Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied in part; Approved in part	**Appeal Number:**	2406296
Decision Date:	07/18/2024	**Hearing Date:**	05/24/2024
Hearing Officer:	Christopher Jones	**Record Open to:**	06/07/2024

Appearance for Appellant:
[redacted]

Appearance for MassHealth:
Sherrianne Paiva – Taunton MEC
Karishma Raja – Premium Billing

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 in part; Approved in part	**Issue:**	Premium Billing; Tax Intercept
Decision Date:	07/18/2024	**Hearing Date:**	05/24/2024
MassHealth's Rep.:	Sherrianne Paiva; Karishma Raja	**Appellant's Rep.:**	[redacted]
Hearing Location:	Virtual	**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 of Refund Applied to Debt or Transferred dated March 26, 2024, $302 of the appellant's tax return was intercepted by the Department of Revenue. (Exhibit 1, p. 3; 815 CMR 9.00.) The appellant filed this appeal in a timely manner on April 19, 2024. (Exhibit 1; 130 CMR 610.015(B).) Agency actions to recover money owed are grounds for appeal. (130 CMR 610.032; see also Exhibit 1, p. 3 ("You have the right to contest the amount of the debt that resulted in this intercept by applying in writing for a hearing."); 815 CMR 9.03; 9.10.)

The hearing record was left open until June 7 for the appellant to submit additional evidence and for MassHealth to review and respond. (See Exhibit 5.)

Action Taken by MassHealth

MassHealth asked the Department of Revenue to intercept the appellant's tax refund in order to recover money the appellant owed for past-due CommonHealth premiums.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 506.011, in referring the appellant to the State Intercept Program, and whether MassHealth correctly determined the amount to be intercepted.

Summary of Evidence

The appellant is a disabled adult. In 2022, the appellant applied for MassHealth coverage on his own. He was denied MassHealth based upon his income and told to purchase subsidized insurance through the Health Connector. MassHealth's representative testified that the appellant was automatically renewed on March 4, 2023. MassHealth's computer system was able to verify his income at 244% of the federal poverty level, but the automatic data match also found out that the appellant was disabled. Based on his disability, the appellant was deemed eligible for the CommonHealth benefit with a $72 premium.

At the time, MassHealth was not sending out premium bills due to protections in place during the Federal Public Health Emergency ("FPHE") related to Covid-19. The FPHE ended in April 2023. MassHealth started sending bills in May for June premiums. The appellant was billed for June, July, August, and September before MassHealth terminated the coverage through a notice dated October 6, 2023. Thereafter, the agency referred the debt to the Department of Revenue ("DOR") for collection. MassHealth's Premium Billing representative testified that the amount owed to MassHealth was $288, for four months of unpaid premiums. She testified that MassHealth received $277 from DOR. This money was applied to the appellant's debt but left $11 owed. Because this was less than a month's premium, his CommonHealth coverage was reinstated. She did not give a reason as to why the appellant was billed for four months before the coverage was terminated. Per regulation, benefits should be terminated after two months of unpaid premiums.

The appellant conceded that he received these notices and bills, and he ignored them because he already had insurance coverage. The appellant did not have a clear history of his own coverage, but he recalled being covered in the past by the Health Connector as well as being covered by his wife's employer-sponsored insurance in the past. His recollection was that he called the Health Connector to cancel his coverage because he was going to enroll in his wife's employer-sponsored insurance. He believes that when he cancelled his Health Connector coverage, it somehow caused him to be enrolled in MassHealth. He testified that he never used his MassHealth coverage. He did not want MassHealth or Health Connector coverage because they kept taking his tax refunds, and he was covered by his wife's insurance.

MassHealth's representative testified that there was nothing in the computer systems that indicated the appellant had called to cancel his Health Connector coverage, or otherwise withdraw his application for medical assistance. MassHealth's representative theorized that the Health Connector coverage was cancelled after the appellant was auto-renewed and found eligible for

CommonHealth, because a member cannot be eligible for both MassHealth and the Health Connector. MassHealth coverage is more comprehensive, therefore it takes precedence in covering members.

The appellant asked MassHealth to close his application and asked that the record be left open for him to submit proof that he called to close his Health Connector coverage. MassHealth closed his coverage, and all new CommonHealth premiums were waived.

The hearing record was left open, but nothing was submitted.

Findings of Fact

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

1) The appellant was approved for MassHealth CommonHealth coverage on March 4, 2023, with a monthly premium of $72, based upon household income equivalent to 244% of the federal poverty level. (Exhibit 4, pp. 7-9.)

2) In May 2023, the appellant was billed $72 for his June premium, and he was billed $72 per month for July, August, and September. (Exhibit 4, p. 5; testimony by MassHealth's Premium Billing Representative.)

3) On October 6, 2023, MassHealth terminated the appellant's CommonHealth coverage for non-payment. (Exhibit 5, p. 6.)

4) The appellant received these notices and the bills, but he ignored them because he was covered by other insurance. (Testimony by the appellant.)

5) Through a Notice of Refund Applied to Debt or Transferred dated March 26, 2024, $302 of the appellant's tax return was intercepted by the Department of Revenue. (Exhibit 1, p. 3.)

6) The Department of Revenue applied $292 of the intercepted refund to the debt owed to MassHealth and applied $10 to a processing fee. (Exhibit 1, p. 3.)

Analysis and Conclusions of Law

After a member or applicant has applied for MassHealth benefits, MassHealth

> reviews eligibility once every 12 months. Eligibility may also be reviewed as a result of a member's change in circumstances, or a change in MassHealth eligibility rules, or as a result of a member's failure to provide verification within requested time frames. The MassHealth agency updates eligibility based on information received as a result of such review. The MassHealth

> agency reviews eligibility … by information matching with other agencies, health insurance carriers, and information sources … .

(130 CMR 502.007(A)(1).)

If a household's "continued eligibility can be determined based on electronic data matches with federal and state agencies," the household "will have their eligibility automatically renewed." (130 CMR 502.007(C)(1).) If the automatic renewal "results in no change in benefits or in a more comprehensive benefit for all members of the household, the MassHealth agency will notify the head of household that eligibility has been reviewed using the automatic renewal process."[1] (130 CMR 502.007(C)(1)(a).) Only where an automatic renewal results in a "downgrade" would MassHealth require the household to complete a renewal application. (130 CMR 502.007(C)(1)(b); see also 502.007(C)(3) (MassHealth automatically implements benefits upgrades based on data match information).)

Certain MassHealth benefits require that the member pay a monthly premium, when the member's income is above certain guidelines. (See 130 CMR 506.011.) MassHealth allows a member "60 calendar days from the date of the eligibility notice and premium notification" to voluntarily withdraw from benefits, and if they do so "MassHealth premiums are waived." (130 CMR 506.011(C)(5).) Furthermore, it is the member's responsibility to notify MassHealth of their intention to "withdraw from receiving MassHealth coverage," and the "member is responsible for the payment of all premiums up to and including the calendar month of withdrawal, unless the request for voluntary withdrawal is made in accordance with 130 CMR 506.011(C)(5)." (130 CMR 506.011(H).)

The CommonHealth benefit has tiered premiums based upon the household's percentage of the federal poverty level. For households with income above 200% of the federal poverty level, the monthly premium starts at $40 and MassHealth will "[a]dd $8 for each additional 10% FPL until 400% FPL." (130 CMR 506.011(B)(2)(b).) If the member has "health insurance to which the MassHealth agency does not contribute," the member pays a reduced premium for their coverage. For income between 200% and 400% of the federal poverty level, the supplemental premium is 65% of the full premium amount. (130 CMR 506.011(B)(2)(c).)

If "the member does not pay the entire amount billed within 60 days of the date on the bill, the member's eligibility for benefits is terminated." (130 CMR 506.011(D)(1).) If a premium remains unpaid for 150 days, MassHealth may refer the member "to the State Intercept Program (SIP) in compliance with 815 CMR 9.00: *Collection of Debts*." (130 CMR 506.011(D)(3).)

[1] MassHealth recently dropped its requirement that disabled adults either work or meet a deductible to qualify for CommonHealth. (See EOM 23-28 (Dec. 2023).) It is unclear if the appellant could have been auto-renewed into CommonHealth if this requirement were in effect at the time.

The appellant admitted that he ignored MassHealth's approval notice, premium bills, and termination notice. He testified that he had called the Health Connector to terminate his coverage and offered to submit proof. However, no proof was submitted. Therefore, I cannot find that MassHealth erred in approving the appellant for CommonHealth, billing him, and then referring his debt to the SIP. This appeal is DENIED in part.

However, the amount of debt referred to the SIP is incorrect. First, the $72 premium calculated by MassHealth is correct if the appellant has no other insurance. He testified that he has been covered by his wife's employer-sponsored insurance, which is why he never used the MassHealth benefit. Based upon the supplemental premium formula, the appellant should only have been charged 65% of the $72 premium, or $46.80. Second, MassHealth should have terminated the appellant's coverage after 60 days of non-payment. This should have resulted in only two premium bills being generated prior to the appellant's coverage being terminated. MassHealth should only have referred $93.60 to the SIP for collection. Because the SIP applied $292 to the referred debt, MassHealth owes the appellant $198.40.

Because the appellant withdrew his application at the hearing, there should be no further premium bills owed for CommonHealth benefits, unless the appellant affirmatively reapplies for MassHealth coverage.

Order for MassHealth

Reimburse the appellant $198.40 for the tax return applied in excess of the $93.60 that should have been referred to the SIP. Waive any remaining debt. Close the appellant's MassHealth application until he completes a new application.

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 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.

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.

Christopher Jones
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 Billing