12.04: continued

(3) Eligibility for ConnectorCare.

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

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

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

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

1. Plan Type 1 - not in excess of 100% of the FPL; provided that for plan years beginning on or after January 1, 2026, the income level for Plan Type 1 shall be less than 100% of the FPL.

2. Plan Type 2 - more than 100% but not in excess of 200% of the FPL, except that persons at or below 150% of FPL will be in Plan Type 2A, and those over 150% and not over 200% of FPL will be in Plan Type 2B; provided that for plan years beginning on or after January 1, 2026, the income levels for Plan Type 2 shall be at least 100% but not in excess of 200% of the FPL.

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

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

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

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

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

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

(4) Eligibility for Small Group Health Plans.

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

1. Be a Small Employer;

2. Be actively engaged in business;

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

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

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

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

12.05: Matching Information

The Connector or its designee initiates information matches with other state and federal agencies and information sources when an Application is received, when eligibility is redetermined, or at other times in the Connector's administrative processes in order to verify eligibility or certain information. These agencies and information sources may include, but are not limited to, the following: the Massachusetts Department of Unemployment Assistance

(Mass. Register #1557, 9/26/2025, emergency reg.)

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(DUA), MassHealth, Massachusetts Department of Public Health's Registry of Vital Records and Statistics (RVRS), Massachusetts Department of Industrial Accidents, Massachusetts Department of Veteran's Services, Massachusetts Department of Revenue (DOR), Massachusetts Bureau of Special Investigations, Internal Revenue Service, Social Security Administration (SSA), Systematic Alien Verification for Entitlements Program (SAVE), Department of Homeland Security, Massachusetts Department of Transitional Assistance (DTA), and Health Carriers.

12.06: Standards for an Eligibility Application

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

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

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

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

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

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

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

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

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

12.08: Eligibility Effective Dates for Connector Programs for Non-group Health Plans

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

(2) The Connector shall provide in written policy a point during the month after which, if an Eligible Individual's eligibility changes, and the Eligible Individual remains eligible for a Connector Program, the effective date of that new eligibility determination will be the first day of the month following the month specified in 956 CMR 12.08(1).

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