MEMORANDUM

To: Health Connector Board Members
Cc: Louis Gutierrez, Executive Director
From: Andrew Egan, General Counsel
Marissa Woltmann, Director of Policy and Applied Research
Date: May 8, 2020
Re: Health Connector Program Regulations—Public Comment Summary and Adoption of Final Regulations

Health Connector staff will be recommending a final vote on the Health Connector's proposed amendments to the Health Connector Program Regulations (956 CMR 12.00), inclusive of modest adjustments to the draft regulations the Board released for public comment with a vote at the October 10, 2019 meeting. This memorandum summarizes public comments and testimony related to the Health Connector's proposed amendments to the Program regulations and notes areas of revision or reconsideration based on the comments received.

BACKGROUND

The Health Connector first promulgated regulations to operate the ConnectorCare program in 2013 as part of Affordable Care Act (ACA) implementation. Building on top of the ACA's Advance Premium Tax Credit (APTC) and Cost Sharing Reduction (CSR) framework with additional state subsidies, the Commonwealth created the ConnectorCare program to provide benefits similar to what were provided in the pre-ACA Commonwealth Care program. In implementing the program, the Health Connector largely modeled ConnectorCare regulations on the earlier Commonwealth Care regulations.

In addition to ConnectorCare, the Health Connector operates other programs, also governed by the ACA, including non-group health coverage for individuals eligible for APTC only (those between 300 and 400% of the federal poverty level (FPL)), non-group health coverage for individuals not eligible for subsidies (>400% FPL), small group health coverage, and dental coverage for both individuals and small groups.

Since 2013, Health Connector staff have identified certain provisions in this regulation that would benefit from amendment. Some provisions held over from the Commonwealth Care regulations have proven to be unnecessary. In addition, because the existing regulations do not include every Health Connector program, there is no single source of legal authority for the full scope of the Health Connector's business.

In October 2019, staff recommended opening a public comment period to receive feedback on proposed modifications to the regulations in five key areas, with the goal of the regulation providing a clear, updated basis for how the full range of the Health Connector's programs operate. Except for reinstatement payment deadline updates, the proposed amendments intended to clarify existing policies and operational processes, not create new ones. Health Connector staff proposed a range of amendments that would:

- Expand the scope of the regulations to include all Health Connector programs, not just ConnectorCare
- Clarify eligibility effective dates to match federal law
- Update appeals/hearings language

- Update and clarify premium processes
- Clean up the regulations to improve clarity and readability

Since reviewing the draft regulations with the Board in October 2019, the Health Connector solicited public comments and made adjustments to the regulations based on those comments, which are outlined in subsequent sections of this memo. Staff respectfully request that the Board approve the final amendments to the regulations at 956 CMR 12.00, as proposed.

SUMMARY AND DISCUSSION OF PUBLIC HEARING AND WRITTEN COMMENTS

Overview

The Health Connector received written comments and/or testimony from four stakeholders. Commenters included carriers and consumer advocate organizations.[1] The commenters provided thoughtful and specific feedback on a variety of provisions proposed. In response, Health Connector staff made the following modifications to the text of the proposed regulations, as further detailed below:

- Added cross-references to federal regulations where appropriate
- Modified the definitions of Appeal Representative and Connector Program
- Clarified language regarding the opportunity to reinstate to emphasize that it is time-limited
- Addressed the possibility of rescinded coverage in the event of fraud
- Expanded minimum available payment methods from "at least one" to "multiple"
- Clarified language regarding how hearing officers must issue decisions consistent with written Health Connector legal interpretations
- Clarified that dental carriers using lockout provisions must do so consistent with state and federal law
- Added a new section accounting for Authorized Representatives

Expansion of Regulations to All Programs

Three commenters[2] discussed the expansion of the regulations to include all Health Connector programs, and all three were supportive of this change. Health Connector staff appreciate support for the expansion of the regulations to provide a clear regulatory framework for all its members and agrees that this is a positive and necessary change to the regulations.

Sub-Regulatory Guidance

One commenter[3] requested that the Health Connector include the location of sub-regulatory guidance and policies in the regulations. In order to ensure appropriate flexibility in providing information to the public, Health Connector staff declined to include exact locations of sub-

[1] Health Care for All (HCFA) submitting jointly with Health Law Advocates (HLA), Massachusetts Law Reform Institute (MLRI), BMC HealthNet Plan (BMCHP), Blue Cross Blue Shield of MA (BCBSMA)
[2] MLRI, HCFA/HLA, BCBSMA
[3] MLRI

regulatory information in these regulations because such locations are subject to change, as webpages may be reorganized occasionally for clarity and accessibility. However, additional information can be found at https://www.MAhealthconnector.org, and Health Connector policies can be found at https://www.MAhealthconnector.org/about/policy-center/policies.

Definitions

One commenter[4] recommended incorporating federal definitions or citations for APTC and household income in the regulations. The commenter also suggested amending the definition of Appeal Representative to include attorneys and non-attorneys acting under attorney supervision, as well as adding a definition for "Authorized Representative." Health Connector staff partially adopted these recommendations. The current definitions for APTC and Modified Adjusted Gross Income (MAGI), which is the basis for household income, already incorporate cross-references to federal law, and, therefore, Health Connector staff declined to add additional cross-references. However, Health Connector staff updated the definition of "Appeal Representative" to include an appellant's attorney or a non-attorney acting under an attorney's supervision and added newly designated section 956 CMR 12.17 to address Authorized Representatives. The Health Connector recognizes Authorized Representatives to the same extent as MassHealth, as described in 130 CMR 501.001.

A second commenter[5] requested that the "Connector Program" definition be expanded to also include dental plans. In response, Health Connector staff have modified the definition of "Connector Programs" to include Dental Plans to improve clarity.

Eligibility for ConnectorCare Programs

One commenter[6] found the organization of section 12.04 confusing in the way that it layers eligibility criteria for Qualified Health Plans (QHPs) as well as subsidies. The commenter suggested that additional cross-references could help clarify this section. The commenter also suggested including cross-references for terms such as "lawfully present" that are taken from federal rules. Health Connector staff acknowledge that there are multiple ways to draft eligibility provisions. However, in order to avoid excessive disruption to the current regulation framework, staff decided to maintain the current structure for eligibility criteria, which accurately incorporates rules for determining eligibility for all Health Connector programs. In order to improve clarity, the staff added a cross-reference to the definition of "lawfully present" in federal regulations at 45 CFR 152.2 to 956 CMR 12.04(1).

A second commenter[7] suggested a technical change in section 12.04 to replace "member" with the defined term "Enrollee." In response, Health Connector staff changed "member" to "Eligible Individual" in the two places it appears in 12.04(3)(c) to ensure additional clarity.

One commenter[8] also suggested that the ConnectorCare eligibility section include a requirement that individuals enroll in a ConnectorCare plan, as well as account for individuals who do not qualify or take APTCs but may take Premium Tax Credits (PTC) at tax time. Eligibility for ConnectorCare does not depend on future enrollment in any plan, and

[4] MLRI
[5] HCFA/HLA
[6] MLRI
[7] HCFA/HLA
[8] MLRI

therefore Health Connector staff declined to include enrollment in a ConnectorCare plan as an eligibility factor for ConnectorCare. In addition, whether a Qualified Health Plan enrollee who did not receive APTC later qualifies for PTC upon tax-filing is governed solely by federal law and processes and is outside the scope of these regulations, which focus solely on how the Health Connector administers its programs.

Premiums for ConnectorCare

Two commenters[9] requested that the Health Connector modify regulation text requiring "at least one" no-premium plan for ConnectorCare Plan Type 1 and 2A individuals and instead require at least two premium-free plans. The Health Connector is committed to making available as many affordable options to its members as possible, including to Plan Type 1 and 2A members. However, this requested regulatory change is beyond the scope of the proposed amendments put out for public comment. For this reason, Health Connector staff maintained the language as proposed but expect to continue to emphasize access to affordable plan options as part of the annual Seal of Approval process.

Matching Information in Eligibility Determinations

One commenter[10] noted the significant use of external data sources in the Affordable Care Act to verify applicants' eligibility and recommended that these regulations should reflect the verification procedures codified in federal regulations. Health Connector staff adopted this recommendation in part. Specifically, Health Connector staff declined to make changes to section *12.05: Matching Information*, because it is not necessary to reproduce the extensive and complex federal ruleset governing verifications. However, for clarity, staff made updates to section *12.06: Standards for an Eligibility Application* and *12.07: Eligibility Review Related to Connector Programs for Non-Group Health Plans* to add cross-references to federal rules.

Annual and Mid-Year Determinations

One commenter[11] expressed their belief that neither the current nor proposed regulation accurately reflect the Health Connector's current policy on renewals. Health Connector staff reviewed and analyzed the proposed amendments in the context of the commenter's concerns. Health Connector staff recognize that renewal is a complex process but do not agree that current renewal language is inconsistent with federal rules or current Health Connector practice. However, in order to improve clarity, Health Connector staff added to its regulation cross-references to applicable federal rules, which contain additional detail governing the renewal processes.

A second[12] commenter requested clarification as to whether a mid-year redetermination of eligibility could lead to a mid-year enrollment. Health Connector staff provide the following clarification in response to this request: outside of annual redeterminations, Applicants or Enrollees may report changes in circumstances resulting in changes in eligibility mid-year, or the Health Connector may make determinations based on eligibility verifications or periodic data matching that may also result in eligibility changes mid-year. Any such mid-year changes

[9] HCFA/HLA, MLRI
[10] MLRI
[11] MLRI
[12] BMCHP

may result in new enrollments or other enrollment changes. No changes to the regulations were made as they were not necessary or suggested.

Notifications of Enrollees and Effective Dates of Changes

Two commenters[13] suggested that the Health Connector define "timely" notices, which are required by federal regulations. One of the commenters[14] requested clarification of the date used to determine when an eligibility would be effective in sections 12.08(1)&(3). Health Connector staff agree with the importance of providing timely notice. Given the complexity of circumstances in which an individual must receive notice, and further given the need to comply with federal eligibility timelines, staff do not believe the Health Connector is able to provide a uniform standard of timeliness for notices. The Health Connector's electronic eligibility system has been designed consistent with federal law, and these amendments are designed to resolve a potential ambiguity in the current text, in a manner consistent with those federal requirements and system rules. To improve clarity, Health Connector staff updated 956 CMR 12.08(3) to be consistent with federal rules and 12.08(1), which base the eligibility effective date on the date of the eligibility notice.

A third commenter[15] was concerned that the eligibility effective dates outlined in Section 12.08 did not account for scenarios of fraud, since the effective dates are only prospective. Section 12.08 addresses only the effective dates of eligibility changes made in the normal course of program operation and is not intended to address exceptional circumstances giving rise to a rescission, such as fraud. To address the possibility of retroactive termination based on fraud, Health Connector staff updated two different sections regarding fraud to clearly indicate that they include rescissions to the extent permitted under federal regulation at 45 CFR 147.128.

Applicant and Enrollee Responsibilities

One commenter[16] suggested that the regulations state that if an individual or small group fails to report changes within 30 days, that a subsequent determination of ineligibility should terminate the enrollee retroactively to the date of the eligibility termination. Consistent with federal regulations, the Health Connector requires enrollees to report changes impacting their eligibility within 30 days. Federal regulations do not consider consequences for enrollees that fail to report changes within this time period. However, in order to ensure that enrollees remain eligible for the programs in which they are enrolled, the Health Connector has implemented robust program integrity measures, such as periodic data matching and a carrier residency validation program. For these reasons, Health Connector staff did not make any changes to the proposed regulations in response to this comment.

One commenter[17] requested clarification around the removal of a section of the regulations related to recovery of money from a third party based on an accident or injury. Health Connector staff, as part of updating and modernizing these regulations, excised provisions outside the scope of its authority, including whether and how third-party liability would be adjudicated. This provision was originally in the Health Connector's earlier Commonwealth

[13] MLRI, HCFA/HLA
[14] MLRI
[15] BCBSMA
[16] BCBSMA
[17] BMCHP

Care program. While the provision was appropriate to include at that time because Commonwealth Care did not operate in the commercial merged market, it is now no longer necessary or relevant to current Health Connector programs.

A commenter[18] requested clarification on the change in the timeframe for reporting changes from 60 to 30 days, and the removal of a reference to reporting "as soon as possible." The requirement to report changes that may impact eligibility within 30 days comes from federal Exchange regulations. Health Connector staff removed the phrase "as soon as possible" because it was ambiguous and may have resulted in an open-ended period of greater than 30 days to report changes. The Health Connector does encourage members to report changes as soon as they occur and no later than 30 days. The requirement to report changes impacting eligibility is separate from whether an individual is eligible for a special enrollment period based on experiencing a qualifying life event. Qualifying life events will continue to give rise to a special enrollment period lasting 60 days from the date of the event.

This commenter[19] also asked for clarification on the addition of immigration status to the list of the types of changes that need to be reported. The original proposed amendments expanded the list of required information that must be reported to be consistent with federal eligibility rules for Health Connector programs. Immigration status bears on whether an individual is lawfully present in the United States, which is an eligibility factor for QHPs. To ensure individuals have the appropriate eligibility determination, they are required to report changes in immigration status.

Special Enrollment Periods

One commenter[20] appreciated the codification of current Health Connector practice in the proposed amendments to section 12.10 regarding special enrollment periods (SEPs), specifically regarding SEPs for transitions out of ConnectorCare into APTC-only coverage and stating that the start date of coverage when a dependent is added is the date of birth, adoption, or placement into foster care. Health Connector staff appreciate the support for its amendments.

A second commenter[21] suggested that the Health Connector specifically cite the Office of Patient Protection's waiver process regulation as a basis for the Health Connector to open a special enrollment period. Health Connector staff agree with this suggestion and added a cross-reference to that regulation.

Employee and Small Employer Premiums

One commenter[22] requested clarification of the phrase "one convenient payment method" in section 12.12 and suggested Health Connector members should have at least the minimum payment options offered in federal rules at 45 CFR 156.1240. Health Connector staff acknowledge that a variety of convenient payment methods supports members in

[18] BMCHP
[19] BMCHP
[20] HCFA/HLA
[21] MLRI
[22] HCFA/HLA

maintaining coverage. As a result, Health Connector staff have replaced "one convenient payment method" with "multiple convenient payment methods" in the regulations.

Hardship Waivers

One commenter[23] expressed appreciation for the continued availability of premium waivers and supported the clarification that a waiver may be retroactive. Health Connector staff appreciate this comment in support of the changes made and maintained the regulation language as proposed.

Reinstatements

One commenter[24] requested clarification about how the updated language regarding reinstatement due dates would be applied in practice. Currently, reinstatements must be requested and paid for within 35 days of the termination notice. The proposed amendments removed that specific timeline to permit flexibility to change the payment deadline for reinstatements to align with the premium payment deadline, which is currently the 23rd day of each month.

A second commenter[25] expressed concern that the proposed change to the reinstatement due date could allow for adverse selection. Health Connector staff appreciate the concerns raised in this comment. The edits to the provision regarding reinstatements do not permit reinstatements without limitation, but instead require requests to be made timely. Health Connector staff added additional text to the regulation in order to reinforce this existing limitation.

Termination of Small Group for Non-payment

One commenter[26] was concerned about the impact of non-payment terminations on employees and recommended a safe harbor for members who lose Health Connector for Business group coverage based on their employer's failure to pay. To clarify, an employee whose small employer's coverage is terminated due to non-payment of premiums is notified by the Health Connector to contact their group health plan issuer directly if they want to receive a temporary continuation of coverage or a conversion plan, as detailed in 940 CMR 9.00. Such employees may further enroll in a non-group plan based on a special enrollment period. The Health Connector is unaware of gaps in coverage for individuals who lose their employer-sponsored coverage that is obtained via Health Connector for Business. For these reasons, Health Connector staff did not make changes to the proposed regulations in response to this comment.

Appealable Actions

One commenter[27] supported the proposed additions to the list of appealable actions in section 12.13. However, this commenter also suggested that the list of appealable actions should not be limited to what is enumerated in section 12.13 in order to be consistent with language in section 12.14, which states that the Health Connector may not restrict an

[23] HCFA/HLA
[24] BMCHP
[25] BCBSMA
[26] HCFA/HLA
[27] HCFA/HLA

individual or employer from appealing. Health Connector staff appreciate the commenter's support of these changes as well as the comment regarding the relationship between section 12.13 and section 12.14. The purpose of section 12.13 is to specify the Health Connector actions that would give rise to a valid appeal, while section 12.14 makes it clear that an Applicant, Eligible Individual, Enrollee, or Employer may always file an appeal, whether or not it is ultimately a valid appeal. The Health Connector has other channels, including its ombudsman team, available to address non-appealable actions. For these reasons, Health Connector staff maintained the regulation language as proposed in response to these comments.

Appeal Process

One commenter[28] recommended including a specific timeframe for acknowledging appeal requests in writing. The Health Connector follows federal regulations regarding acknowledgment of appeal requests, as detailed at 45 CFR 155.520, and included by cross-reference at 956 CMR 12.15(1), which means that it sends out appeal acknowledgments when appeal requests are received.

This commenter also expressed concern that the new section allowing for dismissal of an appeal if the appellant dies while the appeal is pending would result in hardships for surviving spouses and the commenter requested that a spouse be allowed to continue the appeal. The provision regarding dismissal in the event of an appellant's death was added to the proposed amendments in response to federal regulation, and the Health Connector follows federal regulations on this matter. Federal regulations permit family members to be considered "duly authorized," even if they are not formally designated, included surviving spouses of deceased appellants. The Health Connector therefore also recognizes surviving spouses as duly authorized to continue an appeal. For these reasons, Health Connector staff did not make any changes to the proposed regulation language in response to these comments.

Two commenters[29] opposed including language requiring hearing officers to apply the law consistent with the Health Connector's interpretation when an appellant challenges the legality of a law or regulation. The Health Connector has a responsibility to ensure that its hearing process is conducted according to a consistent set of rules. In order to ensure consistency, the Health Connector further amended this provision to clarify that any interpretation relied on by a hearing officer must be in Health Connector rules and regulations or other written guidance.

Dental Plans

One commenter[30] requested clarification on provisions in section 12.16 related to dental waiting and lock out periods. The commenter sought additional information on the allowable length of such periods. The Health Connector is aware that dental plans impose waiting periods for certain services and lockout periods in certain circumstances. The regulation amendments are intended to clarify that such waiting and lockout periods are not inconsistent with current Health Connector program rules, so long as they are otherwise consistent with applicable law. In response to this comment, Health Connector staff added

[28] HCFA/HLA
[29] MLRI, HCFA/HLA
[30] HCFA/HLA

language to section 12.15(5) related to lockout periods in order to clarify that they must be applied by carriers consistent with state and federal law.

CONCLUDING REMARKS

In summary, Health Connector staff appreciate the thoughtful comments and testimony received on the proposed Health Connector Program regulation amendments. After careful consideration of and response to each comment, Health Connector staff believe that the clarifications and revisions incorporated into the regulations reflect important feedback from stakeholders.

In order to administer its programs, the Health Connector relies on a combination of statutes, regulations, and operational policies. The Health Connector Program regulations are intended to provide, at high-level, a clear basis for how the full range of the Health Connector's programs operate.

If the Board votes to approve the final version of the proposed regulations on May 14, the Health Connector will file the final regulations with the Secretary of State on May 15. The adopted final version of the proposed regulations would then be published in the Code of Massachusetts Regulations (CMR) and go into effect on May 29, 2020.