Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2178267
Decision Date:	12/13/2021	**Hearing Date:**	12/10/2021
Hearing Officer:	Christine Therrien		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Sarah Prado, Premium Assistance; Sheri Paiva, Taunton

The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
Board of Hearings
100 Hancock Street, Quincy, Massachusetts 02171

APPEAL DECISION

Appeal Decision:	Denied	**Issue:**	Premium Assistance
Decision Date:	12/13/2021	**Hearing Date:**	12/10/2021
MassHealth's Rep.:	Sarah Prado, Sheri Paiva	**Appellant's Rep.:**	Pro se
Hearing Location:	Taunton MassHealth Enrollment Center		

Authority

This hearing was conducted pursuant to Massachusetts General Laws Chapter 118E, Chapter 30A, and the rules and regulations promulgated thereunder.

Jurisdiction

Through a notice dated 8/20/21, MassHealth notified the appellant that she is no longer eligible for MassHealth Premium Assistance payments (130 CMR 506.012, 956 CMR 5.03 and Exhibit 1). The appellant filed this appeal in a timely manner on 10/28/21 (130 CMR 610.015(B) and Exhibit 2). Denial of assistance is valid grounds for appeal (130 CMR 610.032).

Action Taken by MassHealth

MassHealth notified the appellant that he is no longer eligible for MassHealth Premium Assistance payments.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 506.012 and 956 CMR 5.03, in determining that the appellant is no longer eligible for MassHealth Premium Assistance payments.

Summary of Evidence

The premium assistance representative testified that the appellant had received premium assistance (PA) since 6/2015. The premium assistance representative testified that the appellant was previously enrolled in a Tufts health plan. The premium assistance representative testified that PA unit received the new compliance form from the appellant which showed the appellant had switched to a BCBS plan beginning 7/1/21. The premium assistance representative testified that the compliance form indicated the BCBS health plan has an individual deductible of $2000 and a family deductible of $6,000. The premium assistance representative testified that the PA eligibility limit for a family deductible is $5,700. The premium assistance representative testified that the appellant's new health plan has a family deductible that is too high to qualify for PA. The premium assistance representative testified that if the member is enrolled in a family plan then PA is based on the family deductible, and if the member is enrolled in an individual plan then PA is based on the individual deductible.

The appellant testified that while her family is enrolled in the family plan it is only her son who uses MassHealth. The appellant testified that the PA should be based on the individual deductible. The appellant testified that the other health insurance plan options would cost MassHealth more than the current plan in which they are enrolled. The appellant testified that her son requires special services that are covered under the BCBS insurance plan that were not covered by the Tufts plan.

Findings of Fact

Based on a preponderance of the evidence, I find the following:

1. The appellant had received PA since 6/2015.

2. The appellant was previously enrolled in a Tufts health plan.

3. The PA unit received the new compliance form from the appellant which showed the appellant switched to a BCBS plan beginning 7/1/21.

4. The BCBS health plan has an individual deductible of $2000 and a family deductible of $6,000.

5. The PA eligibility limit for a family deductible is $5,700.

6. If the member is enrolled in a family plan the PA is based on the family deductible, and if the member is enrolled in an individual plan the PA is based on the individual deductible.

Analysis and Conclusions of Law

130 CMR 506.012(B) Criteria.

MassHealth may provide a premium assistance payment to an eligible member when all of the following criteria are met.[1]

(1) The health-insurance coverage meets the Basic Benefit Level (BBL) as defined in 130 CMR 501.001: *Definition of Terms*.

(2) The health-insurance policy holder is either

(a) in the Premium Billing Family Group (PBFG) or

(b) resides with the individual who is eligible for the premium assistance benefit and is related to the individual by blood, adoption, or marriage.

(3) At least one person covered by the health-insurance policy is eligible for MassHealth benefits as described in 130 CMR 506.012(A) and the health-insurance policy is a policy that meets the criteria of the MassHealth coverage type for premium assistance benefits as described in 130 CMR 506.012(C).

Basic-Benefit Level (BBL) is defined as benefits provided under a health-insurance plan that are comprehensive and comparable to benefits provided by insurers in the small-group health-insurance market provided that such plan meets minimum creditable coverage requirements as defined in 956 CMR 5.03: *Minimum Creditable Coverage*; provided further that individual and small group plans issued or renewed in Massachusetts must meet the requirements of qualified medical insurance as defined in 211 CMR 64.00: *Definitions of Qualified Medical Insurance for M.G.L. c. 118E, § 9C.*

956 CMR 5.03: Minimum Creditable Coverage

(2) A Health Benefit Plan, or the aggregate of multiple Health Benefit Plans, that otherwise meets the requirements of 956 CMR 5.03(1) may incorporate the following and continue to be considered as providing minimum creditable coverage:
(a) A Health Benefit Plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers. Exclusions and limitations on benefits should be identified in plain language and non-discriminatory in their design and application. For a Health Benefit Plan that does not have a network design, the overall Health Benefit Plan design must meet the requirements of 956 CMR 5.03(1) to be considered as providing minimum creditable coverage.
(b) A Health Benefit Plan may impose varied levels of Co-payments, Deductibles and Co-insurance, provided that:
1. the plan must disclose to Covered Persons the Deductible, Co-payment and Co-insurance amounts applicable to in-network and out-of-network Covered Services;

[1] 130 CMR 506.012: Family Assistance Premium Assistance Payments (A) Requirements. (1) The MassHealth agency makes monthly payments toward the cost of employer sponsored health insurance for members who meet the requirements of 130 CMR 505.005(B), (C), and (D). The MassHealth agency makes only one premium assistance payment per policy. The amount of the MassHealth agency's payment is based on the following information: (a) the total cost of the member's health insurance premium; (b) the employer share of the member's health insurance premium; and (c) the MassHealth estimated member share of the health insurance premium.

2. any Deductible(s) for in-network Covered Services that are provided as part of the plan benefits shall not in combination exceed $2,000 for an individual and $4,000 for a family;
3. the dollar amounts for individuals specified in 965 CMR 5.03(2)(b)2. shall, unless the Connector Board establishes otherwise for a given calendar year, be adjusted each year by an amount equal to the product of that amount and the premium adjustment percentage for a calendar year as determined by the United States Secretary of Health and Human Services pursuant to 42 U.S.C. § 18022(c)(4).[2] Such amounts are typically published by the Secretary in the annual Notice of Benefit and Payment Parameters regulations. If the amount of any adjustment is not a multiple of $50, such adjustment shall be rounded down to the next lowest multiple of $50. The dollar amounts for a family specified in 956 CMR 5.03(2)(b)2. shall be increased each year to an amount equal to twice the amount in effect for an individual, as adjusted pursuant to 956 CMR 5.03(2)(b)3.;

The HHS Notice of Benefit and Payment Parameters for 2021 Final Rule Fact Sheet states in part, "Reduced Maximum Annual Limitation on Cost Sharing: [w]e finalized a 2021 reduced annual limitation on cost sharing…at $2,850 for self-only coverage and **$5,700 for other than self-only coverage**." [3]

The regulations stipulate that the maximum allowable deductible for a family plan is $5,700 to be considered minimum creditable coverage. Since the appellant is enrolled in the family plan this is the deductible that is used to determine eligibility for PA regardless of the individual deductible amount. The appellant's deductible for her family plan is $6,000 which means it does not meet the minimum creditable coverage standards as set out in 956 CMR 5.03(b)(2). MassHealth's determination to end PA for the appellant based on a non-qualifying plan is correct. This appeal is denied.

Order for MassHealth

None.

Notification of Your Right to Appeal to Court

If you disagree with this decision, you have the right to appeal to Court in accordance with Chapter 30A

[2] 42 U.S.C. § 18022(c)(4) PREMIUM ADJUSTMENT PERCENTAGE. For purposes of paragraph (1)(B)(i), the premium adjustment percentage for any calendar year is the percentage (if any) by which the average per capita premium for health insurance coverage in the United States for the preceding calendar year (as estimated by the Secretary no later than October 1 of such preceding calendar year) exceeds such average per capita premium for 2013 (as determined by the Secretary).

[3] The fact sheet can be found at https://www.cms.gov/files/document/final-2021-hhs-notice-benefit-and-payment-parameters-fact-sheet.pdf

of the Massachusetts General Laws. To appeal, you must file a complaint with the Superior Court for the county where you reside, or Suffolk County Superior Court, within 30 days of your receipt of this decision.

Christine Therrien
Hearing Officer
Board of Hearings

cc:
MassHealth Representative: Justine Ferreira, Taunton MassHealth Enrollment Center.