and CSRs alone would provide. However, ConnectorCare coverage provides fewer benefits, is more costly to consumers, and presents more enrollment barriers than MassHealth coverage.

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<sup>3</sup> Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions*, August 2017. Available at: <https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf>.

<sup>4</sup> See, Declaration of Hannah Dyer Frigand (Health Care For All HelpLine Director) in Support of the States' Motion to Intervene, *United States House of Representatives v. Price*, submitted to the U.S. Court of Appeals for the District of Columbia Circuit, Case 16-5202, p. A-50. Available at: <http://news.delaware.gov/files/2017/05/2017-05-18-States-Motion-to-Intervene-FILED-time-stamped.pdf>.

<sup>5</sup> 42 USC § 18052(b).

<sup>6</sup> Section 106 of the FY2018 state budget allows the Secretary of the Executive Office of Administration and Finance to request a transfer of up to \$185,000,000 from the Commonwealth Care Trust Fund to the General Fund.

<sup>7</sup> EOHHS Presentation: *FY18 MassHealth and Commercial Market Reform Package*, July 25, 2017. Available at: <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/1115-waiver.html>.

We strongly urge the Commonwealth to reconsider shifting non-disabled adults with incomes over 100% FPL from MassHealth to ConnectorCare, as this will result in:

- *Loss of benefits:*
  - *Dental care:* While the Health Connector offers stand-alone dental plans, the cost of these plans is not subsidized, and would be out of reach for most. In addition, the Health Safety Net – which provides “wrap” dental coverage to ConnectorCare enrollees – already has long wait times for patients to receive dental services, and adding more people to ConnectorCare will exacerbate this problem. Many people will have no choice but to seek services at hospital emergency departments, which are ill-equipped to provide comprehensive dental care.
  - *Behavioral health:* ConnectorCare plans are required to cover inpatient and outpatient mental health and substance use disorder services; however, not all ConnectorCare plans offer the same range of behavioral health services as MassHealth. In particular, access to diversionary services, such as Community Support Programs (CSPs) and Emergency Services Programs (ESPs), are not a part of traditional commercial insurance benefit packages and therefore may not be available to individuals covered through ConnectorCare plans.
  - *Prescription drugs:* ConnectorCare plans are able to implement more restrictive formularies than current MassHealth rules allow, and may impose more utilization management techniques, which create barriers to both obtaining needed medications and continuing on a course of treatment.
- *Higher premiums for consumers for all but one MCO:* In MassHealth, only members with incomes above 150% of the federal poverty level (FPL) are charged a premium. In ConnectorCare, anyone eligible for a plan with no premium contribution who does not switch to the new lowest cost plan at next year’s open enrollment will be assessed a premium and terminated after ninety days of non-payment of premiums.<sup>8</sup> Unlike Medicaid or the former Commonwealth Care program, in ConnectorCare there is no legal requirement that the Connector continue to offer a \$0 premium contribution plan to low-income individuals. The premiums for plan options other than the lowest cost plan are substantial – up to \$174 per month in 2017.<sup>9</sup> Many MassHealth members transitioning to ConnectorCare will not be able to continue enrollment in their current health plan or maintain continuity of care due to the higher cost. Data from the 2017 open enrollment period showed that nearly 3,000 members with no premium in December 2016 who did not switch to the new lowest cost plan in 2017 were terminated for non-payment of premiums on March 31, 2017.<sup>10</sup>
- *Higher copays:* ConnectorCare copays for enrollees in Plan Type 2A are substantially higher than those in MassHealth, impacting access to services for members. For example, MassHealth copays for prescription drugs are \$1 or \$3.65 per medication, and MassHealth members cannot be turned away for inability to pay.<sup>11</sup> ConnectorCare Plan Type 2A members are required to pay between \$10-40 to fill each prescription. ConnectorCare imposes copays for a wider range of services than MassHealth, including \$10 for a primary care or mental health/substance use disorder visit, \$18 for a specialist visit, and \$50 for emergency room and other hospital services.<sup>12</sup>
- *Splitting up families:* With the introduction of MassHealth Accountable Care Organizations (ACOs), and the re-procurement of MassHealth MCOs in 2018, there may be less overlap between

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<sup>8</sup> Connector Policy #NG-6B, available at: [https://www.mahealthconnector.org/wp-content/uploads/policies/Policy\\_NG\\_6B.pdf](https://www.mahealthconnector.org/wp-content/uploads/policies/Policy_NG_6B.pdf).

<sup>9</sup> 2017 ConnectorCare Member Contributions, available at: [https://www.mahealthconnector.org/wp-content/uploads/board\\_meetings/2016/2016-09-08/ConnectorCare-Placemat-090816.pdf](https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-09-08/ConnectorCare-Placemat-090816.pdf).

<sup>10</sup> Health Connector presentation, *Recap of Open Enrollment and Community Outreach*, April 13, 2017. Available at: [https://www.mahealthconnector.org/wp-content/uploads/board\\_meetings/2017/04-13-2017/OE2017-Outreach-Update-041317.pdf](https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/04-13-2017/OE2017-Outreach-Update-041317.pdf).

<sup>11</sup> 130 CMR §506.016 and 506.017.

<sup>12</sup> See: [https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare\\_Overview-2017.pdf](https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare_Overview-2017.pdf).

MassHealth and ConnectorCare provider networks. Different networks will disrupt continuity of care and may split up care for families who currently receive care in the same provider system.

- *Reconciliation and tax debts:* ConnectorCare enrollees must reconcile the federal APTC portion of their subsidies, which can lead to a tax debt if the advance credit amount was incorrect or loss of coverage if ConnectorCare members failed to file the right forms with their taxes to reconcile for the prior year.
- *Loss of work incentives for the working poor:* MassHealth has work support programs like Premium Assistance to enable low income individuals to afford ESI and Transitional Medical Assistance to allow working poor parents whose earnings put them over 133% FPL to qualify for twelve months of transitional MassHealth Standard to help them work their way out of poverty without an abrupt increase in the cost of coverage. ConnectorCare does not offer these programs.
- *Enrollment barriers:* MassHealth allows continuous open enrollment throughout the year, and individuals are covered back to the date of application prior to enrolling in a health plan. The former Commonwealth Care program under Chapter 58 also allowed continuous open enrollment. However, the ConnectorCare program is partially governed by federal Exchange rules, and does not allow for continuous enrollment. Being determined newly eligible for ConnectorCare is considered a qualifying event and allows individuals a 60-day special enrollment period, but this does not mitigate enrollment barriers for those who have previously been determined eligible.
- *Increased number of uninsured:* Unlike MassHealth, Connector enrollees must take the step of choosing a plan and paying a premium before their coverage is effectuated. In fact, the most recent numbers provided by the Health Connector for a point in time show that 40% of people eligible for ConnectorCare Plan Type 2A remain unenrolled. ConnectorCare, unlike MassHealth, does not automatically enroll eligible individuals into a health plan. In addition, ConnectorCare has eligibility rules that would bar certain people from qualifying, such as those who have access to employer sponsored insurance (ESI) with a premium that costs less than 9.69% of their family income in 2017; veterans with access to the VA Health System; Deferred Action Childhood Arrivals; and married couples living apart filing taxes separately (with limited exceptions).

In recent years, Connecticut, Maine, and Rhode Island attempted to shift parents from Medicaid to the Marketplace. Before the eligibility change, all three states covered parents at higher income levels than Massachusetts; after the shift, parents in Connecticut and Maine continue to be eligible at higher income levels than Massachusetts eligibility rules currently allow. Despite efforts on the part of these neighboring New England states to mitigate impacts, a substantial number of parents lost coverage. Rhode Island reduced parent eligibility for its RItCare program from 175% FPL to 138% FPL beginning January 1, 2014. Of the 6,574 affected parents, 1,921 (29%) likely became uninsured – 650 chose a Qualified Health Plan (QHP) through the Exchange but never made a payment and 1,271 never submitted an application to enroll in a QHP.<sup>13</sup> In 2015, Connecticut reduced eligibility for its HUSKY program from 200% FPL to 150% FPL. Of the parents who lost coverage, just one in four enrolled in a QHP.<sup>14</sup> Maine reduced eligibility for MaineCare for working parents from 133% FPL to 105% FPL in 2012. As Marketplace coverage was not yet available, 28,500 parents lost coverage.<sup>15</sup> Based on Connecticut and Rhode Island's experiences and the fact that Maine has not restored coverage for parents nor expanded Medicaid, it is likely that the majority of these parents became uninsured.

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<sup>13</sup> Community Catalyst, *Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned*, September 2015. Available at: <https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?tr=y&auid=15902172>.

<sup>14</sup> Connecticut Voices for Children, *HUSKY Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligibility Cut Later in 2016 (Connecticut Voices)*, April 2016. Available at: <http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf>.

<sup>15</sup> Maine Children's Alliance, *Ensuring Coverage for Maine Children with Families in 2014*. Available at: [http://www.mekids.org/assets/files/issue\\_papers/healthcoverage\\_children\\_2014.pdf](http://www.mekids.org/assets/files/issue_papers/healthcoverage_children_2014.pdf).

Children are also impacted by interruptions in coverage for their parent(s). Children in low-income families are three time more likely to be uninsured if their parents are uninsured.<sup>16</sup> Data shows that children with uninsured parents have a greater risk of gaps in coverage, and are less likely to receive check-ups, preventative care and are other health services.<sup>17</sup>

### **MassHealth Limited and ConnectorCare Coverage**

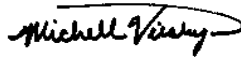
MassHealth proposes to eliminate MassHealth Limited coverage 90 days after an individual is determined eligible for ConnectorCare, as is done with access to the Health Safety Net. We are concerned that those who remain eligible for ConnectorCare but unenrolled will not have access to even emergency coverage after 90 days, and will be foreclosed from enrolling. Therefore, we suggest that the Commonwealth amend its request to provide that MassHealth Limited coverage is terminated only when the coverage is truly redundant; that is, after an individual has successfully enrolled in ConnectorCare. We support the proposed plan to open a special enrollment period for individuals enrolled in MassHealth Limited and eligible for – but unenrolled in – ConnectorCare.

We appreciate the opportunity to provide written comments and enter into dialogue regarding the Commonwealth’s proposed 1332 waiver and related issues. Should you have any questions or wish to discuss these comments further, please contact Suzanne Curry at (617) 275-2977 or [scurry@hcfama.org](mailto:scurry@hcfama.org). Thank you for your time and consideration.

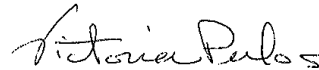
Sincerely,



Suzanne Curry  
Associate Director  
Policy and Government Relations  
Health Care For All



Michelle Virshup  
Staff Attorney  
Health Law Advocates



Victoria Pulos  
Senior Health Law Attorney  
Massachusetts Law Reform Institute

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<sup>16</sup> Connecticut Voices for Children, quoting Schwartz K, *Spotlight on uninsured parents: How a lack of coverage affects parents and their families*, Washington DC: Kaiser Commission on Medicaid and the Uninsured, June 2007. See also: DeVoe JE, Krois L, Edlund C, Smith J, Carlson NE, *Uninsured but eligible children: are their parents insured? Recent findings from Oregon*. Medical Care, 2008 Jan; 46(1): 3-8.

<sup>17</sup> Maine Children’s Alliance, quoting Sara Rosenbaum and R.P.T. Whittington, *Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature*, 5-6 (George Washington University 2007).





August 24, 2017

Audrey Morse Gasteier, Chief of Policy and Strategy  
Emily Brice, Deputy Chief of Policy and Strategy  
Massachusetts Health Connector  
100 City Hall Plaza, 6th Floor  
Boston, MA 02108

***Re: Comments on Section 1332 Waiver Request***

Dear Ms. Gasteier and Ms. Brice:

On behalf of our member hospitals and the patients they care for, the Massachusetts Health & Hospital Association (MHA) appreciates the opportunity to offer comments on the commonwealth's proposed Section 1332 waiver to the Affordable Care Act (ACA).

One of the Connector's 1332 proposals is to establish a Premium Stabilization Fund in lieu of federal Cost-Sharing Reductions (CSRs) for low-income enrollees who purchase health insurance in the Connector. The Connector requests the authority to waive CSRs and for the state to receive any federal premium tax credit savings that will accrue in the form of a "pass-through." The theory is that if the federal government fails to make good on CSRs, premiums will increase significantly thereby increasing the federal premium tax credits resulting from an expected increase in premiums to offset the loss of cost-sharing subsidies. The Connector states it would use this "pass-through" funding to stabilize premiums offered to low-income individuals in the Connector.

MHA shares the Connector's concerns regarding the uncertainty that continues to surround CSR funding and whether the funding will be fulfilled by the federal government. Without this funding, the affordability of low-income health insurance in the Connector will be challenged and could also threaten health insurance participation in low-income ConnectorCare products resulting in reduced consumer choice. According to the Health Connector, health insurance premium rates for silver plans would increase by 16% to 20% in the Massachusetts merged small group / non-group market. Nationwide, the Kaiser Family Foundation states that the average

premium for a benchmark silver plan in ACA marketplaces would need to increase by 19% to compensate for the loss of CSR funding.<sup>1</sup>

MHA supports the Connector's efforts to maintain affordable health coverage offerings for consumers, including low-income residents eligible for ConnectorCare and its subsidized health insurance offerings. Based on the Connector's narrative, we understand that the commonwealth is seeking these funds to provide stability to the insurance market for these coverage offerings and to prevent changes to consumer coverage costs and benefits. MHA is supportive of exploring such methods as proposed by the Connector. Given that the subsidies are intended to support low-income residents using health insurance coverage, alternative methods of issuing this funding must be handled with care. We believe these funds should be protected and devoted solely to ensuring affordable health insurance coverage for low-income residents in the Exchange.

If a Premium Stabilization Fund is created on the commonwealth's books, it should be crafted in a manner that includes protective language to ensure these funds cannot be used for other purposes. We raise this concern in light of General Fund transfers and "sweeps" from the Commonwealth Care Trust Fund in recent years. We have grown concerned with these transfers as this 2006 health reform trust fund was dedicated to providing needed funding to support both affordable healthcare coverage for low-income Massachusetts residents as well as the Health Safety Net. We believe healthcare funding dedicated for defined purposes should not be redirected for other purposes. If a new fund is created or these funds are housed here, increased protections of CSR funding should be included.

MHA appreciates the Connector's efforts to maintain affordable health coverage offerings for Massachusetts residents and we thank you for your consideration of our comments. We look forward to continuing our important partnership with the administration, the legislature, and other stakeholders to keep the ACA successful for Massachusetts residents and the healthcare providers that care for them.

Sincerely,

A handwritten signature in blue ink, appearing to read "Daniel J. McHale". The signature is fluid and cursive, with a large initial "D" and "M".

Daniel J. McHale  
Sr. Director, State Government Finance & Policy  
Massachusetts Health & Hospital Association

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<sup>1</sup> <http://www.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>

August 25, 2017

Ms. Emily Brice  
Deputy Chief of Policy and Strategy  
Commonwealth Health Insurance Connector Authority  
100 City Hall Plaza, 6<sup>th</sup> Floor  
Boston, MA 02108

**Re: AIM Comments for 1332 Waiver Request**

Dear Ms. Brice:

Associated Industries of Massachusetts (AIM) and its thousands of employer members wish to raise a number of points relative to the Commonwealth's application for a State Innovation Waiver under 1332 of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act).

Since the implementation of universal health care in Massachusetts and the Affordable Care Act nationally, our 4,000 employer members statewide have been concerned over the ever-increasing cost of health insurance. AIM members are proud to lead the nation with 76% of Massachusetts employers offering health insurance coverage to their employees compared with 55% of employers nationwide.<sup>1</sup> This rate is even higher for Massachusetts employers with 50 or more employees, of which 98 percent offer coverage.

But providing that coverage has consequences. According to the most recent data available from the Centers for Medicare and Medicaid Services, Massachusetts was the second highest-cost state for health care in 2014, spending over 30 percent more than the national average. Personal health-care spending in Massachusetts, per capita, has increased more than 12 percent in five years – from \$9,417 in 2009 to \$10,559 in 2014. Cost growth like this is unsustainable and has increased unabated in the face of attempts by both employers and the commonwealth to contain it.

Small businesses, in particular, struggle to manage rising costs with virtually no control over the prices handed to them by insurers. In 2015, over 57% of Massachusetts' insured residents received their coverage via their employers.<sup>2</sup> Even with such a large percentage of employers actively participating in the health insurance system, their individual market power to contain costs is limited.

Four years after a major push within Massachusetts toward health care cost containment, businesses have little to show in the way of cost savings and efficiencies. We know it is possible

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<sup>1</sup> Source: 2014 Employer Survey by the Center for Health Information and Analysis.

<sup>2</sup> Source: 2015 Massachusetts Health Insurance Survey by the Center for Health Information and Analysis

to slow the rate of growth in health care costs; but we also know that we must remain vigilant to ensure that cost growth reflects necessary and efficient changes in the market. We also must establish clear, predictable policies that reflect the specific needs and characteristics of the Massachusetts health insurance marketplace and the consumers it serves. It is possible for the market to respond positively to government pressure and changes in consumer behavior.

The State Innovation Waiver program is an opportunity for Massachusetts to tailor ACA health care policies with a goal of increasing efficiency, decreasing administrative burden, and prioritizing cost containment. With a maximum term of five years – and an option to renew after the term has expired – the waiver program also holds out the promise of increased predictability, a characteristic lacking in the market since the roll-out of the ACA in 2014.

Additionally, the 1332 waiver program provides an alternative to the challenging process of advancing legislation through Congress piecemeal. Any changes made to health care or health insurance policy have immediate and direct implications for premium costs shared between employers and employees. In the face of Congressional uncertainty, a clear and definite process will provide the predictability necessary to moderate the consistent increases Massachusetts employers have experienced since the implementation of the ACA.

AIM would like to be recorded in support of the following provisions included in the waiver:

- Promote Market Stability with a Premium Stabilization Fund in Lieu of Cost-Sharing Reductions;
- Revive Permissibility of Section 125 Plans for Non-Benefits Eligible Employees to Enhance Consumer Savings and Promote Private Coverage;
- Permission for the Commonwealth to Administer the Federal Small Business Health Care Tax Credit;
- Allow for State Option to Continue to Use Select State-Based Rating Factors; and,
- Commence a Process to Evaluate the Future of Risk Adjustment in the Commonwealth.

AIM would also like to raise a concern relative to the provisions around the State Employer Shared Responsibility Program, as referenced in the Flexibility Requests. While we support the request to waive the provisions of the federal employer mandate and related requirements, we would request that the Health Connector remove any reference to the newly-created Massachusetts employer contribution as a permanent policy.

As our Commonwealth faces an alarming deficit in its Medicaid program, employers have been required to shoulder the escalating costs of the public healthcare system, in addition to the costs of commercial health insurance. More importantly, our members are being asked to close the MassHealth deficit absent of long-term structural reforms needed to solve the underlying financial problems with the program. This policy, it should be specified, is a temporary, two-year program.

Today, we face an immediate state funding gap that foretells the financial challenges we will face in the coming years if our public health-care system continues without reform. We may well proceed through two years of an employer assessment and face an even worse funding scenario in the MassHealth program.

Eleven years ago, Massachusetts employers joined with doctors, hospitals, patient advocates and lawmakers to forge a health-reform law that required all parties to share the responsibility for improving access to health care. With the flexibility of an approved State Innovation Waiver, and coordinated reform on the state level, Massachusetts can take definitive steps to achieve long-term, comprehensive cost containment across our Commonwealth.

Thank you for taking AIM's position into consideration. Should you have any questions please feel free to contact me directly at 617-262-1180.

Sincerely,

A handwritten signature in cursive script that reads "Katherine E. Holahan".

Katherine E. Holahan  
Vice President for Government Affairs



**Michael T. Caljouw**  
Vice President  
State Government & Regulatory Affairs

August 4, 2017

Louis Gutierrez, Executive Director  
Commonwealth Health Insurance Connector Authority  
100 City Hall Plaza  
Boston, MA 02108

Re: Comments on Draft Request for State Flexibility to Support Commercial Insurance Market Stability and Reforms (Draft Request for State Flexibility)

Dear Executive Director Gutierrez:

This letter provides the comments of Blue Cross and Blue Shield of Massachusetts (“BCBSMA”) on the July 24, 2017 “Draft Request for State Flexibility”. Massachusetts and BCBSMA continue to be national leaders in reducing the number of uninsured while offering high-quality, affordable coverage. While we support the market-based philosophy behind much of the current plan, certain key issues noted below merit changes prior to submission and substantive dialogue with the federal authorities:

### **1. The Vibrant Use of Massachusetts Rating Factors**

Flexibility is critical for the continued use of the state-based rating factors. Action on this request is time-sensitive. Health plans make their next rate filing on January 1, 2018 for the second quarter of 2018 – a filing that includes coverage into 2019.

As seen prior to the Affordable Care Act, the vibrant use of rating factors are important tools for Massachusetts small businesses. A 2013 Oliver Wyman report for the Commonwealth on their impact established that over 180,000 small group enrollees could see premium increases of more than 10 percent if the state rating factors were to be eliminated. As the Draft Request for Flexibility states, although exact estimates may change, “they are indicative of the potential swings in premium rates that could arise....”

BCBSMA strongly supports a flexible approach strengthening employer-based coverage at a critical time. Specifically, the group size and group purchasing cooperative factors should be employed, as they were for many years, as key mechanisms for stability and cost relief. Massachusetts should pursue the flexibility to re-employ these factors, currently at a reduced rate, to their full impact.

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101 Huntington Avenue, Suite 1300 | Boston, MA 02199-7611 | [www.bluecrossma.com](http://www.bluecrossma.com)

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## **2. Risk Adjustment in the Commonwealth**

Risk Adjustment is mandated under federal law. See 42 U.S.C. section 18063. Moreover, federal regulations implementing the law clearly state that “[a] state, or HHS on behalf of the State, must implement risk adjustment for the 2014 benefit year and every benefit year thereafter.” 45 C.F.R. section 153.310(e). For purposes of the risk adjustment program, the requirements imposed by the ACA and the standards set forth in the regulations are binding upon the States and may not be waived. In fact, Massachusetts has transitioned complete oversight of the Risk Adjustment back to the federal government and its consistent nation-wide methodology. Moreover, there have been numerous efforts to repeal or replace various elements of this law and at no time was there any credible attempt to amend or end this mandatory program.

Furthermore, as a policy matter, Risk Adjustment prevents adverse selection against health plan members with comparatively higher actuarial risk and promotes competitive rates for these members. More than a quarter of a million Massachusetts consumers - through BCBSMA and other plans - have already benefitted from Risk Adjustment through significantly lower premiums.

## **3. Section 125 Plans and Private Market Coverage in Massachusetts**

Section 125 plans, drafted precisely, can provide additional options for non-benefit eligible employees to help in the purchase of non-group coverage. In fact, BCBSMA had offered our own Voluntary Blue program after the passage of Chapter 58. Notably, there was very little interest by employers and enrollment in this program remained low.

The Draft Request for Flexibility asserts factors leading to increased interest in the Section 125 plans. If Section 125 plans are authorized, we recommend that enrollment not be restricted to the Connector and that flexibility be applied to enrollment in health plans directly. Also, if authorized, we recommend that this be an optional, rather than mandated, tool and that there be no mandate on employers or health plans to participate.

## **4. Massachusetts and the Federal Small Business Health Care Tax Credit**

Federal law restricts small business health care tax credits to a very limited subset of small employers. For a variety of reasons, including these limits, there has been very low awareness and use of such credits. If such credits are made more widely available for small groups, BCBSMA strongly recommends that they not be limited to the Connector. In order to maintain a level playing field and provide greater relief to small groups, flexibility should allow small groups to use such credits directly from private market health plans, making coverage for small employers more affordable and accessible. Any request for flexibility should include language to expand the availability to employers buying direct from health plans.

Under the more limited version of the Draft Request for Flexibility, the tax credit should only apply to groups that stay together. Without such a restriction, there will be adverse selection (associated with the Employee Choice program).

#### **5. Flexibility for Premium Stabilization**

Should funding for Cost Share Reductions not be made available, BCBSMA supports Massachusetts flexibility for a Premium Stabilization Fund with resulting federal APTC/PTC savings issued to the Commonwealth. The details of this complex issue are important and we pledge to work with you and other stakeholders on the same.

We look forward to our continuing and productive dialogue on these matters.

Sincerely,



Michael T. Caljouw

cc: Gary Anderson, Commissioner of Insurance  
Kevin Beagan, Deputy Commissioner of Insurance  
Audrey Gasteier, Chief of Policy & Strategy  
Emily Brice, Deputy Chief of Policy and Strategy





August 23, 2017

Audrey Morse Gasteier  
Commonwealth Health Insurance Connector Authority  
100 City Hall Plaza, 6<sup>th</sup> Floor  
Boston, MA 02133

Dear Ms. Gasteier:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 member health plans that provide coverage to more than 2.6 million Massachusetts residents, we thank you for your continued commitment and ongoing advocacy as you work to preserve stability in the Commonwealth's health insurance market. We appreciate the opportunity to provide feedback on the state's request for federal flexibility to ensure a sustainable Massachusetts health care system.

**Premium Stabilization Fund Cost Sharing Reductions**

We support the funding request included in the Commonwealth's draft 1332 waiver application for pass-through funds from the federal government should federal CSR payments be reduced or eliminated to ensure the stabilization and viability of the state's individual health insurance market. We believe that the proposed solution will ensure that consumer choice and access to affordable coverage is maintained, while minimizing disruption for low-income state residents.

Our most immediate concern, and one we know you share, is the continuation of Cost Sharing Reduction Payments (CSRs). The loss of these federal subsidies to assist low-income individuals in obtaining medical care will substantially erode our state's coverage gains. Neither Congress nor the Trump Administration has made a commitment to continue CSR funding and it is unclear whether the payments will be forthcoming in subsequent months; conversely, the federal Administration has authority to terminate monthly CSR payments at any time and has repeatedly threatened to do so.

The continuation of CSR payments for 2017-2019 is critical to protect Massachusetts consumers. It is essential for health plans and the consumers they serve to know that funding for cost sharing reduction subsidies will continue uninterrupted. As you know, this financial assistance makes health care more affordable for lower-income enrollees who might not purchase coverage without this support, by directly reducing the out-of-pocket costs for these enrollees, including deductibles, copayments, and coinsurance amounts. Individuals and families with incomes up to 250 percent of the federal poverty level enrolled in the state's ConnectorCare program represent 78 percent of all commercial health plan members who obtain coverage in the individual market through the Health Connector. In 2016, there were 244,400 ConnectorCare enrollees who were able to benefit from these cost sharing reductions.

If this funding is lost, coverage for these low-income individuals will be in grave jeopardy. For the remainder of 2017 (August through December), approximately \$46 million in federal funding is due to the health plans offering coverage to Massachusetts residents; in 2018, an estimated \$125 million in federal funding will be owed. Failure to have a contingency plan in place could expose the more than 155,000 current enrollees and participating health plans to hardship that will threaten access to coverage. Consumers who benefit from these federal subsidies will likely be unable to afford health insurance.

A number of states have taken preemptive measures to address the possible loss of CSR payments. The approach outlined in the federal flexibility request proposal is one creative option for the state to pursue in an effort to protect financing from the federal government and insulate low-income enrollees from the resulting costs if the federal government backs out of its obligation. We would like to continue to work with your Administration on contingency planning should the Trump Administration signal elimination of CSR payments; in the absence of an alternative viable state solution to continue the provision of cost sharing reductions to the ConnectorCare population, we support the efforts by the state to secure federal funding for the continued subsidization of low-income members in the individual market should CSR payments be reduced or eliminated.

Additionally, we believe it is critical that the waiver request be amended to include explicit language that makes clear that all pass-through funding received from the federal government and deposited into the Commonwealth Care Trust Fund shall be utilized only for direct reimbursement to the health plans participating in the ConnectorCare program to reimburse at 100% of the actual CSR payment obligations based on year-end membership and utilization. Moreover, the transfer of funds into and out of the Commonwealth Care Trust Fund must be transparent and traceable, allowing the state and carriers to fully understand the flow of funds.

Finally, we request that the flexibility request be amended to make clear that the Commonwealth is requesting that the alternative payment structure outlined in the request go into effect *only* in the event that federal CSR payments are reduced or eliminated. Such a contingency is important as the ideal outcome for all parties would be the continuation of the status quo with the federal government subsidizing CSR payments on a dollar-for-dollar basis. The federal government has already approved one contingent 1332 waiver request (Alaska's waiver approval was contingent on the passage of certain state legislation), and should be supportive of this contingency from a budget neutrality perspective.

### **Flexibility Relative to Rating Factors**

We strongly support the state's request for authority to continue to allow health plans to apply state-based rating factors beyond the 2018 plan year. The additional flexibility secured by the state has allowed Massachusetts' health plans to continue to use our state-specific rating factors over an extended phase-out period in order to preserve stability in product pricing. The elimination of the state's rating factors once the transition period ends on January 1, 2019 could further exacerbate the challenges that small businesses are facing, driving up costs for many of them. As maintaining the state's rating factors has been an important issue to the business community, we would urge that the Commonwealth seek a permanent waiver that permits the state's current rating factors to continue for all merged market offerings to protect small businesses.

### **Extension of Small Business Tax Credits to Off-Exchange Coverage**

Additionally, we support the Commonwealth's request to administer the federal Small Business Tax Credit at the state level in order to better support Massachusetts employers' ability to purchase commercial coverage in the small group market for their employees. There has been limited uptake of these tax credits among small businesses due to the administrative complexity and a low level of awareness. However, our health plans have strong relationships with the small business community and are confident that the

extension of tax credits to plan members enrolled in coverage outside of the Health Connector would serve to expand the population who is able to take advantage of the financial savings offered.

### **Risk Adjustment**

Finally, we support the creation of a multi-stakeholder workgroup committed to considering whether there exists a need within the Massachusetts market to continue risk adjustment. As you are aware, the marketplace has undergone considerable changes over the last several years due to the ACA. While the ACA has helped to further expand coverage and build upon our state's health reform efforts, various aspects of the law and its implementation have created significant disruption for consumers, employers, health plans and providers. An overwhelming majority of policymakers, advocates, and consumers across the country can agree that the federal health care law is not perfect, but can continue to be improved upon in a number of ways to the benefit of all stakeholders in the system.

Recently, the MAHP Board of Directors voted 11-3 (with three abstentions) to support suspension of the risk adjustment program in favor of the establishment of a more equitable and predictable system for addressing potential adverse selection issues among the health plans. Supported by a majority vote, the Board further agreed that risk adjustment should be suspended until such time as a workgroup of impacted stakeholders can come together to develop a methodology that is both predictable and ensures competition in our market place.

Risk adjustment provisions included in the ACA were intended to stabilize state marketplaces during implementation of federal market reform rules. However, many of these market reform rules, including guaranteed issue and modified community rating, as well as the existence of a merged market and an individual mandate, have been in place for many years in our state. Instead of stabilizing our marketplace, risk adjustment has had the opposite effect in Massachusetts, requiring the transfer of millions of premium dollars between health plans each year, affecting the overall stability of our state's insurance marketplace, and directly contributing to premium increases for employers and consumers.

We continue to have serious concerns about the impact of risk adjustment on the marketplace and the upward pressure it is putting on premium rates for consumers and employers. We believe that federal rules and recent actions contemplate state flexibility in the administration of the risk adjustment program. In May of 2016, CMS released an interim final rule that included a section on risk adjustment. Specifically, the section states:

“Based on our experience operating the 2014 benefit year risk adjustment program, HHS has become aware that certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate....we are sympathetic to these concerns and recognize that States are the primary regulators of their insurance markets. We encourage States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets.”

It is well understood that the state's interest in cost containment efforts, including our cost benchmark, innovative product designs that drive care to low cost providers, and tiered and limited network products that are statutorily required to be sold at a premium differential of 14 percent lower than broad-network products, are efforts to make health coverage more affordable for consumers, especially small businesses. These stated policy goals are significantly undermined by the current risk adjustment methodology that, in fact, discourages innovative product designs, adds to small group and individual premiums, and further thwarts competition in our merged market. We are committed to working with you and members of the proposed workgroup to examine the methodology, to ascertain where improvements can be made to accurately reflect the marketplace, and to ensure that risk adjustment promotes competition and stability in the health care system.

Our member plans remain committed partners in working with the State to ensure that Massachusetts keeps its coverage gains and that we can continue to be a leader in providing high quality health care that is affordable to our citizens. We know you share our interest in ensuring the continued success of our state's health reform efforts and avoiding the potential of higher health care costs for employers and consumers, and we support the Administration's request for flexibility on the issues that we have outlined.

Sincerely,

A handwritten signature in black ink, reading "Lora M. Pellegrini". The signature is written in a cursive, flowing style.

Lora M. Pellegrini  
President and CEO