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May 29, 2007

Commonwealth Health Insurance Connector Authority
Attn: Jamie Katz: Public Comments
100 City Hall Plaza, 6th Floor
Boston, MA 02108

Re: Comments on proposed and emergency regulations: 956 CMR 3.00, 5.00 and 6.00

Dear Mr. Katz,

These comments are submitted by the undersigned non-profit legal services organizations representing the interests of low-income residents of the Commonwealth. We appreciate the work of the Connector staff and board in struggling to reach the right decisions on the many complex policy issues reflected in these regulations and the opportunity to make these comments. We endorse the testimony and comments submitted by the Affordable Care Today Coalition (ACT!!). In addition, we submit these comments addressing more specifically the interests of our low income clients and raising more technical points for your consideration.

956 CMR § 3.00 Eligibility and Hearing Process for Commonwealth Care

§3.11(8) Minimum Monthly Commonwealth Care Enrollee Premium Contribution Schedule

While we commend the Connector for reducing premium charges, we urge it to retain the premium contribution chart in the regulations. The emergency regulations remove the premium chart and replace it with language stating that a separate schedule of premium contributions will be published annually. The affordability of Commonwealth Care is an important public policy issue and should be promulgated as a regulation just as MassHealth premium charges are published at 130 CMR § 506.011.

As a regulation, the premium contribution schedule can always be located in the code of Massachusetts regulation, but it is not obvious where to look for a published schedule. On the Connector website, the only place the new contribution schedule appears is in a document called Frequently Asked Questions. Further, the annual adjustment in premium levels should be preceded by an opportunity for public comment as provided for in the rule-making process. Finally, the premium contribution in Commonwealth Care affects the public and satisfies the

definition of a regulation within the meaning of G.L.c.30A, § 1(5) and for that reason alone should be promulgated in accordance with the law.

Failing promulgation of the contribution schedule as a rule, the regulation at § 3.11(8) should identify where the schedule will be published and provide for an opportunity for public comment before the annual publication of the schedule. We recommend that the schedule be published in the Massachusetts Register and posted on the Connector website under a prominent heading. Indeed, we suggest that all "Commonwealth Care Rules and Regulations" as the phrase is defined in 3.04 be posted on the website under that heading or something similar.

Premium contributions and cost sharing for enrollees with income up to 150 percent of the poverty level

We urge the Connector to not only reduce the premium charges for those from 100 to 150 percent of poverty, but to move this population to Plan Type 1 in the next contract year. The decision to lower the minimum premium contribution to zero for residents with income less than or equal to 150 percent of the poverty level was wise and we thank the Connector for making this change. This should make it possible for tens of thousands of lower income residents to now sign up for health insurance coverage. However, just as residents at this very low income level cannot afford premium charges, they cannot afford the copayments of Plan Type 2 or the costs of paying for dental care out of pocket. Plan Type 1 is more appropriate for this population. Further, regarding dental benefits, Plan Type 2, and indeed all types of Commonwealth Care should include this as a basic component of medical care.

If those from 100-150 percent of poverty are to remain in Plan Type 2 certain additional regulatory changes are needed to allow for automatic enrollment into Plan Type 2 for those who do not select a plan on their own. Currently, the regulations that authorize automatic assignment refer exclusively to those eligible to enroll in Plan Type 1 e.g. §§ 3.13(2) (3) and (7) and 3.17(2)(a).[1] However, based on the experience with automatic enrollment to date, additional automatic enrollment safeguards should be implemented to avoid the problem of low income people who have used the Uncompensated Care pool being locked into health plans that do not include their traditional providers.

The Affordability Schedule

The Affordability Schedule will be an important document for hundreds of thousands of uninsured Massachusetts residents. We appreciate the desire of the Connector to make it an easy to understand document but believe more information must be included in the schedule in order to accomplish that end. We also urge you to promulgate the Affordability Schedule as a regulation for the same reasons set forth above with reference to the Premium Schedule in addition to publicizing the schedule more widely.

Clarify the definition of terms in the introductory paragraph
The Schedule should state that its terms (individual, couple, family, gross income, employer-

1 There is a typographical error in § 3.17(1) where 130 CMR 610 appears as 130 CMR 6.10.

sponsored insurance) are defined in the regulations at 956 CMR 6.04. The schedule refers in several places to the requirement to purchase affordable "health insurance." The statute requires purchase of "creditable coverage;" not all health insurance will satisfy the definition of creditable coverage (particularly in 2009 when the final regulatory definition of minimum creditable coverage takes effect). See, G.L. c. 111M § 2(a). It is not necessary to use the unfamiliar term "creditable coverage" in the Schedule itself, but the term that is used –health insurance—should be defined in the 6.04 regulations to mean "creditable coverage" as defined in chapter 111M. The reference in paragraph (4) to insurance that can be purchased through the Connector should also be more clearly defined either in the Schedule or in the 6.04 regulations.

Simplify the exemption for those deemed unable to afford anything other than free insurance in paragraphs (1)-(3).

The Schedule states that certain persons not eligible for Commonwealth Care who earn less than a threshold amount will not be penalized if they fail to obtain insurance. We commend this decision. However, describing the exemption as applicable to those who are not eligible for Commonwealth Care raises unnecessary difficulties. It should not be necessary for these individuals to verify that they have applied for Commonwealth Care and been denied, instead all those under 150 percent of the poverty level should be exempted from the tax penalty in 2007.

The 2007 penalty was intended to be lighter than future year penalties to allow residents time to learn about health reform: the availability of new coverage options as well as the mandate. However, those whose incomes are so low that only no-premium insurance is affordable to them and who will therefore not be subject to the penalty in tax year 2008 and beyond which is based on the lowest cost affordable insurance, will be subject to the penalty in tax year 2007 which is based on loss of the personal exemption. This unintended result can be avoided by simply exempting all those under 150 percent of poverty not just those who learned about Commonwealth Care, applied for it, and were denied. Outreach and the joint Uncompensated Care Pool/MassHealth/Commonwealth Care application process will assure that these very low income individuals are enrolled.

We appreciate that a dollar schedule is more intelligible than reference to percentages of the federal poverty level. However, it is unfair to uninsured working families of four or more who are ineligible for Commonwealth Care to face a tax penalty when smaller size families at the same level of poverty are exempt. For larger families, it also compounds the unfairness of being ineligible for Commonwealth Care simply because they cannot afford an employer's offer of insurance. For example, a family of five earning $35,000 that is eligible for Commonwealth Care will have no premium contribution, but a family of five at the same income level that is not eligible for Commonwealth Care will be expected to pay up to $140 per month (and in 2007 and 2008 the payment may be for health insurance that has large deductibles or narrow limitations on covered services). Families of four or more are not rare. According to Census data there are about as many 4-person as 3-person families in Massachusetts. This unfairness can be addressed by combining paragraphs (1) to (3) as follows:

(1) Residents with an annual gross family income that is 150 percent of the federal poverty level or less are deemed to be unable to afford anything other than insurance available at no premium cost to them, and thus are not subject to any penalty for failure to purchase health insurance. In 2007, 150 percent of the federal poverty level

is $15, 324 for an individual, and $5,220 more for each additional family member.[2]

Clarify the type of insurance that is meant in paragraph (4)

It is not self-evident from the chart whether the cost of insurance shown on the chart for families represents the cost of family coverage or individual coverage, and whether the cost for couples represents the cost of dual coverage/ the combined cost of two individual policies or individual coverage. From attendance at the Board Meeting where the schedule was presented and explained, it seems clear that the intention was that the relevant cost for families is the cost of family coverage and the relevant cost for couples is the cost of dual coverage or the combined cost of two individual policies. This is the only fair measure. Adults in families should not be expected to forego coverage for other family members. It can be clarified by adding this phrase to the end of the last sentence in paragraph (4):

> (4) …"Monthly Premium" set forth on the schedule for individual coverage, couple coverage, or family coverage respectively.

Change the parenthetical explaining Families from "(3+ individuals)" to "(with one or more children)"

Describing Families as 3 or more individuals leaves out a single parent family with one child. The definition of Family in 6.04 is based on the presence of a child in the home not the presence of three or more individuals. A single parent with one child does not fall within the 6.04 definition of couple and in any event would be disadvantaged by treatment as a couple compared to a larger family with children at the same level of poverty. Changing the chart parenthetical to correspond with the definition of Family will clarify this.

Include a second Family chart for Families with 2 or more children

Basing the measure of affordability for families of all sizes on the federally poverty level for a family size of three disadvantages larger families. For example, for a family of four, the no-premium income range ends at 125 percent of poverty; a family of four at 150 percent of poverty will be expected to pay $70. These discrepancies grow with family size. The Schedule can better balance the interests of presenting a simple and easy to use schedule with fairness to larger families by including a second schedule for families. We recommend that the current schedule apply to families with at least one child, and that a second family chart based on the federal poverty level for a family size of four be developed for families with 2 or more children. While this will still disadvantage families of five or more, it strikes a better balance between simplicity and fairness to larger families than the current schedule.

956 CMR 6.00 Determining Affordability for the Individual Mandate

6.04 Definitions.

Clarify terms, define family and gross income as adjusted gross income consistently with the tax system, and define employer-sponsored insurance as insurance that meets the 2009 standards for minimum creditable coverage.

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2 These amounts reflect the method of rounding used by the Office of Medicaid in determining eligibility for MassHealth and Commonwealth Care. 130 CMR § 506.007.

Appeal Representative. This definition describes someone who can pursue an appeal in the absence of the appellant. There should also be a more straightforward definition of representative as someone acting at the direction of the appellant such as a lawyer or non-lawyer advocate. See, the definition of "Representative" in the DALA regulations at § 1.02(3).

Application. This term is commonly used with reference to an application for benefits such as Commonwealth Care, and may be a source of confusion in reference to a request for appeal. We suggest instead using the phrase Request for Appeal and defining it to include any written request including but not limited to a request made on a form prescribed by the Connector. Insisting on use of a particular form is not consistent with a simple, easy to use appeal process accessible to the general population.

Connector or Authority. For purposes of appeals to the Connector, we urge you to define a responsible unit within the Connector such as an Office of Appeals or similar designation and to assure that decisions of the Office of Appeals are made by impartial individuals who were not involved in making the Connector decision under appeal.

Employer-sponsored insurance. This phrase, used in the Affordability Schedule, is defined here in terms of the employer's contribution to the cost of coverage. These contribution percentages are used in the Commonwealth Care statute to identify ineligible employees, and have been used in one of the two tests adopted by DHCFP to determine whether an employer with more than 10 employees is subject to an employer assessment. However, it is not clear why either measure is relevant to the Affordability Schedule. For purposes of the Affordability Schedule, the question is the amount of the employee's premium share for employer-sponsored insurance that constitutes creditable coverage. Because the Schedule directly asks for the employee share of the premium cost there is no need to look to the employer's contribution as a proxy. Further, few employees will know what percentage of premium costs are paid by their employers.

On the other hand, the Affordability Schedule does not capture the cost-sharing and scope of coverage of the employer-sponsored insurance. These factors directly affect the affordability of coverage, and the legislature has specifically directed the Connector to take the costs of deductibles into account when determining the affordability of a health benefit plan. G.L. c. 176Q, § 3(p) as amended by ch. 356, § 55, St. 2006. Further, the statute requires a determination not just that any employer-sponsored insurance is affordable, but that creditable coverage is affordable. G.L. c. 111M, § 2 (a). Therefore, employer-sponsored insurance should generally be defined as creditable coverage available from an employer.

A key component of the statutory definition of creditable coverage is the Connector's regulatory definition of minimum creditable coverage. The proposed regulations on minimum creditable coverage at 956 CMR 5.00 adopt a broad definition until calendar year 2009 when more meaningful standards take effect. 5.03 (1) and (2). For purposes of determining Affordability it is appropriate to use the definition of minimum creditable coverage that will take effect in 2009 in the definition of employer sponsored insurance. What this means is that an individual who has insurance in 2007 and 2008 will have that insurance compared to the broad definition of MCC in § 5.03(1). However, an individual who does not have insurance will only be expected to contribute the premium shown in the Affordability Schedule for insurance that satisfies the more

meaningful definition of MCC in 5.03(2). Uninsured individuals will not be expected to purchase high deductible or mini-med policies in 2007 and 2008 if they are not offered or cannot afford better coverage.

The definition of MCC in § 5.03(2) is complex. In 2009 when the definition of MCC in 5.03(2) takes effect, employees will likely be notified by their employers whether the insurance offered by the employer is MCC. However, in 2007 neither employees nor perhaps employers are likely to know how offered coverage compares to the standards in § 5.03(2). However, this can be addressed in the way the tax system currently addresses other complexities. The Department of Revenue can adopt a simplified version of the MCC criteria for those tax filers who choose to use it. One or two questions might suffice: Did your employer's plan have a deductible of more than $2000; and a question designed to identify the mini-med policies. Not ideal, but better than penalizing employees for failing to purchase insurance that is affordable only because it falls short of the basic protections of insurance.

Couple; Family The proposed definitions are based on the MassHealth/Commonwealth Care definitions but do not fit well with the tax and insurance aspects of the mandate. For example the definitions do not treat as a family a married couple living with a disabled adult child who can file one tax return and buy one family coverage policy for all three members. If the parents are uninsured, they will be compared to the higher couple standard rather than the family standard that reflects their actual circumstances. Similarly, the definitions do include as a family an unmarried couple with a common child who cannot file a single tax return.

In order for enforcement through the tax system to be fair and workable, we suggest a "couple" be defined as two individuals who file a tax return as married and claim no qualified dependent children for tax purposes, and that a "family" be defined as two or more individuals who file a tax return and claim one or more qualified dependent children for tax purposes.

Gross income The proposed definition of gross income allows for no deductions whatever and does not cross-reference to any other definitions of income. This is an unreasonable standard and corresponds to neither the MassHealth/Commonwealth Care income standard nor the tax standards for measuring income. MassHealth and Commonwealth Care measure income under the Office of Medicaid methodology which recognizes "business income" net of allowable business deductions for the self-employed as well as various other exclusions and deductions from income. 130 CMR §§ 506.003 and 506.004.

Gross income should be based on taxable income and reflect deductible business expenses for the self-employed. For example, line 22 of Form 1040 shows total income including business income (or loss) after allowable business deductions. Line 37 of Form 1040 shows adjusted gross income with additional deductions for alimony.

The Affordability Schedule can still use the term gross income. Most people will understand that gross income means "before tax" income, and those who look up the definition will understand that gross income is defined the same way as adjusted gross income for tax purposes.

Add a definition for Health insurance as discussed above and define it as creditable coverage

under c. 111M § 1.

6.06 Financial Hardship Appeals

We commend the use se flexible criteria and a simple process in the early years of implementation. Implementation of an individual mandate is something new for the residents of Massachusetts as well as for the Connector and other agencies charged with enforcing the mandate. It makes sense to have a simple, easy to use method of filing appeals open to a wide range of hardship situations in 2007 and 2008. We commend the Connector for including an open-ended opportunity to show hardship in § 6.07 (5). However, some refinement of this section of the regulations would help clarify the scope of appeals for residents and make appeals easier for the Connector to administer.

Add "affordable" before "health insurance" in paragraph (1).

In paragraph (2) reference to granting an appeal is a confusing phrase; it is not clear if what has been granted is the right to a hearing, or the relief sought. Also the reference to "sole discretion" is not appropriate. Appeals will presumably be heard by hearing officers who will not be making discretionary decisions but will be applying the regulations subject to a right of review. We suggest this paragraph be rewritten as follows:

> (2) The Connector may grant relief to a taxpayer who appeals from the assessment of a tax penalty based upon the appellant's financial hardship as defined in this regulation.

The criteria in (3) are the same criteria which give rise to a premium hardship waiver in Commonwealth Care. However, since the mandate appeal is retrospective, and in 2007 applies only if one is uninsured on December 31 and in 2008 applies on a month by month basis, it may be clearer to add to the opening phrase: …the Appellant "was unable to afford creditable coverage in one or more months due to one or more of the following circumstances:" The reference to "current" eviction or foreclosure should also be removed since the relevant time is the prior year.

Add factors that raise a presumption of hardship

The criteria in (4) are mandatory and additive. This suggests that in order to grant relief to an individual who was homeless for example, the appellant must first make a showing on each of the mandatory factors to be considered in (4). This will be a barrier to a simple appeal process in the case of obvious hardship such as most of the circumstances identified in (3). We suggest that the factors in (4) instead of being identified as those that the Connector "shall also" consider; be identified as factors that the Connector "may" consider. Further, the regulation should explain how the listed factors are relevant. We also suggest the following additional factors, particularly if the changes we suggested in the Affordability Schedule are not adopted:

- The following factors if present will raise a presumption of financial hardship:
  - Whether the appellant had a family size larger than 3 and gross family income less than 150 percent of the federal poverty level.
  - Whether the health insurance offered by the appellant's employer at a premium charge at or below the affordable monthly premium on the Schedule fails to satisfy the criteria for minimum creditable coverage in 956 CMR § 5.03 (2) in

2007 and 2008.

- Whether the appellant had an application pending for MassHealth or Commonwealth Care during the months in the tax year that he or she was not insured.
- Whether the appellant experienced a change in income or family size during the tax year such that the cost of coverage after the change in income or family size is no longer affordable under the Schedule.
- Whether the appellant has housing expenses that constitute more than 30 percent of his or her income.[3]
- Whether after deduction of unreimbursed child care expenses paid during the tax year or of child support and alimony payments or other court-ordered payments made during the tax year, the resulting annual income is not sufficient to afford insurance under the Schedule.

Recognize hardship for those unaware of affordable insurance options in 2007/2008 if they enroll in 2008/2009

The goal of the individual mandate is to create an incentive for individuals to obtain insurance. In the early years of the mandate residents who were unaware of affordable options for coverage should have an opportunity to avoid the tax penalty by obtaining insurance: We strongly urge the Connector to adopt the following additional standard for hardship appeals particularly in tax years 2007 and 2008.

- The following factors if present will raise a presumption of financial hardship:
  - Whether the appellant was unaware of the availability of affordable insurance through the Connector and has applied for said insurance at the time of filing his or her appeal and enrolled in said insurance if determined eligible to do so.

Section 6.07 Annual Certification

This section should include a provision for notifying residents who have sought to purchase coverage from the Connector of the availability of the Certification process and how to make a request.

Section 6.08 Right to a Hearing

Add "affordable" before the words "health insurance" in (1).

Section 6.10 Hearings

The DALA regulations do not include a time frame for appeals to be heard or decisions on appeal to be made. The 6.0 regulations should include such a time frame.

Section 6.11 Payment of penalty pending appeal

An individual seeking review of the penalty assessment should not be subject to accrued interest or late penalties. This should be stated in these regulations and those of the Department of Revenue.

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3 Large regional variation in housing costs and other individual circumstances significantly affect affordability. See, Dryfoos, Paul, *Understanding Cost of Living and Cost of Health Care in Massachusetts*,(March 2007).

Judicial review
By statute the appellate decisions of the Connector are subject to judicial review. G. L. c. 30A, § 14. This should be acknowledged in the regulations. See, G.L. c. 30A, 11(8) (notice of right to judicial review should be included in the notice of decision).

956 CMR 5.00 Minimum Creditable Coverage

We endorse the comments of the ACT!! Coalition regarding the MCC regulations. Specifically, we commend the Connector for recognizing that prescription drugs must be included in any policy of health insurance that deserves the name, and urge reasonable limits on lifetime caps and deductibles.

Thank you for the opportunity to make these comments; we look forward to continuing to work with the staff and Board of the Connector to make the promise of health care reform in Massachusetts a success.

Yours truly,

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