ConnectorCare Advocacy Guide

About Massachusetts Law Reform Institute

The Massachusetts Law Reform Institute (MLRI) is a statewide nonprofit poverty law and policy center. Our mission is to advance economic, racial, and social justice through legal action, policy advocacy, coalition building, and public information and to promote policies that meet the fundamental needs of traditionally underserved, low-income populations. We defend against policies and actions that harm and marginalize people living in poverty and advocate for systemic reforms that achieve social and economic justice. Our activities include advice, litigation, policy analysis, research, technical assistance and public information.

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Scope of this Guide

This Guide is about ConnectorCare, private insurance plans available through the Health Connector with both premiums and cost sharing subsidized for people with income not over 300% of the federal poverty level (FPL). The Health Connector also offers other plans besides ConnectorCare plans. Check the citations in each Q & A to see whether the rule or policy described may also apply to a Health Connector plan that is not a ConnectorCare plan.

ConnectorCare by the numbers in April 2019

- ~211,000 enrolled
- 24% of enrollees have income at or under 150% FPL; 76% have income over 150% FPL but at or under 300% FPL
- 52% were enrolled in Tufts Health Direct; 38% in BMC Health Net & 10% in one of the three other ConnectorCare Health Maintenance Organizations (HMOs)

Basic information about ConnectorCare

- The Connector’s 2-page ConnectorCare Overview including benefits and copays, income limits, minimum premium contributions, and participating plans for the year is in Appendix 3.
- MLRI’s Table entitled “MassHealth & Other Health Programs: Upper Income Levels” showing the current annual income limits for ConnectorCare by Plan Type is in Appendix 1.
- The Connector’s map showing ConnectorCare premium contributions by HMO and by Region for 2019. [Link](https://www.masslegalservices.org/system/files/library/ConnectorCare%20En rollee%20Contribution%20by%20Region%202019.pdf)
Part 1
Background and Overview of Eligibility

1 How did the Affordable Care Act expand affordable private insurance coverage?

Under the federal Affordable Care Act (ACA), starting in 2014, individuals meeting certain eligibility criteria with income not in excess of 400% of the federal poverty level (FPL) can qualify for federal Premium Tax Credits to lower the cost of private insurance. The Premium Tax Credit is refundable, meaning it is not only a credit against any tax due; it can be paid to an eligible taxpayer if it exceeds the amount of any tax due. It is also advanceable, meaning it can be paid out in advance during the tax year. The Advance Premium Tax Credit (APTC) is an estimated amount based on expected income for the tax year that the IRS pays directly to the insurance carrier to lower the enrolled individual’s monthly premium costs. A Premium Tax Credit can only be used to lower the costs of private insurance meeting the criteria to be Qualified Health Plans (QHP) that are purchased through an Exchange (also called a Marketplace). The ACA created a federal Marketplace but also allows states to use their own state-based Marketplaces instead.

Massachusetts is one of just 12 states with a state-based Marketplace. The Commonwealth Health Insurance Connector Authority (the Health Connector) is the Massachusetts state-based Marketplace. Individuals can purchase QHPs through the Health Connector with or without help paying the costs. For individuals with income not in excess of 300% FPL, Massachusetts has lowered the costs of a subset of QHPs by supplementing the federal Premium Tax Credits with added state-funded premium and cost-sharing subsidies in order to create ConnectorCare coverage and make it as affordable as a predecessor Massachusetts program called Commonwealth Care. Individuals with income
over 300% FPL but not over 400% FPL may purchase QHPs through the Health Connector and qualify for federal Premium Tax Credits under the ACA but do not qualify for the added state subsidies and other state-defined features of ConnectorCare.

In 2019, nine carriers offered over 50 non-group QHPs in the Health Connector. In April 2019 about 55,000 people were enrolled in unsubsidized QHPs and another 17,000 with income between 300% and 400% FPL were enrolled in QHPs with APTCs. This compares to 211,000 people enrolled in one of the five ConnectorCare plans. The Health Connector also offers dental plans, and plans for small businesses.

The ACA also created a Medicaid option for adults not previously eligible for Medicaid. In 2014, Massachusetts began covering working age adults 21-64 with income up to 133% FPL in a MassHealth program called CarePlus. A Table in Appendix 4 compares CarePlus and ConnectorCare.

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What is ConnectorCare?

ConnectorCare is a program of subsidized private health insurance plans for certain individuals with family income that does not exceed 300% of the federal poverty level (FPL) and who are not eligible for MassHealth, Medicare or other affordable health coverage. ConnectorCare includes a standardized set of benefits offered by private health maintenance organizations (HMOs), no deductibles, three levels of copays based on income, and sliding scale premiums as a percent of income. ConnectorCare “Plan Types” all cover the same services, but different Plan Types determine minimum premium contributions and copay levels based on income as a percentage of the federal poverty level as follows:

<table>
<thead>
<tr>
<th>Plan Type 1</th>
<th>Plan Type 2A</th>
<th>Plan Type 2B</th>
<th>Plan Type 3A</th>
<th>Plan Type 3B</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-100%</td>
<td>&gt;100-150%</td>
<td>&gt;150-200%</td>
<td>&gt;200-250%</td>
<td>&gt;250-300%</td>
</tr>
</tbody>
</table>
3  What is the Health Connector?

The Commonwealth Health Insurance Connector Authority (Health Connector) performs all the functions of a Marketplace (also called an Exchange) under the ACA. It also continues to administer a 2006 state health reform law that among other things imposed a tax penalty on adults who fail to enroll in health insurance that meets the Health Connector’s standards of affordability. It is an independent authority governed by an 11 member appointed board of directors. The Secretary of EOHHS is the *ex officio* chairperson of the Connector board. Board meetings are open to the public and the Connector website (mahealthconnector.org) posts copies of monthly enrollment trends and presentations made to the board at its monthly meetings. The Connector has a central office in Boston and walk-in centers in Boston, Brockton, Worcester and Springfield shown in the Resource section of this Guide.

G.L. c. 176Q.

4  Who is eligible for ConnectorCare?

To be eligible for ConnectorCare, individuals must –

1). satisfy the federal eligibility criteria for purchasing a Qualified Health Plan (QHP) through the Health Connector;

2). satisfy the federal eligibility criteria to qualify for Premium Tax Credits. (The Health Connector determines the amount of *Advance* Premium Tax Credits payable during the tax year, and the IRS determines the final amount of Premium Tax Credits (PTC) due when taxes are filed for the tax year after “reconciling” any amount received in advance), and

3). individuals must have annual income at or under 300% FPL to qualify for the subset of QHPs that are ConnectorCare plans under state law.

Each of these criteria is discussed further below and in later Q & As.
1). To be eligible to purchase a Qualified Health Plan (QHP) through the Health Connector individuals must be --

- Residents of Massachusetts,
- Not incarcerated at the time of enrollment, and
- U.S. citizens or non-citizens who are “lawfully present” in the U.S.

  o Lawfully present non-citizens include all legal permanent residents; there is no 5-year waiting period as there is for adults in MassHealth Standard or CarePlus. It also includes other categories of non-citizens who are not eligible for MassHealth Standard or CarePlus such as those with Temporary Protected Status, asylum applicants with work authorization and many others. A full list is in Appendix 2.

45 CFR 155.305(a) (1)-(3).

2) To be eligible for an Advanced Premium Tax Credit an individual must --

- Have expected annual “Modified Adjusted Gross Income” (MAGI) over 100% FPL but not over 400% FPL

  o EXCEPTION: There is no minimum income for lawfully present non-citizens with income less than 100% FPL who are not eligible for MassHealth due to their immigration status.

- Not be eligible for or enrolled in “minimum essential coverage,”

- Not be eligible for or enrolled in employer-sponsored insurance that constitutes “minimum value” and is considered “affordable” as those terms are defined by the ACA, and

- File a federal tax return with required forms for each year in which the individual receives an Advance Premium Tax Credit and, if “married” at the end of the tax year, files as married filing jointly unless the reason for filing as married filing separately is abuse or abandonment by the other spouse.

45 CFR 155.305(f).

3). To also qualify for ConnectorCare, an individual must –

- Have expected annual MAGI not in excess of 300% FPL, and
• Enroll in a designated ConnectorCare plan.

956 CMR 12.04 and 12.08, and Health Connector Policy: Eligibility to Purchase Individual/Family Plan, Policy # NG-1A (2-12/16) Eligibility for Federal and State Financial Support for Individual/Family Plan, Policy # NG-1B (4-21-16).

5 How do you obtain information about a client’s ConnectorCare eligibility or enrollment?

The client is the initial source of information and may have copies of notices from MassHealth and the Health Connector or may be able to obtain additional information by checking his or her online account described below. However, usually additional information will be needed from Health Connector staff to fully understand the situation.

Health Connector Customer Service & Walk-In Centers. An individual’s application and enrollment information is confidential. To obtain information about a client from the Health Connector’s Customer Service Center over the telephone or at one of its five walk-in Centers (listed in the Resource section), your client must authorize the Health Connector to release information to you. A client can do this if he or she is with you in person or is on the telephone. Otherwise, the Health Connector must have a copy of your client’s signed Permission To Share Information (PSI) Form or Authorized Representative Form. These are the same forms used by MassHealth and once submitted to MassHealth or the Health Connector will be accessible to staff at both agencies. These forms are available online in the MassHealth Member Forms section of its website: https://www.mass.gov/service-details/masshealth-member-forms

Online accounts. An individual may also be able to supply more information from his or her online account. Someone who initially applied online will have created an online account and should have a username and password to access the account. An account is created for all applications including those filed on paper or by telephone. Individuals who don’t yet have online access to their account may obtain it by first calling Health Connector Customer Service. Customer service will send out an invitation via email, and the individual will need to
follow the instructions which include answering questions to verify identity. With access to his or her online account, an individual can complete or update his or her application, select a health plan, check on the status of the application and the status of verification requested or submitted, see the eligibility results and appeal. Navigators and certified application assisters, with the individual’s written consent, can also access his or her account using the assister portal.
Part 2
Eligibility: Income, Other Coverage, and Tax Filing

6 How is income calculated?

Eligibility for ConnectorCare is based on an individual’s Modified Adjusted Gross Income (MAGI) for his or her tax household for the tax year in which he or she is enrolled in a ConnectorCare plan. Eligibility for ConnectorCare and the amount of the Advance Premium Tax Credit is based on the applicants’ best estimate of their annual MAGI income for the tax year as they expect it to be shown on IRS Form 1040 when they file their return in the following year.

What income is counted? The MAGI rules count all income that would be included in adjusted gross income (AGI) on the applicant’s federal tax return for the tax year. In addition the MAGI rules count three types of non-taxable income: Non-taxable social security income, tax exempt interest income and certain tax exempt foreign income. These amounts are shown on IRS Form 1040 and associated schedules as shown below:

- Form 1040 (2017)

  Adjusted Gross Income is on line 37. Line 37 equals the difference between Total income on line 22 less adjustments to income online 36.

  Plus the following nontaxable income

  - Non-taxable social security income (line 20a (total social security) less line 20b (taxable social security))
  - Tax exempt interest income (line 8b), and
  - Tax exempt foreign income (Form 2555)
Part 2 ■ Eligibility: Income, Other Coverage, and Tax Filing

■ Form 1040 (2018)

Adjusted Gross Income is on line 7. Line 7 includes additions to income from Schedule 1 line 22, less adjustments to income from Schedule 1 line 36.

*Plus the following nontaxable income*

- Non-taxable social security income (line 5a (total social security) less line 5b (taxable social security))
- Tax-exempt interest income, (line 2a), and
- Tax-exempt foreign income. (Form 2555)

This would be easy if financial eligibility were based on the most recent year’s tax return, but eligibility is based on what applicants expect their current MAGI to be. A past year’s return will be helpful only if the current year is likely to be similar to the past year. There are several excellent guides to the MAGI rules from national advocacy organizations listed in the Resource section. The website at IRS.gov also contains extensive information including interactive tools designed for consumers. In some situations, applicants may need the advice of a tax professional. Low income tax clinics are listed in the Resource section.

Some common types of income that are not taxable include: welfare payments such as TAFDC and SSI, child support income, gifts and inheritances, Veteran’s Administrations payments, and Worker’s Compensation. A recent change in the tax laws has complicated the treatment of alimony. It is income for the recipient and a deduction for the payer if the alimony order was made before Jan. 1, 2019 but not if the alimony order was made on Jan. 1, 2019 or later. Tax losses from self-employment, rental income or investment income that reduce AGI will also reduce MAGI. Pre-tax deductions from earnings that reduce the amount of taxable wages will also reduce MAGI. To the extent that people make decisions that will reduce their AGI, such as purchasing certain IRAs, they will also reduce MAGI for purposes of ConnectorCare eligibility.

**Whose income is counted?** The tax household includes the tax filer and spouse, if married filing jointly, and anyone they may claim as a dependent on their federal return. Under IRS rules, dependents are not limited to minor children. In certain circumstances, adult children, elderly parents, unmarried partners and other individuals supported by the tax filer may also qualify as dependents.

The tax household determines family size. The income of the tax filers (including a spouse filing jointly) always counts. However, the income of a dependent is included in the MAGI of the tax household only if the dependent’s income is high
Eligibility: Income, Other Coverage, and Tax Filing ■ Part 2

enough to require him or her to file a return under IRS rules. An unmarried child claimed as a dependent with earnings as high as $12,000 (and no unearned income) is not required to file in 2018. For purposes of determining whether a dependent must file a return, the IRS does not count the dependent’s non-taxable social security as unearned income. The income of a dependent who is not required to file a return but *chooses* to do so, e.g. to obtain a refund, does not count.

Consult IRS Publication 501 or the guides in the Resource section for more information on who may qualify as a dependent, and the filing requirements for dependents.

**How does MAGI affect eligibility?** Once the MAGI of the tax household has been calculated, it is compared to the applicable federal poverty level (FPL) standards for the family size to determine if the amount is at or under the upper income levels for ConnectorCare (300% FPL). If MAGI is over 300% FPL but not over 400% FPL, the applicant may qualify for an Advance Premium Tax Credit for a Qualified Health Plan. The federal government adjusts the Federal Poverty Level standards every year in late January. However, under federal law, the Connector uses the most recent FPL at the time open enrollment begins in November for the following calendar year. This is why the Connector uses the 2018 FPL standard that was in effect in November 2018 to determine eligibility for any month in 2019. See Appendix 1 for 2019 amounts.

**Differences between Connector MAGI and MassHealth MAGI.** MassHealth also use MAGI to determine financial eligibility for most people under age 65. However, MassHealth is based on current monthly income, not expected annual income, and MassHealth makes various exceptions to both the tax household rules and the income-counting rules applied in the Connector. If an individual’s current monthly MassHealth MAGI income is over MassHealth income eligibility standards, but expected annual Connector MAGI is under 100% FPL, a special "safe harbor" rule deems the individual’s income to be under 100% FPL for MassHealth too. 130 CMR 506.008(D)

7 What is “minimum essential coverage”?

To qualify for ConnectorCare, individuals must not be eligible for Minimum Essential Coverage (MEC). For purposes of ConnectorCare eligibility, MEC includes government-sponsored programs, “affordable” employer-sponsored plans and certain other health benefits as described below. Sometimes MEC eligibility alone is disqualifying, but sometimes an individual who is eligible for a type of MEC but not actually enrolled is still eligible for ConnectorCare.

26 CFR 1.36B-2(c) (Premium tax credit) and 1.5000A-2 (Minimum Essential Coverage)

8 When does eligibility for government-sponsored coverage affect ConnectorCare?

Eligibility for the following types of government-sponsored programs counts as Minimum Essential Coverage (MEC) and disqualifies someone from eligibility for ConnectorCare:

- Medicare Part A.

Eligibility for premium-free Medicare Part A.

- A person enrolled in Medicare Part A or Medicare Advantage or eligible for premium-free Part A is not eligible for ConnectorCare.

EXCEPTIONS:

- Individuals age 65 and over who are eligible for but not enrolled in Medicare who would be charged a premium for Part A are not considered eligible for MEC, and may qualify for ConnectorCare.

- Individuals potentially eligible for Medicare solely based on End Stage Renal Disease (ESRD) who have not applied for Medicare and been found eligible may qualify for ConnectorCare.

IRS Notice 2013-41 (June 26, 2013)
Eligibility: Income, Other Coverage, and Tax Filing ■ Part 2

- The current March 2019 application form asks if individuals are enrolled in Medicare or eligible for premium-free Part A. If the answer is yes or if data sources show enrollment in Medicare Part A or Medicare Advantage, the individual will not be eligible for ConnectorCare.

- After an eligible individual enrolls in ConnectorCare, the Connector conducts periodic data matches with Medicare during the year. An individual who later enrolls in Medicare Part A or Medicare Advantage will be notified that he or she is no longer eligible for ConnectorCare. Generally, insurance carriers cannot sell duplicate coverage to Medicare beneficiaries; however, a beneficiary who loses ConnectorCare can remain enrolled in the same QHP for the balance of the year with no subsidy. (The Connector does not offer Medicare Supplement plans).

✔ Advocacy Reminder:
If people do not enroll in Medicare Part B during their initial enrollment period or certain special enrollment periods, they may face late enrollment penalties that increase the amount of their Part B premiums and may not be able to enroll in Medicare until later in the year. Being enrolled in a plan obtained through a Marketplace/Exchange, like the Health Connector, does not exempt individuals from these disadvantages the way that being enrolled in employer-sponsored insurance may. In recent years, Medicare has given individuals enrolled in the Marketplace an opportunity to avoid the disadvantages of delaying enrollment in Part B. This relief extends to those who could have enrolled in Medicare Part B but did not do so during their Medicare Initial Enrollment Period or Part B SEP for the working aged or disabled, and currently are or were enrolled in coverage through the Marketplace during certain dates from 2013 to Sept. 30, 2019. See, https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/SHIP-and-Navigators-Fact-Sheet-10-10-2018.pdf Individuals can obtain more information about this assistance and about making the transition from ConnectorCare to Medicare from local SHINE counselors listed in the Resource section.

Medicaid and the Children’s Health Insurance Program (CHIP)

- Medicaid and CHIP are both called MassHealth and eligibility for any type of MassHealth, other than MassHealth Limited (which only covers emergency services), counts as MEC.
Part 2 ■ Eligibility: Income, Other Coverage, and Tax Filing

- The Children’s Medical Security Program (CMSP) and the Health Safety Net, like MassHealth Limited are not considered MEC.

- There is a common application system for MassHealth (Medicaid and CHIP) and for ConnectorCare. An applicant who is found eligible for any kind of MassHealth except Limited will not be eligible for ConnectorCare. However, if an individual is initially eligible for ConnectorCare and is later found eligible for MassHealth, including a retroactive eligibility determination, the MEC disqualification will begin no earlier than the first day of the month beginning after the date of the MassHealth eligibility notice.
  - This is one of several situations where individual may have overlapping MassHealth and ConnectorCare without it being considered an excess payment of APTCs by the IRS. This will be important during the annual reconciliation process for advance premium tax credits discussed below in the Q & A 30.

■ TRICARE.

Eligibility for medical coverage under TRICARE, 10 USC 55, for active duty service members and their families is counted as MEC. Certain limited benefit TRICARE coverage is not considered MEC.

■ Veterans programs.

- The Veteran’s Administration health system under 38 USC 1710 and 1705 is available to most but not all veterans. Veterans enrolled in the VA health system have MEC. However, veterans who are not eligible for the VA health system, as well as those who are eligible, but choose not to enroll, are not counted as eligible for MEC, and may be eligible for premium tax credits and ConnectorCare.

- The family members of veterans are generally not eligible for VA health benefits, but family members of certain veterans may be eligible for the VA Civilian Health and Medical Program (CHAMPVA) or for the spina bifida health care program. CHAMPVA and the spina bifida program both count as MEC.

■ Peace Corp program.

Eligibility for the health plans for Peace Corps volunteers under the law at 22 USC sections 2504(e) is counted as MEC.
Eligibility: Income, Other Coverage, and Tax Filing  • Part 2

26 CFR 1.36B-2(c) (2) Government-sponsored MEC; IRS Publication 974, Premium Tax Credits (2018).

A note on age: There is no upper or lower age limit for ConnectorCare, but most people under 19 or age 65 and older do not qualify because they are eligible for government-sponsored MEC. Children and youth under age 19 who are US citizens or lawfully present non-citizens with family income not over 300% FPL generally qualify for MassHealth, and most individuals age 65 or older qualify for Premium-Free Medicare Part A.

9

When does eligibility for employer-sponsored insurance affect ConnectorCare?

An employee or an employee’s family member who is qualified to enroll in employer-sponsored insurance that is “affordable” and provides “minimum value” is not eligible for a premium tax credit or ConnectorCare for any month in which the employee or family member could have enrolled in the employer plan. However, the disqualification does not extend to any required waiting period before employer-sponsored coverage becomes effective, or to family members who are not claimed as tax dependents by the employee.

Employer-sponsored coverage is “affordable” for purposes of the MEC definition if --

- The employee’s required premium contribution for the lowest cost self-only coverage does not exceed a certain percentage of household income for the year;
  - The required contribution percentage was 9.5% in 2014 but is adjusted annually. In 2019 the percentage is 9.86%.
  - If the employer offers coverage to the employee’s family members, affordability for the family members is also based on the cost of self-only coverage for the employee not the often much higher costs of couple or family coverage. This is sometimes called the “family glitch” but the IRS has determined this is how it must apply the ACA unless Congress amends the law.
Part 2 ■ Eligibility: Income, Other Coverage, and Tax Filing

Employer-sponsored coverage provides “minimum value” if the plan’s share of the total cost of benefits provided to the employee are at least 60%. This provision will rule out plans with extremely high cost-sharing and deductibles; such plans are unusual for employer-sponsored plans in Massachusetts.

- Employees can learn whether their health plan meets minimum value by requesting a Summary of Benefits and Coverage (SBC) from their employer. The SBC is a required plan document and should clearly state whether the plan meets the minimum value requirement.

Individuals enrolled in employer-sponsored insurance. If an individual is actually enrolled in employer-sponsored insurance it is considered MEC regardless of affordability or minimum value or the fact that a family member is not claimed as a dependent by the employee.

Former employees. Eligibility for coverage as a former employee under a retiree, COBRA or mini-COBRA plan counts as MEC only in the months in which an individual is actually enrolled.

Health Reimbursement Accounts (HRAs) and Qualified Small Employer HRAs. Currently, federal rules address affordability of Qualified Small Employer HRAs but not HRAs generally, check the rules for more information.

26 CFR 1.36B-2(c)(3) (Employer-sponsored MEC); 1.36B-6 (minimum value); 1.5000A-2 (Minimum essential coverage).

10 How does tax filing affect eligibility for ConnectorCare?

ConnectorCare is subsidized through a premium tax credit that may be paid in advance to the HMO to lower the member’s premium costs during the year. In order to qualify for a premium tax credit and ConnectorCare the following criteria related to federal tax filing must be satisfied:

- An individual must file a federal tax return for the year in which the taxpayer is seeking a premium tax credit for the taxpayer, spouse or other individuals claimed as tax dependents, and an applicant for ConnectorCare
must attest that he or she will file a federal tax return for the tax year in which the premium tax credit is paid in advance.

- An individual, who will be “married” within the meaning of 26 USC 7703 as of Dec 31, is not eligible for a premium tax credit if he or she plans to file a return as married filing separately unless the taxpayer is unable to file jointly due to abuse or abandonment of the other spouse.
  
  o **Head of household.** A person who is married but living apart from a spouse during at least the last 6 months of the year, and who supplies over half the costs of maintaining a household that is the principal home for a child for more than half the year and can claim the child as a tax dependent may file as a “head of household” and is not considered “married” under 26 USC 7703.

  o **Domestic abuse** is broadly defined as physical or emotional including efforts to control or intimidate and may include abuse of the victim’s child or other family member. 26 CFR 1.36B-2T(a)(2)(iii).

  o **Abandonment** in a taxable year is defined as being unable to locate a spouse after reasonable diligence. 26 CFR 1.36B-2T(a)(2)(iv).

- An individual who received an advanced premium tax credit in any year and failed to file a federal return and the required form to reconcile the amount of the credit received in advance with the amount due, as described in Q & A 30, will not be eligible for an advance premium tax credit or ConnectorCare until filing the required tax forms for the prior period. However, a current enrollee will be notified in advance and given an opportunity to file the required tax forms before having their ConnectorCare terminated. 45 CFR 155.305(f)(4)
Part 2 ▪ Eligibility: Income, Other Coverage, and Tax Filing
Part 3
Application and Verification

11 How do you apply for ConnectorCare?

MassHealth and the Health Connector use a common application that also serves as an application for the Health Safety Net and the Children’s Medical Security Program (CMSP). It uses a common computer-based eligibility system called HIX (the Health Insurance Exchange). While there are limitations on when you can enroll in ConnectorCare, described in a later Q & A on open enrollment, there are no limitations on when you can apply.

There are many ways to apply including by completing an online application at mahealthconnector.org, by completing a paper application form and submitting it by mail or fax as directed on the form, by telephone at 800-841-2900, or in person at one of the five MassHealth offices (in Taunton, Chelsea, Quincy, Tewksbury and Springfield) or one of the four Health Connector Walk-In Centers (in Boston, Brockton, Worcester, and Springfield) or with the assistance of a Navigator or Certified Application Counselor, sometimes called Enrollment Assisters or Patient Financial Counselors.

Individuals age 65 or older. Older adults who are not enrolled in Medicare Part A or Medicare Advantage who want to submit a single application to see if they qualify for MassHealth, the Health Safety Net and/or ConnectorCare, must complete the paper application called “Application for Health Coverage for Seniors and People Needing Long-Term-Care Services” (SACA-2) and they must check the boxes for MassHealth or Health Safety Net AND Health Connector Programs on page one of the form. Seniors who are only interested in ConnectorCare may apply online at mahealthconnector.org.

Identity-proofing. In order to apply online, an individual must verify his or her identity in order to create an online account. This is not an eligibility criterion but a security measure specific to the online application. The screen asks various
questions to verify an applicant’s identity; if the applicant is unable to answer the questions correctly he or she will be asked to submit proof of identity before proceeding with the online application. More information about this step is available here: https://www.mahealthconnector.org/identity-id-proofing-what-you-need-to-know

Enrollment Assistance. Under the ACA, the Health Connector makes annual grants to organizations that can act as Navigators to spread the word about available coverage options and to assist individuals in applying for and enrolling in subsidized coverage. In addition, the Office of Medicaid trains and certifies application counselors to similarly assist individuals in applying for and enrolling in subsidized coverage. Both Navigators and certified application counselors are required to complete an initial training on program rules and using the HIX for online applications, and selecting a plan. They are also provided additional trainings throughout the year about policy and operational changes and have access to MassHealth and the Connector through an online assister portal and an assister telephone line. More information on how to locate enrollment assistance is in the Resources section of this Guide.

12 How is information on the application verified?

Data matching. When individuals apply online or when agency employees enter the information from a paper or telephone application into the system, the HIX attempts to verify certain key information from federal and state data sources. This information includes, state residence, income, US citizenship or eligible immigration status and certain government-sponsored MEC. In many cases, the system can make a real time determination about the applicant’s eligibility for available programs without requiring any additional proof.

Paper verification. If information cannot be verified electronically, a notice will go out to the applicant asking for information to be submitted within 90 days. As discussed in the following Q & A, the Health Connector can generally make a temporary eligibility decision based on the self-declared information without having to wait for the paper verification.
Proof of income. The application asks for both current monthly income and expected annual income for each member of the tax household. The information on current monthly income is used to determine eligibility for MassHealth. If an individual is not eligible for MassHealth, expected annual income is used to determine eligibility for advance premium tax credits and ConnectorCare. The system checks federal data sources that include income information from the IRS based on the most recent return filed in the last three years. If the applicant’s self-declared annual income is “reasonably compatible” with the data sources it is considered verified. For purposes of ConnectorCare, the attested income is reasonably compatible if it is either higher than the income shown in the data source, or, no more than 10% lower than the income in the data source.

- Federal law requires a reasonable compatibility threshold of no less than 10% over the attested income amount. The federal Marketplace uses a 25% threshold, but Massachusetts uses the 10% minimum.

45 CFR 155.315 and 155.320.

13 What happens to a ConnectorCare application if eligibility factors are not verified electronically?

If self-declared information cannot be electronically verified, the HIX will make a temporary ConnectorCare eligibility determination based on the self-declared information. In Massachusetts, this is called “provisional eligibility,” in the federal regulations it is referred to as the “inconsistency period.” The applicant will be asked to submit required proof within 90 days to remain eligible but in the meantime will be able to enroll in a plan based on the self-attested information. However, provisional eligibility does not apply if the data shows the person is dead or already enrolled in Medicare or MassHealth.

✓ Advocacy Reminder:
The Connector may extend the 90 day provisional eligibility period on request if the applicant has been making a good faith effort to obtain the required proof. 45 CFR 155.315(f)(3). On a case by case basis, the Connector may also accept self-attestation and an explanation of why proof is not reasonably
available as sufficient verification except with respect to proof of US citizenship or an eligible immigration status. 45 CFR 155.315(g).

When proof is submitted on or before the deadline, the HIX will make a new determination based on the proof. If the Connector receives no proof by the deadline, and the data source has information, HIX will make a new decision based on the data source. If the data source does not have information, HIX will issue a notice that, depending on the missing factor, will deny eligibility to purchase a QHP (based on lack of residence, citizenship/lawful presence, or incarceration) or allow purchase of a QHP but deny eligibility for a premium tax credit and ConnectorCare (based on excess income, tax filing factors, or minimum essential coverage).

✓ Advocacy Reminder:
   An individual can supply the missing information after the 90 day deadline, but may no longer be within open enrollment. Enrolling outside of open enrollment requires a special enrollment period. If the delay in enrollment was based on an error on the part of MassHealth or the Health Connector, such as a delay in processing verification that was submitted on time, the Health Connector may approve a special enrollment period and a request for retroactive enrollment. 45 CFR 155.420 (d)(13) and (b)(2)(iii).

Differences between MassHealth and Connector Provisional Eligibility.
MassHealth also has provisional eligibility but it can only be used once in a 12-month period, and does not extend to unverified income for most adult applicants. These differences in provisional eligibility policies between MassHealth and the Health Connector may create a delay in coverage for applicants who attest to income under the MassHealth upper income limits but who in fact have income too high for MassHealth but within ConnectorCare upper income limits. Such applicants will receive neither MassHealth nor ConnectorCare until submitting proof of income. If the proof shows they are eligible for MassHealth, its coverage is retroactive, but if the proof shows higher income making them eligible for ConnectorCare, ConnectorCare will not ordinarily be retroactive, but see the Advocacy Tip above. Once enrolled in ConnectorCare, members who report an unverified decrease in income that would make them eligible for MassHealth may remain in ConnectorCare until they are found eligible for MassHealth based on verified income, unless they attest to income below the 100% FPL minimum income level and do not fall under the immigrant exception.

Part 4
Enrollment into an HMO

14 When does ConnectorCare coverage begin?

In MassHealth, eligibility and coverage are concurrent, but that is not true in the Health Connector. Once found eligible for ConnectorCare, an applicant must take further action to affirmatively enroll by certain deadlines before coverage can begin. Enrollment can only occur during an annual open enrollment period or after a qualifying event that occurs outside open enrollment and creates a special enrollment period as discussed in the next three Q & As.

In general, enrollment is prospective after selecting a plan and paying any premium due. At initial enrollment, plan selection and payment of the first month’s premium must be completed by the end of the day on the 23rd of the month in order for coverage to begin on the 1st of the following month. The applicant can also select a date on the first of a later month within the enrollment period, however, an individual who misses the deadline for the initial month he or she selected will have to “shop” again and affirmatively select coverage for a later month within the enrollment period.

✓ Advocacy Reminder:
There are limited opportunities for retroactive enrollment in ConnectorCare. Retroactive enrollment will always require a special request to Customer Service or an appeal. After certain kinds of special enrollment periods including those based on errors, or misrepresentation by the Health Connector or its agents, contract violations, “special circumstances” identified by the Connector or in some failure to verify situations, the effective date of coverage may be an “appropriate date based on the circumstances of the special enrollment period.” 45 CFR 155.420(b)(2)(iii). As discussed below in a later Q & A, a hearing officer can also set a retroactive effective date after a successful appeal.
• In training for enrollment assisters in the summer of 2018, the Connector described a policy for retroactive enrollment based on an error by the Health Connector, a member’s hospitalization, a death in the family or other exceptional circumstances that prevented an individual from selecting a plan and paying the premium. The process requires the applicant to request retroactive enrollment from a Health Connector Customer Service representative and pay all monthly premiums for the requested months as well as the next month’s premium. The process may take 10-15 business days to complete and some requests may require health plan approval.


## 15 What is open enrollment?

**Open enrollment** is an annual period in which individuals can enroll in or change their coverage for the year beginning January 1. The federal government selects the open enrollment period for the federal Marketplace, but state-based Marketplaces like the Health Connector can select a different enrollment period. In 2019, open enrollment in Massachusetts was Nov. 1, 2018 to Jan. 23, 2019 for 2019 coverage.

**Enrolling outside of open enrollment** or changing plans once enrolled is only allowed after a “qualifying event” creates a “special enrollment period” (SEP) during which an individual may enroll or change plans. Generally the SEP is 60 days from the qualifying event.

## 16 What qualifying events create a special enrollment period (SEP)?

Federal law requires certain qualifying events but state-based Marketplaces like the Health Connector can also define additional qualifying events. An individual
applying online or by telephone will be asked about the existence of a qualifying event if that is needed to enroll. An individual applying by paper will receive a notice with information about SEPs with the eligibility determination. If the Health Connector confirms that an SEP applies, the individual may enroll but may be asked to supply proof of the qualifying event within 90 days. If proof is not supplied, the individual will be terminated from coverage. Within 35 days of the termination notice, the individual can request reinstatement in the same plan provided he or she submits the proof and pays the premium for the balance owed and the next month. If the Health Connector denies a request for an SEP, it issues a written decision that is subject to appeal.

**Qualifying events defined in federal law, 45 CFR 155.420**

- A change in household because of:
  - Marriage
  - Birth
  - Adoption or placement for adoption
  - Death, divorce or legal separation from spouse

- A loss of health insurance because of:
  - Loss of job or reduced hours
  - Change in job or move outside service area of current plan
  - Change in eligibility for employer plan or significant change in plan options
  - Change in employer plan or employee’s FPL such that employer plan no longer affordable or minimum value
  - No longer MassHealth eligible
  - Loss of coverage on parent’s plan on turning 26
  - Health plan no longer QHP
  - Expiration of COBRA
  - No longer student health plan eligible

  NOTE: Loss of coverage based on failure to pay premiums or voluntarily terminating coverage is not a qualifying event.

- Changes making an individual newly eligible
  - A change in status as US citizen or lawfully present immigrant
Part 4 • Enrollment into an HMO

- A change in FPL that makes an unsubsidized QHP enrollee or dependent newly eligible for PTC or ineligible for PTC
- Release from incarceration
- Permanent move to Massachusetts from prior place of residence

- Victims of domestic abuse or spousal abandonment and dependents who are enrolled in coverage with the abuser or the abandoning spouse and seek to obtain separate coverage

- An applicant who is assessed as potentially eligible for MassHealth and is determined ineligible for MassHealth after open enrollment has ended or initial SEP expired.

- Individuals who gain or maintain status as an Indian and their dependents; they may enroll or change QHP one time per month

- Special circumstances affecting enrollment include:
  - Enrollment or failure to enroll due to error, misrepresentation or inaction by the Health Connector, certified application counselors or Navigators
  - The individual demonstrates that material error influenced decision to enroll or not enroll
  - Misconduct by a Navigator, broker or certified application counselor
  - The ConnectorCare plan/QHP significantly violated its contract with the consumer
  - At the option of the Health Connector, the individual provides satisfactory evidence to verify eligibility after termination due to failure to verify within the required period
  - The consumer experienced other exceptional circumstances preventing enrollment as the Connector may provide, this currently includes hospitalization or a death in the family

Additional qualifying events in ConnectorCare regulations, 956 CMR 12.10(5)(b)-(e)

- Being determined newly eligible for ConnectorCare
  - Applicants do not have to identify this qualifying event or request an SEP, HIX will recognize when an applicant is newly eligible for
Enrollment into an HMO - Part 4

ConnectorCare. However this qualifying event will not help an individual who was previously found eligible for ConnectorCare and did not enroll by the deadline. He or she will have to wait until open enrollment unless another qualifying event applies.

- A change to a different one of the three Plan Types for an existing enrollee.
- Approval of a premium hardship waiver.
- The expiration of a hardship waiver.

Individuals generally have 60 days to enroll or change plans from the date of one of these triggering events.

Additional qualifying events in state law: OPP waiver, 958 CMR 4.00

- If the Health Connector denies enrollment because someone does not have a qualifying life event and open enrollment has ended, the denied applicant can request a waiver from the Office of Patient Protections (OPP), an office of the Health Policy Commission.
- The waiver request must be filed within 30 days of the denial notice and include a copy of the denial. The waiver form asks the applicant to explain why they did not enroll during open enrollment or after losing coverage and the applicant must certify that he or she did not intentionally forego coverage. If a waiver is granted, the individual may return to the Connector and complete enrollment.

See also, Health Connector Policy, NG-1E, Mid-Year Life Events or Qualifying events, rev. Jan. 27, 2016

17 How do Special Enrollment Periods (SEPs) affect the start date of coverage?

Most SEPs consist of a 60 day period in which an individual can enroll prospectively by selecting a plan and paying the premium by the 23rd of the month for coverage to begin in the following month. However, certain SEPs may allow for a retroactive effective date.
Advocacy Reminder:
The SEP for the birth or adoption of a child provides for retroactive enrollment in a QHP to the date of birth or adoption. However, a child born to a mother enrolled in ConnectorCare will ordinarily be eligible for MassHealth. If the mother is not on MassHealth, newborn coverage is only retroactive for 10 days from application. The birth to a mother who is not herself enrolled in MassHealth should be reported within 10 days of birth to assure that if the child is eligible for MassHealth, enrollment will go back to the date of birth.

Certain other SEPs allow for a special effective date of coverage based on the circumstances of the SEP and may also be retroactive. They include: enrollment or non-enrollment due to error by the Connector, its agents, or by enrollment assisters, the plan’s material violation of its contract, a MassHealth determination of ineligibility that does not occur until after Connector enrollment periods have expired, other material error, other exceptional circumstances such as hospitalization or a death in the family or, at the option of the Connector, satisfactory verification of eligibility following denial for failure to verify. 45 CFR 155.420(b)(2)(iii). As a practical matter the effective date in these situations is usually worked out through a 3-way negotiation among the applicant/enrollee, Health Connector staff and the health plan. The denial of an SEP is appealable as discussed in a later Q & A.

45 CFR 155.420(b); 956 CMR 12.10

18 How does ConnectorCare work with MassHealth Limited and the Health Safety Net?

The Health Safety Net. The Health Safety Net (HSN) is available to state residents with income that does not exceed 300% FPL using the MassHealth MAGI and income verification rules. Acute care hospitals and community health centers bill HSN for services to HSN-eligible individuals who are uninsured or underinsured. However, if HSN-eligible individuals are also found eligible for ConnectorCare, it will limit their HSN eligibility period. Such individuals will be eligible for HSN from the “medical coverage date” (10 days prior to the date of
Enrollment into an HMO  ■  Part 4

application for those under 65) and for up to 90 days after application. However, since July 2018, the Office of Medicaid has required proof of income for most adults before it approves HSN eligibility and, since then, the 90-day clock starts from the date HSN is approved. See, MassHealth Eligibility Operations Memo 18-02 (July 1, 2018). After that time elapses, or they enroll in ConnectorCare, whichever comes first, they will retain HSN only for adult dental services not covered in ConnectorCare. An individual who fails to enroll in ConnectorCare when eligible to do so will later lose all HSN benefits except for dental.

MassHealth Limited. MassHealth Limited only covers emergency services and doesn’t count as government sponsored MEC. Certain lawfully present non-citizens may be eligible for both MassHealth Limited and ConnectorCare at the same time. These individuals will be non-citizens whose MassHealth MAGI income is at or under 133% FPL and who are lawfully present for purposes of the Health Connector but do not meet MassHealth immigrant eligibility rules for MassHealth Standard or CarePlus.

✓ Advocacy Reminder:

When individuals are found eligible for ConnectorCare and Limited and receive an approval notice from MassHealth and a MassHealth card, they may easily be confused about their coverage. They may not understand that Limited covers only emergencies, and fail to take further action to enroll in ConnectorCare during open enrollment. Language issues may contribute to the confusion. In such situations, it may be possible to obtain a special enrollment period or a waiver from the Office of Patient Protections to enable the individual to enroll in ConnectorCare.

Despite the confusion, there are some advantages to being found eligible for ConnectorCare and Limited: An infant born to a mother eligible for Limited will be automatically enrolled in MassHealth Standard effective on the date of birth; Limited eligibility will be retroactive 10 days prior to the date of application for those under 65 or up to 3 months retroactive from the month of application for those 65 or older, and, for those who do not enroll in ConnectorCare, Limited will be available to cover emergency services even after full Health Safety Net coverage has expired.

101 CMR 613.04(6)(a)(2) (HSN primary and secondary) and (7) (HSN eligibility period) and 613.02 (definition of medical coverage date); MassHealth Eligibility Operations Memo 18-02 (July 1, 2018). 130 CMR 506.006 and 519.009 (Limited eligibility), 450.105(F) (Limited coverage) and 505.002(B)(1)(b) (Newborns).
Part 5
Losing and Regaining Coverage

19 How is ConnectorCare renewed?

ConnectorCare, like MassHealth, has an annual renewal process. In the Health Connector renewal occurs at the same time each year in the run-up to the next open enrollment period for coverage in the following calendar year. In early fall, the Health Connector updates information from available data sources and sends a preliminary determination to all current members with a preview of their income and Plan Type for the following year and a request that individuals update information that may not be correct or no longer an accurate projection for the following year. Individuals may do this directly through an online account or by other means. Mixed households --ConnectorCare members who live in a household with MassHealth members--who need to take action to renew MassHealth, will be sent a single notice from both the Health Connector and MassHealth directing them to complete the MassHealth renewal process. Later in the fall, individuals will receive a final eligibility determination based on updated data or any changes the individual has reported. They will also be notified that they will be renewed into the same ConnectorCare HMO they have now (if it is available in the following year) unless they make a different selection and what their new premium will be.

Loss of subsidy at renewal. If people are no longer eligible for ConnectorCare but remain eligible for a QHP without a subsidy, they will remain enrolled with the same HMO (if it is available in the following year) but at full premium cost.

✓ Advocacy Reminder:
Individuals who lose their subsidies and who have authorized automatic payments for their ConnectorCare premium contribution should be warned to
cancel automatic payments unless they want the full premium amount for an unsubsidized QHP deducted from their bank account.

Current enrollees may lose eligibility for subsidized coverage for a variety of reasons including:

- No income data is available
- The Health Connector is unable to use data matching because the individual has no SSN and the individual did not supply updated income information
- At application, the individual did not authorize on-going data match with IRS for purposes of renewal
- The IRS data match flagged the case for “Failure to Reconcile” (FTR) i.e. failure to file a federal return and reconcile APTC received in prior years
  - IRS privacy rules prevent the Health Connector from explicitly identifying this reason. Notices will include it among a menu of possible reasons why the individual is no longer eligible for subsidies.
- Data show the individual is now enrolled in Medicare, MassHealth or other MEC
- Data show income over 300% FPL (ConnectorCare) or over 400% FPL (PTC with QHP)

Even if individuals remain eligible for ConnectorCare, they may experience a premium increase based on:

- Change in income or family size resulting in higher Plan Type, or
- Current HMO no longer being one of the lowest cost plans for which only the minimum premium contribution is charged

✔ **Advocacy Reminder:**

Many of the problems described above can be remedied by supplying updated information and obtaining a new determination, or taking other steps such as filing a federal return for a past period, or changing to a lower cost plan.

956 CMR 12.07 (Eligibility Review)
Losing and Regaining Coverage ■ Part 5

20 At what other times may individuals lose eligibility?

The Connector may disenroll or terminate an enrollee at any other time during the benefit year for the following reasons:

- For failure to pay enrollee premium contributions as required;
- For fraud or abuse;
  - An enrollee terminated for fraud may be subject to recoupment.
- When the Enrollee no longer meets an eligibility requirement based on a change reported by the enrollee, or a periodic data match initiated by the Connector.

956 CMR 12.07 (eligibility review) 12.10(6) (disenrollment); 12.11 (enrollee premiums); Health Connector Policy NG-, Redeterminations during the Benefit Year, Jan. 2015.

21 How can individuals regain coverage in ConnectorCare?

A notice denying or terminating eligibility or enrollment in ConnectorCare can be appealed within 35 days of the date on the notice. A timely appeal can prevent ongoing benefits from ending while the appeal is pending. A successful appeal can also provide for the reinstatement of benefits wrongly denied. A later Q & A provides more information about resolving disputes and appealing in ConnectorCare.

The Connector has also developed policies to reinstate ConnectorCare back to the termination date for certain specific situations as described below.
Problem: A member was involuntarily terminated from ConnectorCare for failure to pay premiums, failure to supply proof of a qualifying event, or after mail was returned as addressee unknown.

Solution: The member can be reinstated into the same ConnectorCare HMO if, within 35 days of the date on the termination notice, he or she-

- Calls Customer Service and requests reinstatement,
- Supplies any missing information such as proof of the qualifying event or a new address, and
- Pays any premium balance due and the next month’s premium.

Problem: A member was enrolled in a ConnectorCare HMO. The Health Connector sends a request for information needed to determine if the individual is still eligible for subsidized coverage to which the member does not reply by the deadline. The Health Connector makes a new decision terminating coverage for subsidized coverage but leaving the member enrolled with the same HMO at full premium cost. The member cannot afford the higher premium and is terminated for non-payment.

Solution: The member can be relieved of the full premium amount owed to the HMO and reinstated into the same ConnectorCare HMO if, within 35 days of the date of the termination notice, he or she-

- Provides the missing information and it shows he or she is still eligible for ConnectorCare,
- Calls Customer Service and requests reinstatement, and
- Pays the amount of any ConnectorCare premium contribution for the balance due and the next month’s coverage.

22 What happens when MassHealth members become eligible for ConnectorCare?

Sometimes when people are no longer eligible for MassHealth, they may become eligible for ConnectorCare. This might be based on an increase in income, decrease in family size, or a change in age, health status or immigration status. In this situation, MassHealth will time the termination of benefits for the last day of the month, or the end of the following month to allow time for ConnectorCare enrollment. To avoid a gap in coverage, the individual must select a plan and pay any premium due by the 23rd of the month to be enrolled in ConnectorCare by the first of the following month. 130 CMR 502.006(D).

✓ Advocacy Reminder:
If parents living with children under 19 have an increase in earned income that puts them over 133% FPL, there is a special work incentive program called Transitional Medical Assistance (TMA) that will continue the family’s MassHealth Standard coverage for 12 months. 130 CMR 505.002(L)(3). At the end of the 12 months, MassHealth will send a form seeking updated income information and if family income is not over 300% FPL and the parents do not have other Minimum Essential Coverage, they should transition to ConnectorCare and the children to Family Assistance. The children will be exempt from a Family Assistance premium if their parents are paying a premium for ConnectorCare. 130 CMR 506.012(J)(4)
Part 5 ■ Losing and Regaining Coverage
23 What health services are available in ConnectorCare?

ConnectorCare provides comprehensive benefits through participating managed care organizations comparable to commercial insurance plans for individuals and small employers. See the ConnectorCare Overview in Appendix 3 for the list of benefits and copays by Plan Type in 2019. ConnectorCare benefits are similar to the benefits in MassHealth CarePlus. However, ConnectorCare, unlike CarePlus, does not include a dental benefit for adults, or non-emergency transportation. See the Table in Appendix 4 comparing ConnectorCare with CarePlus.

ConnectorCare has three plan types for purposes of co-payment levels. Plan Types 1, 2, and 3 each have a different schedule of copayments, but the required benefits in all plan types are the same. Plan Type 1 is for individuals under the poverty level and has the lowest copays; Plan Type 2 is for those with income over 100% FPL and up to and including 200% FPL; and Plan Type 3 is for those with income over 200% FPL up to and including 300% FPL with the highest copays. There are no deductibles in ConnectorCare.

The Connector’s annual “seal of approval” process requires plans to offer at least all “Essential Health Benefits” required under the ACA set to specified cost-sharing levels. The Connector executes a contract with each ConnectorCare HMO. The Department of Insurance must approve the Evidence of Coverage (EOC) prepared by each HMO as the official description of benefits for members. New members are sent a member handbook with this information. It can also be found on the carriers’ websites along with a Summary of Benefits and Schedule of Benefits. Advocates should look to the EOC for the most detailed account of covered benefits. Links to the ConnectorCare HMO’s websites are shown in the Resource section.
Part 6 ▬ Covered Services and Costs

45 CFR 155, Subpart K and 45 CFR 156, Subpart C (QHP minimum standards); 956 CMR 5.00 (Minimum Creditable Coverage). G.L. c. 176J.

24 How does ConnectorCare deliver health services?

ConnectorCare delivers services exclusively through Health Maintenance Organizations (HMOs). Participating HMOs are selected annually based on what the Health Connector calls its “seal of approval” process. In 2019, there are five HMOs available in ConnectorCare:

- BMC HealthNet Plan,
- Tufts Health Plan Direct,
- Fallon Health,
- Health New England, and
- Allways Health Partners (formerly Neighborhood Health Plan).

These are referred to as ConnectorCare plans in Health Connector notices and on the HMOs’ plan cards. Other individual plans available through the Health Connector are referred to as Qualified Health Plans (QHPs) or Health Connector Plans not as ConnectorCare plans.

Unlike MassHealth, ConnectorCare has no fee-for-service system or Primary Care Clinician Plan or Accountable Care Organizations (ACOs). However, there has always been significant overlap between Connector subsidized plans and MassHealth. In 2019, all five of the ConnectorCare HMOs also participate in MassHealth as MassHealth HMOs, as Accountable Care Partnership Plans or as both.

✔ Advocacy Reminder:
If individuals are not sure whether they are enrolled in MassHealth or ConnectorCare, ask them to look at their plan card. The HMO card with the name of the health plan will also show the ConnectorCare name and logo if it
is a ConnectorCare plan. Low income immigrants may have both a blue
MassHealth card (for MassHealth Limited) and a ConnectorCare HMO card.

Each HMO has a network of participating hospitals and other providers, and
enrollees are restricted to its network of providers. Because the required benefits
of each ConnectorCare plan are the same, and all charge the same co-payments
by Plan Type, the primary basis for selecting one HMO over another is whether it
is available in the member’s service area, the required premium contribution, and
the HMO’s network of participating providers.

The Connector Seal of Approval process encourages plans to compete based on
price. The HMO providing the standard ConnectorCare benefits at the lowest
price to the Health Connector will be available to members at the lowest enrollee
premium contribution. Members will have to pay a higher premium contribution
for selecting an HMO that charges a higher cost to the Health Connector for
providing the same benefits.

ConnectorCare plans are subject to state insurance laws and enrollees are
protected by consumer protections as described in a later Q & A on resolving
disputes.

25 How much does ConnectorCare cost?

The ACA established income-based premium and cost-sharing standards, but
these minimum federal standards would have resulted in coverage that was less
affordable than the former Commonwealth Care program administered by the
Health Connector from 2006-2014. In order to maintain affordable coverage for
individuals with income not over 300% FPL, Massachusetts contributes added
state-funded subsidies towards the costs of ConnectorCare.

There are two kinds of member costs in ConnectorCare: Monthly premium
contributions and copayments. Monthly premium contributions are paid directly
to the Connector and it distributes the member contribution and state subsidies to
the insurance plans. Federal advance premium tax credits are sent directly from
the IRS to the health plans. Member premium contributions vary by income/plan
type, by choice of HMO, and by region. Premiums are per member per month.
Copayments are charges to the member that are collected by the provider at the point of delivering certain services. Once copays reach the annual out of pocket maximum or cap, the member is relieved from further copays for the year. Copayments vary only by income/plan type. ConnectorCare HMOs do not have deductibles or coinsurance. The following costs are in effect through December 31, 2019 and also shown in the ConnectorCare Overview in Appendix 3:

- Gross family income does not exceed 100% FPL (Plan Type 1)—
  - At least one HMO with no premium charge; in many regions there is a choice among two HMOs with no premium charge; premium charges for other HMO choices;
  - Copayments no higher than MassHealth, i.e., $3.65 for most drugs, $250/$500 (individual/family) annual cap for drug copayments.

- Gross family income over 100 but not over 150% FPL (Plan Type 2A)—
  - At least one HMO with no premium charge; in many regions there is a choice among two HMOs with no premium charge; premium charges for other HMO choices;
  - Copayments less than in average commercial plans, e.g., $10 for an office visit. Maximum medical out of pocket $750/$1500 (individual/family); maximum drug out of pocket $500/$1000.

- Gross family income over 150 but not over 200% FPL (Plan Type 2B)—
  - At least one HMO for $44 per month; higher premiums for other HMO choices;
  - Copayments higher than Plan Type 2 e.g., $15 for an office visit; maximum medical out of pocket $1500/$3000 (individual/family), maximum drug out of pocket $750/$1500.

- Gross family income over 200 but not over 250% FPL (Plan Type 3A)—
  - At least one HMO for $85 per month; higher premium for other HMO choice;
  - Copayments same as Plan Type 2A.

- Gross family income over 250 but not over 300% FPL (Plan Type 3B)—
  - At least one HMO for $126 per month; higher premium for other HMO choice;
  - Copayments same as Plan Type 3B.
The minimum premium contribution and copayment and benefits schedules are determined annually by the Board of the Connector and published by posting on [www.mahealthconnector.org](http://www.mahealthconnector.org). Premiums and copayments are adjusted annually for the benefit year (Jan 1 to Dec 31).

956 C.M.R. 12.04 (Plan Types) See Appendix 3 for the copayment schedules through Dec 31, 2019.

### 26 What happens if a person cannot afford the premiums in ConnectorCare?

After an eligibility determination, a person who will be charged a premium cannot enroll until paying the premium or obtaining a hardship waiver in advance of the first month of enrollment. Enrollment will take place only after the premium is paid or the premium waiver is granted. The first month’s premium is the “binder” premium and it must be received (or waived) to “effectuate” enrollment.

After initial enrollment, members will receive an invoice early in the month with a due date by the 23rd of the month for coverage in the following month. The Connector does not currently accept credit card payments, but does accept electronic fund transfers. See, [https://www.mahealthconnector.org/how-to-pay](https://www.mahealthconnector.org/how-to-pay).

If a payment is missed by the due date, the enrollee receives an initial delinquency notice. If a second payment is missed by the due date, the enrollee will be notified that if payment is not received in full by the “delinquency payment date” which must be no less than 35 days from the second delinquency notice, coverage will be terminated. If the delinquency payment date is missed, the Connector sends a termination notice retroactive to the last day of the first unpaid month (30 day grace period).

*Example:* Payment missed Mar 23, 1st delinquency notice in early April. Payment missed April 23, 2d delinquency notice in early May and warning of termination if not paid in full by “delinquency payment due date” in June (must be at least 35 days from May notice). Payment not made in full by delinquency payment date. June notice of termination for nonpayment of premiums retroactive to April 30. Payment for four months’ premiums will be required.
Part 6  ■ Covered Services and Costs

to reinstate coverage (past due amounts for coverage in April, May and June and advance payment for July).

An enrollee terminated for non-payment may reinstate coverage within 35 days of the termination notice if all outstanding premiums are paid along with the next month’s premium. The termination notice will include reinstatement information including the date by which the Health Connector must receive the request and full payment.

If the individual fell behind because of a decrease in income, or increase in family size (or other change in circumstance that may affect eligibility), he or she should notify the Connector so that a new determination can be made that may reduce or eliminate future premium contributions.

If the premium is due but the individual is experiencing an extreme financial hardship, he or she can request a waiver of premium payments for the duration of the hardship situation for up to 11 months at a time. The Health Connector has a request form for this purpose that can be obtained by calling Customer Assistance. The Connector may waive or reduce the amount of future premium contributions or arrears. The following circumstances are considered hardships if the enrollee:

- is homeless, more than 30 days behind in housing payments or has received eviction or foreclosure notices within the last 60 days;
- has a current shut-off notice or service refusal for an essential utility within the last 60 days;
- has incurred significant unexpected increase in essential expenses in the last six months due to domestic violence, death of a spouse, family member or partner with primary child care responsibility, major illness of a child requiring a working parent to hire a full time child care worker or other natural or human-caused event causing substantial household or personal damage or
- has filed for bankruptcy within the last 12 month and debts are not yet discharged.

Approval of a premium hardship waiver or expiration of a waiver gives rise to a 60 day SEP to change plans.
A member may withdraw from ConnectorCare but remains liable for any premium up to and including the month in which he or she notifies the Connector of withdrawal.

956 C.M.R. § 12.11(Enrollee Premium Contributions); Health Connector Policy #NG-6B, Termination of Coverage-Non-Payments of Premium, 3/1/2019
Part 7
Appeals and Reconciliation

27 How do you resolve disputes in ConnectorCare?

There are two different paths for resolving disputes in ConnectorCare depending on whether the adverse decision was made by the Health Connector, or the ConnectorCare plan.

If the dispute is with an action or failure to act by the Health Connector, in most cases, the first step will be to attempt to resolve a dispute informally through the customer service office. When customer service is unable to satisfactorily resolve a dispute, it can be “escalated” to the Health Connector Ombudsman. Certain disputes with the Health Connector can also be appealed to the Health Connector Appeals Unit. Individuals must be careful not to let appeal deadlines expire while trying to resolve a case informally.

If the dispute is with an action of the managed care plan, the first step will similarly be to attempt to resolve the matter with the plan’s customer service office. However, the plans all have formal procedures for resolving disputes internally and an enrollee must pursue the plan’s internal appeal process before he or she can appeal to the Office of Patient Protection.

In addition, individuals who are disputing the decision finding them eligible for ConnectorCare instead of MassHealth or finding them ineligible for either program may file appeals from the decisions of both agencies. Each agency is required to coordinate appeals by transmitting information to the other agency in order to minimize the burden on the appellant. 45 CFR 155.510

Appealing decisions made by the Connector. Applicants and enrollees have a right to a hearing to appeal from the following decisions by the Connector:
- Any adverse decision concerning any ConnectorCare eligibility factor, (see Q & A above Who is eligible for ConnectorCare?)

- Any decision concerning the amount of any premiums due or assignment to a Plan Type

- The Connector’s denial of a premium waiver or reduction based on financial hardship

- The Connector’s denial of a special enrollment period to enroll in a plan or change plans outside of the open enrollment period

- The Connector’s failure to give timely notice of decision

956 CMR 12.12 and 45 CFR 155.505 (b)(Right to appeal)

**Appealing decisions made by a ConnectorCare plan.** Most disputes about access to and payment for a particular medical service should be raised in the first instance with the ConnectorCare HMO. Each HMO has a grievance/appeal process for resolving such disputes that is described in the member handbook. If a dispute about the medical necessity of a covered service cannot be resolved with the HMO, an enrollee is entitled to an external appeal. In some cases it may also be helpful to bring such a dispute to the attention of the Connector legal office if it appears that a plan’s actions may be in violation of its contractual obligations to the Connector.

ConnectorCare plans are subject to state insurance regulation and enrollees are entitled to the consumer protections of the state managed care law. After an individual has exhausted the plan’s internal appeal process, there is a further appeal to the Office of Patient Protections (OPP) under the state managed care law. Since 2013, the OPP has operated under the Health Policy Commission. The OPP can resolve disputes over whether a service is medically necessary including whether the service requires an out of network provider. In most cases ongoing treatment can be continued pending appeal. There is also a consumer complaint process with the Department of Insurance.

G.L. c. 176O (Health Insurance Consumer Protections); 211 CMR 52, Division of Insurance, Managed Care Consumer Protections; 958 CMR 3.0, Health Policy Commission, Health Insurance Consumer Protections (includes requirements for carriers’ internal grievance procedures and the requirements for external reviews of carriers’ medical necessity adverse determinations), and Office of Patient Protection sub-regulatory guidance, bulletins and memos available at https://www.mass.gov/service-details/hpc-regulations-and-guidance.
28  How do you appeal a decision by the Health Connector?

For most issues subject to appeal, the Connector will send a written notice of its decision, the reason for its decision, appeal rights and a form for appealing the decision. It must receive the request for appeal within 30 days of the date that the individual receives the adverse notice. It presumes the individual received the notice within 5 days of mailing. In an appeal from an action taken without notice, the individual has 120 days from the date of the action or failure to act to appeal. 956 CMR 12.13

The Appeals Unit receives and reviews appeals but individual appeals are heard by private attorneys under contract with the Health Connector. Appeals are generally conducted by telephone and use the procedures for informal hearings set out in 801 CMR 1.02.

A decision of the hearing officer is final unless the director of the Appeal Unit orders a re-hearing for good cause either at the request of the appellant or on her own initiative. A request for re-hearing stays the initial decision of the hearing officer for purposes of judicial review until a decision is made by the director or her designee. 956 CMR 12.15

Fair hearing decisions by the Connector are subject to judicial review under G.L. c. 30A section 14.

Federal regulations also provide a right to appeal to the HHS Appeals Entity within 30 days of a final decision from the Connector hearing officer. 45 CFR 155.520(c). The Federal Appeals Entity also hears appeals from the 38 states that do not have a state-based Marketplace like Massachusetts and instead use the Federal Marketplace.

29  What happens after an appeal is filed?

If benefits are reduced or terminated at the annual redetermination or after a redetermination based on a report of a change or periodic data match the appellant
Part 7 ■ Appeals and Reconciliation

is entitled to have benefits continued pending appeal at the level of benefits prior to the redetermination. Aid pending appeal is available so long as the member filed a valid appeal received by the Connector within 35 days of the date on the notice. 45 CFR 155.525. However, if the appeal is unsuccessful, the appellant may have to repay advance premium tax credits received pending appeal through the reconciliation process described in Q & A 30.

The appellant is entitled to at least 15 days’ notice of the hearing unless he or she has asked for an expedited appeal. The appellant has the right to review the case file and all information to be presented at the hearing in advance. At the hearing, the appellant may bring witnesses, and cross-examine witnesses. The appeal is de novo meaning that the hearing officer considers not just evidence used in making the initial decision but all additional evidence presented at the hearing relevant to the issue on appeal. 45 CFR 155.535.

The appeal decision must be in writing, based on the evidence and the applicable regulations, and must ordinarily be issued within 90 days of the appeal request, or in the case of an expedited appeal, as soon as possible.

Upon receiving the decision, the Connector must implement the decision on the first of the following month or an earlier date as determined by the hearing officer. The hearing officer may order a retroactive enrollment date, however, the appellant may elect not to have a retroactive effective date. For example, the appellant may not want to pay premiums for a past period in which he or she incurred no medical expenses, and may instead elect a future effective date. The Connector must also redetermine the eligibility of other household members who did not appeal but whose eligibility may be affected by the decision. 45 CFR 155.545.

30 How are the amounts of advance premium tax credits reconciled with the amounts due?

The Health Connector calculates the amount of available advance premium tax credits (APTC) by using information about the individual’s expected income and expected tax household for the calendar year in which the person is enrolled in subsidized coverage. The eligibility notice will identify the maximum amount of the premium tax credit on a monthly basis and the individual can choose whether
to take the full amount or a smaller amount in advance. The Health Connector
then notifies the IRS how much APTC should be sent directly to the insurance
company on the member’s behalf. Electing to take less than the maximum
available APTC will increase the amount of the member’s monthly premium
contribution. An individual making this choice will be able to collect the full
premium tax credit amount when he or she files a federal tax return.

In the following year, the Health Connector sends out federal tax form 1095-A
which shows the amount of APTC paid on behalf of the members of the tax
household for the prior year. The tax filer needs this form to complete IRS Form
8962 Premium Tax Credit. On form 8962 the tax filer will list his or her actual
adjusted gross income as shown on the tax return together with the added non-
taxable income counted for MAGI purposes and certain other information about
the premium cost of a reference plan (the second lowest cost silver plan) to
calculate the amount of Premium Tax Credit he or she was actually due. The tax
filer may be due a larger credit than the amount he or she received in advance or
the tax filer may have received a larger credit in advance then he or she was due.
In the latter case, the individual will have an added tax liability.

For individuals who received an excess payment, repayment amounts will be in
the amount of the excess payment up to a capped amount for those with income
not over 400% FPL as shown in the Table below

<table>
<thead>
<tr>
<th>Cap on Repayment of Excess APTC Based on Income</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income as % of FPL</td>
</tr>
<tr>
<td>&lt;200%</td>
</tr>
<tr>
<td>≥200%&lt;300%</td>
</tr>
<tr>
<td>≥300%&lt;400%</td>
</tr>
<tr>
<td>&gt;400%</td>
</tr>
</tbody>
</table>

Married taxpayers who filed separately based on abuse or abandonment must
check a box on Form 8962 to identify themselves as exempt from the married
filing jointly requirement for APTC eligibility.

If an individual fails to file a federal return for the year in which he or she
received an APTC along with Form 8962, the IRS will relay this information to
the Health Connector at the time of open enrollment for the following year. An individual who is flagged for “failure to reconcile” will not be eligible for ConnectorCare until he or she files a return along with Form 8982 for the relevant year. (Tax privacy laws limit the information available to the Health Connector, therefore the notice will include failure to reconcile as only one of several possible reasons for loss of subsidy eligibility). Once the individual files the required tax forms, the individual may then attest to the Health Connector that he or she has filed, and the individual may once more be eligible for ConnectorCare. However, if the Connector cannot verify the tax filing by a later data match with IRS, the individual may again lose ConnectorCare/APTC.

IRS Form 8962 and Instructions for IRS Form 8962.
Part 8
Additional Resources

The Massachusetts Health Connector Authority

Health Connector Main Website: https://www.mahealthconnector.org

Health Connector Help Center webpage (Hours and locations of walk-in centers; name, telephone & website of Navigator organizations, link to site where you can enter zip code and find Navigator or certified application counselor near you)
https://www.mahealthconnector.org/help-center/health-connector-walk-in-centers

Health Connector Administrative Offices (including Appeals Unit)

100 City Hall Plaza
Boston, MA 02108
617-933-3030


Health Connector Walk-In Center Locations

**Boston**
133 Portland Street
Boston, MA 02114

**Brockton**
63 Main Street
Brockton, MA 02301

**Springfield**
88 Industry Avenue
Springfield, MA 01104

**Worcester**
146 Main Street
Worcester, MA 01608
Website for contacting the Health Connector Ombudsman Office
https://www.mahealthconnector.org/about/contact#contact-ombudsman

Health Connector website with information and links for all plans
https://www.mahealthconnector.org/learn/plan-information/health-dental-insurance-carriers

All the carriers offering ConnectorCare plans also offer other insurance plans. Check that the information on the carrier’s website applies to its ConnectorCare plans.

**ConnectorCare Health Plan (2019)**

**AllWays Health Partners**  Complete HMO ConnectorCare 0/0 (Plan Type 1); Complete ConnectorCare 10/18 (Plan Type 2); Complete HMO ConnectorCare 15/22 (Plan Type 3)
https://www.allwayshealthpartners.org/explore-plans/you-and-your-family/connector#_panel1
Customer Service: 866-414-5533

**Boston Medical Center HealthNet Plan**, ConnectorCare I, II, and III
https://www.bmchp.org/I-Am-A/Member/Documents-and-Forms/Benefit-Documents
Customer Service: 855-833-8120

**Fallon Health**, Community Care Network HMO ConnectorCare Wrap Type I, II and III
https://www.fchp.org/plandocs
Customer Service: 800-868-5200

**Health New England**, HMO ConnectorCare 1, 2 and 3
http://healthnewengland.org/2019-Connector-Plans
Customer Service: 413-787-4004
Toll-free: 800-310-2835

**Tufts Health Plan Direct**, ConnectorCare Plans I, II, and III
https://tuftshealthplan.com/explore-our-plans/tufts-health-direct
Customer Service for Tufts Health Direct Members: 888-257-1985
MassHealth

MassHealth Customer Service: 800-841-2900
MassHealth website: mass.gov/masshealth
MassHealth Training Forum (MTF) website: https://www.masshealthmtf.org/

State Organization Websites

Legal Resource Finder website to locate free legal services nearby: https://www.masslegalservices.org/FindLegalAid
Masslegalservices.org (information for advocates)
Masslegalhelp.org (information for consumers)
Health Care for All (HCFA) website: hcfama.org
HCFA Help Line: 800-272-4232 (617-350-7279)
SHINE (Serving the Health Information Needs for Everyone) https://www.mass.gov/health-insurance-counseling
To schedule an appointment call (800) 800-243-4636. Press 3 or press 5 if calling from cell phone to be connected with your local SHINE counselor.

Low-income tax clinics

Low income taxpayer clinics (LITC) offer free help with tax problems for people with income under 250% of the federal poverty level.

Greater Boston Legal Services Low Income Tax Clinic
Address: 197 Friend Street, Boston, MA 02114
Phone: (800)323-3205; (617)371-1234
Website: https://www.gbls.org/our-work/employment/employment-direct-client-services

Legal Services Center of Harvard Law School LITC
Address: 122 Boylston Street, Jamaica Plain, MA 02130
Phone: (866)738-8081; (617)522-3003
Website: http://www.legalservicescenter.org/about-the-legal-services-center/our-clinics/
Part 8 ■ Additional Resources

Springfield Partners LITC
Address: 721 State Street, Springfield, MA 01109
Phone: (413)263-6500
Website: http://www.springfieldpartnersinc.com/whatwedo/litc/

Bentley University Low Income Taxpayer Clinic
Address: 175 Forest Street, MOR 133, Waltham, MA 02452
Phone: (800)273, 9494; (781)891-2083 (intake phone number)

National Organization Websites

Center on Budget and Policy Priorities, Beyond the Basics website
https://www.healthreformbeyondthebasics.org/

The Health Care Assisters Guide to Tax Rules,

<table>
<thead>
<tr>
<th>Population/Program</th>
<th>Seniors (MassHealth Standard)</th>
<th>Adults under 65 (MassHealth Standard or MassHealth CarePlus)</th>
<th>Children &amp; Young Adults under Age 21 (MassHealth Standard) Full Health Safety Net</th>
<th>Pregnant women &amp; infants (MH Standard); HIV+ individuals (MassHealth Family Assistance)</th>
<th>MassHealth Family Assistance (Children under 19); Small Business Premium Assistance, Partial Health Safety Net with a deductible</th>
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<tbody>
<tr>
<td>Percent of federal poverty</td>
<td>100% (plus $20 mo. disregard)</td>
<td>133%+ 5%</td>
<td>150%+5%</td>
<td>200%+5%</td>
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<td>$414.95</td>
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<td>$566.35</td>
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<tr>
<td>4</td>
<td>$2,166</td>
<td>$499.88</td>
<td>$2,962</td>
<td>$683.59</td>
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<td>$3,470</td>
<td>$800.83</td>
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<td>$669.97</td>
<td>$3,979</td>
<td>$918.30</td>
<td>$4,469</td>
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<tr>
<td>7</td>
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<td>$754.90</td>
<td>$4,487</td>
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<td>$840.06</td>
<td>$4,995</td>
<td>$1,152.78</td>
<td>$5,610</td>
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</table>

For people under 65 in MassHealth, Children’s Medical Security Plan (CMSP) & Health Safety Net (HSN), eligibility is based on current monthly Modified Adjusted Gross Income (MAGI); programs that use the new 5% of poverty guideline income deduction are shown in this table as 5% FPG higher than the standard e.g. the 133% standard is shown as 138%. Monthly amounts are rounded; weekly amounts are monthly amounts divided by 4.333.

Add the fetus to the family size of pregnant women in MassHealth, CMSP & HSN but not for the Connector.
For Seniors, eligibility is based on countable monthly income after deductions and there is an asset test. For Seniors, a $20 per monthly standard disregard is added to the 100% FPG standard in this table; the 5% MAGI deduction does not apply. The Senior deductible income standard is $522 per mo. for an individual; $650 per mo. for a couple. The income standard for an institutionalized individual is $72.80 per month.
<table>
<thead>
<tr>
<th>Population/Program</th>
<th>March 1, 2019 to February 29, 2020</th>
<th>2018 FPLs are used for coverage in Jan - Dec 2019</th>
<th>ConnectorCare</th>
<th>Qualified Health Plans with Premium Tax Credits</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Percent of federal poverty</strong></td>
<td>250% +5%</td>
<td>400% + 5%</td>
<td>100%</td>
<td>150%</td>
</tr>
<tr>
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<tr>
<td><strong>Each addtl.</strong></td>
<td>$940</td>
<td>$1,493</td>
<td>$344.56</td>
<td>$4,320</td>
</tr>
</tbody>
</table>

For ConnectorCare & Qualified Health Plans with Premium Tax Credits, eligibility is based on expected annual MAGI income with no 5% of poverty level income deduction. 2018 FPL levels are used for coverage in 2019.

Children with income over 405% of the poverty level can buy-in to the Children's Medical Security Program (CMSP) at full cost. There is no income upper limit or deductible for disabled children or working disabled adults in CommonHealth.

The CommonHealth deductible income standard for nonworking adults is $542 per mo. for one person & $670 for a couple.

The upper income level for PACE and other home & community based waiver programs is $ 2,313 monthly in 2019.

The 2018 poverty levels were published in the Jan. 31, 2018 Federal Register, 82 FR 8831.

The 2019 poverty guidelines were published in the Feb 1, 2019 Federal Register 84 FR 1167.

Massachusetts Law Reform Institute, www.mlri.org, Feb. 6, 2019
Appendix 2: Lawfully Present Non-Citizens

All Lawfully Present non-citizens are eligible for Health Connector plans in the same way as US citizens. The terms Qualified and Qualified Barred are terms used in MassHealth affecting eligibility of adults for certain types of MassHealth. These terms are not relevant to the Health Connector where both Qualified and Qualified Barred Non-Citizens are Lawfully Present.

Lawfully Present and also Qualified or Qualified Barred

- Lawful permanent resident (LPR/Green Card holder)
- Asylee
- Refugee
- Cuban/Haitian entrant
- Person paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered spouse, child, or parent
- Victim of trafficking and his or her spouse, child, sibling, or parent
- Person granted Withholding of Deportation or Withholding of Removal, under the INA
- Member of a federally recognized Indian tribe or American Indian born in Canada

Lawfully Present but not Qualified or Qualified Barred

- Person paroled into the US for less than one year
- Person granted Withholding of Deportation or Withholding of Removal under the Convention against Torture (CAT)
- Individual with valid non-immigrant status (including student visas (F-visa), crime victims (U-visa), specialty workers (H-visa), religious workers (R-visa) and others)
- Temporary Protected Status (TPS)
- Deferred Enforced Departure (DED)
- Deferred Action Status (except Deferred Action for Childhood Arrivals (DACA); they are Nonqualified PRUCOL under MassHealth rules)
• Applicant for:
  o Special Immigrant Juvenile Status
  o Adjustment to LPR Status with an approved visa petition
  o Asylum who has either been granted employment authorization, OR is under 14 and has had an application for asylum pending for at least 180 days.
  o Withholding of Deportation or Withholding of Removal, under the INA or under the CAT who has either been granted employment authorization, OR is under 14 and has had an application for withholding of deportation or withholding removal under the immigration laws or under the CAT pending for at least 180 days.

• Individuals with employment authorization under 8 CFR 274a.12(c) including:
  o Registry applicants
  o Those under an Order of supervision
  o Applicants for Cancellation of Removal or Suspension of Deportation
  o Applicants for Legalization under IRCA
  o Applicants for Temporary Protected Status (TPS)
  o Persons granted legalization under the LIFE Act

• Lawful temporary resident granted under legalization program (8 USC 1160 or 1255a)

• Granted an administrative stay of removal by the Department of Homeland Security (DHS)

For Additional information on Immigrant eligibility –

Understanding the Affordable Care Act: Non-citizens’ eligibility for MassHealth & other subsidized health benefits, (MLRI March 2018),
https://www.masslegalservices.org/content/understanding-immigrants-eligibility-masshealth-other-subsidized-coverage-2018

Description of documents, how to find codes from different documents and photos of sample documents (link from Getting Started Guide on mahealthconnector.org):
https://betterhealthconnector.com/immigration-document-types

Definition of Lawful Presence: 45 CFR 155.20, 152.2, and 155.305; 956 CMR § 12.05.

MassHealth Definition of Lawful Presence: 130 CMR 504.003 (A)(1)(2) and (3); 504.006(A) and (B) (under 65); 130 CMR 518.003(A)(1)(2) and (3); 518.006 (A) and (B) (65 & older).
Appendix 3:
ConnectorCare Overview

ConnectorCare Health Plans:
Affordable, high-quality coverage from the Health Connector

ConnectorCare plans have low or low monthly premiums, low out-of-pocket costs, and no deductibles.

What kind of coverage do you get with ConnectorCare?

ConnectorCare plans offer great coverage with important benefits like doctor visits, prescription medications, and emergency care. ConnectorCare plans have low monthly premiums, low co-pays, and no deductibles. There are different ConnectorCare Plan Types, which are based on your income. All of the plans offered for each Plan Type will have the same benefits and co-pays for covered services. You can see the co-pays for different services in the chart on the next page. You can also see examples of the monthly premiums for each Plan Type.

ConnectorCare plans are offered by some of the leading insurers in the state. Each insurer’s plan may have different doctors or hospitals in their provider networks. Before you enroll, use our online tools to see if it is possible for you to see the doctors or hospitals in the plan’s network. You can find these tools at: PlanFinder.MAhealthconnector.org.

Who can qualify for a ConnectorCare plan?

People with household incomes that are at 300% of the Federal Poverty Level (FPL) or lower may qualify for ConnectorCare. If your income is higher than 300% of the FPL, you won’t qualify for a ConnectorCare plan. However, you may still be able to get tax credits that help to lower the cost of your monthly premiums. To qualify for a ConnectorCare plan, you will need you will also need to meet the following requirements:

- Live in Massachusetts
- Be a US Citizen, National, or lawfully present immigrant in the United States
- Not have access to an employer’s affordable, comprehensive health insurance (including plans you are offered, but are not enrolled in)
- Not be in jail or prison
- Not qualify for Medicare, MassHealth (Medicaid) or other public health insurance programs

Which ConnectorCare plan can you qualify for?

The cost of ConnectorCare plans differ depending on the health insurer and the Plan Type. The Plan Type you qualify for is based on your income. The chart on the right shows the FPL ranges for different ConnectorCare Plan Types.

<table>
<thead>
<tr>
<th>Household Size</th>
<th>300% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$36,420</td>
</tr>
<tr>
<td>2</td>
<td>$49,360</td>
</tr>
<tr>
<td>3</td>
<td>$62,340</td>
</tr>
<tr>
<td>4</td>
<td>$75,300</td>
</tr>
</tbody>
</table>

For each additional person in the household, add $12,960

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>FPL Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Type 1</td>
<td>0 - 100% FPL</td>
</tr>
<tr>
<td>Plan Type 2A</td>
<td>100.1 - 150% FPL</td>
</tr>
<tr>
<td>Plan Type 2B</td>
<td>150.1 - 200% FPL</td>
</tr>
<tr>
<td>Plan Type 3A</td>
<td>200.1 - 250% FPL</td>
</tr>
<tr>
<td>Plan Type 3B</td>
<td>250.1 - 300% FPL</td>
</tr>
</tbody>
</table>

There are different coverage options for American Indians and Alaska Natives. American Indians and Alaska Natives may qualify for lower out-of-pocket costs through ConnectorCare plans and other Health Connector plans. Visit MAhealthconnector.org to learn more.
## Lowest-cost ConnectorCare Plan Premiums in 2018

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan Type 1</th>
<th>Plan Type 2A</th>
<th>Plan Type 2B</th>
<th>Plan Type 3A</th>
<th>Plan Type 3B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lowest Cost Plan</td>
<td>$0</td>
<td>$0</td>
<td>$44</td>
<td>$85</td>
<td>$126</td>
</tr>
</tbody>
</table>

## ConnectorCare Benefits & Co-pays

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Plan Type 1</th>
<th>Plan Types 2A &amp; 2B</th>
<th>Plan Types 3A &amp; 3B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Maximum Out-of-Pocket (Individual/ Family)</td>
<td>$0</td>
<td>$750/$1,500</td>
<td>$1,500/$3,000</td>
</tr>
<tr>
<td>Prescription Drug Maximum Out-of-Pocket (Individual/ Family)</td>
<td>$250/$500</td>
<td>$500/$1,000</td>
<td>$750/$1,500</td>
</tr>
<tr>
<td>Preventive Care/Screening/Immunization</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Primary Care Visit to treat Injury or illness (exc. Well Baby, Preventive and X-rays)</td>
<td>$0</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>Specialist Office Visit</td>
<td>$0</td>
<td>$10</td>
<td>$22</td>
</tr>
<tr>
<td>Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services</td>
<td>$0</td>
<td>$10</td>
<td>$15</td>
</tr>
<tr>
<td>Rehabilitative Speech Therapy</td>
<td>$0</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Rehabilitative Occupational and Physical Therapy</td>
<td>$0</td>
<td>$10</td>
<td>$20</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>$0</td>
<td>$50</td>
<td>$100</td>
</tr>
<tr>
<td>Outpatient Surgery</td>
<td>$0</td>
<td>$50</td>
<td>$125</td>
</tr>
<tr>
<td>All Inpatient Hospital Services (including Mental/Behavioral Health and Substance Abuse Disorder Services)</td>
<td>$0</td>
<td>$50</td>
<td>$250</td>
</tr>
<tr>
<td>High Cost Imaging (CT/PEI Scans, MRIs, etc.)</td>
<td>$0</td>
<td>$30</td>
<td>$60</td>
</tr>
<tr>
<td>Laboratory Outpatient and Professional Services</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>X-Rays and Diagnostic Imaging</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>$0</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Retail Prescription Drugs:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generics</td>
<td>$1</td>
<td>$10</td>
<td>$12.50</td>
</tr>
<tr>
<td>Preferred Brand Drugs</td>
<td>$3.65</td>
<td>$20</td>
<td>$25</td>
</tr>
<tr>
<td>Non-Preferred Brand Drugs</td>
<td>$3.65</td>
<td>$40</td>
<td>$50</td>
</tr>
<tr>
<td>Specialty High Cost Drugs</td>
<td>$3.65</td>
<td>$40</td>
<td>$50</td>
</tr>
</tbody>
</table>

### Questions?

- You can find more information about ConnectorCare on our website at [MAhealthconnector.org](http://MAhealthconnector.org).
- Get free, in-person help. There are many places where you can get free, in-person help with applying and enrolling. Everyone can get help—even if you don’t have low income. For a list of places to get help near you, go to [www.MAhealthconnector.org/here-to-help](http://www.MAhealthconnector.org/here-to-help).

**ATENCIÓN:** si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-623-6766 (TTY: 1-877-623-7773).  

Appendix 4:
Table Comparing MassHealth CarePlus and ConnectorCare (2019)

<table>
<thead>
<tr>
<th>Criteria</th>
<th>CarePlus</th>
<th>ConnectorCare</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residence: Living in state with intent to reside; or entered for work or seeking work. Fixed address not required.</td>
<td>G.L. 118E:8; 42 CFR 435.503; 130 CMR 503.007</td>
<td>45 CFR 155.305(a)(3); 956 CMR 12.03</td>
<td>Essentially the same definition in both programs. Connector has rules for members of same tax household with different residences.</td>
</tr>
<tr>
<td>Incarceration</td>
<td>Not an inmate of a public institution (excl a patient in a medical inst) 42 CFR 435.1009-1010</td>
<td>Not incarcerated except pending disposition of charges. 45 CFR 155.305(a)(2)</td>
<td>The Connector rule is broader in allowing for pre-trial detainees to be eligible.</td>
</tr>
<tr>
<td>Eligible immigrants</td>
<td>Must be “Qualified” and not under 5-year bar 130 CMR 504.003(A)(1) and 504.006(A)</td>
<td>Must be “lawfully present” (no 5-year bar) 45 CFR 155.20 and 152.2</td>
<td>MassHealth CarePlus covers fewer types of immigration status than the Connector but MassHealth Family Assistance covers more.</td>
</tr>
<tr>
<td>Age limit</td>
<td>21 - 64 130 CMR 505.008(A)</td>
<td>No age limit</td>
<td>Other types of MassHealth have different age limits than CarePlus.</td>
</tr>
<tr>
<td>Provisional eligibility –temporary eligibility pending verification</td>
<td>Provisional eligibility for all eligibility factors except income 130 CMR 502.003</td>
<td>Provisional eligibility for all eligibility factors including income 45 CFR 155.315(f)</td>
<td>Provisional eligibility for income in MassHealth is limited to adults eligible for Standard or Family Assistance based on certain health conditions (pregnancy, BCCTP, HIV+) &amp; to children</td>
</tr>
<tr>
<td>MAGI income limits</td>
<td>Current monthly income not over 133% FPL 130 CMR 505.008(A) FPL updated in March</td>
<td>Expected annual income greater than 100% FPL (except for those ineligible for Medicaid due to immigration status) but not over 300% FPL. FPL updated for Open Enrollment 26 CFR 1.36B-1; 45 CFR 155.305; 956 CMR 12.04</td>
<td>Much higher income limit in ConnectorCare. No minimum income in MassHealth. See MAGI Q &amp; A for more differences between MassHealth and Connector MAGI rules. APTC is available for those over 300% FPL to 400% FPL.</td>
</tr>
<tr>
<td>Criteria</td>
<td>CarePlus</td>
<td>ConnectorCare</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>MAGI household</td>
<td>Exceptions to use of tax household for non-filers, certain tax dependents, pregnant women, spouses living together, and disabled adults. 130 CMR 506.002</td>
<td>Household includes taxpayer and tax dependents, no exceptions to tax household 26 CFR 1.36B-1; 45 CFR 155.305</td>
<td></td>
</tr>
<tr>
<td>MAGI income rules: MAGI counts taxable income includable in AGI plus nontaxable Social Security Income, tax exempt interest &amp; certain tax exempt foreign income</td>
<td>5% FPL standard deduction; lump sum only counted as income in month of receipt &amp; certain added deductions 42 CFR 435.603, 130 CMR 506.003-506.004</td>
<td>No standard deduction; no special treatment for lump sum income.</td>
<td></td>
</tr>
<tr>
<td>Access to other insurance (minimum essential coverage)</td>
<td>Must not be eligible for Medicare or MassHealth Standard but may be eligible for any other insurance. MassHealth will be secondary to any other insurance. 130 CMR 505.008(A)</td>
<td>Must not be eligible for Medicare, MassHealth, Tricare, “affordable” employer insurance or enrolled in VA health system, employer insurance or COBRA. 26 CFR 1.36B-2; 45 CFR 155.</td>
<td>CarePlus is the only MassHealth program that excludes Medicare beneficiaries. See Q &amp; A for more on “minimum essential coverage”</td>
</tr>
<tr>
<td>Tax filing</td>
<td>No tax filing requirement 130 CMR 506.002</td>
<td>Must file federal return for any tax year in which seeking premium tax credit. Married must file jointly unless abuse/abandonment. 26 CFR 1.36B-2; 45 CFR 155.</td>
<td>ConnectorCare applicants must intend to file for current year; enrollees must have also filed for past periods in which they received ConnectorCare/APTC</td>
</tr>
<tr>
<td>Open enrollment</td>
<td>Continuous. Can enroll at any time.</td>
<td>Can only enroll during annual open enrollment or after a Qualifying event including being newly eligible for ConnectorCare. 45 CFR 155.410 and 155.420; 956 CMR 12.10</td>
<td>2019 open enrollment was Nov 15, 2018 to Jan. 23, 2019 for coverage beginning Jan. 1 or Feb 1 2019</td>
</tr>
<tr>
<td>Criteria</td>
<td>CarePlus</td>
<td>ConnectorCare</td>
<td>Comment</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Start date of coverage</td>
<td>10 days prior to date of application</td>
<td>1st of month after selecting a plan and paying any premium due by 23d of prior month</td>
<td></td>
</tr>
<tr>
<td></td>
<td>130 CMR 505.008(E) &amp; 502.006</td>
<td>956 CMR 12.10</td>
<td></td>
</tr>
<tr>
<td>Enrollment &amp; Auto-enrollment (default enrollment)</td>
<td>If MassHealth is primary, auto-enrolled in managed care if no plan selection by deadline. Until then, or if MassHealth is secondary, coverage is fee for service. 130 CMR 508.003(B)</td>
<td>Able to enroll during open enrollment or by deadline after a qualifying event (generally 60 days). No auto-enrollment. 45 CFR 155.410 and 155.420; 956 CMR 12.10</td>
<td>Individuals who are eligible for ConnectorCare and do not enroll will lose all but HSN-dental.</td>
</tr>
<tr>
<td>Managed Care</td>
<td>Managed care is mandatory if MassHealth is only form of coverage (primary). Managed Care options include ACOs, Primary Care Clinician Plan and MCOs. Coverage is fee for service if individual has other insurance and MassHealth is secondary. 130 CMR 508</td>
<td>All coverage is through Health Maintenance Organizations (HMOs) 956 CMR 12.03 (Def. of health plan)</td>
<td>.</td>
</tr>
<tr>
<td>Managed Care Lock-In</td>
<td>90 days to freely change plan during Plan Selection period; after which can only change for cause during Fixed Enrollment period. 130 CMR 508.003(C)</td>
<td>Can change plans during open enrollment or after a qualifying event. 45 CFR 155.410 and 155.420; 956 CMR 12.10</td>
<td>MassHealth good cause criteria and ConnectorCare qualifying events have some overlap but differ.</td>
</tr>
<tr>
<td>Criteria</td>
<td>CarePlus</td>
<td>ConnectorCare</td>
<td>Comment</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Scope of covered benefits</td>
<td>Comprehensive including dental and nonemergency transportation. CarePlus members requiring certain long term services &amp; supports not available in CarePlus may upgrade to Standard as “medically frail.” 130 CMR 450.105(B) and 130 CMR 505.008(F)</td>
<td>Comprehensive but not including dental or nonemergency transportation. Up to 100 days in SNF or Chronic Hospital (combined). Home health agency benefit is only benefit for help with activities of daily living in the home. See, 45 CFR 156.100-156.155 (min. standard for Essential Health Benefits)</td>
<td>CarePlus benefits are listed in Medicaid state plan as “Alternate Health Benefit Plan” &amp; in state regulations &amp; health plan contract and member book. ConnectorCare benefits are listed in plan contract and plan’s member book/evidence of coverage.</td>
</tr>
<tr>
<td>Premiums &amp; Cost-Sharing</td>
<td>No premiums. Copayments for drugs of $1 or $3.65, and $3 copay for inpatient hospitalization. No deductibles 130 CMR 506.011 (premiums); 506.014 (copayments)</td>
<td>Premiums depend on income and plan selection. $0 premium option for lowest cost plans for applicants with income under 150% FPL. Minimum premiums from $44 to $126 per person per month for those over 150% to 300% FPL (2019). Copays same as MassHealth for Plan Type 1 (income up to 100% FPL). Higher copays for Plan Types 2 and 3. No deductibles. 956 CMR 12.10(3) and 12.11</td>
<td></td>
</tr>
<tr>
<td>Reconciliation</td>
<td>N/A</td>
<td>Amount of federal premium tax credit received in advance must be reconciled with amount due at time of tax filing. May result in higher or lower federal credit/tax liability. 26 CFR 1.36B-4</td>
<td>See Q &amp; A 30 for more information on reconciliation</td>
</tr>
<tr>
<td>Criteria</td>
<td>CarePlus</td>
<td>ConnectorCare</td>
<td>Comment</td>
</tr>
<tr>
<td>------------------------</td>
<td>----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Appeal Process         | Right to notice and fair hearing at MassHealth Board of Hearings when denied eligibility or services. If enrolled with managed care must first follow managed care internal appeal process to appeal decisions of managed care entity to Board of Hearings. 42 CFR 431; 130 CMR 610 | Right to notice and fair hearing over disputes about eligibility, enrollment, premiums and adverse decision made by the Connector before Connector hearings officers. 45 CFR 355.; 956 CMR 12.12  
Disputes with managed care plans over medical necessity or covered services may be raised with Office of Patient Protections after first following managed care internal appeal process. 965 CMR 12.14, 958 CMR 3.00 | See Appeals Q &As for more about ConnectorCare appeals.                                                                                           |