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Final Connector Program Regulations Amendments (VOTE)

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Overview

1. Review of proposed changes
2. Summary of public comments received
3. Discussion and analysis of comments
4. Next steps

Review of Proposed Changes

In October 2019, staff proposed to the Board modifying ConnectorCare regulations in five key areas with the goal of providing a clear basis for how the full range of the Health Connector's programs operate.

- Except for reinstatement payment deadline updates, these amendments are intended to clarify existing policies and operational processes, not create new ones
- Since reviewing the draft regulations with the Board in October 2019, the Health Connector solicited public comments and made some minor adjustments to the regulations based on those comments, which are outlined in subsequent slides
- Staff respectfully request that the Board approve as final amendments to the regulations at 956 CMR 12.00 to better reflect current Health Connector practice:
    - Expand scope 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
    - Generally clean up the regulations

Review of Proposed Changes

Staff recommended the following targeted amendments to the regulations:

Category of Change	Overview of Proposed Regulatory Change	Reasons for Update
Expand scope to include all Health Connector programs	• Add content to reflect current Health Connector practices related to administering eligibility and enrollment for non-group coverage with Advance Premium Tax Credit (APTC)-only subsidies or no subsidies, dental coverage, and small group coverage, alongside ConnectorCare administration	• Address Health Connector programs outside ConnectorCare to unify and consolidate disparate Health Connector requirements and provide transparency and accountability for members. • Fill regulatory void left by repeal of federal SHOP provisions
Clarify eligibility effective dates to match federal law	• Reword effective date rules to more clearly reflect current HIX behavior, existing policy, and federal regulations	• Clarify regulatory language around effective dates to help members and applicants know what to expect when their eligibility changes.
Update appeals/hearings language	• Clearly incorporate federal Exchange appeals rules, including bases for dismissal and appealable actions • Codify existing practices for hearings decisions, including that the decision is based on a preponderance of the evidence	• Incorporate the expansion to all Health Connector program types as well as clarify existing appeal rights and practices

Review of Proposed Changes, cont'd

Staff recommended the following targeted amendments to the regulations:

Category of Change	Overview of Proposed Regulatory Change	Reasons for Update
Update and clarify premium processes	• Codify existing practices around premium waivers • Provide flexibility on reinstatement payment due dates	• Provide transparency and accountability for members • Allow operational flexibility on reinstatements to reduce consumer confusion and streamline processing
Generally clean up the regulations	• Update definitions, remove dated references, clarify meaning of certain requirements, reorder provisions	• Improve clarity and readability of regulations

Summary and Discussion of Public Comments Received

Summary of Comments and Testimony

The Health Connector received written comments and/or testimony from four stakeholders.

- Commenters included carriers and consumer advocate organizations
- Commenters provided thoughtful and specific feedback on a variety of provisions proposed, based on which the Health Connector made some modifications to the text of the regulations:
    - Added cross-references to federal regulations where appropriate
    - Modified definitions 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 new section accounting for Authorized Representatives in the non-group space

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Expansion to all programs: Three commenters discussed the expansion of the regulations to include all Connector programs, and all three were supportive of the change.	Acknowledged	Health Connector staff appreciate support for the expansion of the regulations to provide a clear regulatory framework for all Health Connector members.
Sub-regulatory guidance: One commenter requested that the Health Connector include the location of sub-regulatory guidance/policies in the regulations.	Maintained language as proposed	In order to ensure appropriate flexibility in providing information to the public, Health Connector staff decline to include exact locations of sub-regulatory information in these regulations. 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.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Definitions: One commenter recommended incorporating federal definitions or citations for APTC and household income. Further, the commenter 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." A second commenter requested that the "Connector Program" definition be expanded to include dental plans.	Adopted in part	The current definitions for APTC and Modified Adjusted Gross Income, which is the basis for household income, already incorporate cross-references to federal law, so Health Connector staff decline to add additional cross-references. Health Connector staff have 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. Health Connector staff have modified the definition of "Connector Programs" to include Dental Plans for clarity.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Eligibility for Connector Programs: One commenter found the organization of section 12.04 confusing in the way it layers eligibility criteria for Qualified Health Plans (QHPs) as well as subsidies. The commenter suggested additional cross-references could help clarify, including for terms such as "lawfully present" that are taken from federal rules. A second commenter suggested a technical change to replace "member" with the defined term "Enrollee."	Adopted in part	Staff acknowledge that there are multiple ways to draft these 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. For clarity, Health Connector staff have added a cross-reference to the definition of "lawfully present" in federal regulations at 45 CFR 152.2 to 956 CMR 12.04(1). The staff also changed "member" to "Eligible Individual" in the two places it appears in 12.04(3)(c).

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Eligibility for Connector Programs, cont'd: One commenter also suggested that this section include a requirement that individuals enroll in a ConnectorCare plan, as well as account for individuals who do not qualify or take Advance Premium Tax Credits but may take them at tax time.	Maintained language as proposed	Eligibility for ConnectorCare does not depend on future enrollment in any plan, and therefore staff declined to include enrollment as an eligibility factor for ConnectorCare. Whether a QHP enrollee who did not receive APTC later qualifies for Premium Tax Credits (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 requested that the Health Connector modify the text requiring "at least one" no-premium plan for Plan Type 1 and 2A individuals to require at least two premium-free plans.	Maintained language as proposed	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. Staff expect to continue to emphasize access to affordable plans as part of the annual Seal of Approval process.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Matching information in eligibility determinations: One commenter noted the significant use of external data sources in the ACA to verify applicants' eligibility and recommended that these regulations should reflect verification procedures codified in federal regulations.	Adopted in part	Health Connector staff decline to make changes to section *12.05: Matching Information*, because it is not necessary to reproduce the extensive and complex federal ruleset governing verifications, but for clarity did make updates to *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 redeterminations: One commenter believed that neither the current nor proposed rules accurately reflected the Health Connector's current policy on renewals.	Adopted in part	Health Connector staff reviewed the proposed amendments to this section, based on this comment. 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. For clarity, staff added in cross-references to applicable federal rules, which contain additional detail governing renewal processes.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Annual and mid-year redeterminations, cont'd: A second commenter requested clarification as to whether a mid-year redetermination of eligibility could lead to a mid-year enrollment.	Explanation provided	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 may result in new enrollments or other enrollment changes.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Notification of enrollees: Two commenters suggested that the Health Connector define "timely" notices, which are required by federal regulations. One of the commenters requested clarification of the date used to determine when an eligibility would be effective in sections 12.08(1)&(3). A third commenter was concerned that the eligibility effective dates outlined did not account for scenarios of fraud.	Adopted in part	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. For clarity, 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. 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 this possibility, staff have indicated that terminations based on fraud in 956 CMR 12.10(5) and 12.11(5) include rescissions to the extent permitted under federal regulation at 45 CFR 147.128.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Applicant and Enrollee responsibilities: One commenter suggested that the regulation 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.	Maintained language as proposed	Consistent with federal regulations, the Health Connector requires enrollees to report changes impacting their eligibility within 30 days. Federal regulations do not contemplate consequences for enrollees that fail to report changes within this time period. However, the Health Connector has implemented robust program integrity measures, such as periodic data matching and a carrier residency validation program, to ensure that enrollees remain eligible for the programs in which they are enrolled.
Applicant and Enrollee responsibilities, cont'd: One commenter 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.	Explanation provided	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 a holdover from the Health Connector's earlier Commonwealth Care program and was appropriate to include there because that program did not operate in the commercial merged market. However, it is no longer necessary or relevant to current Health Connector programs.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Applicant and Enrollee responsibilities, cont'd: A commenter 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 commenter also asked for clarification on the addition of immigration status to the list of the types of changes that need to be reported.	Explanation provided	The requirement to report changes that may impact eligibility within 30 days comes from federal Exchange regulations. Staff removed "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 encourages members to report changes as soon as they occur and in no event 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. The original proposed amendments expanded the list of required information that must be reported to be consistent with federal eligibility rules for Connector programs. Immigration status bears on whether an individual is lawfully present in the United States, an eligibility factor for QHPs. To ensure individuals have the appropriate eligibility determination, they are required to report changes in immigration status.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Special enrollment periods: One commenter appreciated the codification of Health Connector current practice in the proposed amendments to section 12.10, specifically regarding special enrollment periods for transitions out of ConnectorCare into APTC-only coverage and coverage effective dates for dependents added due to birth, adoption, or foster care placement. A second commenter 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.	Acknowledged and Adopted	Health Connector staff appreciate both the support for its amendments as well as the suggested reference to the Office of Patient Protection and added a cross-reference to that regulation.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Enrollee and Small Employer Premiums: One commenter requested clarification of the phrase "one convenient payment method" and suggested Health Connector members should have at least the minimum payment options offered in federal rules at 45 CFR 156.1240.	Adopted in part	Health Connector staff acknowledge that a variety of convenient payment methods supports members in maintaining coverage. As a result, Health Connector staff have replaced "one convenient payment method" with "multiple convenient payment methods" in the regulatory text.
Hardship waivers: One commenter appreciated the continued availability of premium waivers and supported the clarification that a waiver may be retroactive.	Acknowledged	Health Connector staff appreciate this comment in support of these changes.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Reinstatements: One commenter requested clarification about how the updated language regarding reinstatement due dates would be applied in practice.	Explanation provided	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.
Reinstatements, cont'd: A second commenter expressed concern that the proposed change to the reinstatement due date could allow for adverse selection.	Added text to clarify	Health Connector staff appreciate the concerns raised in this comment. To clarify, 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 reinforce this existing limitation.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Termination of small group for non-payment: One commenter was concerned about the impact of non-payment terminations on employees and recommended a safe harbor for members who lose coverage based on their employer's failure to pay.	Maintained language as proposed	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 the Health Connector.
Appealable actions: One commenter supported the proposed additions to the list of appealable actions in 12.13 but suggested the list not be limited to what is enumerated to be consistent with language in 12.14 stating the Health Connector may not restrict an individual or employer from appealing.	Maintained language as proposed	Health Connector staff appreciate this comment in support of these changes as well as the comment regarding the relationship between 12.13 and 12.14. The purpose of 12.13 is to specify those Health Connector actions that would give rise to a valid appeal, while 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.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Appeal process: One commenter recommended including a specific timeframe for acknowledging appeal requests in writing. The commenter also expressed concern that the new section allowing for dismissal of appeal in the event the appellant dies while the appeal is pending would result in hardships for surviving spouses and requested that a spouse be allowed to continue the appeal.	Maintained language as proposed	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). 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.
Appeal process, cont'd: Two commenters 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.	Added text to clarify	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, staff further amended this provision to clarify that any interpretation relied on by a hearing officer must be in Connector rules and regulations or other written guidance.

Summary of Comments and Testimony, cont'd

Comment	Health Connector Response	Rationale
Dental plans: One commenter requested clarification on provisions in section 12.16 related to dental waiting and lock out periods to elaborate on the allowable length of such periods.	Added text to clarify	The Health Connector is aware that dental plans impose waiting periods for certain services and lockout periods in certain circumstances. These 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. Health Connector staff added language to section 12.15(5) related to lockout periods to clarify that they must be applied by carriers consistent with state and federal law.

Next Steps

Proposed Regulation Amendment Timeline

October 2019

- 10/10: Presented proposed program regulation amendments for Board Vote
- 10/11: Sent out Local Government Advisory Committee Letters
- 10/30: Public comment period opened

November 2019

- 11/25: Held public hearing; public comment period closed

March 2020

3/11: Filed amended small business impact statement

May 2020

- 5/8: Memo to Board of Public hearing and final regulations
- **5/14:** Hold Board vote on final version of proposed regulations
- **5/15:** File final regulations with Secretary of Commonwealth
- **5/29:** Publication of adopted final version of proposed regulations in the CMR; Effective date of finalized Connector Program regulations

Vote

Health Connector staff recommend that the Board issue the final Health Connector program regulation amendments at 956 CMR 12.00, as proposed.

Appendix

Proposed Update: Clarify and Update Premium Processes

Topic	Amendments
Premium Waiver/ Reductions	▪ Codify existing rule that the most that can be waived is the portion of premium equal to the minimum premium for an individual's ConnectorCare Plan Type ▪ Clarify and document current processes regarding the applicability of premium waivers to prospective enrollment, periods of delinquency, and premium owed in order to reinstated following a termination
Reasons for Premium Changes	▪ Clarify bases for premium changes, and peg premium change effective dates to eligibility change effective dates
Reinstatement Deadlines*	▪ Provide flexibility to the Health Connector to operationalize a reinstatement payment deadline that is consistent with the regular premium payment deadline • This streamlined process would reduce member confusion and improve administrative efficiency *Unlike other amendments, this may result in a change to current operations

General Clean Up

Topic	Amendments
Language and definitions	▪ Where possible, use language used elsewhere (e.g. in Health Connector policy, federal regulations, etc.) in these regulations ▪ Add new definitions for new concepts • *E.g.* "Connector Program," "Dental Plan," "Small Employer," etc. ▪ Remove or update other definitions • *E.g.,* "Abuse," "Adverse Eligibility Determination," "Health Care Provider," and "Service Area" all removed because no longer used • *E.g.* "Household," "Federal Poverty Level," and "Resident" all updated to more closely follow federal definitions
Provisions outside Health Connector purview	▪ Removed reference to Health Plan recovery rights in the event a third party is found liable for an accident or injury ▪ Removed language regarding Health Connector right to recoup money on behalf of a health care provider ▪ Removed reference to mechanisms for adjudicating disputes with health plans
Miscellaneous	▪ Corrected typos