Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2413237
Decision Date:	10/4/2024	**Hearing Date:**	09/25/2024
Hearing Officer:	Susan Burgess-Cox		

Appearance for Appellant:
[redacted]

Appearances for MassHealth:
Nicole Veras (Tewksbury MEC) &
Roxana Noriega (Premium Assistance)

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:	10/4/2024	**Hearing Date:**	09/25/2024
MassHealth's Reps.:	Nicole Veras & Roxana Noriega	**Appellant's Rep.:**	[redacted]
Hearing Location:	All Parties Appeared by Telephone	**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 June 28, 2024, MassHealth determined that the appellant has insurance available through her job that meets the rules for MassHealth Premium Assistance and eligible family members must enroll in this insurance or their MassHealth benefits may end. (130 CMR 503.007; Exhibit 1). The notice also states that the appellant will be eligible for Premium Assistance once she enrolls in this insurance and MassHealth will pay all or part of the premium. (130 CMR 506.012). The Board of Hearings received a request for hearing on August 26, 2024. (130 CMR 610.000; Exhibit 2). An agency action to suspend, reduce, terminate, or restrict a member's assistance is valid grounds for appeal. (130 CMR 610.032).

Action Taken by MassHealth

MassHealth notified the appellant that family members eligible for her employer-sponsored insurance must enroll in this insurance or their MassHealth benefits may end. (130 CMR 503.007).

Issue

Whether MassHealth was correct in determining that they may end benefits for the appellant's family members who qualify for her employer-sponsored insurance.

Summary of Evidence

All parties appeared by telephone. MassHealth had representatives from the Tewksbury MassHealth Enrollment Center (Tewksbury MEC) and Premium Assistance Unit (PAU) present at hearing. The representative from the Tewksbury MEC testified that the appellant is a member of a family group of four that includes herself, her spouse and two children. The appellant is employed and has a monthly gross income of $3,628.53. The appellant's spouse is employed and has a monthly gross income of $2,729.79. After applying a 5% disregard of $130, the appellant's monthly adjusted gross income (MAGI) $6,228 is at 239.54% of the federal poverty level. The Tewksbury MEC representative testified that based upon this information, the appellant and her spouse are not eligible for MassHealth, but the appellant's children are eligible for MassHealth Family Assistance. The Tewksbury MEC representative testified that every applicant and member must obtain and maintain available health insurance as MassHealth is a payor of last resort. Failure of a member to obtain and maintain available health insurance may result in a loss or denial of eligibility.

The PAU representative testified that the appellant's employer-sponsored insurance meets the minimum credible coverage (MCC) requirements to qualify for premium assistance payments. The PAU representative testified that MassHealth will pay 100% of the appellant's premiums. The PAU representative noted that members receive premium assistance payments one month in advance of when their premium payment is due. The PAU representative testified that for the first month of enrollment, a member will receive 2 payments to ensure coverage for the first month of enrollment and an advance payment for the second month. The appellant will continue to receive payments one month in advance.

The appellant did not dispute the facts that her employer offers insurance, and that she is not enrolled in a plan through her employer. The appellant testified that enrolling her employer's health insurance would be financially catastrophic. The appellant testified that her family relies on every penny they make to cover expenses such as mortgage payments, child care and utilities. The appellant did not feel comfortable having insurance premiums withdrawn from her bi-weekly paycheck and then relying on MassHealth for reimbursement. The appellant stated that she understood that MassHealth provides monthly payments but did not believe that these payments would be consistent and timely. The appellant asked MassHealth to allow her children to continue to receive coverage through MassHealth Family Assistance, without requiring her to enroll in her employer-sponsored insurance.

Findings of Fact

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

1. The appellant has a household of 4.

2. The appellant's household has a modified adjusted gross income (MAGI) of $6,228.

3. The appellant's MAGI places her household at 239.54% of the federal poverty level.

4. The appellant has access to employer-sponsored insurance.

5. The employer-sponsored insurance meets the minimal credible coverage requirements for the appellant to receive premium assistance.

6. Premium assistance will cover 100% of the monthly premium for the private insurance.

7. As of the hearing date, the appellant had not enrolled in the employer-sponsored insurance.

Analysis and Conclusions of Law

MassHealth is the payer of last resort and pays for health care and related services only when no other source of payment is available, except as otherwise required by federal law. (130 CMR 503.007). Every applicant and member must obtain and maintain available health insurance in accordance with 130 CMR 505.000: Health Care Reform: MassHealth: Coverage Types. (130 CMR 503.007(A)). Failure to do so may result in loss or denial of eligibility unless the applicant or member is:

(a) receiving MassHealth Standard or MassHealth CommonHealth; and
(b) younger than 21 years of age or pregnant. (130 CMR 503.007(A)).

No one in the appellant's family group is receiving MassHealth Standard or CommonHealth. The appellant's children are eligible for MassHealth Family Assistance.

Pursuant to 130 CMR 505.005(B)(2), MassHealth may perform an investigation to determine if individuals potentially eligible for MassHealth Family Assistance

(a) have health insurance that MassHealth can help pay for; or
(b) have access to employer-sponsored insurance in which MassHealth wants the individual to enroll and for which MassHealth will help pay

In performing the investigation, if MassHealth determines the individual has access to employer-

sponsored health insurance, the employer is contributing at least 50% of the premium cost, and the insurance meets all other criteria described at 130 CMR 506.012: Premium Assistance Payments, the individual is notified in writing that they must enroll in this employer-sponsored coverage that meets the criteria described in 130 CMR 506.012: Premium Assistance Payments. (130 CMR 505.005(B)(2)(b)2.a.). MassHealth allows the individual up to 60 days to enroll in this coverage. (130 CMR 505.005(B)(2)(b)2.a.). Once enrolled in this health insurance plan, MassHealth provides MassHealth Family Assistance Premium Assistance Payments. (130 CMR 505.005(B)(2)(b)2.a.). Failure to enroll in the employer-sponsored health insurance plan at the request of MassHealth will result in the loss or denial of eligibility. (130 CMR 505.005(B)(2)(b)2.a.).

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

    1. in the PBFG [Premium Billing Family Group]; or
    2. 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). (130 CMR 506.012).

The basic-benefit Level (BBL) is defined as:

(1) 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 annual deductible and the annual maximum out-of-pocket costs under that plan do not exceed the maximum amounts the Massachusetts Health Connector sets for deductibles and out-of-pocket costs in order for a plan to be considered minimum creditable coverage, as set forth at 956 CMR 5.03(2)(b)2 and 3, and 956 CMR 5.03(2)(c), respectively, and as may be illustrated in administrative bulletins published by the Massachusetts Health Connector, and as are in effect on the first day coverage under that plan begins

(2) Exceptions.

(a) For the avoidance of doubt, 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.

(b) The MassHealth agency reserves the right to set its own annual deductible and maximum out-of-pocket limits. If the MassHealth agency deems it appropriate to set its own annual deductible and maximum out-of-pocket limits, a sub-regulatory bulletin will be issued.

The minimum creditable coverage core services requirements in 956 CMR 5.03(1)(a) include:

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 Health Services and primary care;
7. Mental health and substance abuse services;
8. Prescription drugs;
9. Radiation therapy and chemotherapy

The maximum annual deductible for in-network covered services that are provided as a part of the plan benefits shall not in combination exceed $2,000 for an individual and $4,000 for a family. (956 CMR 5.03(2)(b)2). 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). (956 CMR 5.03(2)(b)3). Such amounts are typically published by the Secretary in the annual Notice of Benefit and Payment Parameters regulations. (956 CMR 5.03(2)(b)3).[1] If a Health Benefit Plan includes deductibles, Co-payments, or Co-insurance for in-network covered Core Services, the plan must set Out-of-pocket Maximums for in-network Covered Services. (956 CMR 5.03(2)(c)).

[1] For calendar year 2024, the applicable deductibles are as follows: Individual Coverage Deductible $2,950; Individual Coverage Separate Prescription Deductible $360 Family Coverage Deductible $5,900; Family Coverage Separate Prescription Deductible $720.

The appellant did not demonstrate that her employer-sponsored health insurance does not meet the criteria described at 130 CMR 506.012. (130 CMR 505.005(B)(2)(b)2.a.). The appellant has not enrolled in this insurance. The decision made by MassHealth to end the coverage for the appellant's children was 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 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.

Susan Burgess-Cox
Hearing Officer
Board of Hearings

MassHealth Representative: Sylvia Tiar, Tewksbury MassHealth Enrollment Center, 367 East Street, Tewksbury, MA 01876-1957, 978-863-9290