Office of Medicaid
BOARD OF HEARINGS

Appellant Name and Address:

[redacted]

Appeal Decision:	Denied	**Appeal Number:**	2504160
Decision Date:	5/5/2025	**Hearing Date:**	04/07/2025
Hearing Officer:	Susan Burgess-Cox		

Appearance for Appellant:
Pro se

Appearance for MassHealth:
Faisal Mugimi (Charlestown 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	**Issue:**	Premium Billing
Decision Date:	5/5/2025	**Hearing Date:**	04/07/2025
MassHealth's Rep.:	Faisal Mugimi (Charlestown MEC) & Karishma Raja (Premium Billing)	**Appellant's Rep.:**	Pro se
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

On January 21, 2025, MassHealth notified the appellant that he does not qualify for MassHealth as he has past due premiums. (130 CMR 506.011). The appellant filed a timely appeal on February 6, 2025. Any MassHealth 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 he does not qualify for MassHealth as he has past due premiums. (130 CMR 506.000)

Issue

Whether MassHealth was correct in determining that the appellant has past due premiums.

Summary of Evidence

MassHealth representatives from the Premium Billing Unit (PBU) and the Charlestown MassHealth Enrollment Center (Charlestown MEC) provided testimony regarding the appellant's eligibility, premium calculations and the receipt of premium payments. The representative from the PBU provided documents that were incorporated into the hearing record as Exhibit 4.

The Charlestown MEC representative testified that in October 2024, the appellant was deemed eligible for MassHealth CommonHealth as a family group of one with annual income of $54,199 or monthly income of $4,516.58. After applying the 5% regulatory disregard of $62.75, the appellant had a modified adjusted gross income (MAGI) of $4,453.83. This income is at 354.88% of the federal poverty level (FPL). Using a regulatory formula, individuals with income above 200% of the FPL have a base premium of $40 and $8 is added for each 10% of the FPL. An individual with income at 354% of the FPL would have a premium of $160 [$40 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 + $8 = $160].

Members who have health insurance to which MassHealth does not contribute have a lower supplemental premium. Under this formula, members with income between 200% to 400% of the FPL pay 65% of the full premium. A member with a monthly premium starting at $160 would have a supplemental premium of $104 [$460 x 0.65 = $104]. This is the premium amount testified to at hearing by both MassHealth representatives. All of the parties stated that the appellant does not have other insurance, yet the agency appears to have utilized this supplemental premium formula. These facts provide context as to the agency's calculation of past premiums, they are not appealable actions at this time as the appellant had the opportunity to appeal any premium calculations at the time of the notices issued with the premium amounts due. Also, at this hearing, the appellant did not present any evidence to challenge the amounts utilized by the agency in calculating a premium.

In April 2024, the appellant was eligible for MassHealth CommonHealth with a premium of $119.60 beginning in May 2024. In July 2024, the appellant was redetermined eligible for CommonHealth with a premium of $104 beginning in August 2024. On July 23, 2024, the appellant's coverage was terminated due to nonpayment of the premium. The appellant requested a payment plan, MassHealth agreed with the plan and the appellant became eligible for MassHealth CommonHealth on August 8, 2024 with a premium of $104 beginning September 2024. Appellant defaulted on the payment plan and MassHealth terminated coverage. MassHealth agreed to a second payment plan and the appellant became eligible for MassHealth CommonHealth with a premium of $104. The appellant defaulted on that plan and coverage terminated in January 2025. The PBU representative testified that the agency cannot agree to a third payment plan. As of January 2025, the appellant has a total balance of $479.20 due on the account.

The appellant did not agree with the amount due and asked MassHealth to consider other expenses in determining eligibility for calculating a premium. The appellant did not present

evidence of other expenses for the agency to consider or to challenge the calculation of the premium. None of the parties presented evidence of appeals filed on any other notices terminating coverage or the agency's calculation of a premium. The appellant did not dispute the fact that he entered into payment plans in the past to pay the amount due as determined by the agency in July 2024 and August 2024.

Findings of Fact

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

1. The appellant is a disabled adult and a family group of one.

2. In April 2024, the appellant was eligible for MassHealth CommonHealth with a premium of $119.60 beginning in May 2024.

3. In July 2024, the appellant was redetermined eligible for CommonHealth with a premium of $104 beginning in August 2024.

4. On July 23, 2024, the appellant's coverage was terminated due to nonpayment of the premium.

5. The appellant requested a payment plan, MassHealth agreed with the plan and the appellant became eligible for MassHealth CommonHealth on August 8, 2024 with a premium of $104 beginning September 2024.

6. The appellant defaulted on that payment plan and MassHealth terminated coverage.

7. MassHealth agreed to a second payment plan and the appellant became eligible for MassHealth CommonHealth.

8. The appellant defaulted on that second plan and MassHealth terminated coverage as of February 4, 2025.

9. As of January 2025, the appellant has a total balance of $479.20 due on the account.

Analysis and Conclusions of Law

MassHealth is responsible for the administration and delivery of health-care services to eligible low- and moderate-income individuals, couples, and families under MassHealth. (130 CMR 501.002(A)). MassHealth provides access to healthcare by determining eligibility for the coverage type that provides the most comprehensive benefits for an individual or family who may be

eligible. (130 CMR 501.003(A)). The rules of financial responsibility and calculation of financial eligibility are detailed in 130 CMR 506.000: Health Care Reform: MassHealth: Financial Requirements. (130 CMR 505.001).

MassHealth may charge a monthly premium to MassHealth Standard, CommonHealth, or Family Assistance members who have income above 150% of the federal poverty level (FPL), as provided in 130 CMR 506.011. (130 CMR 506.011). If MassHealth has billed a member for a premium payment, and 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)). The member will be sent a notice of termination before the date of termination. (130 CMR 506.011(D)(1)). The member's eligibility will not be terminated if, before the date of termination, the member

(a) pays all delinquent amounts that have been billed;
(b) establishes a payment plan and agrees to pay the current premium being assessed and the payment-plan-arrangement amount;
(c) is eligible for a nonpremium coverage type;
(d) is eligible for a MassHealth coverage type that requires a premium payment and the delinquent balance is from a CMSP benefit; or
(e) requests a waiver of past-due premiums as described in 130 CMR 506.011(G). (130 CMR 506.011(D)(1).

If the member does not make payments in accordance with the payment plan within 30 days of the date on the bill, the member's payment plan is terminated and the past due balance is due in full. (130 CMR 506.011(D)(2)(a)). If the member defaults on a payment plan, is in a premium-paying coverage type and does not pay the past due amount within 60 days of the date on the bill, the member's eligibility is terminated. (130 CMR 506.011D)(2)(b)). If a member has defaulted on a payment plan twice within a 24-month period, the member must pay in full any past due balances before they can be determined eligible for a coverage type that requires a premium payment. (130 CMR 506.011(D)(2)(c)). A member may be granted additional payment plans if the member has been approved for a hardship waiver as described at 130 CMR 506.011(F). (130 CMR 506.011(D)(2)(d)).

In this case, the appellant defaulted on a payment plan twice within a 24-month period. Therefore, he must pay in full any past due balances before he can be determined eligible for a coverage type that requires a premium payment.[1] (130 CMR 506.011(D)(2)). Neither party

[1] While the summary of facts includes information about the premium calculations issued in past notices, that information is included to provide the appellant with context as to this recent decision to terminate coverage. The opportunity to appeal those prior decisions has lapsed. The regulations governing MassHealth specifically state that the Board of Hearings must receive a request for a fair hearing within 60 days after an applicant or member receives written notice from the MassHealth agency of the intended action. (130 CMR 610.015(B)). In the absence of evidence or testimony to the contrary, it will be presumed that the notice was received on the fifth day after

presented evidence that the appellant would be eligible for a coverage type that does not require a premium payment. Additionally, neither party presented evidence regarding the submission of a hardship waiver.

The decision made by MassHealth 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: Thelma Lizano, Charlestown MassHealth Enrollment Center, 529 Main Street, Suite 1M, Charlestown, MA 02129

mailing. (130 CMR 610.015(B)(1)). The appellant did not present any evidence denying the receipt of those notices.