

The following pages describe the “robust” and “generous” waivers - both adjectives were used by the Connector in newspaper articles that also threatened residents with the loss of the personal state exemption and severe monthly tax penalties for 2008 if they did not purchase health insurance. Also keep in mind that the law states that there must be a “generous” appeals process if a person cannot afford the insurance.

EXEMPTION RULES:

Requesting a Certificate of Exemption for 2007

To be considered for a Tax Year 2007 Certificate of Exemption, you must demonstrate that you cannot afford a Connector health insurance product because you experienced at least one qualifying financial hardship event. Commonwealth Care is not a Connector health insurance product so if you are eligible for Commonwealth Care, you cannot apply for a Certificate of Exemption. The Connector may revoke a Certificate if it determines at a later date that any of the information contained in the application for a Certificate of Exemption is inaccurate.

- Therefore, C. CARE may not apply for an EXEMPTION, only C. CHOICE has a chance for this. The reason is that C. CARE is strictly a non-commercial product. It is clearly written in the law that if "affordability" is met, that's it. There's virtually no way out. The state has decided you can afford to pay a certain amount based on your monthly gross income and if you cannot, you must appeal said decision by the state which is the "Hardship Appeal."

- There is NO EXEMPTION for <300% FPL (C. CARE), only a "Hardship appeal" as written below:

114.6 CMR: DIVISION OF HEALTH CARE FINANCE AND POLICY MEDICAL SECURITY BUREAU

114.6 CMR 13.00: HEALTH SAFETY NET ELIGIBLE SERVICES

13.05: Medical Hardship Services

(1) General. An applicant at any income level may qualify for Medical Hardship if Allowable Medical Expenses have so depleted the family's income that he or she is unable to pay for Eligible Services. The Health Safety Net Office will process Medical Hardship applications based on the documentation submitted by the Provider. A determination of Medical Hardship is a one time determination and not an ongoing eligibility category.

(2) Eligibility. An applicant qualifies for Medical Hardship if:

(a) he or she is a Massachusetts Resident;

(b) the applicant's Allowable Medical Expenses must exceed a specified percentage of the applicant's gross income as follows:

Income Level / Percentage of Gross Income

| | |
|----------------|-----|
| 0 - 200% FPL | 10% |
| 201 - 300% FPL | 15% |
| 301 - 400% | 20% |
| 401 - 600% FPL | 30% |
| > 601% FPL | 40% |

(3) Eligibility Determination. An applicant for Medical Hardship must complete a Medical Hardship application and provide the required documentation of medical expenses. Providers must assist the applicant to complete the Medical Hardship application and assemble the required documentation. The Health Safety Net Office will approve an application for Medical Hardship if the applicant's Allowable Medical Expenses exceed the percentage of Family Income listed above.

(4) Allowable Medical Expenses. The Division will determine the applicant's Allowable Medical Expenses based on review of the submitted documentation. Allowable Medical Expenses include Family medical bills from any health care Provider that, if paid, would qualify as deductible medical expenses for federal income tax purposes. Allowable Medical Expenses include unpaid bills for which the patient is responsible incurred up to twelve months prior to the date of application for Medical Hardship, including bills incurred prior to the date of Low Income Patient eligibility determination, and patient paid and unpaid bills for which the Provider may not bill the Health Safety Net Office. **Unpaid bills included in a Medical Hardship determination will not be included in a subsequent Medical Hardship application.**

(5) Applicant Contribution. The applicant's required contribution is the specified percentage of Family Income in 114.6 CMR 13.05(2). There is one Medical Hardship contribution per Family per Medical Hardship determination. The applicant will remain responsible for Allowable Medical Expenses equal to the required contribution, including bills from health care providers other than Massachusetts Hospitals and Community Health Centers.

(6) Notification of Determination. The Health Safety Net Office will notify applicants of the determination. The notice will explain that the person is eligible for Medical Hardship; include the dates for which allowable Medical Expenses may be included; include the amount of the applicant's Medical Hardship contribution; inform the patient of any required deposit for non-emergency services; include information about written payment plans; explain how to reapply at the end of the eligibility period; list the services that do not qualify as Eligible Services; include the name and number of a contact person for more information. The Office will also notify Providers with bills included in the applicant's Allowable Medical Expenses of the determination and will allocate the applicant's Contribution to each Health Safety Net Provider based on the gross charges of services provided to the applicant's family.

(7) Claims. Providers may submit claims for Medical Hardship Services upon notification of an approved Medical Hardship application. The Provider may submit a claim for any balance for Eligible Medical Expenses above the patient's Medical Hardship contribution, noting the Applicant's Medical Hardship contribution on the claim. The Provider may bill the Applicant for the Medical Hardship contribution in accordance with the Health Safety Net Office notice under 114.6 CMR 13.05(5).

- In other words, the individual must first be enrolled in C. CARE, spend a large amount of money, apply for a HARD-SHIP APPEAL, then maybe get it or not.

- FOR C. CARE or C. CHOICE there is Waiver or Reduction of Enrollee Premium as written below:

(5) Waiver or Reduction of Enrollee Premium Contribution for Extreme Financial Hardship.

(a) Extreme financial hardship means that the Enrollee has shown to the satisfaction of the Connector that the Enrollee:

1. is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice; or
2. has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone); or
3. within the 12 month period immediately preceding the date of the waiver application, has non-cosmetic medical and/or dental out-of-pocket expenses (exclusive of premium payments), totaling more than 7.5% of the individual or family's gross annual income that are not subject to payment by a third-party. (In this case non-cosmetic medical and/or dental out-of-pocket expenses must be incurred by the individual or family for services rendered while enrolled in a Commonwealth Care plan and incurred within the 12 months immediately preceding the date of the waiver application.); or
4. has incurred a significant, unexpected increase in essential expenses within the last six months resulting directly from the consequences of:
 - a. domestic violence;
 - b. the death of a spouse, family member, or partner with primary responsibility for child care;
 - c. the sudden responsibility for providing full care for an aging parent or other family member, including a major, extended illness of a child that requires a working parent to hire a full-time caretaker for the child; or
 - d. a fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the Enrollee.

(b) If the Connector determines that the requirement to pay an Enrollee Premium Contribution results in extreme financial hardship for the Enrollee, the Connector, in its sole discretion, may waive payment of such Contribution or reduce the amount of such Contribution assessed to a particular individual or family.

(c) If the Connector determines, in the case of an Enrollee whose annual income is at or below 150% of FPL, that the payment of any Co-payment results in extreme financial hardship for such Enrollee, the Connector, in its sole discretion, may waive or reduce any Co-payment incurred by such Enrollee.

(d) Hardship waivers will be authorized for up to six months. The six-month time period begins in the month after a documented hardship waiver is granted. An Enrollee who is granted a hardship waiver will be assigned to the lowest cost Coverage Type available in that Enrollee's Service Area. At the end of the six-month period, the Enrollee may submit another request. Requests for Enrollee Premium Contribution or Co-payment relief should be addressed to the Connector.

Voluntary Withdrawal. If an Enrollee wishes to voluntarily withdraw from receiving Commonwealth Care coverage, it is the Enrollee's responsibility to notify the Connector of his or her intention by phone or, preferably, in writing. Coverage continues through the end of the calendar month of withdrawal. The Enrollee is responsible for the payment of all Enrollee Premium Contributions up and including the calendar month of withdrawal.

Change in Enrollee Premium Contribution Calculation. The Enrollee Premium Contribution amount is recalculated when the Connector is informed of changes income, family group size, or health-insurance status, and may be changed whenever

er an adjustment is made in the Commonwealth Care Premiums paid to one or more Contracted MMCO's or as a result of MMCO's changing their service areas .

- There is POSSIBLE waiver for >300% FPL (Comm. CHOICE levels only) , but standards are ridiculously high and apply only to devastating life events.

EXEMPTION circumstances:

- You are homeless, or more than 30 days behind in rent or mortgage payments, or have received a current eviction or foreclosure notice.
- You have a shut-off notice from your utility company (gas, electric, oil, water, or telephone), or one of your utilities has been shut off, or one or more of your utility companies is refusing to deliver services because you cannot pay.
- You have a large increase in expenses in the past six months due to domestic violence.
- You have a large increase in expenses in the past six months due to death of your spouse, family member, or partner with primary responsibility for child care.
- You have a large increase in expenses in the past six months due to the sudden responsibility for providing full care for an aging parent or other family member, including a major long illness of your child that requires a working parent to hire a full-time person to care for your child.
- You have a large increase in expenses in the past six months due to a fire, flood, natural disaster, or other unexpected natural or human-caused event causing large damage to you or, your home, or your property or personal possessions.
- You have had non-cosmetic medical and/or dental out-of-pocket expenses (not including premium payments) totaling more than 7.5% of your household's adjusted gross income that were not subject to payment by a third party.
- You can establish that the expense of purchasing health insurance that meets minimum credible coverage would have caused you to experience serious deprivation of food, shelter, clothing or other necessities.
- Your family size is so large that reliance on TABLE 1 to estimate what monthly premium you can afford would result in significant inequity.

- Anyone can apply but unless you fall into the absolute "down and out" category, you're not going to get it. This is a deep and expensive bureaucratic maze meant to confuse, bewilder and deny. A team of 28 attorneys has been hired by the state to determine if an exemption or hardship waiver is applicable.

- So long and short, for HARDSHIP APPEAL:

<0 - 200% FPL (C. Care) must have paid 10%

201 - 300% FPL (C. Care) must have paid 15%

(C. CARE) must first have spent these percents of their very limited of their incomes on 'approved medical expenses' before applying for a "HARDSHIP APPEAL"

>300% FPL (C. CHOICE) must have dire life circumstances before applying for a WAIVER or

>300% FPL (C. CHOICE) may also apply for a "HARDSHIP APPEAL" if they have spent a high and varying amount.

301% - 400% must have paid 20%

401% - 600% FPL must have paid 30%

>601% FPL must have paid 40%

- If you find that you can no longer afford the C. CARE, C. CHOICE or "private plan" that you have, you can apply for "Waiver or Reduction of Enrollee Premium Contribution for Extreme Financial Hardship". Very difficult, restrictive and time limited.

Appeals Process

Jamie Katz, General Counsel for the Connector Authority, outlined the role of the Connector and steps for both the individual mandate waiver and the financial hardship appeal to the Board.

He stressed that all individuals can submit a mandate appeal with their tax return. Once DOR receives the appeal, it will submit a request for additional documentation if necessary. The documentation must be returned in 30 days or the appeal

will be dismissed. After collecting the documentation, DOR enters the information on a shared-secured website used between the Connector and DOR. The Connector will make a determination on the appeal. Their goal is respond to all appeal requests in 90 days.

Jamie stressed that the appeals forwarded to the Connector are only for people without insurance, and who are deemed able to afford insurance under the 2007 affordability schedule. Individuals who become exempt under other criteria, such as for religious reasons, will be fall under the purview of DOR.