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January 11, 2017

The Honorable Kevin McCarthy
Majority Leader
United States House of Representatives
H-107, U.S. Capitol Building
Washington D.C., 20515

Leader McCarthy,

Thank you for the opportunity to provide initial input on how to improve upon the goals of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). For more than ten years, the Commonwealth of Massachusetts has been deeply engaged in designing and implementing health care reform solutions, first on a state level with our comprehensive, bipartisan state reform in 2006, and later with implementation of the Affordable Care Act. Although our state's initial implementation of the Affordable Care Act was deeply flawed, today more than 220,000 individuals have health care coverage through our state exchange, 180,000 low to modest income residents receive federal and state subsidies, and an additional 300,000 adults are enrolled in Medicaid as a result of the expansion allowed through the Affordable Care Act.

As an overarching statement, Massachusetts believes strongly in health care coverage for its residents. Working with the federal government, we have made considerable progress toward a goal of ensuring near universal health care coverage for our residents. Over 96.4% of Massachusetts residents were insured in 2015, the highest in the country.¹ Massachusetts retains a vital employer-sponsored insurance market, covering just under 60% of those insured.² And, the Massachusetts state-based exchange, known as the "Connector" maintains a robust individual insurance market with more than 10 health insurers. Affordability of health care remains a significant challenge, including double digit health care premiums.

Additionally, while health coverage is important first and foremost for its benefits to residents, health care is an economic engine for Massachusetts. The health care industry contributed \$19.77 billion to the state's economy, outpacing any other industry. One out of every ten workers is employed in health care related fields.³

¹ <http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf>.

² <http://www.chiamass.gov/assets/docs/r/survey/mhis-2015/2015-MHIS.pdf>.

³ <http://247wallst.com/special.report/2016/09/23/largest-industry-in-each-state-3/6/>

Massachusetts attributes much of its success in expanding health care coverage through a strong bipartisan effort across insurance, business, health care, political and advocacy communities that began in the 1990's and resulted in the passage of our state's health care reform law in 2006. Our belief is that health care coverage is a shared commitment, not the singular responsibility of government. Some of the changes to its health care law that Massachusetts had to make to comport with federal provisions have resulted in unintended consequences particularly impacting the employer sponsored insurance market and Medicaid program. Since 2011, the Commonwealth has seen a costly shift of approximately half a million lives from the commercial, employer-sponsored market into public coverage. The Medicaid program now accounts for just under 40% of the state's budget. Since 2012, the percent of residents on commercial insurance has decreased by 7 percentage points while Medicaid enrollment increased by 7 percentage points and now covers 28% of the population. The uninsurance rate has remained constant at 3%. The significant shift in lives from private to public coverage as a result of implementing the ACA – without a change in the uninsurance rate – has disrupted the stability of the Commonwealth's coverage landscape and contributed to challenges in the growth of the Medicaid program.

Massachusetts seeks flexibility to achieve the goals inherent in the Affordable Care Act and Medicaid programs while meeting the needs of its state.

In addition to expanding health care coverage, there are other important provisions contained within the Affordable Care Act. These include but are not limited to patient protections such as the ban on pre-existing condition exclusions, elimination of annual or lifetime limits and gender inequities. The ACA also closed the Medicare "donut" hole, extended the solvency of the Medicare trust fund and allowed for young people to remain on their parents' coverage through the age of 26. In addition, the ACA authorizes an important demonstration for integrating care for individuals dually eligible for Medicaid and Medicare.

However, as is true for any complex and complicated piece of national legislation with significant impact on the delivery of health care in 50 unique states, there is an opportunity to review and amend legislation to ensure it meets its intended goals and provides states with flexibility to implement health care reform in a way that meets states' needs. Any changes to the Affordable Care Act must also take into account the impact changes would have on the Medicaid program. MassHealth, the Massachusetts Medicaid and Children's Health Insurance Programs, provides health care coverage for nearly 1.9 million residents; it is an important safety net for a significant portion of our state's population. Medicaid is a shared federal/state partnership. Proposals that suggest states may be provided with more flexibility and control must not result in substantial and destabilizing cost shift to states.

As Congress considers options related to health reform, we believe that a measured and objective analysis of the opportunities and challenges for states in the current federal landscape is essential. During this period of deliberation, it is important that coverage gains, patient protections and market stability are maintained. Our overall recommendations going forward include:

- Maintaining market stability as reform options are considered.
- Reviewing and revising key provisions of the Affordable Care Act and Medicaid program to provide states with flexibility to meet the unique needs of their state's population.
- Providing ample time for transitioning into new health care coverage and/or delivery models to ensure operational readiness.

- Maintaining state health care safety nets, including retaining existing federal subsidies and uncompensated care pools that support health care coverage and charity care providers.
- Avoiding proposals that only offer more flexibility and control in exchange for shifting costs to states.
- Expanding state flexibility in response to unique state needs that meet the overarching goals of health care coverage, access, quality and affordability in both the ACA and in the Medicaid program.

Massachusetts passed a version of universal health care coverage. The Affordable Care Act has provided both opportunities and challenges. The opportunities included further expanding coverage and receiving increased federal support for expansion. The challenges include implementing provisions that have added to state health care complexity and cost, rather than outcomes and affordability. We believe the path forward is to build upon a strong federal and state partnership in agreeing to the goals we all share while allowing states sufficient flexibility to tailor their health care system to meet the needs and demands of their unique state.

Sincerely,

A handwritten signature in cursive script that reads "Charles D. Baker". The signature is written in black ink and is positioned to the right of the word "Sincerely,".

Charles D. Baker
Governor

1. What changes should Congress consider to grant more flexibility to states to provide insurance options that expand choices and lower premiums?

- Massachusetts has appreciated the flexibility that Congress and the Department of Health and Human Services have made available to states in the past, such as existing Section 1115 and Section 1332 waiver pathways. Massachusetts values the availability of federal infrastructure and funding for states to continue innovating to meet the specific needs of their populations and markets. Critically, and during the next few years, we request that Congress offer states the option to maintain state flexibility agreements already in place, when considering any future changes.
- Massachusetts believes there are opportunities to expand upon flexibility provided to states with both the 1115 and Section 1332 authorities. State innovation is key to achieving health care coverage, managing health care costs and affordability, as well as improving patient outcomes and satisfaction.
- Going forward, greater flexibility should be provided to states with regard to:
 - state specific benefit rules, beyond what is permitted under Essential Health Benefit standards
 - state specific actuarial value calculator for benefit standards
 - state specific rating factors to apply for small group premium development
 - a more flexible risk adjustments system or elect not to apply risk adjustments
 - insurance products offered through group purchasing cooperatives and professional employer organizations
 - administrative rules and regulations, simplification regarding compliance and other reporting requirements.
 - greater authority and flexibility to ensure that mental health parity rules are complied with.

2. What legislative and regulatory reforms should Congress and the incoming administration consider to stabilize your individual, small group, and large group health insurance markets?

- Congress and the incoming administration should introduce any legislative or regulatory changes on a gradual timeline, ideally with state flexibility to opt out or grandfather existing programs, to prevent market shocks and to improve market stability.
- Congress should consider:
 - allowing states to maintain the individual mandate to allow stability within risk pools
 - maintaining risk corridor and reinsurance payments in 2017 with coverage in place in 2016
 - maintaining risk adjustment for 2017 as carriers have built risk adjustment into already offered 2017 premiums.
 - allowing states to determine risk adjustment system for 2018 and onward.
 - permitting states to develop state specific open enrollment rules.
- **What are key administrative, regulatory, or legislative changes you believe would help you reduce costs and improve health outcomes in your Medicaid program, while still delivering high quality care for the most vulnerable?**

- Medicaid represents a significant portion of state budgets (just under 40% in Massachusetts) and is a shared federal/state partnership. While we strongly support maintaining and increasing flexibility for states (such as through existing Section 1115 waiver authorities), proposals that suggest states be provided with more flexibility and control must not result in substantial and destabilizing cost shift to states. We are very concerned that a shift to block grants or per capita caps for Medicaid would remove flexibility from states as the result of reduced federal funding. States would most likely make decisions based mainly on fiscal reasons rather than the health care needs of vulnerable populations and the stability of the insurance market. The federal/state share varies by state, ranging from 80/20 to 50/50; Massachusetts is a 50/50 state. Any Medicaid reform should start with the assumption that every state's current federal share establishes the baseline.
- Medicaid provides the option for states to pursue flexibility through the use of Section 1115 Demonstration Waivers. Massachusetts has had an 1115 in place since 1997, allowing the state to deviate from traditional Medicaid rules with expanded eligibility, streamlined eligibility processes, mandatory managed care and, most recently, a move to value-based purchasing and Accountable Care Organization programs. Our projections show that this move to ACOs will result in reducing spending while also improving health outcomes. We urge our federal partners to maintain flexibility for states through 1115 waivers.
- While our Medicaid program has been a crucial prong in the state's approach towards achieving almost universal health coverage for our residents, we do believe that the Medicaid program could be improved through certain changes to Medicaid rules allowing greater flexibility around benefit design while maintaining patient protections. In particular, the ACA added new Essential Health Benefits (EHB) requirements to the coverage provided to the Medicaid expansion population. This construct is unnecessary and adds unneeded complication to the development of benefit packages. States already make decisions regarding the optional benefits provided to their non-expansion populations and the EHB requirement for expansion populations removes the flexibility states may need to make appropriate benefit decisions for their populations. We also would support the removal of the requirement to provide non-emergency medical transportation to the expansion population.

3. What can Congress do to preserve employer-sponsored insurance coverage and reduce costs for the millions of Americans who receive health coverage through their jobs?

- The Affordable Care Act changed important elements of the Commonwealth's previous version of health care reform with unintended consequences. The ACA employer mandate (for employers with 50 or more FTEs) replaced the Commonwealth's fair share contribution for employers with 11 or more FTEs and added significant administrative burden for employers. In addition, the ACA changed a number of previous rules governing eligibility for subsidized coverage for individuals with access to employer sponsored coverage, changing the dynamic between employers, employees and taxpayer-funded programs in concerning ways.
- As a result, over the past several years, the Commonwealth has seen a shift of ~500,000 lives from the commercial, employer-sponsored market into public coverage. Since 2012, the percent of residents on commercial insurance decreased by 7 percentage points from ~65% to 58%; over the same period, Medicaid enrollment increased by 7 percentage points and now covers 28% of the population. The

uninsurance rate has remained constant at 3%. The significant shift in lives from private to public coverage as a result of implementing the ACA – without a change in the uninsurance rate – has disrupted the stability of the Commonwealth's coverage landscape. It has also contributed to challenges in the growth of the Medicaid program, with 85% of growth over the past several years being driven by enrollment.

- Massachusetts maintains an unwavering commitment to universal coverage and, based on its experience, supports maintaining many components of the ACA, combined with increased flexibility for states to make adjustments based on state-specific needs. This must include more flexibility for states through 1332 waivers to sustain universal coverage, including allowing states to waive the ACA employer mandate for employers with more than 50 FTEs with certain conditions attached (e.g., if states have a better suited alternative) and giving states more flexibility to stabilize commercial coverage options for both individuals and small employer segments.
- As Congress considers changes to the employer-sponsored insurance market, we would request consideration of the need for ample lead-time in order to ensure that employers, insurers, and individuals are able to prepare and possibly alter their choices without undue disruption.
- We suggest revisiting mechanisms to support employers seeking to contribute to coverage through targeted, market-based incentives and administrative simplifications.
- To control the shifting of cost and responsibility for coverage from the commercial market to public programs, rules that allow individuals with access to employer sponsored coverage to enroll in Medicaid should be revised.
- States should be allowed to waive certain ACA provisions, such as the employer mandate for employers with more than 50 FTEs and the definition of full time as 35 hours/week, which can be done with certain conditions attached (e.g. under condition of implementing an approach better suited to the particular state).
- Tax subsidies should be offered to small employers providing affordable coverage to low income employees.
- Flexibility on utilization of existing (and hopefully new) 2 year SB tax subsidies – allow states to access available funds immediately and disburse it by setting own customized eligibility for businesses.
- Allow access to APTC to eligible employees, before applying defined contribution funds provided by employer.
- For example, Congress could:
 - revisit tax code provisions that prohibit employers from setting aside pre-tax money under a Section 125 plan or other tax-preferred mechanisms, so that non-benefit eligible employees can use pre-tax dollars to purchase the non-group coverage of their choice. Massachusetts has substantial experience administering a similar program.
 - refine the ACA's small business health care tax credit, by allowing states to repurpose federal funds toward small group coverage incentive programs that meet local business needs.
- Congress should give states more flexibility to:
 - establish state-specific benefit rules, beyond what is permitted under Essential Health Benefits standards.
 - establish preventive health standards and applicable cost-sharing requirements.
 - develop a state-specific Actuarial Value Calculator to establish benefit standards or elect not to use one.
 - establish state-specific rating factors to apply for small group premium development.

- develop a more flexible risk adjustment system or elect not to apply risk adjustment.
- permit insurance products offered through group purchasing cooperatives and professional employer organizations.
- eliminate ACA premium taxes, including the so-called Cadillac tax.

4. What key long-term reforms would improve affordability for patients?

- Over ten years of state-level reform, Massachusetts has learned that lower-income residents require a substantial level of subsidization in order to take-up and maintain coverage.
- In addition to federal subsidies, Massachusetts offers a program that “wraps” around individual coverage available through the Exchange with additional subsidies for eligible low-income individuals who do not qualify for Medicaid. This level of subsidization, exceeding the current federal level, is critical to enrollment and retention of a healthy risk pool. Massachusetts recommends flexibility to preserve this program in order to boost coverage efforts among hard-to-cover populations.
- Congress must address the growing cost of prescription drugs and foster greater transparency in the cost of high cost health care providers.

5. Does your state currently have or plan to enact authority to utilize a Section 1332 Waiver for State Innovation beginning January 1, 2017?

- a. If allowed, would your state utilize a coordinated waiver application process for both 1115 Medicaid and 1332 State Innovation Waivers for benefit year 2017?**
 - b. If allowed, would your state utilize a model waiver for expedited review and approval similar to the Medicare Part D transition and assistance for Hurricane Katrina evacuees?**
 - c. If allowed, which requirements would your state seek to waive under a 1332 waiver?**
 - d. If allowed—and if applicable—what changes would be necessary to current guidance to accelerate your states’ ability to pursue a 1332 waiver?**
- Massachusetts supports granting states more flexibility under a variety of waiver authorities (Section 1332, Section 1321(e) for states with pre-ACA state health reforms, and Medicaid 1115 waivers) to maintain stable, universal coverage. Massachusetts would also welcome the opportunity to participate in the development of “fast-track” waiver authority to expedite processing and approvals.
 - Specific examples of flexibilities include allowing states to:
 - Waive the ACA employer mandate for employers with more than 50 FTEs and the definition of full time as 35 hours/week with certain conditions attached (e.g., if states have a better suited alternative), and/or significantly simplify the administrative burden on employers for reporting
 - Support employers who are seeking to contribute to coverage through market-based incentives, including:
 - More flexibility for Section 125 plans (for example, Defined Contribution models to purchase coverage on the exchanges)
 - Flexibility to ensure effective implementation of new provisions from the 21st Century Cures Act related to Health Reimbursement Accounts

(HRAs) and opportunities for employees to make tax-deductible contributions for employees purchasing coverage on the exchanges

- Maintain flexibility for low-income coverage options through Medicaid 1115 waivers (the Commonwealth's 1115 waiver allows for premium and cost-sharing wraps for individuals purchasing coverage on the exchange with income <300% of FPL)
- Access small business tax credits and other subsidies
- Waive conflicting eligibility standards between Medicaid and the Exchange (income standards, household size, etc.)
- Implement state-specific Actuarial Value Calculators and rating factors
- Maintain flexibility through Medicaid 1115 waivers on the structure of uncompensated care pools

6. As part of returning more choice, control, and access to the states and your constituents, would your state pursue the establishment of a high-risk pool if federal law were changed to allow one?

- Massachusetts has to date not considered such a plan. The establishment of a high risk pool would depend on the rules and structure of the program; however, we would be concerned given the history of high-risk pools, which has not been particularly successful.

7. What timing issues, such as budget deadlines, your legislative calendar, and any consumer notification and insurance rate and form review requirements, should we consider while making change?

- We appreciate Congress' attentiveness to the local timing needs that would be critical to the successful implementation of any ongoing federal reforms.
- Carriers need clear guidance to develop appropriate products and to set premiums for the insurance market.
- Key deadlines in Massachusetts include:
 - For all individual plans and some small group plans effective January 1, 2018 insurance carriers must complete their development of plan designs and submit them to the Division of Insurance by April 1, 2017 for their review and approval in the previous mid-summer. Carriers must submit the development of rates and submit them to the Division of Insurance by July 1 for their review and approval by mid-summer. For example, plans starting January 1, 2018 will be proposed by insurers by early July 2017.
 - For small group plans effective other than January 1, insurance carriers must forward plan design and rates to the Division of Insurance at least 90 days prior to their effective dates.
 - Open enrollment for individual plans begins November 1, 2017 and ends January 31, 2018. Small group plans have open enrollment on a continuous basis throughout the calendar year.
 - IT and systems changes for the state-based Exchange are generally calendared at least one year in advance – for example, the Massachusetts Health Connector has planned and budgeted for its 'systems releases' through Fall 2017.
 - Legislative sessions in Massachusetts are for two years, with the new session starting January 2017. Formal sessions run through November in the first year and July 31 in the second year. Massachusetts government is funded on a fiscal

year basis, running from July 1 through June 30. The annual budget process begins each year when the Governor files recommendations as a bill by the 4th Wednesday of January. If federal changes that affect the annual state budget were to materialize, the Governor's primary opportunity to propose any required policy adjustments would arise the following January in his annual recommendation with final implementation the following July.

8. Has your state adopted any of the 2010 federal reforms into state law If so, which ones? What impact would repeal have on these state laws?

- Massachusetts has enacted many health reform-related provisions into law, some of which predate the ACA but are substantially similar (such as the state's individual requirement to maintain coverage).
- However, since Massachusetts has not adopted every provision of the ACA into state law, and in some cases state law refers to federal citations, any Congressional repeal effort on a rapid timeline could cause significant confusion in the market. We ask Congress to offer states an ample runway to prepare for any significant federal changes with corresponding state law changes, as needed.
- Massachusetts is actively working to manage health care costs for federal and state payers, individuals, and businesses -- such as through the launch of a comprehensive payment reform initiative in the Medicaid program.
- Massachusetts has enacted many legislative changes relative to the Affordable Care Act (ACA) include:
 - Changed definition of "eligible individual" in Small Group Laws.
 - Established transition period for phase-out of certain small group rating factors in Small Group Laws.
 - Revised timing of filing rates in Small Group Laws.
 - Established authority for Division of Insurance to enforce ACA provisions.
 - Conformed dependent coverage provisions to ACA (age 26).
 - Conformed Massachusetts preexisting conditions and waiting periods to ACA.
 - Revised timing of submission of rate filings to conform with ACA.
 - Conformed external review process to ACA.
 - Granted authority for EOHHS and Connector (Exchange) to obtain necessary data from any state or public entity for certain administrative functions.
 - Conformed Medicaid eligibility requirements to the ACA.
 - Revised Connector's enabling statute; removed references to Connector Care.
 - Enacted technical changes authorizing Connector to administer premium and cost-sharing wrap.
 - Conformed Connector premium requirements to ACA.