956 CMR: COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY

956 CMR 12.00: ELIGIBILITY, ENROLLMENT, AND HEARING PROCESS FOR CONNECTOR CARE 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. ch. 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 Care, enrollment, Connector Programs, Enrollment, responsibility of Enrollees, enrollee premium contributions, Premiums, disenrollment, and the related appeal process under M.G.L. ch. 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:

**Abuse.** Physical or verbal abuse which poses a threat to health care providers or other insureds of the Health Plan and which is unrelated to the Enrollee’s physical or mental condition.

**Adverse Eligibility Determination.** A determination that an applicant is not eligible to participate in ConnectorCare or a determination that an Enrollee is no longer eligible to participate in ConnectorCare.

**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 12.4213.

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

**Application.** A form prescribed by the Connector to be completed by the applicant or a representative of the 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 enrollment in ConnectorCare, 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 or Authority.** 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.

**ConnectorCare.** The program administered by the Authority pursuant to M.G.L. c. 176Q to provide premium assistance payments and point-of-service cost-sharing subsidies to Eligible Individuals enrolled in Health Plans.
ConnectorCare 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 the ConnectorCare program.

ConnectorCare. The program administered by the Connector pursuant to M.G.L. c. Co-176Q to provide Premium Assistance Payments and Cost Sharing Subsidies to Eligible Individuals at or below 300 percent of the Federal Poverty Level who are also eligible for Advance Premium Tax Credits.

Cost Sharing. A payment. A type of payment made by or billed to an Enrollee at the point of service cost-sharing, including a fixed amount paid by an Enrollee for, 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 services or for prescription medications at the time they are provided, 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 ConnectorCare’s policy.

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

Eligibility Determination. A determination that an applicant is eligible or not eligible to participate in ConnectorCare.

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 ConnectorCare Connector Program for Non-Group Health Plans in accordance with M.G.L. c. 176Q and 956 CMR 12.0804.

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. The selection of a Health Plan.

Enrollment Effective Date. The first day of the calendar month following the completion of the Enrollment Process except in the case of birth, adoption or placement for adoption or foster care, the Enrollment Effective Date is the date of the birth, adoption or placement for adoption or foster care.

Enrollment Process. The process in which an Eligible Individual chooses a Health Plan and pays any dependent of such Employee also enrolled in such Small Group Health Plan, through the Connector, consistent with applicable Enrollee Premium Contribution 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.

Enrollee Family. 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 ConnectorCare as defined in 26 CFR 1.36B-1(d) 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 Advance Premium Tax Credit. Payment made pursuant to 26 U.S.C. § 36B on behalf of an eligible individual to reduce the value of a health benefit plan premium.

Federal Poverty Level (FPL). The income standard, by such name, issued annually. The most recently published Federal poverty level, updated periodically in the Federal Register, as adjusted to account for the last calendar year’s increase in prices by the Secretary of Health and Human Services under the authority of 42 USC 9902(2), as measured by the Consumer Price Index 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 the ConnectorCare Program to himself, 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 Care Provider. A facility or health care professional, a physician or other health care practitioner licensed, accredited or certified to perform specified health services consistent with the law.
Health Plan Carrier. Any managed care organization or insurance carrier that is contracted with the Connector to provide covered services to ConnectorCare 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; disenrollments of Enrollees; Enrollee Premium Contributions in a Health Plan; and denials of waiver decisions regarding requests to waive or reduce a ConnectorCare Premium for extreme financial hardship.


Plan Type. A type of coverage for ConnectorCare Enrollees with income within a certain range.

Point- Plan Types differ in terms of service cost-sharing subsidy. A the amount of Premium Assistance payment made to a Health Plan by the Connector to reduce point of service cost sharing expenses of an individual which shall include, but not be limited to, co-payments, co-insurance and deductibles 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 Payment. A periodic payment made to a Health Plan Carrier by the Commonwealth or the Connector on behalf of an ConnectorCare Enrollee to reduce the value amount of a health plan premium paid by the individual.

Premium Contribution or Enrollee Premium Contribution. An Enrollee's actual required periodic financial contribution for coverage under ConnectorCare, determined in accordance with applicable regulations of the Connector, paid to the Connector.

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), the person. Such an individual is a resident if the person 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). For an individual who) within the Commonwealth; (b) is under the age of 21, a resident is a person 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), the person. Such an individual is a...
resident if the person resides in Massachusetts, including without a fixed address; or if the person’s parent or caretaker with whom the individual resides is a resident of Massachusetts; (c) is not described in (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 (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.

Service Areas. The Authority’s grouping of the cities and towns within the Commonwealth into distinct areas for Health Plans participating in ConnectorCare, as established by contract with the Contracted carrier or managed care organization.

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.

(4) To be eligible for ConnectorCare, the individual must:
1. Have an expected Household MAGI for the year for which the individual is seeking ConnectorCare that is at or below 300 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 includes for ConnectorCare will include a determination of both:

(a) whether the Plan Type, based on family’s Household MAGI, as a percentage of the FPL for the year for which the individual is financially eligible for seeking ConnectorCare;

and

(b) whether the individual meets other eligibility requirements, including eligibility for federal advance premium tax credits, as set forth in 45 CFR § 155.305(f) and as determined by the Connector.

(2) The financial eligibility for various ConnectorCare Plan Types is determined by comparing the family’s MAGI with the applicable income standard for the specific Plan Type in accordance with 12.04(3).

(3) Included in the financial eligibility determination will be a determination of the Plan Type to which an Eligible Individual should belong based on family MAGI. Covered Services, Premium Contributions and Co Payments, 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:

(a) 1. Plan Type I-1 – not in excess of 100% of Federal Poverty Level (FPL).

(b) 2. Plan Type II-2 – more than 100% but not in excess of 200% of Federal Poverty Level (FPL), except that persons who at or below 150% of Federal Poverty Level FPL will be in Plan Type II A2A, and those over 150% and not over 200% of Federal Poverty Level FPL will be in Plan Type II B2B.

(c) 3. Plan Type III–3 – more than 200% but not in excess of 300% of Federal Poverty Level FPL, except that persons at or below 250% of Federal Poverty Level FPL will be in Plan Type III A3A, and those over 250% and not over 300% of Federal Poverty Level FPL will be in Plan Type III B3B.

(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 members 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 members Eligible Individuals that will cost the minimum Premium set by the Board in accordance with 956 CMR 12.12(10) 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 of its full-time employees through the Health Connector; or offer coverage to each eligible

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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 Division 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, Massachusetts Bureau of Special Investigations, Internal Revenue Service, Social Security Administration (SSA), Systematic Alien Verification Information System (SAVE), Department of Homeland Security, Massachusetts Department of Transitional Assistance (DTA), and health insurance 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 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 insurance carriers;

(b) through an update of the Enrollee's circumstances;

(c) based on information in the Enrollee's case file 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 Connector Programs.
Program; or
(b) the Enrollee’s current circumstances require a change in Connector Program eligibility, including a change in ConnectorCare Plan Type or Premium Contribution.

(3) The Connector or its designee will notify the Enrollee and the Eligible Individual’s authorized representative if there is a change in Plan Type or Premium Contribution, Connector Program eligibility or a change in Enrollee’s eligibility.

(4) In the event of a determination that the Enrollee is no longer eligible, the Enrollee will be sent a notice of termination at least 35 days before the termination occurs for any Connector Program.

12.08: Eligibility Requirements

Effective Dates for Connector Programs for Non-Group Health Plans

(1) An individual who is a resident of the Commonwealth shall be eligible to participate in ConnectorCare in accordance with (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 occurs.

M.G.L. c. 176Q if:
(a) a family’s MAGI does not exceed 300% of the Federal Poverty Level; and
(b) the individual is eligible for federal advance premium tax credits, as set forth in 45 CFR § 155.305(f);

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 Enrollee Premium Contributions, 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 sixty days or as soon as possible, changes that may affect eligibility or Enrollee Premium Contributions. Such changes include, but are not limited to, residency, address, income, employment, the availability of health insurance, and third-
party liability, household composition changes, and immigration status.

(3) Third Party Liability. If an Enrollee is involved in an accident or suffers an injury in some manner and subsequently receives money from a third party as a result of that accident or injury, the Enrollee’s then current Health Plan may have a right to recover some or all of those funds to repay the then current Health Plan for certain medical services provided to the Enrollee by the Health Plan. In the event that the Health Plan intends to recover any funds from an Enrollee, the Health Plan will provide notice to the Enrollee of any obligation to pay funds back.

12.10: Enrollment in, Open Enrollment and Special Enrollment Periods Applicable to, and Disenrollment

(1) Termination Enrollment. Following a determination of eligibility, Eligible Individuals will be instructed to enroll in a Health Plan. Eligible Individuals will be permitted to choose a Health Plan from among those that operate in their Service Area. 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. In the event that a Health Plan ceases operation in a Service Area, the Connector shall notify the Eligible Individuals and permit such Eligible Individuals to choose from among the Non-Group Health Plans that operate in their Service Area.

(2) Enrollment Effective Date. Eligible Individuals must complete the Enrollment Process in order to receive Covered Services. Coverage will begin on the Enrollment Effective Date, which is the first date of the month following the completion of Enrollment except in the case of birth, adoption or placement for adoption or foster care, the Enrollment Effective Date is the date of the birth, adoption or placement for adoption or foster care.

(3) Premium Contributions. Premium Contributions paid by Enrollees within the same Plan Type may vary depending on the Health Plan selected. The differentials in Premium Contributions 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 I and Plan Type IIA members that has no Premium Contribution provided that the Enrollee chooses to elect the full amount of federal advance premium tax credits available to that Enrollee. There will be at least one Health Plan available to Plan Types IIB and III members that will cost the minimum Premium Contribution set by the Board in accordance with 956 CMR 12.11(8) provided that the Enrollee chooses to elect the full amount of federal advance premium tax credits available to that Enrollee.

(4) Notification. The Connector will notify an Enrollee in writing of the name and address of the Enrollee’s Health Plan and Enrollment Effective Date.

(5) Open Enrollment and Special Enrollment Periods. The Enrollee may enroll in a Health Plan in that Enrollee’s Service Area 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 a one Non-Group Health Plan or enroll in a different available Non-Group Health Plan, outside of the open enrollment period only during a special enrollment period established by the Connector only 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) a qualified individual is determined newly eligible for a ConnectorCare plan in accordance with 956 CMR 12.08;

(c) the Enrollee changes Plan Types in accordance with 956 CMR 12.04(3);

d) the Enrollee’s eligibility changes Plan Types in accordance with 956 CMR 12.04(3);

e) The Enrollee has been approved for a hardship waiver in accordance with 956 CMR 12.4412; or

(e) 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.

(6) Disenrollment. (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 disenroll or 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 and federal law, including, but not limited to, the following reasons:

(a) upon request of the Health Plan, if the Health Plan has established that the Enrollee has committed Fraud or Abuse;

(b) for (a) For Fraud, including rescissions consistent with 45 CFR 147.128;

(b) for failure to pay Enrollee Premium Contribution payments Premiums under 956 CMR 12.4412; or

(c) for Fraud or Abuse;

(d) when the Enrollee is no longer eligible for coverage;

(e) (6) If the Connector disenrolls an Enrollee pursuant to 956 CMR 12.10(65), it will provide the enrollee with written notice stating the reason for the action.
The Connector may recoup any monies paid on behalf of an Enrollee to a Health Carrier for a Health Plan or a health care provider from the Enrollee directly if it is determined that the Enrollee committed fraud or the enrollee is terminated for Fraud.

### 12.11: Enrollee Premium Contributions

(1) Enrollee Premium Contribution Payments. Enrollees who are assessed an Enrollee Premium Contribution may recoup such monies paid on behalf of the enrollee to a Health Carrier or a health care provider from the Enrollee directly if it is determined that the Enrollee committed fraud or the enrollee is terminated for Fraud.

(2) 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 at least one 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 Premium Contribution Payments. Premiums for Non-Group Health Plans Without Financial Assistance. An Enrollee in a Non-Group Health Plan without Financial Assistance who fails to pay his/her monthly Enrollee Premium Contribution Payment in full by the payment due date will be considered delinquent and may be notified on the day following the payment due date when his/her account is one month 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 payment is not received by the second 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 again be considered delinquent and will be notified on the day following the payment due date when his/her account is past due. If an Enrollee’s account is delinquent for two consecutive months past due, this Notice the Enrollee will be notified by a notice of Delinquency which will inform the Enrollee that, if payment of all outstanding monthly contribution 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.

(3) Disenrollment (5) Termination from a Non-Group Health Plan with Financial Assistance for Failure to Pay Premiums. If an Enrollee who is delinquent Enrollee has not paid his/her outstanding Enrollee Premium Contribution Payments-Premiums, their account is delinquent for all Premiums owed in full by the due date indicated after receiving the second notice described in the Notice of Delinquency, 956 CMR 12.12(4), then the coverage is terminated on the day following that date. The coverage end date is retroactive to the last day of the first coverage month in which the Enrollee was delinquent. The Enrollee is will be notified of the termination by mail or electronically with a Notice of Termination.

(4-6) Reinstating Coverage in a Non-Group Health Plan Following Disenrollment Termination for Failure to Pay Premiums. An Enrollee in a Non-Group Health Plan who was terminated for non-payment of Premiums and who makes a timely request to may reinstate coverage may do so within thirty (30) days from the date coverage was terminated. All, provided that all outstanding monthly contributions must be Premiums for such terminated Enrollee have been paid in full, as well as the next month’s contribution Premium, by the deadline determined by the Connector.

(57) 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 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. fire, flood, natural disaster, or other unexpected natural or human-caused event causing substantial household or personal damage for the Enrollee;
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 an Enrollee's Premium Contribution or arrears would result in extreme financial hardship for the Enrollee, the Connector may waive payment of such Contribution Premium or arrears; or reduce the amount of such Contribution Premium or arrears assessed to the particular individual. The Connector will assume payment to the Health Plan Carrier of the amount of the Enrollee'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. The waiver or reduction period begins on the first of the month of the next full billing cycle following the date the waiver or reduction of premium is granted. An individual who is granted a waiver or reduction will be allowed to enroll in a Health Plan, as made available into that Enrollee’s Service Area individual through the Health Connector. At the end of the waiver or reduction period, the Enrollee may submit another request if the extreme financial hardship persists. Requests for Enrollee Premium Contribution relief should be addressed to the Connector.

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

(6) Voluntary Withdrawal. If an Enrollee wishes to voluntarily withdraw from receiving ConnectorCare, 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 to and including the calendar month of withdrawal.

(7) Change in Enrollee Premium Contribution Calculation. The Enrollee Premium Contribution amount is recalculated when the Connector is informed of changes in income, family size, or health insurance status, and may be changed whenever the cost to the Connector of contracting with a Health Plan changes or as a result of a change in a Health Plan’s Service Area.

(8) 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 EnrolleeConnectorCare Premium Contributions Schedule. The Board shall determine annually the minimum monthly Premium Contributions for each Plan Type. The Premium Contributions 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 will be paid by the Connector to Health Carriers for Health Plans on behalf of ConnectorCare Enrollees monthly from, using funds appropriated by the Commonwealth for the purpose, or otherwise made available to the Connector together with the Enrollee Premium Contributions received by the Connector, to pay the premiums due to the Contracted Health Plan.

(11) Termination of Health Insurance. If an Enrollee’s ConnectorCare terminates for any reason, beginning the first day of the following month the Enrollee Premium Contributions and the allocable ConnectorCare Premium Assistance Payments and Point-of-service cost-sharing subsidies end.

(12) 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.

(13) 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.

(14) 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 a Hearing

Applicants and Eligible Individuals, Enrollees, and Employers are entitled to a hearing to appeal the following actions:

1. Any adverse eligibility decision based on any eligibility factor in accordance with 956 CMR 12.0804;
2. Any determination of the premium assistance payment APTC amount, or assignment to a ConnectorCare Plan Type; or
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, or 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 12.4.12.

12.4.14: Times and Methods for Filing Appeal Requests for Hearings

(1) The Applicant or Eligible Individual, Enrollee, or Employer will receive a notice in writing of an Appealable Action identified in 956 CMR 12.4.2 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 a hearing 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.)
   2. 120 days from the date of an Appealable Action if the MassHealth agency or 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 12.4.14(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 or Eligible Individual, Enrollee, or Employer, the Connector will provide the Applicant or Enrollee with a form to request an appeal. The Connector and or its agent/designee may not restrict the Applicant’s or individual’s or Enrollee’s or Employer’s freedom to request an appeal, a hearing.

12.14: Appeal from Health Plan Actions

Any inquiries, complaints or grievances by an Enrollee against a Health Plan, or any appeal by an Enrollee from an adverse determination by a Health Plan shall be subject to the review and appeal procedures contained in M.G.L. 176O, including appeals to the Office of Patient Protection within the Health Policy Commission, as set forth in 958 CMR 3.00.

12.15: Hearings Appeal Process

(1) Hearings 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.
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 for hearing if:
   (a) The request 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 12.14;
   (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;
   (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 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 his/her 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 the Director or another hearing officer whom the Director designates. Within 30 days after the order requiring re-hearing, the Director or 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 his/her 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 Enrollee Premium Contributions during the pendency of the appeal. Persons who are appealing a denial of a
premium waiver or reduction application must pay Enrollee Premium Contributions 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 Eligible Individuals and Employees cannot enroll, if the individual 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) Health Plans, Providers, and Eligible Individuals should refer to the ConnectorCare Rules and Regulations, and other documents published affecting these plans and programs for 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, Health Plan bulletins and other documents as necessary.


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. c16c. 176Q.