956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 12.00: ELIGIBILITY, ENROLLMENT, AND HEARING PROCESS FOR CONNECTOR PROGRAMS

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12.01: Purpose

The purpose of 956 CMR 12.00 is to implement the provisions of M.G.L. c. 176Q and thereby facilitate the availability, choice and adoption of qualified health plans to eligible individuals, families and groups.

12.02: Scope

These regulations at 956 CMR 12.00 contain the Connector's regulations governing eligibility for Connector Programs, Enrollment, responsibility of Enrollees, Enrollee Premiums, disenrollment, and the related appeal process under M.G.L. c. 176Q. The Connector also promulgates other regulations and publishes other documents affecting its programs, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, administrative information bulletins and other documents as necessary.

12.03: Definitions

As used in 956 CMR 12.00, the following terms shall mean:

Advance Premium Tax Credit (or APTC). A payment made by the U.S. Department of Health and Human Services pursuant to 42 USC § 18082 on behalf of an eligible individual to reduce the amount of a Non-Group Health Plan premium.

Appeal Representative. A person who:

(a) is sufficiently aware of an appellant's circumstances to assume responsibility for the accuracy of the statements made during the appeal process, and who has been provided with written authorization from the appellant to act on the appellant's behalf during the appeal process; or

(b) has, under applicable law, authority to act on behalf of an appellant in making decisions related to health care or payment for health care. An appeal representative may include, but is not limited to, an attorney or a non-attorney acting under an attorney's supervision, a guardian, conservator, executor, administrator, holder of power of attorney or health care proxy.

Appealable Action. Any of the actions listed in 956 CMR 12.13.

Applicant. An individual or a Small Employer who completes and submits an application for a Connector Program.

Application. A form prescribed by the Connector to be completed by an Applicant or on the Applicant's behalf, and submitted to the Connector or its designee as a request for a determination that the Applicant is eligible for a Connector Program.

Board. The Board of the Commonwealth Health Insurance Connector Authority, established by M.G.L. c. 176Q, § 2.

Commonwealth. The Commonwealth of Massachusetts.

Commonwealth Health Insurance Connector Authority or Connector. The entity established pursuant to M.G.L. c. 176Q, § 2 and authorized under M.G.L. c. 176, § 3 to perform all the duties and responsibilities required of an American Health Benefit Exchange, as that term is defined by the Patient Protection and Affordable Care Act, Pub. L. 111-148, as amended from time to time.

Connector Program. Any program administered by the Connector to allow individuals to enroll in Health Plans or Dental Plans, including with Financial Assistance, or to allow Small Employers to offer Health Plans or Dental Plans to their Employees and for Employees to enroll in those Health Plans or Dental Plans. Connector Programs include Non-Group Health Plans without Financial Assistance; Non-Group Health Plans with Financial Assistance; and Small Group Health Plans.

Connector Rules and Regulations. All regulations, bulletins and other written directives duly adopted or issued by the Connector relating to Connector Programs.

ConnectorCare. The program administered by the Connector pursuant to M.G.L. c. 176Q to provide Premium Assistance Payments and Cost Sharing Subsidies to Eligible Individuals at or below 500 percent of the Federal Poverty Level who are also eligible for Advance Premium Tax Credits.

Cost Sharing. A payment made by or billed to an Enrollee at the point of service, including, but not be limited to, co-payments, co-insurance and deductibles.

Cost Sharing Subsidy. A payment made to a Health Plan by the Connector to reduce Cost Sharing expenses of ConnectorCare Enrollees. If applicable, this term may also encompass additional federal payments made to a Health Plan by the federal government to reduce Cost Sharing expenses of certain ConnectorCare enrollees under 45 CFR 156.410.

Covered Services. The range of medical services required to be provided by a Health Plan under its policy.

Day. A calendar day unless a business day is specified.

Dental Carrier. Any dental insurance carrier that is contracted with the Connector to provide dental services to Connector Program Enrollees.

Dental Plan. Any individual or group policy of insurance issued by a Dental Carrier and offered through the Connector.

Eligible Individual. An individual who is a Resident of the Commonwealth and who is eligible to participate in a Connector Program for Non-Group Health Plans in accordance with M.G.L. c. 176Q and 956 CMR 12.04.

Eligible Small Employer. A Small Employer that is eligible to participate in a Connector Program for Small Group Health Plans, in accordance with 956 CMR 12.04.

Employee. Any individual who is an Employee as that term is defined by section 2791 of the Public Health Services Act.

Employer. Any Employer, as that term is defined in section 2791 of the Public Health Services Act, except that "Employer" includes employers with one or more employees.

Enrollee. An Eligible Individual enrolled by the Connector or its designee in a Health Plan after completing Enrollment. Enrollee also means an Employee enrolled in a Small Group Health Plan, and any dependent of such Employee also enrolled in such Small Group Health Plan, through the Connector, consistent with applicable law and the terms of the Small Group Health Plan. Provided that at least one Employee enrolls in a Small Group Health Plan through the Connector, Enrollee also means a business owner enrolled in a Small Group Health Plan through the Connector, or the dependent of a business owner enrolled in a Small Group Health Plan through the Connector.

Enrollment. The selection of a Health Plan and, if applicable, the payment of the Premium for that Health Plan by the deadline established by the Connector.

Household. A single household for purposes of eligibility for a Non-Group Health Plan with Financial Assistance, which means the tax filer and the individuals for whom a tax filer properly expects to claim a personal exemption under the Internal Revenue Code.

Federal Poverty Level (FPL). The most recently published Federal poverty level, updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC 9902(2), as of the first day of the annual open enrollment period for coverage in a Health Plan through the Connector, as specified in 45 CFR 155.410.

Financial Assistance. Any subsidy provided to an Eligible Individual enrolled in a Health Plan, including plans with APTC only, Premium Assistance provided through ConnectorCare, or Cost Sharing Subsidies.

Fraud. An intentional deception or misrepresentation made by a person or corporation with the knowledge that the deception could result in some unauthorized benefit under a Connector Program to the person, the corporation, or some other person. It also includes any act that constitutes fraud under applicable Federal or state health care fraud laws. Examples of Enrollee fraud include, but are not limited to: improperly obtaining prescriptions for controlled substances and card sharing.

Health Carrier. Any managed care organization or insurance carrier that is contracted with the Connector to provide Covered Services to Connector Program Enrollees.

Health Plan. Any individual or group policy of insurance issued by a Health Carrier and offered through the Connector.

Hearing. An administrative, adjudicatory proceeding pursuant to 801 CMR 1.02 and 45 CFR 155.500 et seq. to determine the legal rights, duties, benefits or privileges of Applicants (in certain, limited circumstances) and Enrollees pertaining to eligibility for Connector Programs; enrollment in a Health Plan; and decisions regarding requests to waive or reduce a ConnectorCare Premium for extreme financial hardship.

Modified Adjusted Gross Income (MAGI). Income used to determine eligibility for Financial Assistance, as defined in the Internal Revenue Code at 26 USC § 36B(d)(2)(B).

Non-Group Health Plan. A Health Plan sold to an Eligible Individual, consistent with M.G.L. c. 176J § 1.

Plan Type. A type of coverage for ConnectorCare Enrollees with income within a certain range. Plan Types differ in terms of the amount of Premium Assistance payment and Cost Sharing Subsidy provided.

Premium. An Enrollee's or Small Employer's required periodic payment for coverage under a Connector Program, paid to the Connector.

Premium Assistance. A periodic payment made to a Health Carrier by the Connector on behalf of a ConnectorCare Enrollee to reduce the amount of a Premium paid by the individual.

Resident. For an individual who:

(a) is age 21 and over, a Resident is a person who is not living in an institution as defined in 42 CFR 435.403(b), is capable of indicating intent, and is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f). Such an individual is a Resident if the individual is living and intends to reside, including without a fixed address, or has entered with a job commitment or is seeking employment (whether or not currently employed) within the Commonwealth;
(b) is under the age of 21, a Resident is an individual who is not living in an institution as defined in 42 CFR 435.403(b), is not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act as addressed in 42 CFR 435.403(g), is not emancipated, and is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f). Such an individual is a Resident if the individual resides in the Commonwealth, including without a fixed address, or if the individual's parent or caretaker with whom the individual resides is a Resident of the Commonwealth;
(c) is not described in 956 CMR 12.03: Resident(a) or (b) of this definition, the individual shall be a Resident if the individual satisfies the residency requirements described in 42 CFR 435.403; or
(d) is a member of a Household where at least one other member is a Resident under 956 CMR 12.03: Resident(a), (b), or (c) above, then that individual shall also be treated as a Resident, except where that individual is a tax dependent of married spouses who enroll in a Health Plan through a single Exchange other than the Connector.

Small Employer. An Employer with at least 1 but not more than 50 Employees. The number of Employees is determined using the method set forth in section 4980H(c)(2) of the Internal Revenue Code.

Small Group Health Plan. A Health Plan sold to an eligible small business or group, as defined in M.G.L. c. 176J § 1.

12.04: Eligibility for Connector Programs

(1) Eligibility for a Non-Group Health Plan Without Financial Assistance. To be eligible for a Non-Group Health Plan without financial assistance, the individual must:

(a) Be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States, as defined in 45 CFR 152.2, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;
(b) Not be incarcerated, other than incarceration pending the disposition of charges; and
(c) Be a Resident.

To be eligible for a Non-Group Health Plan that is a catastrophic plan, as described at 42 USC § 18022(e), an individual must meet the above eligibility requirements and also not have reached the age of 30 before the beginning of the plan year or have a qualifying exemption from the requirement to maintain minimum essential coverage under section 5000A of the Internal Revenue Code, as described at 45 CFR 155.305(h)(2).

(2) Eligibility for a Non-Group Health Plan with APTC Only. To be eligible for a Non-Group Health Plan with APTC only, the individual must:

(a) Meet the eligibility requirements for a Non-Group Health Plan Without Financial Assistance set forth in 956 CMR 12.04(1);
(b) Meet the eligibility requirements for federal Advance Premium Tax Credits set forth in 45 CFR 155.305(f); and
(c) Not meet the eligibility requirements for ConnectorCare set forth in 956 CMR 12.04(3).

(3) Eligibility for ConnectorCare.

(a) To be eligible for ConnectorCare, an individual must:

1. Have an expected Household MAGI for the year for which the individual is seeking ConnectorCare that is at or below 500 percent of the FPL; and

2. Meet the eligibility requirements for a Non-Group Health Plan with APTC only, as set forth in 956 CMR 12.04(a)(2)(a) and (b).

(b) The eligibility determination for ConnectorCare will include a determination of the Plan Type based on the individual's Household MAGI as a percentage of the FPL for the year for which the individual is seeking ConnectorCare. Premium Assistance amounts and Cost Sharing Subsidies will vary among Plan Types, as determined by the Board. The following are the different levels of such income for each Plan Type:

1. Plan Type 1 – not in excess of 100% of the FPL.

2. Plan Type 2 – more than 100% but not in excess of 200% of the FPL, except that persons at or below 150% of FPL will be in Plan Type 2A, and those over 150% and not over 200% of FPL will be in Plan Type 2B.

3. Plan Type 3 – more than 200% but not in excess of 500% of FPL, except that:

a. persons at or below 250% of the FPL will be in Plan Type 3A;

b. persons above 250% of the FPL and not over 300% of the FPL will be in Plan Type 3B;

c. persons above 300% of the FPL and not over 400% of the FPL will be in Plan Type 3C; and

d. persons above 400% of the FPL and not over 500% of the FPL will be in Plan Type 3D.

(c) Premiums for ConnectorCare. Premiums paid by ConnectorCare Enrollees within the same Plan Type may vary depending on the Health Plan selected. The differentials in Premiums for Health Plans will be determined by the Connector based on the difference in cost of the Health Plans. There will be at least one Health Plan available to Plan Type 1 and Plan Type 2A Eligible Individuals that has no Premium provided that the Enrollee chooses to elect the full amount of APTC available to that Enrollee. There will be at least one Health Plan available to Plan Types 2B and 3 Eligible Individuals that will cost the minimum Premium set by the Board in accordance with 956 CMR 12.12(9) provided that the Enrollee chooses to elect the full amount of APTC available to that Enrollee.

(4) Eligibility for Small Group Health Plans.

(a) Small Employer Eligibility to Offer Small Group Health Plans. To be an Eligible Small Employer, an Employer must:

1. Be a Small Employer;

2. Be actively engaged in business;

3. Offer at a minimum all full-time Employees, defined as all Employees who are employed on average at least 30 hours of service per week, coverage in a Small Group Health Plan;

4. Either have its principal business address in the Commonwealth and offer coverage to all its full-time employees through the Health Connector; or offer coverage to each eligible employee through a Small Business Health Options Program established under 42 USC § 18031, serving that employee's primary worksite; and

5. Meet minimum participation or contribution requirements, or both, as established by Connector policies, except that such participation and contribution requirements shall be waived during the Small Group Open Enrollment Period set forth in 956 CMR 12.11(3).

(b) A Small Employer that has enrolled in coverage for its Employees shall not cease to be an Eligible Small Employer during a coverage year merely because the number of Employees it employs increases over 50.

12.05: Matching Information

The Connector or its designee initiates information matches with other state and federal agencies and information sources when an Application is received, when eligibility is redetermined, or at other times in the Connector's administrative processes in order to verify eligibility or certain information. These agencies and information sources may include, but are not limited to, the following: the Massachusetts Department of Unemployment Assistance (DUA), MassHealth, Massachusetts Department of Public Health's Registry of Vital Records and Statistics (RVRS), Massachusetts Department of Industrial Accidents, Massachusetts Department of Veteran's Services, Massachusetts Department of Revenue (DOR), Massachusetts Bureau of Special Investigations, Internal Revenue Service, Social Security Administration (SSA), Systematic Alien Verification for Entitlements Program (SAVE), Department of Homeland Security, Massachusetts Department of Transitional Assistance (DTA), and Health Carriers.

12.06: Standards for an Eligibility Application

In making an eligibility determination for Connector Programs, the Connector will require an Applicant to complete an Application and provide the information requested in that Application. Based on the information supplied in that Application, and, consistent with 45 CFR 155.315 and 155.320, matching information as described in 956 CMR 12.05, additional information may be requested to determine eligibility status.

12.07: Eligibility Review Related to Connector Programs for Non-Group Health Plans

(1) The Connector or its designee may review eligibility for Connector Programs for Non-Group Health Plans every 12 months, consistent with 45 CFR 155.335, or more frequently as part of a mid-year redetermination, consistent with 45 CFR 155.330. Eligibility may also be reviewed more frequently as a result of an Eligible Individual's change in circumstances, or a change in Connector Program eligibility rules. The Connector or its designee updates the case file based on information received as the result of such review. The Connector reviews eligibility:

(a) By information matching with other state and federal agencies, Health Carriers, and information sources as set forth in 956 CMR 12.05;

(b) Based on information obtained from an Applicant, Eligible Individual, or Enrollee, subject to verification.

(2) The Connector determines, as a result of this review, whether:

(a) The Eligible Individual continues to be eligible for a Connector Program; or

(b) The Eligible Individual's current circumstances require a change in Connector Program eligibility, including a change in ConnectorCare Plan Type or Premium.

(3) The Connector or its designee will notify the Eligible Individual if there is a change in Connector Program eligibility or if the individual is no longer eligible for any Connector Program.

12.08 Eligibility Effective Dates for Connector Programs for Non-Group Health Plans

(1) In general, any eligibility determination for Non-Group Health Plans, including a change in eligibility in accordance with 956 CMR 12.07, will be effective on the first day of the month following the month in which the Connector notifies the Eligible Individual of the eligibility determination.

(2) The Connector shall provide in written policy a point during the month after which, if an Eligible Individual's eligibility changes, and the Eligible Individual remains eligible for a Connector Program, the effective date of that new eligibility determination will be the first day of the month following the month specified in section 12.08(1).

(3) Notwithstanding the foregoing, any eligibility determination that results in an Eligible Individual no longer being eligible for any Connector Program for Non-Group Health Plans will be effective on the first day of the month after the month in which the Connector notifies the Eligible Individual of the eligibility determination.

12.09: Responsibilities of Applicants, Eligible Individuals, Eligible Small Employers, and Enrollees

(1) Responsibility to Cooperate. The Applicant, Eligible Individual, Eligible Small Employer, or Enrollee must cooperate with the Connector or its designee in providing information necessary to establish and maintain eligibility and to bill and collect Premiums, and must comply with all the rules and regulations of the Connector or its designee. An Applicant's failure to provide information requested during the eligibility determination process may result in a delay in the eligibility determination, or a denial of eligibility.

(2) Responsibility to Report Changes. The Applicant, Eligible Individual, Eligible Small Employer, or Enrollee must report to the Connector or its designee, within 30 days, changes that may affect eligibility or Premiums. Such changes include, but are not limited to, residency, address, income, the availability of health insurance, household composition changes, and immigration status.

12.10: Enrollment in, Open Enrollment and Special Enrollment Periods Applicable to, and Termination from Non-Group Health Plans

(1) Open Enrollment and Special Enrollment Periods for Non-Group Health Plans. Eligible Individuals may enroll in a Non-Group Health Plan, and Enrollees may transfer from one Non-Group Health Plan to a different Non-Group Health Plan, as made available to that Eligible Individual or Enrollee through the Health Connector, during any open enrollment periods established by state or federal law. Eligible Individuals may enroll in a Non-Group Health Plan, and Enrollees may transfer from one Non-Group Health Plan to a different available Non-Group Health Plan, outside of the open enrollment period only during a special enrollment period established by the Connector for one of the following reasons:

(a) The Enrollee experiences a triggering event, as set forth in 45 CFR 155.420 and applicable state law, including but not limited to enrollment waivers available under 958 CMR 4.00;
(b) An individual is determined newly eligible for a ConnectorCare plan in accordance with 956 CMR 12.04(3);
(c) The Enrollee's eligibility changes Plan Types in accordance with 956 CMR 12.04(3);
(d) The Enrollee's eligibility changes from being eligible for ConnectorCare to being eligible for a Non-Group Health Plan with APTC Only;
(e) The Enrollee has been approved for a hardship waiver in accordance with 956 CMR 12.12; or

(f) The Enrollee's hardship waiver period has ended.

Enrollees will have sixty (60) days to enroll in a Health Plan from the date of one of the events described above.

(2) Enrollment in Non-Group Health Plans. Eligible Individuals who may enroll under 956 CMR 12.10(1) will be permitted to choose a Health Plan from among those that are made available to them through the Health Connector, and must choose a Health Plan in order to be enrolled. Eligible Individuals who are required to pay a Premium must pay the first month's Premium on or before a due date set by the Connector in order to complete the Enrollment process. Premiums for a Non-Group Health Plan shall be the full cost of such Health Plan, and Premiums for Non-Group Health Plans with Financial Assistance shall be the cost of such Health Plans reduced by the amounts of any applicable APTC and Premium Assistance.

(3) Enrollment Effective Date for Non-Group Health Plans. Eligible Individuals must complete the Enrollment process in order to be covered in a Non-Group Health Plan, including paying any required premium by the due date set by the Connector. Coverage will begin on the first day of the month following the completion of Enrollment, including payment of Premium by the due date, except that in the case of the addition of a dependent to an existing enrollment resulting from the birth, adoption or placement for adoption or foster care of the new dependent, the new dependent's effective date may alternately be the date of the birth, adoption or placement for adoption or foster care. Eligible Individuals who do not pay any required premium by the due date set by the Connector shall not be enrolled in coverage, unless otherwise permitted to enroll at a future date in accordance with 956 CMR 12.10(4).

(4) Notification. The Connector will notify an Enrollee in writing of the name and contact information of the Enrollee's Health Plan and enrollment effective date.

(5) Termination of Enrollees. The Connector may terminate an Enrollee in accordance with any applicable grace periods as set forth in 45 CFR 156.270(d) and (g) and any applicable state law, for the following reasons:

(a) For Fraud, including rescissions consistent with 45 CFR 147.128;
(b) For failure to pay Premiums under 956 CMR 12.12; or
(c) When the Enrollee is no longer eligible for coverage.

(6) If the Connector terminates an Enrollee pursuant to 956 CMR 12.10(5), it will provide the enrollee with written notice stating the reason for the action.

(7) The Connector may recoup any monies paid on behalf of an Enrollee to a Health Carrier for a Health Plan from the Enrollee directly if the enrollee is terminated for Fraud.

(8) Voluntary Termination of Coverage. If a Non-Group Health Plan Enrollee wishes to voluntarily terminate coverage, it is the Enrollee's responsibility to notify the Connector of such. The Connector shall establish a date during a month by which an Enrollee must request termination in order for the termination to be effective at the end of the month in which it is requested. A termination request made after such a date shall be effective at the end of the month following the month in which it was requested, unless coverage is terminated earlier for another reason unrelated to the request to voluntarily terminate. Any

Enrollee who requests termination of coverage shall be responsible for any Premium owed for all coverage months.

12.11: Enrollment in, Open Enrollment and Special Enrollment Periods applicable to, and Termination from Small-Group Health Plans

(1) Enrollment in Small-Group Health Plans. Following a determination of eligibility, Eligible Small Employers will be instructed to select a Small Group Health Plan for their Employees, and Employees must enroll in the plan or waive participation. Eligible Small Employers will be permitted to choose a Health Plan from among those that the Health Connector makes available to the Small Employer. Eligible Employers may allow Employees to choose among more than one Small Group Health Plan in a manner specified by the Health Connector in accordance with 45 CFR 155.706(b). Employees may select a Small Group Health Plan once the Eligible Small Employer completes the employer portion of the application, and must complete plan selection by the deadline determined by the Health Connector. Eligible Small Employers must satisfy all applicable Connector contribution and participation requirements and must pay the first month's Premium on or before a due date set by the Connector in order to complete the Enrollment process. Premiums paid by Small Employers must be the total Premium owed for all of the Small Employer's participating Employees.

(2) Enrollment Effective Date for Small-Group Health Plans. Small Employers and Employees must complete the Enrollment process in order to be covered in a Small Group Health Plan, including paying all Premium owed by the due date set by the Connector. Coverage will begin on the first day of the month following the completion of Enrollment, except that in the case of a new enrollment resulting from birth, adoption or placement for adoption or foster care of a child, the new dependent's effective date may be the date of the birth, adoption or placement for adoption or foster care or the first day of the month following the event, at the election of the employee.

(3) Annual Open Enrollment for Eligible Small Employers. Eligible Small Employers may apply for coverage in a Small Group Health Plan at any time during the year. From November 15 to December 15 of a given year, Small Employers that would be eligible to participate but for the inability to satisfy any minimum contribution and minimum participation requirements set forth in Connector policy will be considered as eligible without having to satisfy such requirements.

(4) Open Enrollment and Special Enrollment Periods for Employees. Employees may enroll during an annual enrollment period set by the Small Employer or at the time of hiring or qualification for health benefits under the Employer's rules. Employees who waived coverage shall be able to enroll in a Small Group Health Plan, and enrolled Employees shall be able to transfer from one Small Group Health Plan to a different Small Group Health Plan, or terminate their Small Group Health Plan, during a special enrollment period established by the Connector if the Enrollee experiences a triggering event, and acts within applicable time frames, as set forth in 45 CFR 155.726(j).

(5) Termination of Enrollees. The Connector may terminate a Small Employer or Employee from a Small Group Health Plan for the following reasons:

(a) For Fraud, including rescissions consistent with 45 CFR 147.128;
(b) For failure of the Small Employer to pay Premium under 956 CMR 12.12; or
(c) When the Small Employer is no longer eligible for coverage.

(6) If the Connector terminates a Small Employer or an Enrollee pursuant to 956 CMR 12.11(5), it will provide the Small Employer or Enrollee with written notice stating the reason for the action.

(7) Voluntary Termination of Coverage. If a Small Employer wishes to voluntarily terminate coverage, it is the Small Employer's responsibility to notify the Connector of such. The Connector shall establish a date during a month by which a Small Employer must request termination in order for the termination to be effective at the end of the month in which it is requested. A termination request made after such a date shall be effective at the end of the month following the month in which it was requested, unless coverage is terminated earlier for another reason unrelated to the request to voluntarily terminate. Any Small Employer who requests termination of coverage shall be responsible for any premium owed for all coverage months. As stated in 956 CMR 12.11(4) an Employee or dependent Enrollee may only terminate coverage during a special enrollment period.

12.12: Premiums, Delinquency, and Reinstatement

(1) Enrollee and Small Employer Premiums. Enrollees who are assessed a Premium and Small Employers are responsible for monthly payments that must be paid on or before a due date set by the Connector. The Connector will establish and maintain multiple convenient payment methods for Enrollees and Small Employers. The Connector will transmit Premium payments received from Enrollees or Small Employers to the Health Plans in which they are enrolled.

(2) Delinquent Enrollee Premiums for Non-Group Health Plans Without Financial Assistance. An Enrollee in a Non-Group Health Plan without Financial Assistance who fails to pay a monthly Enrollee Premium in full by the payment due date will be considered delinquent and will be notified when the account is past due. This notice of delinquency will inform the Enrollee that, if payment of all outstanding Premium is not received in full on or before the payment due date indicated in the notice, then the coverage will be terminated retroactively to the last day of the last month for which the Enrollee has paid for coverage in full.

(3) Termination from a Non-Group Health Plans Without Financial Assistance for Failure to Pay Enrollee Premiums. If a delinquent Enrollee in a Non-Group Health Plan has not paid outstanding Premiums in full by the due date indicated in the notice of delinquency, then the coverage is terminated retroactively to the last day of the last month for which the Enrollee has paid for coverage in full. The Connector shall notify the Enrollee of the termination.

(4) Delinquent Enrollee Premiums for Non-Group Health Plans with Financial Assistance. An Enrollee in a Health Plan with APTC Only or in ConnectorCare who fails to pay a monthly Premium in full by the payment due date will be considered delinquent and will be notified when the account is past due. If an Enrollee's account is delinquent for two consecutive months, the Enrollee will be notified by a notice of delinquency which will inform the Enrollee that, if payment of all outstanding Premium is not received in full on or before the payment due date indicated in the notice, then the coverage will be terminated retroactively to the last day of the first coverage month in which the Enrollee was delinquent.

(5) Termination from a Non-Group Health Plan with Financial Assistance for Failure to Pay Enrollee Premiums. If an Enrollee who is delinquent fails to pay all Premiums owed in full by the due date after receiving the second notice described in 956 CMR 12.12(4), then the coverage is terminated retroactively to the last day of the first coverage month in which the Enrollee was delinquent. The Enrollee will be notified of the termination with a notice of termination.

(6) Reinstating Coverage in a Non-Group Health Plan Following Termination for Failure to Pay Premiums. An Enrollee in a Non-Group Health Plan who was terminated for non-payment of Premium and who makes a timely request to reinstate coverage may do so, provided that all outstanding Premiums for such terminated Enrollee have been paid in full, as well as the next month's Premium, by the deadline determined by the Connector.

(7) Waiver or Reduction of Premium for Extreme Financial Hardship.

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

1. Is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received an eviction or foreclosure notice within the last sixty (60) days; or

2. Has a shut-off notice, or has been shut off, or has a refusal to deliver essential utilities within the sixty (60) days prior to application (gas, electric, oil, water, or sole telephone); or

3. 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 need to provide full-time care for self, for an aging parent or for another 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 individual; or

4. Has filed for bankruptcy within the last twelve (12) months as long as the debts have not yet been discharged.

(b) If the Connector determines that the requirement to pay a Premium or arrears would result in extreme financial hardship for an individual, the Connector may waive payment of such Premium or arrears; or reduce the amount of such Premium or arrears assessed to the individual. The Connector will assume payment to the Health Carrier of the amount of the individual's Premium that is waived or reduced during the waiver period. The Connector will waive or reduce only the portion of Premium that equals the minimum Premium for the individual's ConnectorCare Plan Type.

(c) An Applicant who has been found eligible for ConnectorCare may request a premium waiver prior to enrollment, although the filing of such request does not entitle such Applicant to enroll at a reduced Premium or without paying the Premium while the request is pending. Further, where any Applicant is approved for a reduced Premium, but must continue to pay a portion of Premium because the Applicant was not approved for a full waiver of Premium, the Applicant has not chosen to enroll in the lowest-cost ConnectorCare Plan, or the Applicant has not chosen to apply all APTC toward the Applicant's ConnectorCare Plan, such Applicant shall not be enrolled unless the Applicant pays the remaining portion of Premium by the deadline established by the Connector.

(d) Waivers or reduction of premium may be authorized for up to 12 months. Waivers or reduction of premium may be retroactive, including where an Enrollee has become delinquent in accordance with 956 CMR 12.12(4) and is seeking to reduce Premium for the period of delinquency, or where an Enrollee has been terminated in accordance with 956 CMR 12.12(5), is seeking to reinstate coverage in accordance with 956 CMR 12.12(6), and is seeking to reduce Premium for the period of reinstated coverage. An individual who is granted a waiver or reduction will be allowed to enroll

in a Health Plan, as made available to that individual through the Health Connector. At the end of the waiver or reduction period, the individual may submit another request if the extreme financial hardship persists.

(e) Enrollees who have been approved for a waiver or reduction of premium or whose waiver or reduction period has ended may transfer to a different Health Plan within sixty (60) days.

(f) Premiums for Non-Group Health Plans with APTC only or Non-Group Health Plans without Financial Assistance shall not be eligible for a waiver or reduction of Premium for extreme financial hardship.

(8) Change in Premium for Non-Group Health Plans.

(a) Premiums for individuals enrolled in Non-Group Health Plans may change based on changes in Household composition, eligibility, or Enrollee address, and such Premium changes will follow the eligibility effective date provisions found at 956 CMR 12.08.

(b) Premiums for individuals enrolled in Non-Group Health Plans may change from year to year.

(9) Minimum Monthly ConnectorCare Premium Schedule. The Board shall determine annually the minimum monthly Premium for each Plan Type. The Premiums shall be set forth in a schedule that will be published annually.

(10) Monthly ConnectorCare Premium Assistance Payments. The Connector will make Premium Assistance payments to Health Carriers for Health Plans on behalf of ConnectorCare Enrollees monthly, using funds appropriated by the Commonwealth for the purpose, or otherwise made available to the Connector.

(11) Delinquent Small Employer Premiums for Small Group Health Plans. A Small Employer that fails to pay its monthly Premiums in full by the payment due date will be considered delinquent and will be notified when its account is past due. This notice of delinquency will inform the Small Employer that, if payment of all outstanding monthly Premium is not received in full on or before the payment due date indicated in the notice, then the coverage will be terminated retroactively to the last day of the last month for which the Small Employer has paid for coverage in full.

(12) Termination from a Small Group Health Plan for Failure to Pay Premiums. If a delinquent Small Employer has not paid its outstanding Premiums in full by the due date indicated in the notice of delinquency, then the coverage is terminated retroactively to the last day of the last month for which the Small Employer has paid for coverage in full. The Small Employer and any Enrolled Employees will be notified of the termination with a notice of termination.

(13) Reinstating Coverage in a Small Group Health Plan Following Termination for Failure to Pay Premiums. A Small Employer that was terminated for non-payment of Premiums may reinstate coverage within thirty (30) days from the date coverage was terminated. All outstanding monthly Premium must be paid in full as well as the Premium for the following month of coverage.

12.13: Right to Appeal

Applicants, Eligible Individuals, Enrollees, and Employers are entitled to appeal the following Appealable Actions:

(1) Any eligibility determination based on any eligibility factor in accordance with 956 CMR 12.04;

(2) Any determination of APTC amount, or of ConnectorCare Plan Type;

(3) Any determination regarding a Special Enrollment Period related to a Non-Group Health Plan based on the reasons listed at 12.10(4)(a)-(f); or

(4) The Connector's denial of a financial hardship waiver or reduction of premium, the renewal of a financial hardship waiver or reduction of premium, or the period of time to which a financial hardship waiver or reduction of premium applies, under 956 CMR 12.12.

12.14: Times and Methods for Filing Appeal Requests

(1) The Applicant, Eligible Individual, Enrollee, or Employer will receive a notice in writing of an Appealable Action identified in 956 CMR 12.13 from either MassHealth or the Connector or both. That notice will also include notice of the right to an appeal, including to a hearing with an independent hearing officer, of the method by which an appeal may be requested, and of the right to use an Appeal Representative. The notice will also include a form for appealing the action.

(2) The request for an appeal must be received within the following time limits:

(a) For any Appealable Action regarding a Connector Program for Non-Group Health plans

1. 30 days after the receipt of the notice of the Appealable Action. (In the absence of evidence to the contrary, it will be presumed that the notice was received 5 days after the date on the notice); or

2. 120 days from the date of an Appealable Action if the Connector fails to send written notice of such action or fails to act on a request for an eligibility determination.

(b) For any Appealable Action regarding a Connector Program for Small Group Health plans, 90 days after receipt of the notice of the Appealable Action or from the date of an Appealable Action if the Connector fails to send written notice of such action or fails to act on a request for an eligibility determination. (In the absence of evidence to the contrary, it will be presumed that the notice was received 5 days after the date on the notice.)

(3) The time periods in 956 CMR 12.14(2) will expire on the last day of such periods unless the day falls on a Saturday, Sunday, or legal holiday, in which event the last day of the time period will be deemed to be the following business day.

(4) Upon request by an Applicant, Eligible Individual, Enrollee, or Employer, the Connector will provide a form to request an appeal. The Connector and or its agent/designee may not restrict an individual's or an Employer's freedom to request an appeal.

12.15: Appeal Process

(1) Appeal requests will be processed and hearings will be conducted by the Connector using the policies and procedures for informal hearings set forth in 801 CMR 1.02, as well as the procedures set forth in 956 CMR 12.00 or in any administrative bulletins issued by the Connector. In addition, regarding appeals of Connector Programs related to Non-Group Health Plans, the Connector will use the policies and procedures at 45 CFR 155.500 – 155.550, and regarding appeals of Health Connector Programs related to Small Group Health Plans, the Connector will use the policies and procedures at 45 CFR 155.741.

(2) The Connector may dismiss any appeal request if:

(a) It is not received within the time periods specified in 956 CMR 12.14;

(b) It does not state a valid ground for appeal under 956 CMR 12.13;

(c) The appeal is withdrawn by the appellant or Appeal Representative;

(d) The appellant dies while the appeal is pending, except if the executor, administrator, or other duly authorized representative of the estate requests to continue the appeal; or

(e) For any reason stated in 801 CMR 1.02.

(3) The Connector may designate a hearing officer to hear any appeals. The hearing officer may, at the request of a party or on his or her own initiative, order that the hearing be conducted by telephone.

(4) Basis of Hearing Decisions

(a) The hearing officer's decision is based upon evidence, testimony, materials, and legal rules presented at the Hearing, as well as the Connector's rules, policies, and regulations, of which the hearing officer may take administrative notice.

(b) The decision shall be based upon a preponderance of evidence.

(c) The decision must be rendered in accordance with the law.

1. The law includes the state and federal constitutions, statutes, and duly promulgated regulations, as well as decisions of the state and federal courts.

2. Notwithstanding 956 CMR 12.15(4)(c)1, the hearing officer shall not render a decision regarding the legality of federal or state law including, but not limited to, Connector regulations. If the legality of such law or regulations is raised by the appellant or is otherwise the subject of consideration when rendering a hearing decision, the hearing officer shall render a decision based on the applicable law or regulation as interpreted by the Connector and as reflected in Connector Rules and Regulations, or other written guidance of the Health Connector.

(5) The decision of the hearing officer designated by the Connector will be final, except that within 14 days of the issuance of the hearing officer's decision, the Director of the Appeals Unit for the Connector, or the Director's designee, may, for good cause, and at the request of the appealing party or on his or her own initiative, order a re-hearing before another hearing officer. In the event that the Director or the Director's designee orders a re-hearing, the Director will give notice in writing to all parties of the date, time, and location of the re-hearing. The re-hearing will be conducted before another hearing officer whom the Director designates. Within 30 days after the order requiring re-hearing, the designated hearing officer will conduct the re-hearing and will either issue a superseding decision or decide not to issue a superseding decision. A request for re-hearing stays the initial decision of the hearing officer, and that initial decision will not be deemed final for purposes of the filing of an action for judicial review under G.L. c. 30A, § 14, until the Director or the Director's designee issues a superseding decision or decides not to supersede the initial decision.

(6) Enrollees who have brought an appeal must continue to pay all required Premiums during the pendency of the appeal. Persons who are appealing a denial of a premium waiver or reduction application must pay any applicable Premiums while the appeal is pending.

12.16: Dental Plans

(1) Eligibility for Dental Plans.

(a) Any individual who meets the eligibility requirements for Non-Group Health Plans without Financial Assistance, listed at 956 CMR 12.04(1)(a)-(c), shall also be eligible to purchase a Dental Plan; for purposes of clarity, an individual does not need to be eligible for a Connector Program for Non-Group Health Plans to be eligible for Dental Plans. Any time an individual no longer

meets the requirements listed at 956 CMR 12.04(1)(a)-(c), such individual shall no longer be eligible for a Dental Plan.

(b) Any Employer that is eligible to offer a Small Group Health Plan, in accordance with 956 CMR 12.04(4)(a), shall be eligible to offer a Dental Plan for its Employees. Any time an Employer loses eligibility for Small Group Health Plan coverage through the Connector, such Employer shall also lose eligibility for a Dental Plan.

(2) Applicability of Other Provisions. In general, any regulation in 956 CMR 12.00 that applies to a Health Carrier or a Health Plan shall apply equally to a Dental Carrier or a Dental Plan, including but not limited to eligibility review; eligibility effective dates; responsibilities of Applicants, Eligible Individuals, Eligible Small Employers, and Enrollees; termination of coverage; Premiums; and the right to appeal.

(3) Exceptions to Applicability of Other Provisions. Notwithstanding the foregoing, the following shall apply to Dental Plans:

(a) Eligible Individuals do not need a Special Enrollment Period to Enroll in a Dental Plan outside of the Open Enrollment Period;

(b) Where no APTC is applied to a Dental Plan, the delinquency, termination, and reinstatement rules applicable to Non-Group Health Plans without Financial Assistance, found at 956 CMR 12.12(2), (3), and (6) shall apply to Dental Plans, even where an enrollee is eligible for Non-Group Health Plans with Financial Assistance;

(c) Dental Plans are not eligible for Premium waivers or reductions under 956 CMR 12.12(7); and

(d) Dental Plans are not subject to the participation and contribution requirements applicable to Small Group Health Plans at 956 CMR 12.04(4)(a)5.

(4) Dental Plan Waiting Periods. A Dental Carrier may impose waiting periods on certain services following the start date of coverage in the Dental Plan, as consistent with state and federal law.

(5) Dental Plan Lockout Periods. A Dental Carrier may impose lockout periods on Dental Plans during which individuals and Employees cannot enroll, if the Eligible Individual or Employee is terminated from the Dental Plan because of failure to pay Dental Plan Premium or because of voluntary termination, as consistent with state and federal law.

12.17 Authorized Representatives

The Connector shall recognize any person or organization identified as the authorized representative of an Applicant for a Connector Program for Non-Group Health Plans, an Eligible Individual, or Enrollee in a Non-Group Health Plan, consistent with the provisions of 130 CMR 501.001.

12.18 Administrative Information Bulletins

(1) The Connector may issue administrative information bulletins that set out policies that are consistent with the substantive provisions of 956 CMR 12.00. In addition, the Connector may issue administrative information bulletins, which specify the information and documentation necessary to implement 956 CMR 12.00. The Connector may also issue administrative bulletins containing interpretations of 956 CMR 12.00 and other information to assist persons subject to 956 CMR 12.00 meet their obligations under 956 CMR 12.00.

(2) The Connector may publish policies and procedures describing the operationalization and implementation Connector Programs to provide more detailed information and guidance, including statements of policy and procedure, conditions of participation, guidelines, billing instructions, Health Carrier bulletins, and other documents as necessary.

12.19: Severability of Provisions

The provisions of 956 CMR 12.00 are hereby declared to be severable. If any such provisions or the application of such provisions or circumstances shall be held invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 956 CMR 12.00 or the applications of such provisions or circumstances other than those held invalid.

REGULATORY AUTHORITY:

956 CMR 12.00: M.G.L. c. 176Q.