Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Approved	**Appeal Number:**	2300035
Decision Date:	4/14/2023	**Hearing Date:**	02/17/2023
Hearing Officer:	Casey Groff, Esq.	**Record Closed:**	04/10/2023

Appearance for Appellant:
[redacted]

Appearance for MassHealth:
Gladys Pacheco, Premium Assistance
Liz Nickoson, Taunton MEC

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:	Approved	**Issue:**	Premium Assistance
Decision Date:	4/14/2023	**Hearing Date:**	02/17/2023
MassHealth's Rep.:	Gladys Pacheco; Liz Nickoson	**Appellant's Rep.:**	Father/Guardian
Hearing Location:	Remote	**Aid Pending:**	No

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 December 14, 2022, MassHealth notified Appellant, a MassHealth member over the age of 18, that it was terminating his premium assistance payments because he no longer qualified for the benefit. See 130 CMR 506.012 and Exhibit (Exh.) 2. On January 3, 2023, Appellant's father submitted a timely appeal on Appellant's behalf. See Exh. 1 and 130 CMR 610.015(B). On January 4, 2023, the Board of Hearings (BOH) dismissed the appeal because the fair hearing submission did not demonstrate proper authority to request the appeal. See Exh. 3. On January 12, 2023, Appellant's father submitted paperwork showing he was Appellant's court appointed legal guardian. See Exh. 4. Accordingly, BOH vacated the dismissal and scheduled a hearing for February 17, 2023. See Exh. 5. Denial of assistance is valid grounds for appeal. See 130 CMR 610.032. After the hearing took place, the record was re-opened for the parties to submit additional evidence. See Exh. 6. The record closed on April 10, 2023. Id.

Action Taken by MassHealth

MassHealth terminated Appellant's premium assistance benefit.

Issue

The appeal issue is whether MassHealth was correct in terminating Appellant's premium assistance benefit.

Summary of Evidence

A MassHealth eligibility representative appeared at the hearing and testified as follows: Appellant is a disabled male, over the age of 18. Since 2016, he has been enrolled in MassHealth Standard as a secondary insurance. Appellant receives primary insurance through his father's employer sponsored insurance (ESI) Blue Cross Blue Shield (BCBS) family plan.

A representative from MassHealth's premium assistance (PA) unit appeared at the hearing and testified that until the notice at issue, Appellant had been enrolled in premium assistance whereby MassHealth issued payments to Appellant's father, as the policy holder of Appellant's private insurance, of approximately $402 per-month to cover the cost of the premium. In December of 2022, MassHealth received information indicating that the plan's annual deductible increased from $3,500 to $6,000. According to the PA representative, MassHealth pays eligible members' private insurance premium if their plan meets the criteria set forth under 130 CMR 506.012(B), which includes the requirement that the health insurance coverage meets the "basic benefit level" (BBL), as defined in 130 CMR 501.001. According to the PA representative, to meet the BBL, the maximum annual deductible for a family plan must not exceed $5,700. Because Appellant's deductible increased beyond the limit, his plan no longer met the BBL. Accordingly, on December 14, 2022, MassHealth notified Appellant that it was terminating his premium assistance payments because he no longer qualified for the benefit. See 130 CMR 506.012 and Exh. 2. The last PA payment was issued in November of 2022 which covers the following month's premium. Thus, the PA benefit officially ended in December of 2022.

Appellant's father appeared at the hearing by telephone. The father testified that he retired from his job at the end of July 2022. He was able to keep his ESI through BCBS, but the change in employment caused his annual family deductible to increase from $3,500 to $6,000. According to the father, this was the only change in his BCBS policy from prior years when his plan qualified for PA payments. After the termination, Appellant's father spoke numerous times with his former employer to see if he could enroll in a plan with a lower deductible. Despite such efforts, he has been advised that his current BCBS "silver" plan is the only program offered to retired individuals and he has been unable to get a plan with a different deductible amount.

Appellant's father also took issue with the December 14, 2022 termination notice, arguing that it was vague and only set forth a bullet point list of possible reasons for the termination – none of which seemed to apply to his case. Appellant explained that he had the exact same health insurance, which previously qualified, and the only change was the increased annual deductible. Upon receiving the termination notice, he called MassHealth's premium assistance unit to inquire about its rational for ending coverage. It was only upon speaking with someone from MassHealth that he was informed that the program limits coverage to individuals whose ESI deductibles do not exceed $5,700 for family coverage. MassHealth, however, has yet to provide reference to any policy or notice where this deductible limit is embedded. After this conversation, Appellant's father spent hours researching and reviewing the MassHealth's premium assistance policies and procedures and has been unable to find any source that captures this deductible limitation.

Finally, Appellant's father argued that his son's PA benefit termination will disadvantage MassHealth. The father explained without the assistance, he may ultimately remove his son from the policy because the premium is too costly. Doing so would cause MassHealth to become Appellant's primary insurance payor and would cost the agency thousands more in medical expenses than it currently pays for the $402 monthly premium.

MassHealth was then asked where the agency obtains the deductible limits, including from what source the $5,700 figure was derived, as it is not specifically referenced in the BBL definition. The PA representative explained that annual figures regarding deductible limits are obtained from the Health Connector, but did not cite to a specific policy or document.

After the hearing concluded, the record was re-opened for the parties to provide more information to the Hearing Officer on the plan's annual out-of-pocket expense costs. See Exh. 6. In response, Appellant's father submitted his plan's "Summary of Benefits and Coverage" document for coverage period 01/01/2023 through 12/31/2023. See Exh. 7, p. 1. According to the document, Appellant is enrolled in a "silver" BCBS high deductible health plan (HDHP) through his former employer. Consistent with the testimony at hearing, the summary showed an in-network annual deductible of $6,000 annually for family coverage ($3,000 for individual). Id. The plan's "out-of-pocket limit" for in-network services is $10,000 for family coverage ($5,000 for individual). See id. The "out-of-pocket limit" is defined as the most the insured would pay in a year for covered services, including deductible, copayment, and coinsurance costs for in-network care, and excluding costs for premiums, balance-billed charges, or costs for non-covered services. Id.

Findings of Fact

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

1. Appellant is a disabled male, over the age of 18.

2. Since 2016, he has been continuously enrolled in MassHealth Standard.

3. Appellant receives primary insurance through his father's employer sponsored insurance BCBS family plan, which is a high deductible health plan (HDHP).

4. Appellant was previously enrolled in MassHealth's premium assistance program whereby MassHealth issued payments to Appellant's father, as the policy holder of Appellant's private insurance, of approximately $402 per-month to cover the cost of the premium.

5. Upon retiring, Appellant's father's ESI remained with BCBS but this caused his annual deductible to increase from $3,500 to $6,000 for in-network family coverage.

6. On December 14, 2022, MassHealth notified Appellant that it was terminating his premium assistance payments because he no longer qualified for the benefit.

7. For calendar year 2023, the ESI plan's "out-of-pocket limit" for in-network services is $10,000 for family coverage ($5,000 for individual).

8. The "out-of-pocket limit" is the most the insured would pay in a year for covered services, including deductible, copayment, and coinsurance costs for in-network care, and excludes costs for premiums, balance-billed charges, and costs for non-covered services.

Analysis and Conclusions of Law

Through its Premium Assistance program, MassHealth provides financial assistance to eligible members that have access to private health insurance, to help cover the cost of their health insurance premiums. See 130 CMR 506.012(C). Eligibility for this benefit is based on "the individual's coverage type and the type of private health insurance the individual has or has access to." See 130 CMR 506.012(C). Once enrolled, MassHealth issues "premium assistance payments" to the policyholder of the plan. The PA payment is the amount MassHealth contributes to the cost of health insurance coverage for the member. See 130 CMR 501.001.

MassHealth establishes the following criteria to determine eligibility for premium assistance:

> (B) Criteria. MassHealth may provide a premium assistance payment to an eligible member when all of the following criteria are met.
>
> (1) **The health insurance coverage meets the Basic Benefit Level (BBL) as defined in 130 CMR 501.001: *Definition of Terms*.** Instruments including but not limited to Health Reimbursement Arrangements, Flexible Spending Arrangements, as described in IRS Pub. 969, or Health Savings Accounts, as described at IRC § 223(c)(2), cannot be used to reduce the health insurance deductible in order to meet the basic-benefit level requirement.
>
> (2) The health insurance policy holder is either
>
> (a) in the 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).[1]

130 CMR 506.012(B) (emphasis added).

In this appeal, MassHealth argues that Appellant does not qualify for premium assistance payments

[1] Subsection (C) of 130 CMR 506.012 includes employer sponsored insurance (ESI) as one of the enumerated qualifying policy types.

because his ESI plan no longer meets the criteria specified in subsection (B)(1), above. Specifically, MassHealth determined that Appellant's ESI plan does not meet the basic benefit level (BBL) because his annual deductible exceeds the maximum limit. MassHealth defines the BBL as follows:

> benefits provided under a health-insurance plan that include a broad range of medical benefits as defined in the ***minimum creditable coverage core services requirements in 956 CMR 5.03(1)(a);*** provided that the ***sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under that plan does not exceed the maximum amounts described at IRC § 223(c)(2) for high deductible health plans.***

130 CMR 501.001 (Rev. 12/18/17) (emphasis added).

Under this definition, the inquiry for determining whether a plan meets the BBL is two-fold. First, the plan must cover the following "core services" enumerated in 956 CMR 5.03(1)(a), as follows:

> 5.03: Minimum Creditable Coverage
>
> (1) …
>
> (a) A health benefit plan provides core services and a broad range of medical benefits, in accordance with at least the minimum standards set by state and federal statutes and regulations governing the particular health benefit plan. "A broad range of medical benefits" shall include, at a minimum, coverage for:
>
> 1. Ambulatory patient services, including outpatient, day surgery and related anesthesia;
> 2. Diagnostic imaging and screening procedures, including x-rays;
> 3. Emergency services;
> 4. Hospitalization (including at a minimum, inpatient acute care services which are generally provided by an acute care hospital for covered benefits in accordance with the member's subscriber certificate or plan description);
> 5. Maternity and newborn care, including prenatal care, post-natal care, and delivery and inpatient services for maternity care;
> 6. Medical/surgical care, including preventive and primary care;
> 7. Mental health and substance abuse services;
> 8. Prescription drugs;
> 9. Radiation therapy and chemotherapy.

956 CMR 5.03(1)(a).

In this case, MassHealth does not allege that Appellant's insurance plan stopped covering the core services cited above.[2] Rather, MassHealth's decision to terminate Appellant's PA benefit is based

[2] MassHealth previously approved Appellant's ESI plan for premium assistance payments based on a determination that it met the BBL. Absent any evidence to indicate otherwise, it is presumed this part of his insurance plan continues to comply with 956 CMR 5.03(1)(a).

solely on an increase in the deductible amount. The central issue on appeal, therefore, turns to the second inquiry posited under the BBL definition. Here, MassHealth must find that "***the sum of*** *[Appellant's] annual deductible and the other annual out-of-pocket expenses required to be paid under that plan [must] not exceed* ***the maximum amounts described at IRC § 223(c)(2)*** *for high deductible health plans*." 130 CMR 501.001 (emphasis added).

The Internal Revenue Code (IRC) describes the "maximum amounts" referred to above, as follows:

> (2) High deductible health plan
> (A) In general
> The term "high deductible health plan" means a health plan—
> (i) which has an annual deductible *which is not less than*—
> (I) $1,000 for self-only coverage, and
> (II) twice the dollar amount in subclause (I) for family coverage, and
> ***(ii) the sum of the annual deductible and the other annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—***
> ***(I) $5,000 for self-only coverage, and***
> ***(II) twice the dollar amount in subclause (I) for family coverage.***

26 U.S.C. § 223(c)(2) (emphasis added).

Where subsection (A)(i), above, prescribes the base-level deductible amounts to qualify as a "high deductible health plan" (HDHP), subsection (A)(ii) provides the limitation on maximum out-of-pocket expenses the HDHP can impose on its members. The monetary figures described therein (i.e. $5,000 for individual and $10,000 for family) are subject to mandatory annual premium adjustments determined by the Department of Health and Human Services (HHS) in accordance with the methodology outlined in the Affordable Care Act (ACA).[3] See ACA § 1302(c)(4); 45 CFR § 156.130(a); see also Commonwealth Health Connector Administrative Information Bulletin (AIB) 02-17 (Feb. 2017). For calendar year 2023, HHS's application of the ACA indexing methodology updated the maximum amounts described in IRC § 223(c)(2)(A)(ii) to ***$9,100 for self-only coverage and $18,200 for family coverage***. See CMS 2023 PAPI Parameters Guidance (Dec. 2021); see also Comm. Connector AIB 02-22, p. 2 (May 2022).[4]

The evidence shows that Appellant has a HDHP with an out-of-pocket limit for family coverage of $10,000 for calendar year 2023.[5] See Exh. 7. This amount includes the annual family deductible

[3] Massachusetts uses this same methodology to calculate the maximum out of pocket amounts, as published annually in the Federal Register, and this is codified in 956 CMR 5.03(2)(c). See Connector AIB 02-22 (2022).
[4] The cited publications are respectively available at the following internet addresses: https://www.cms.gov/files/document/2023-papi-parameters-guidance-v4-final-12-27-21-508.pdf and https://www.mahealthconnector.org/wp-content/uploads/rules-and-regulations/AdminBulletin02-22.pdf.
[5] The ESI plan's Summary of Benefits and Coverage explicitly states that the out-of-pocket limit does *not* include premiums, balance-billed charges, and/or non-covered services, but does include cost sharing amounts including the deductibles, copayments, and coinsurance for in-network services. See Exh. 7.

and other required expenses for covered benefits, consistent with the criteria under 130 CMR 501.001 and 26 U.S.C. § 223(c)(2). Therefore, Appellant's annual out-of-pocket limit of $10,000 *does not* exceed the maximum amount under IRC § 223(c)(2), as adjusted annually, of $18,200 for family coverage in calendar year 2023. Appellant's ESI coverage therefore meets both components of the BBL definition and satisfies the criteria in 130 CMR 506.012(B)(1) to qualify for premium assistance payments

At hearing, MassHealth explained that because Appellant's annual family deductible exceeded $5,700, he no longer qualified for the PA benefit. Although not specifically cited at hearing, this figure is derived from a separate provision of 956 CMR 5.03; specifically, subsection (2)(b), which limits the deductible amounts health plans can set in order to establish Minimum Credible Coverage (MCC).[6] See Comm. Connector AIB 02-22, p. 1.

While subsection (2)(b) is pertinent to the Commonwealth Connector for purposes of determining whether a health benefit plan provides MCC, it is irrelevant to MassHealth for purposes of making premium assistance eligibility determinations. MassHealth regulations make no reference to subsection (2)(b) of 956 CMR 5.03 as it pertains to PA eligibility. In defining BBL, MassHealth specifically limited its incorporation of MCC criteria solely to subsection (1)(a), regarding its core services requirement. Additionally, the BBL definition explicitly places a limit on the total *combined* (i.e. "the sum of") out-of-pocket expenses required to be paid by its members to pay for covered services described in IRC § 223(c). While the total limit includes deductible costs, the inquiry is not limited to that figure alone. Finally, it is noted that the out-of-pocket limits described in IRC § 223(c)(2) are incorporated by reference in subsection (2)*(c)* of 956 CMR 5.03. While the BBL does not specifically refer to this portion of the MCC criteria, it is noted that limitations mandated therein are essentially the same as those described in IRC § 223(c)(2).[7]

As explained above, Appellant's ESI plan meets both components of the BBL definition, and thus satisfies the criteria to qualify for premium assistance payments under 130 CMR 506.012(B)(1). Based on the foregoing, this appeal is APPROVED.

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[6] Specifically, 956 CMR 5.03(1)(c) sets forth the MCC requirement that plans limit deductibles for in-network covered services at amounts specified therein, and which are modified annually by the premium adjustment percentage determined by HHS. The 2023 deductible limit for this requirement was $2,850 for an individual and $5,700 for family coverage. See Comm. Connector AIB 02-22, p. 1.

[7] For context, it is noted that prior to July 14, 2017, MassHealth defined BBL as follows:

> 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 the minimum credible coverage requirements as defined in 956 CMR 503**: *Minimum Credible 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.* See 130 CMR 501.001 (Rev. 01/01/14)).

Thus, the pre-July 14, 2017 definition of BBL adopted the entirety of MCC criteria as set forth in 956 CMR 5.03 et. seq. However, in 2017, MassHealth revised the definition of BBL with the purpose of "increas[ing] transparency and eas[ing] administration of the premium assistance program." See MassHealth Eligibility Letter 218 (July 14, 2017). The revision led to its current definition, which incorporates *only* subsection (1)(a) of 956 CMR 5.03, regarding the MCC core services requirement. Additionally, the updated definition limited qualifying plans to those that set maximum out-of-pocket expenses not to exceed the amounts under IRC § 223(c)(2).

Order for MassHealth

Rescind termination notice dated 12/14/22. Deem Appellant's health insurance coverage to have met criteria specified in 130 CMR 506.012(B)(1); approve premium assistance payments retroactive to termination date.

Implementation of this Decision

If this decision is not implemented within 30 days after the date of this decision, you should contact your MassHealth Enrollment Center. If you experience problems with the implementation of this decision, you should report this in writing to the Director of the Board of Hearings, at the address on the first page of this decision.

Casey Groff, Esq.
Hearing Officer
Board of Hearings

cc:
MassHealth Representative: Justine Ferreira, Taunton MassHealth Enrollment Center, 21 Spring St., Ste. 4, Taunton, MA 02780

MassHealth Representative: Premium Assistance Unit.