The Commonwealth of Massachusetts
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza
Boston, MA 02108
617-933-3030

DEVAL PATRICK
Governor

TIM MURRAY
Lieutenant Governor

LESLIE KIRWAN
Board Chair

JON M. KINGSDALE
Executive Director

To: MCOs, Commonwealth Care enrollees, and their representatives

From: Jamie Katz, General Counsel

Re: Administrative Bulletin 01-07

Date: May 31, 2007

Attached is the Commonwealth Health Insurance Connector Authority's Administrative Bulletin 01-07. This Administrative Bulletin makes clear how the Connector intends to interpret and implement the regulations set out in 956 CMR 3.00 dealing with eligibility, enrollment, waivers, and appeals for the Commonwealth Care program. The Administrative Bulletin is effective as of today.

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Administrative Information Bulletin 01-07:

Notice Regarding Commonwealth Care Procedures

May 31, 2007

Pursuant to 956 CMR 3.18, the Commonwealth Health Insurance Connector Authority (the "Connector") is issuing this administrative information bulletin ("Bulletin") to clarify procedures for the Commonwealth Care Health Insurance Program ("Commonwealth Care"). The Bulletin covers procedures to (a) enroll in Commonwealth Care; (b) request a change of health plans; (c) request a waiver or reduction of premiums or a waiver of copayments because of a claim of extreme financial hardship; and (d) bring an appeal under 956 CMR 3.14 to challenge decisions relating to Commonwealth Care. [1]

1) Eligibility and Enrollment Process:

a. Eligibility Determination: Eligibility to enroll in Commonwealth Care is determined by MassHealth through the MassHealth eligibility system. MassHealth will notify individuals if they have been found eligible to enroll in Commonwealth Care and will advise individuals of their right to appeal to the MassHealth Board of Hearings ("BOH") if they wish to dispute the eligibility determination.

b. Plan Type Determination: Commonwealth Care provides several types of coverage, known as Plan Types, some of which require premiums and some of which do not. An individual's income determines whether he is found eligible for non-premium or premium-paying Plan Types. That determination is made by MassHealth as part of the eligibility process. The notification of eligibility provided by MassHealth will state whether a premium will be required.

c. Health Plan Selection: Several health plans offer Commonwealth Care. Health plan availability varies based on the residence of the individual seeking coverage. All health plans cover all Plan Types. Health plans have different provider networks. Information about the health plan options can be obtained by calling the Commonwealth Care Customer Service Center ("Center") at 1-877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773 for the hearing impaired), Monday through Friday, from 8 a.m. to 5 p.m., or on the Commonwealth Care website (www.macommonwealthcare.com). Applicants will be given an opportunity to select a health plan as part of the enrollment process. Applicants who have been found eligible for a Plan Type that requires payment of premiums will not be enrolled unless they have selected a health plan and paid their first month's premium. Applicants who have been found eligible for a Plan Type that does not require payment of premiums, but who do not select a health plan within a time period specified by the Connector, will be automatically assigned to a health plan.

[1] For ease of reference, this Bulletin refers only to "he" and "his". All references to "he" or "his" are intended to refer to both "he" and "she" or "his" and "her" and are intended to be gender-neutral.

d. Methods of Enrollment: An individual who has been found eligible for Commonwealth Care and who wishes to enroll ("Applicant") can do so by any of the following methods: (i) calling the Center and completing an enrollment by phone with a customer service representative at the Center; (ii) registering and enrolling on the Commonwealth Care website at (www.macommonwealthcare.com); or (iii) faxing or mailing the Connector-designated enrollment forms for Commonwealth Care to the Center.

e. Payment of First Month's Premium. Individuals who are found eligible for Plan Types that require the payment of monthly premiums must make their first payment so that it is received by the 20th day of the month preceding the first month of coverage. For example, for coverage to commence on April 1, the first month's premium must be received by March 20. Payment can be made by mail after receipt of the first invoice. Applicants who wish to make their payment more quickly in order to enroll as soon as possible can send payments before receipt of an invoice, and/or make payments in person at the Customer Service Center, or by overnight mail. Information about these options can be obtained from the Customer Service Center.

2) Changes in Health Plan

a. Notification of Health Plan Assignment : An individual who has completed the enrollment process set forth in Section 1 above ("Enrollee") will receive a confirmation letter ("Confirmation Letter") from the Connector indicating the Enrollee's health plan. The Confirmation Letter will also state the date on which the health plan coverage becomes effective ("Effective Date").

b. Requests to Change Health Plans Within 60 Days from Start of Coverage: An Enrollee may change his health plan for any reason within 60 days of the Effective Date set forth in the Confirmation Letter. Changes to a health plan may be requested by any of the following methods: (i) calling the Center; (ii) electronic submission through the Connector website; or (iii) mailing or faxing the Connector-designated enrollment form for Commonwealth Care to the Center.

c. Requests to Change Health Plans After 60 Days from Start of Coverage: After 60 days from the Effective Date, an Enrollee will be allowed to change his Health Plan only for one of the following reasons:

i) the Enrollee has moved and the new residential address is outside of his Health Plan's service area;
ii) the Enrollee demonstrates to the Connector that (a) he has a medical condition and continued enrollment in his Health Plan will result in a lack of continuity of care, and (b) his Health Plan has not provided him with access to health care providers that meet his health care needs over time, even after he has asked the Health Plan for help;
iii) the Enrollee's primary care provider is no longer a contracted provider with his Health Plan;
iv) the Enrollee's health care access has been adversely affected by a significant change in his Health Plan's group of providers, which may include, without limitation, the Health Plan's loss of a contract with a hospital, health center, physician group or specialty provider group;
v) the Enrollee has an eligibility change in Plan Types, except for a member-requested change between Plan Types 3 and 4;
vi) the Enrollee is homeless and that status has been reported to the MassHealth eligibility system,; or
vii) the enrollment materials sent to the Enrollee were returned to the Center without being delivered.

d. Procedure for Requesting a Health Plan Change After 60 Days from Start of Coverage: An Enrollee who wishes to change health plans after 60 days must first call the Center and explain the reasons for the change. The Center may require that the Enrollee provide documentation or other proof on a form specified by the Center, that he falls within one of the reasons listed in this subsection for a plan change. Failure to provide proof or to properly complete any plan change form required by the Center will be grounds for dismissing the Plan Change request. The Connector will determine, based on the

information provided to the Customer Service Center, whether an Enrollee has demonstrated that he meets any of the reasons. An Enrollee will receive notice of the Connector's decision about the request to change plans. An Enrollee who believes that the Connector erroneously concluded that he did not fit within one of the reasons for a plan change, based on the documentation or other proof provided by the Enrollee, may file an appeal in accordance with the provisions set forth in Section 8 of this Bulletin. An Enrollee cannot bring an appeal regarding plan changes or plan assignments until he has completed this process.

3) Premium Payment Due Dates.
Premiums for premium-paying Plan Types are paid monthly and must be received on the twentieth (20^{th}) day of the preceding month. For example, an Enrollee's premium payment for April must be received on March 20^{th}. In addition to regular mail, Enrollees may make payments by overnight mail or by delivery in person to the Customer Service Center; information about these options can be obtained from the Customer Service Center.

4) Procedures for Disenrollment Due to Failure to Pay Premiums.

a. Procedures to Collect Overdue Payments. If an Enrollee fails to submit a monthly premium by the due date, the next invoice he receives will include a notice warning him that he is in danger of having his health insurance cancelled because his premium is overdue. If the overdue amount is still not paid by the 20^{th} day of the following month, the Enrollee will receive a second notice that he is in danger of having his health insurance cancelled. For example, an Enrollee's premium payment for April is due on March 20. If he does not pay by that date, he will receive a notice in April stating that he is one month overdue on his April premium, and an invoice stating that he must pay premiums for both April and May by April 20. If he does not pay by that date, he will receive a second notice in May, stating that the premiums for both April and May are overdue, and that, if he does not pay that overdue amount, he will be disenrolled. He will also receive an invoice stating that he must pay premiums for April, May and June by May 20. Each of these notices will include information about filing a Premium Waiver or Reduction Application ("Premium Waiver-Reduction Application"), as set forth in Section 5 of this Bulletin. The notices will also provide information about how the Enrollee can establish a payment plan for the past due amounts.

b. Procedure to Cancel Coverage for Overdue Payments. If no payment is made, a cancellation notice will be sent out in the first half of the third month after the payment was initially due. This notice will advise the Enrollee that his health insurance will be cancelled at the end of the month unless payment of the two months' overdue premiums is received by three business days before the end of the month. Using the example in Section 4(A) above, if the Enrollee has still not paid his premium for April and May, he will receive a cancellation notice in the first half of June telling him that his coverage will be cancelled effective June 30 unless he pays the April and May premium by three business days before the end of June. The cancellation notice will include information about filing a Premium Waiver-Reduction Application. The cancellation notice will also provide information about how to establish a payment plan.

c. Continuation of Coverage Pending Waiver-Reduction Determination. If the Center receives the Premium Waiver-Reduction Application by the third business day before the end of the month in which the cancellation notice was sent, the Enrollee's health insurance will remain in force until a decision is made on the waiver-reduction request. If the Premium Waiver-Reduction Application is received after that date, the Connector will consider the application, but coverage will not be in place while that decision is being made. If coverage remains in place while the application is being decided, and the decision is made to deny the Premium Waiver-Reduction Application, the Enrollee must pay at least the amount that was more than 60 days overdue at the time that the Premium Waiver-Reduction Application was filed in order to retain coverage. The Connector may in its discretion waive or reduce the balance of the overdue premiums. Using the example in Section 4(A) above, if the Enrollee files a Premium Waiver-Reduction Application by three business days before the end of June, the Enrollee will not have to pay the overdue amounts or the premium for July while the Connector decides the Application. If the Connector decides in July to deny the Application, the Enrollee will be disenrolled

unless he pays the April and May premiums. The Connector may, in its discretion, waive or reduce the premiums owed for June and July. Notwithstanding the foregoing, if the Connector determines that the Premium Waiver-Reduction Application is the second or subsequent one filed and the previous application was unsuccessful, the Connector may require the payment of the overdue amount while the second or subsequent application is pending, and, if no payment is received, proceed with the disenrollment procedure in accordance with Section 4(A) or (B) of this Bulletin, depending on how long the overdue amount has been owed.

d. Re-enrollment After Disenrollment for Failure to Pay Premium. An Enrollee who has been disenrolled for failure to pay premiums may not re-enroll unless he pays at least two months of the overdue premiums or has made all payments due to date under a payment plan approved by the Connector. The Connector may in its discretion waive or reduce the balance of the amount that was overdue at the time of disenrollment. Re-enrollment will be permitted only if there is no waiting list for enrollment in Commonwealth Care. If a waiting list exists at the time of request for re-enrollment, the member will be put on the waiting list only after he has paid the overdue premiums. When the waiting list is open for enrollment, re-enrollments for individuals on the waiting list will be processed in the order they were placed on the waiting list.

e. Payment Plans. Enrollees who owe any overdue premium amount may request a payment plan. Payments plans will be for periods of three, six or nine months, at the Enrollee's option. Once a plan is in place, an Enrollee cannot extend the time period. An Enrollee may obtain only one payment plan within a 12-month period. If a payment plan is established in accordance with Section 4(B) of this Bulletin for an Enrollee to prevent disenrollment after 2 months of overdue payments and the Enrollee subsequently does not make timely payments in accordance with the payment plan, the Connector will proceed with disenrollment at the end of the month.

5) Procedure for Applying for Waivers or Reductions ("Hardship Waiver Process") Any Enrollee, or any person who was disenrolled due to non-payment of premiums ("Former Enrollee"), who believes that his Premiums should be reduced or waived due to extreme financial hardship or any Enrollee of a non-premium paying Plan Type who believes that any copayment should be waived due to extreme financial hardship must first call the Center to notify the Connector that he wishes to apply for a hardship waiver or reduction. The circumstances that will constitute an extreme financial hardship are set forth in 956 CMR 3.11(5)(a). A Premium Waiver-Reduction Application or a Copayment Waiver Application will be provided by the Center. Hardship waivers or reductions will be provided for up to six months, but may be less. A waiver or reduction will go into effect in the month after the waiver or reduction is granted. A waiver or reduction may also apply to past-due premiums. Waivers of copayments will be prospective only. At the end of the period provided for the waiver or reduction, an Enrollee may apply to renew the waiver or reduction, if the circumstances giving rise to the hardship still exist. Enrollees in Plan Types that require premiums may not apply for waivers or reductions of their copayments. Enrollees in a non-premium paying plan type who are homeless and have reported that status to the MassHealth Enrollment Center may obtain a waiver of copayments by calling the Customer Service Center before or during enrollment; if the Customer Service Center confirms that homeless status in the records of the MassHealth Enrollment Center, a six-month waiver will be granted without submission of a Copayment Waiver Application, and will be renewed, upon the Enrollee's request, if the homeless status is still reflected in the MassHealth Enrollment Center records.

6) Hardship Waiver Process Applies to Applicants: Any Applicant who has been found eligible for a premium-paying Plan Type, but who believes that his premiums should be reduced or waived due to an extreme financial hardship, consistent with 956 CMR 3.11(5)(a), may submit a Premium Waiver-Reduction Application prior to becoming enrolled with Commonwealth Care, provided that the Applicant complies with the Hardship Waiver Process set forth in section 5 of this Bulletin. An Applicant is required to pay one month's premium in order to enroll for coverage, even if the Applicant is filing a Premium Waiver-Reduction Application. If the Applicant pays the premium in order to enroll and the Connector subsequently determines to grant a waiver or reduction, the premium will be refunded in whole or in part. If the Applicant files a Premium Waiver-Reduction Application but does not submit one month's premium, the Connector will still decide the Premium Waiver-Reduction Application, but the Applicant will not be

enrolled in Commonwealth Care while that decision is being made. An Applicant who has been found eligible for a non-premium-paying Plan Type, and who believes that his copayments should be waived due to an extreme financial hardship, consistent with 956 CMR 3.11(5)(a) may submit a Copayment Waiver Application prior to becoming enrolled with Commonwealth Care, provided that the Applicant complies with the Hardship Waiver Process set forth in section 5 of this Bulletin.

7) Payment While a Waiver-Reduction Application is Pending:

   a. Payment of Premiums. Once an Enrollee in a premium-paying Plan Type submits a completed Premium Waiver-Reduction Application to the Center, the Enrollee will not be required to pay his premium until the Connector has issued a decision on the application. Enrollees who owe overdue premiums and who submit a completed application will not be required to pay the overdue premiums until the Connector has issued a decision on the application. If the application is denied, an Enrollee must pay at least the premiums that were more than 60 days overdue at the time that the Premium Waiver-Reduction Application was filed. The Connector may in its discretion waive or reduce the balance of overdue amounts. Notwithstanding the foregoing, if the Connector determines that the Premium Waiver-Reduction Application is the second or subsequent one filed, and the previous application was unsuccessful, the Connector may require payment of overdue and future premiums while the second or subsequent application is pending, and, if no payment is received, may proceed with the disenrollment process in accordance with Section 4(A) or (B) of this Bulletin, depending on how many months' premiums are overdue.

   b. Payment of Copayments. Any Enrollee in a non-premium paying Plan Type who has filed a completed Copayment Waiver Application will not be required to make copayments until the Connector has issued a decision on the Copayment Waiver Application. Notwithstanding the foregoing, if the Connector determines that the Application is the second or subsequent one filed, and the previous Application was unsuccessful, the Connector may require payment of copayments while the second or subsequent application is pending.

8) How to Request an Appeal: Commonwealth Care members have the right to bring appeals of the actions set forth in 956 CMR 3.14 ("Appealable Actions"). In accordance with 956 CMR 3.17(1), the MassHealth Board of Hearings (BOH) will hear appeals brought under 956 CMR 3.14(1). The Connector will hear all remaining appeals Any Applicant, Enrollee, or Former Enrollee who wishes to bring an appeal under 956 CMR 3.14(2)-(5) must use the Connector's Appeal Request Form, which is available from the Center. The Appeal Request Form must be completed and sent to the Center, consistent with the form's instructions. The instructions provide additional information on the steps for filing and pursuing an appeal. If an appeal under 956 CMR 3.14 is incorrectly filed at BOH or at the Connector, the procedures for transfer set forth in Section 13 of this Bulletin will be followed. No appeal that is timely filed will be dismissed only because it was incorrectly filed at either BOH or the Connector.

9) Representative Form and Rules: Any person who has requested an appeal ("Appellant") who wishes to designate someone to be his representative ("Representative") for the appeal or any person who has filed a request to change plans after 60 days from Effective Date, Premium Waiver-Reduction Application or a Copayment Waiver Application and wishes to designate a Representative for the request or Application must do so by submitting the form for designation of representative provided by the Center ("Representative Form"). The Connector will accept a designation of Representative only on the Representative Form provided by the Connector.

10) Times for Filing Appeals: The request for an appeal must be received within the following time limits:

   a. 30 days after the receipt of written notice of an Appealable Action (in the absence of evidence to the contrary, it will be presumed that the notice was received on the third day after mailing);

   b. 120 days from the date of an application or request when the MassHealth agency or the Connector fails to act on that application or request; or

c. 120 days from the date of an Appealable Action if the MassHealth agency or the Connector fails to send written notice of such action.

Computation of these time periods will be on the basis of calendar days. Time periods 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.

11) Requirement To Pay Premiums or Copayments During Pendency of Appeal: If an Appellant is enrolled in a Plan Type that requires the payment of premiums, the Appellant must continue to pay his premiums and copayments during the pendency of his appeal. An Appellant who is enrolled in a Plan Type that does not require the payment of premiums must continue to make his copayments during the pendency of his appeal.

12) Connector Designated Hearing Officer. Appeal requests will be forwarded to the Connector's Appeal Unit ("Unit"), which will designate a hearing officer ("Presiding Officer") to hear the appeal.

13) Transfer to MassHealth Board of Hearings ("BOH"): If the Connector or the Presiding Officer determines that the matter being appealed should be heard by the BOH in accordance with 956 CMR 3.17(1), the Connector will communicate with the BOH to determine the appropriateness of a transfer. If the Connector and the BOH agree that a transfer is appropriate, the Connector will transfer the appeal to the BOH and notify the Appellant that his appeal is being transferred. If the appeal is transferred to the BOH, the Appellant must then follow the BOH rules and procedures for appeals. The procedures set forth in this Administrative Bulletin will apply only to appeals conducted by the Connector.

14) Date of Hearing: At least 10 calendar days before the Hearing, the Unit will send a notice to the Appellant setting forth the date, time, and place of the Hearing. The Presiding Officer, on his own initiative or by request of a Party, may, in his discretion and for good cause, order an accelerated hearing. Requests for telephone hearings may be granted in the discretion of the Presiding Officer for good cause.

15) Preparation for Hearing: Appellants have a right to review their case file, and to request to subpoena documents and/or witnesses to the hearing. An Appellant who wishes to review his file must make his request by 4:30 p.m. two business days before the date that he wishes to review the file. Requests should be made by calling the Center.

16) Hearing Procedures. The Presiding Officer will conduct the hearings consistent with the procedures set forth in the informal hearing rules at 801 CMR 1.02. Appellants may represent themselves, or may be represented by counsel or a Representative. Appellants who need an interpreter or other assistance during the hearing may request this on the Appeal Request Form.

17) Decision of Presiding Officer Final/No Further Administrative Appeals: The Decision of the Presiding Officer shall be final, except as provided in Section 18 of this Administrative Bulletin.

18) Rehearing at Discretion of Connector Director: The Connector Director ("Director") or the Director's designee ("Designee") may, for good cause shown, send an order for the Presiding Officer to conduct a rehearing of an appeal. The Director or Designee shall conduct the rehearing.

    a. An order to conduct a rehearing is not to be construed, for any purpose, as indicating any position by the Director or Designee on the merits of the appeal.

    b. The Director or Designee may order such a rehearing on his own initiative or at the Appellant's request, provided that within 14 calendar days of the date of the Presiding Officer's Decision:

        i. the Director or Designee receives the Appellant's rehearing request; or
        ii. the Director or Designee notifies the Appellant of his intent to consider a rehearing.

c. The Director or Designee shall send a written notice to all parties, including the date, time, and location of such rehearing. After the rehearing, the Director or Designee may issue a superseding decision no later than 30 days after the order to conduct a rehearing.

d. Any party to an appeal may request the Unit to treat an order to conduct a rehearing as an order to remand the appeal for further consideration by the Presiding Officer or Designee who rendered the original Decision.

e. A request for a rehearing or notice of the Director's intent to consider a rehearing stays the Decision until such request is denied or the Director otherwise decides not to order a rehearing, or the superseding rehearing decision is issued.

This Bulletin takes effect immediately.

APPEALS REQUEST FORM

Your Right to Appeal:

You may use this form to appeal one of the following actions (Appealable Actions): (1) the Connector's decision on your request to change your health plan; (2) your disenrollment from a health plan or Commonwealth Care for non-payment of premiums or for any other reason; (3) the Connector's decision on your Copayment Waiver Application or Premium Waiver-Reduction Application for extreme financial hardship; or (4) your copayment maximum limits.

If you have a question or problem that does not fit within one of the above circumstances, please call the Commonwealth Care Customer Service Center.

Enrollee Payment While Appeal is Pending:

You will not be disenrolled for submitting an appeal. If you are a premium paying individual, you are required to pay those premiums while you wait for a decision on your appeal to keep your health insurance coverage. Co-payment paying individuals are required to continue paying co-payments while waiting for an appeal decision.

Transfer to MassHealth Board of Hearings:

If you are appealing an eligibility determination, the matter will be heard by the MassHealth Board of Hearings. We will notify you that your appeal is being transferred. You must then follow the MassHealth Board of Hearing rules and procedures for appeals.

Assistance with this Form:

Please mail or fax this Appeal Request Form, a copy of the notice that you are appealing, and any other materials for us to consider. Keep a copy for your records.

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Appeal Request Form, please contact the Commonwealth Care Customer Service Center. Please note that failure to properly complete this Form, or send it in on time, may prevent your Appeal from being accepted. Only Connector approved formats will be accepted.

SECTION I: Clearly Print Your Information

First Name Initial Last Name

Mailing Address

City State Zip

Home Address (if different)

Home Telephone Gender

Daytime Telephone (if different)

Date of Birth ID Number (Usually SS#)

Name of Your Health Plan (*if applicable*)

SECTION II: Reason for Appeal

☐Connector's decision on your request to change your health plan;

☐Your disenrollment from a health plan or Commonwealth Care for any reason;

☐Connector's decision on your waiver/reduction application for extreme financial hardship; or

☐Your copayment maximum limits.

SECTION III: Please Describe Why Are You Appealing. (More space on other side. Attach additional sheets, if needed):

Timelines for Filing an Appeal:

We must receive this Form, properly completed, no later than 30 calendar days from the date you received notice of the action you are appealing. If this Form is received past that date, your appeal will be dismissed.

Date of Hearing:

At least 10 calendar days before the Hearing, we will send you a letter telling you the date, time, and place of the Hearing. If you do not reschedule or appear on time at the Hearing without documented good cause, your Appeal will be dismissed.

Telephonic Hearing:

If you have good cause for not being able to come to the Hearing, you must call the Commonwealth Care Customer Service Center before the Hearing date. We will determine whether a telephonic hearing is appropriate.

Accelerated Hearing:

If you want to have the Hearing scheduled as soon as possible, check the appropriate box in Section IV of this Form for an accelerated Hearing and explain why you need it. However, it is up to us to decide if you will get an accelerated Hearing.

Your Right to Be Helped at the Hearing:

At the Hearing, you may be represented by a lawyer or by a designated Representative at your own expense. You may contact a local legal service or community agency to receive advice or representation at no cost. To obtain information about legal service or community agencies, call the Commonwealth Care Customer Service Center.

If You Need an Interpreter or an Assistive Device:

If you do not understand English and/or are hearing or sight impaired, we will provide, at our expense, an interpreter and/or assistive device for you at the Hearing. Please check the appropriate box in Section IV of this Form if you need an interpreter or assistive device, or call the Commonwealth Care Customer Service Center at least five business days before the Hearing.

Your Right to Review Your Case File:

You and/or your Representative can review your Commonwealth Care case file before the Hearing. Call the Commonwealth Care Customer Service Center by 4:30 p.m. two business days before you wish to review your file. If you do not call within this time period, your file may not be available. The file shall be available for review Monday-Friday 8am-5pm, upon request, at the following location: Commonwealth Care Customer Service Center, 55 Summer Street, Boston, MA 02110.

SECTION IV: Appeal Information (Check any and all of the boxes that apply to you. If none apply, leave blank.)

☐ I need an interpreter to be provided by the Connector. (State what language you need):

_____

_____

☐ I need an assistive device to be provided by the Connector. (State what device you need):

_____

_____

☐ I want to request an Accelerated Hearing for good cause (Describe below, but note that we determine if you will have an Accelerated Hearing]:

_____

_____

_____

SECTION V: Appeal Representative (if any)

You may designate someone as your Representative for purposes of completing this Form. To have a Representative at the Hearing or to have a Representative receive information on your behalf regarding your appeal, you must submit a *Representative Form* that is signed by both you and/or your Representative. The Connector will only accept this Representative on the *Representative Form*. By designating this Representative, you are authorizing the Connector to share your personal health information with that Representative. To submit the *Representative Form*, call the Commonwealth Care Customer Service Center.

SECTION VI: Member Signature

I certify that I have read, or had read to me, the information on this Appeal Request Form and that I understand my rights and responsibilities. I further authorize the release of my personal health information and other confidential data to the Connector and Connector contracted entities for the purpose of making a decision on my appeal request.

_____

Signature (*Sign*) Date

_____

First Name and Last Name (Print)

☐ *Check here if you are a Representative signing on behalf of the named individual. [If so, you must fill out the Representative Form to receive information.]*

HEALTH PLAN CHANGE REQUEST FORM

Health Plan Change Request Process:

You have received this Health Plan Change Form because:

- You called the Commonwealth Care Customer Service Center to request a change in your Health Plan more than 60 days after you were first enrolled in that plan; *and*
- You reported that you have a medical condition and you believe that continued enrollment in your current Health Plan will result in a lack of continuity of care; *and*
- You believe that your Health Plan has not provided you with access to health care providers that meet your health care needs over time, even after you asked the Health Plan for help.

If this does not apply to you, but you believe that you have another reason for changing your health plan, you should call the Customer Service Center.

You must complete this Health Plan Change Form if you are seeking to change plans because you want to continue seeing a health care provider who is not in your current health plan. Then you must sign Section III and that provider must sign Section IV of this Form. You should also include any proof you have to support your claims. Failure to properly complete this Form will be grounds for dismissing your health plan change request.

Request Determination:

The Connector will determine whether you have demonstrated that you qualify for a change to your health plan. The determination will be made based on whether the information you have submitted demonstrates that:

- You have a medical condition and you have had active treatment for a period of time from a PCP or specialist who is not in your current health plan;
- Continued enrollment in the current plan will result in lack of continuity of care; and
- Disruption in care will likely have negative consequences for your health.

You will receive notice of the Connector's decision about your request to change health plans. You will be able to appeal the Connector's decision if you feel it was erroneous; information about how to exercise your appeal right will be included in notice of the decision.

SECTION I: Clearly Print Your Information

First Name Initial Last Name

Mailing Address

City State Zip

Home Address (if different)

Home Telephone Gender

Daytime Telephone (if different)

Date of Birth ID Number (Usually SS#)

Name of Your Health Plan Now

Name of the Health Plan You Want

SECTION II: Details of Request (Additional Space on Other Side)

1. Please describe your medical condition that is the basis for this request.

2. If you want to change your health plan to go to a certain health care provider (PCP or specialist), please describe how long you have been going to this health care provider.

3. Please describe how often you have visited this health care provider (PCP or specialist).

4. Have you asked your current health plan for help?
☐ Yes ☐ No

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773)
Fax: 1-877-623-2155 / *Business Hours* Monday-Friday 8am-5pm

Turn Over

Fill Out Both Sides

Designation of Representative:

You may designate someone as your Representative for purposes of completing this Form. To designate a Representative to receive information on your behalf regarding your Health Plan Change Request Form, you must submit a *Representative Form* that is signed by both you and/or your Representative. The Connector will only accept this Representative on the *Representative Form*. By designating this Representative, you are authorizing the Connector to share your personal health information with that Representative. To submit the *Representative Form*, call the Commonwealth Care Customer Service Center.

Assistance with this Form:

Please mail or fax this Form, documentation for your request, and any other materials for us to consider. Keep a copy for your records.

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Form, please contact the Commonwealth Care Customer Service Center. Please note that failure to properly complete this Form, may prevent your Form from being accepted. Only Connector approved formats will be accepted.

5. Please describe what assistance your current health plan has provided (if any).

6. Please describe how your treatment will be affected if you stay enrolled in your current health plan.

7. Please attach any other documents supporting your answers that you would like us to consider, such as a statement from your health care provider about your medical condition, other evidence of your condition and treatment, any correspondence you have had with your health plan, or any additional information for the Connector to consider.

SECTION III: Member Signature

I certify that I have read, or had read to me, the information on this Health Plan Change Request Form and that I understand my rights and responsibilities. I further authorize the release of my personal health information and other confidential data to the Connector and Connector contracted entities for the purpose of making a decision on my health plan change request.

Signature (*Sign*) Date

First Name and Last Name (Print)

☐ *Check here if you are a Representative signing on behalf of the named individual. [If so, you must fill out the Representative Form to receive information.]*

SECTION IV: Provider Signature

I certify that continued enrollment in the member's current Health Plan will result in a lack of continuity of care and information on this Health Plan Change Request Form regarding the member's medical condition is correct and complete to the best of my knowledge.

Signature of Member's Health Care Provider (Not in Current Health Plan)

First and Last Name (Print Name) Date

If you do not get your provider's signature, then you should provide some other evidence to support your claims about your health condition, such as a note from the provider or other documentation.

COPAYMENT WAIVER APPLICATION

Requesting a Waiver

You may use this form if you believe you experienced extreme financial hardship and feel you may qualify for a waiver of your copayment. You may seek a waiver of your copayment only if you do not pay monthly premiums for your health insurance. Only certain events are considered extreme financial hardship and they are listed in Section II.

To be considered for a waiver of your copayment, you must prove to us that you experienced at least one of the qualifying events listed in Section II. The maximum amount of time for which you could be granted a waiver is six months and it could be less. For details, please see 956 CMR 3.11(5)(d).

If you have a question or problem that does not fit within one of the circumstances listed in Section II, please call the Commonwealth Care Customer Service Center so we can assist you.

SECTION I: Clearly Print Your Information

First Name Initial Last Name

Mailing Address

City State Zip

Home Address (if different)

Home Telephone Gender

Daytime Telephone (if different)

Date of Birth ID Number (Usually SS#)

Name of Your Health Plan (*if applicable*)

SECTION II: Qualifying Event (Check All that Apply)

- ☐ You are homeless, or more than 30 days behind in rent or mortgage payments, or have received a current eviction or foreclosure notice.
- ☐ You have a shut-off notice from your utility company (gas, electric, oil, water, or telephone), or one of your utilities has been shut off, or one or more of your utility companies is refusing to deliver services because you cannot pay.
- ☐ You had a large increase in expenses in the past six months due to domestic violence.

SECTION II: Continued

- ☐ You had a large increase in expenses in the past six months due to death of your spouse, family member, or partner with primary responsibility for child care.
- ☐ You had a large increase in expenses in the past six months due to the sudden responsibility for providing full care for an aging parent or other family member, including a major long illness of your child that requires a working parent to hire a full-time person to care for your child.
- ☐ You had a large increase in expenses in the past six months due to a fire, flood, natural disaster, or other unexpected natural or human-caused event causing large damage to you or, your home, or your property or personal possessions.
- ☐ While on Commonwealth Care and during the past 12 months, you have accrued medical and dental bills that are more than 7.5% of your annual income before taxes or your family's annual income before taxes and are not payable by someone else. These bills are for services provided to you or your family and are non-cosmetic and do not include premium payments.

SECTION III: Please Describe Why You Are Requesting a Copayment Waiver. (Attach additional sheets, if needed)

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773)
Fax: 1-877-623-2155 / *Business Hours* Monday-Friday 8am-5pm

Turn Over

Timelines for Filing a Waiver:

You may file a Waiver Application at any time.

Enrollee Payment While Application is Pending:

The first time we receive your properly completed Copayment Waiver Application, you will not be required to pay your copayment until the Connector has issued a decision on your Application. If you submit a second Copayment Waiver Application after the Connector has denied an earlier Application, then you may be required to pay all applicable copayments while the Connector considers your subsequent Application. If the Connector denies your Copayment Waiver Application, then you must immediately begin to pay all applicable copayments for the calendar year starting from the amount you reached at the time we received your Application. If your Application is denied and you appeal that decision, you will have to pay your copayments while you wait for a decision on your subsequent appeal.

Designation of Representative:

You may designate someone as your Representative for purposes of completing this Application. To designate a Representative to receive information on your behalf regarding your Copayment Waiver Application, you must submit a *Representative Form* that is signed by both you and/or your Representative. The Connector will only accept this Representative on the *Representative Form*. By designating this Representative, you are authorizing the Connector to share your personal health information with that Representative. To submit the *Representative Form*, call the Commonwealth Care Customer Service Center.

Assistance with this Form:

Please mail or fax this Application, proof of your hardship, and any other materials for us to consider. Please send photocopies of your proof as we will not return originals. Keep a copy for your records.

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Application, please contact the Commonwealth Care Customer Service Center. Please note that failure to properly complete this Application, may prevent your Application from being accepted. Only Connector approved formats will be accepted.

SECTION IV: Proof of Hardship

You must attach evidence (proof) of your hardship. Evidence of your hardship must include copies (*do not send originals as they will not be returned*) of relevant documentation such as bills, receipts, or letters from your landlord, mortgage, and/or utility company. *You must include evidence for each box you check in Section II.*

SECTION V: Proof of Hardship Attachments

Please list each of the attachments that you are including with this Application. If you need more space, please attach a separate sheet:

_____
_____
_____
_____

SECTION VI: Copayment Waiver Request

What is your average monthly copayment expense? $_____

What can you afford to pay each month?
$_____

SECTION VII: Length of Waiver

It is the Connector's discretion, pursuant to our regulations, 956 CMR 3.11(5)(b) and (c), whether or not you will get a waiver of your copayment. The maximum amount of time you could be granted a waiver is six months and it could be less.

SECTION VIII: Member Certification

I certify that I have read, or had read to me, the information on this Copayment Waiver Application and that I understand my rights and responsibilities. I further certify under the penalty of perjury that the information on this Application, and any attachments or supplements to it, are correct and complete to the best of my knowledge. I further authorize the release of my personal health information and other confidential data to the Connector and Connector contracted entities for the purpose of making a decision on my Copayment Waiver Application.

_____
Signature (*Sign*) Date

_____
First Name and Last Name (Print)

☐ *Check here if you are a Representative signing on behalf of the named individual. [If so, you must fill out the Representative Form to receive information.]*

Send this to the Commonwealth Care Customer Service Center with your proof. Keep a copy for your records.

Fill Out Both Sides

PREMIUM WAIVER-REDUCTION APPLICATION

Requesting a Waiver

You may use this form if you believe you experienced extreme financial hardship and feel you may qualify for a waiver or reduction of your premium. Only certain events are considered extreme financial hardship and they are listed in Section II.

To be considered for a waiver or reduction of your future or past premium, you must prove to us that you experienced at least one of the qualifying events listed in Section II. The maximum amount of time for which you could be granted a waiver or reduction is six months and it could be less. For details, please see 956 CMR 3.11(5)(d).

If you have a question or problem that does not fit within one of the circumstances listed in Section II, please call the Commonwealth Care Customer Service Center so we can assist you.

SECTION I: Clearly Print Your Information

First Name Initial Last Name

Mailing Address

City State Zip

Home Address (if different)

Home Telephone Gender

Daytime Telephone (if different)

Date of Birth ID Number (Usually SS#)

Name of Your Health Plan (*if applicable*)

SECTION II: Qualifying Event (Check All that Apply)

- ☐ You are homeless, or more than 30 days behind in rent or mortgage payments, or have received a current eviction or foreclosure notice.
- ☐ You have a shut-off notice from your utility company (gas, electric, oil, water, or telephone), or one of your utilities has been shut off, or one or more of your utility companies is refusing to deliver services because you cannot pay.
- ☐ You had a large increase in expenses in the past six months due to domestic violence.

SECTION II: (Continued)

- ☐ You had a large increase in expenses in the past six months due to death of your spouse, family member, or partner with primary responsibility for child care.
- ☐ You had a large increase in expenses in the past six months due to the sudden responsibility for providing full care for an aging parent or other family member, including a major long illness of your child that requires a working parent to hire a full-time person to care for your child.
- ☐ You had a large increase in expenses in the past six months due to a fire, flood, natural disaster, or other unexpected natural or human-caused event causing large damage to you or, your home, or your property or personal possessions.
- ☐ While on Commonwealth Care and during the past 12 months, you have accrued medical and dental bills that are more than 7.5% of your annual income before taxes or your family's annual income before taxes and are not payable by someone else. These bills are for services provided to you or your family and are non-cosmetic and do not include premium payments.

SECTION III: Please Describe Why You Are Requesting a Waiver or Reduction. (Attach additional sheets, if needed)

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL (1-877-623-6765) (TTY: 1-877-623-7773)
Fax: 1-877-623-2155 / *Business Hours* Monday-Friday 8am-5pm

Turn Over

Timelines for Filing a Waiver:

You may file a Waiver Application at any time.

Enrollee Payment While Application is Pending:

The first time we receive your properly completed Waiver-Reduction Application, you will not be required to pay your premium until the Connector has issued a decision on your Application. If you submit a Waiver-Reduction Application after the Connector has denied an earlier Application, then you may be required to pay a premium while the Connector considers your subsequent Application.

If the Connector denies your Application, then you may be required to pay the premiums that accrued while you waited for a decision on your Application, in order to keep your health insurance coverage going forward.

If your Application is denied and you appeal that decision, you will have to pay premiums while you wait for a decision on your appeal. If you fail to make your premium payments, you may be disenrolled.

Designation of Representative:

You may designate someone as your Representative for purposes of completing this Application. To designate a Representative to receive information on your behalf regarding your Waiver-Reduction Application, you must submit a *Representative Form* that is signed by both you and/or your Representative. The Connector will only accept this Representative on the *Representative Form*. By designating this Representative, you are authorizing the Connector to share your personal health information with that Representative. To submit the *Representative Form*, call the Commonwealth Care Customer Service Center.

Assistance with this Form:

Please mail or fax this Application, proof of your hardship, and any other materials for us to consider. Please send photocopies of your proof as we will not return originals. Keep a copy for your records.

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Application, please contact the Commonwealth Care Customer Service Center. Please note that failure to properly complete this Application, or send it in on time if you have received notice of a pending disenrollment due to non-payment of premium, may prevent your Application from being accepted. Only Connector approved formats will be accepted.

SECTION IV: Proof of Hardship

You must attach evidence (proof) of your hardship. Evidence of your hardship must include copies (*do not send originals as they will not be returned*) of relevant documentation such as bills, receipts, or letters from your landlord, mortgage, and/or utility company. *You must include evidence for each box you check in Section II.*

SECTION V: Proof of Hardship Attachments

Please list each of the attachments that you are including with this Application. If you need more space, please attach a separate sheet:

_____
_____
_____

SECTION VI: Waiver or Reduction Request

I am requesting a:
- □ Waiver of future premium
- □ Waiver of past due premium
- □ Reduction of future premium
- □ Reduction of past due premium.

What premium amount can you afford to pay each month? $_____

SECTION VII: Length of Waiver or Reduction

It is the Connector's discretion, pursuant to our regulations, 956 CMR 3.11(5)(b) and (c), whether or not you will get a waiver or reduction. The maximum amount of time you could be granted a waiver is six months and it could be less.

SECTION VIII: Member Certification

I certify that I have read, or had read to me, the information on this Waiver-Reduction Application and that I understand my rights and responsibilities. I further certify under the penalty of perjury that the information on this Application, and any attachments or supplements to it, are correct and complete to the best of my knowledge. I further authorize the release of my personal health information and other confidential data to the Connector and Connector contracted entities for the purpose of making a decision on my Waiver-Reduction Application.

_____
Signature (*Sign*) Date

_____
First Name and Last Name (Print)

☐ *Check here if you are a Representative signing on behalf of the named individual. [If so, you must fill out the Representative Form to receive information.]*

Send this to the Commonwealth Care Customer Service Center with your proof. Keep a copy for your records.

Fill Out Both Sides

REPRESENTATIVE FORM

Designating a Representative:

You may choose a Representative to help you with (1) applying for a waiver or reduction of premium, if you are a premium paying member, due to extreme financial hardship; (2) applying for a waiver of your copayment, if you are a non-premium paying member, due to extreme financial hardship; (3) requesting a health plan change; or (4) appealing any appealable action of the Commonwealth Health Insurance Connector Authority (the Connector). You may limit the authority of your Representative to one of the above listed responsibilities or allow your Representative to have authority over all responsibilities. By designating a Representative, you are authorizing the Connector to share your personal health information with that Representative.

Filling Out the Representative Form:

- If you are designating a Representative, you must fill out *Section I, A-D.*
- If you cannot designate in writing your chosen Representative due to your mental or physical condition, your Representative must fill out *Section I, A-C and Section II.*
- If your Representative has been appointed by law, they must fill out *Section I, A-C and Section III.*
- If your Representative is representing you due to your mental or physical condition *and* they have been appointed by law, they must fill out *Section I, A-C, Section II and Section III.*
- All Representatives must fill out Section IV.

Assistance with this Form:

Please mail or fax this Representative Form, and any other materials for us to consider. Keep a copy for your records.

Commonwealth Care Customer Service Center
P.O. Box 120089 Boston, MA 02112-9914
1-877-MA-ENROLL Fax: 1-877-623-2155
Business Hours Monday-Friday 8am-5pm

If you need assistance in completing this Form, please contact the Commonwealth Care Customer Service Center. Please note that only Connector approved formats will be accepted.

SECTION I:

A. Clearly Print Member Information

First Name Initial Last Name

Mailing Address

City State Zip

Home Address (if different)

Home Telephone Gender

Daytime Telephone (if different)

Date of Birth ID Number (Usually SS#)

B. Authorization

My Representative shall have the authority to be my Representative in the following matter(s):

□ My *Waiver Application* □ My *Appeal*
□ *My Health Plan Change Request Form* □ *All*

My permission to share information is good until the conclusion the matter indicated above or until _____ [insert date]

C. Name of Representative

Representative First Name Last Name

Representative Telephone Number

Representative Mailing Address

City State Zip

Name of Representative Organization/Business

Representative Relationship

D. Member Signature

I certify that I have read, or had read to me, the information on this form and that I understand my rights and responsibilities. I further authorize the release of my personal health information and other confidential data related to this representation to my designated Representative.

Signature (*Sign*) Date

First Name and Last Name (Print)

Who Can Be a Representative:

A Representative can be a friend, family member, relative, or other person who has a concern for your well-being and who agrees to help you. A Representative is a person you choose. The Connector will not choose your Representative.

If, because of a mental or physical condition, you cannot designate in writing whom you want to be your Representative, a person who is acting responsibly on your behalf can be your Representative if that person certifies that you are not able to fill out the application yourself, and that he or she is acting responsibly on your behalf.

A Representative can also be someone who has been appointed by law to act on your behalf or on behalf of your estate. Either you or this person must submit to the Connector a copy of the applicable legal document stating that this person is lawfully representing you or your estate. This person may be a legal guardian, conservator, holder of power of attorney, or health-care proxy, or an estate administrator or executor.

Dismissing a Representative:

Anytime you no longer want this person to be your Representative, you must send a letter stating this to: Commonwealth Care Customer Service Center, Attn: Representative Dismissal, P.O Box 120089, Boston, MA 02112-9914.

SECTION II. If Unable to Sign

I agree to be the designated Representative, for the named Individual, for the length of time as indicated on this Form. I further understand my duties and responsibilities as this named Individual's Representative in said matter(s) as selected in this Form and that this named Individual cannot provide written designation. I have also told this named Individual that he or she may remove me as Representative at any time as provided in this Form. I am also authorized to receive the named Individual's personal health information and other confidential data connected with this representation.

Representative Signature (*Sign*) Date

First Name and Last Name (Print)

SECTION III. If Appointed By Law

I am the legally designated Representative for the named Individual. I have included copies of applicable legal document(s) conferring legal representative status. I am also authorized to receive the named Individual's personal health information and other confidential data connected with this representation.

Legal Representative Signature (*Sign*) Date

First Name and Last Name (Print)

SECTION IV: Representative Disclosure

Representatives must answer the questions below. (Additional space is provided to the left.)

1. Do you or did you receive any compensation of any form, by any individual or entity, other than the named Individual you are representing, for any and all actions taken on behalf of said Individual?

□ YES □ NO (If checked yes, please describe)

2. Do you or did you have any financial, contractual, legal, or other business interests with or in any health care provider or Commonwealth Care health plan, which has a relationship with the named Individual?

□ YES □ NO (If checked yes, please describe)

I certify the information is complete and that I have disclosed any interests to the named Individual.

Representative Signature (Sign) Date

Fill Out Both Sides