

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



Appeal Decision:	Denied	Appeal Number:	2512694
Decision Date:	12/3/2025	Hearing Date:	10/02/2025
Hearing Officer:	Susan Burgess-Cox	Record Open to:	10/27/2025

Appearance for Appellant:
Pro se

Appearances for MassHealth:
Elizabeth Nickoson (Taunton 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:	12/3/2025	Hearing Date:	10/02/2025
MassHealth's Reps.:	Elizabeth Nickoson (Taunton MEC) & Roxana Noriega (Premium Assistance)	Appellant's Rep.:	Pro se
Hearing Location:	All Parties Appeared via Microsoft Teams	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 August 11, 2025, MassHealth determined that they can no longer help the appellant pay for their private insurance premium. (130 CMR 506.012; Exhibit 1). The Board of Hearings received a request for hearing on September 2, 2025. (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).

At the request of the parties, the record was held open to provide additional evidence. (Exhibit 5). This extended the decision due date.

Action Taken by MassHealth

MassHealth notified the appellant that they can no longer help the appellant pay for their private insurance premium.

Issue

Whether MassHealth was correct in determining that they can no longer help the appellant pay for their private insurance premium.

Summary of Evidence

All parties appeared via Microsoft Teams. Documents submitted by the appellants prior to the hearing are incorporated into the hearing record as Exhibit 4. MassHealth had representatives from the Taunton MassHealth Enrollment Center (Taunton MEC) and Premium Assistance Unit (PAU) at the hearing. The Taunton MEC representative testified that the appellants have a family group of three. The appellants' son is eligible for MassHealth CommonHealth with a premium. The household income consists of \$950 each month from self-employment and \$5,597 from an employer. After applying a 5% disregard of \$111.05, the appellants' monthly adjusted gross income (MAGI) of \$6,436 is at 289.8% of the federal poverty level (FPL). The Taunton MEC representative testified that the agency has a formula to calculate premium amounts and disabled children younger than 8 years of age with household income above 250% to 300% of the FPL have a monthly premium of \$28.

The PAU representative testified that the appellants were deemed ineligible for premium assistance (PA) because their employer-sponsored insurance does not meet the agency's minimum credible coverage (MCC) requirements as the deductible exceeds \$5,900 which is the maximum amount the Massachusetts Health Connector set for deductibles and out-of-pocket costs in order for a plan to be considered MCC, as set forth at 956 CMR 5.03(2)(b)2. and 3., and 956 CMR 5.03(2)(c).¹ The appellant's employer provides a high-deductible insurance plan along with a Medical Expense Reimbursement Plan (MERP). The PAU representative testified that the MERP involves the use of a Visa card for medical expenses. The PAU representative testified that the agency cannot verify how the card is used or if it lowers the deductible to be considered to meet the requirements for minimal credible coverage. The PAU representative testified that MassHealth is a payor of last resort and the agency cannot determine whether that is the case when using this card. The PAU representative testified that she asked if there could be an exception for this case but that request was denied.

The appellants presented a letter from the employer stating that the MERP is funded by the employer for a high-deductible plan which eliminates the copay for their health plan. The insurance plan itself has a deductible in the amount of \$16,100 per family. The MERP covers certain out-of-pocket in-network services up to \$14,100 even before the individual or family meets the deductible. The employer states that this results in a member paying \$1,050 for each individual. The records presented by the appellant indicate that the plans together would require a

¹ The Health Insurance Connector Authority's Administrative Bulletin 02-24 provides the 2025 guidance regarding Minimum Creditable Coverage (MCC) which notes maximum out-of-pocket dollar amounts of \$2,950 for an individual and \$5,900 for a family group as of March 2024.

family group to pay a total of \$2,000. In their letter, the employer states that they cover 97% of the funds available for claims, deductibles, copays, medication, and anything directly approved by their Health Plan. These funds are not directly available to employees or to be used at their discretion. The employer states that funds used under the MERP are to be substantiated with Medical Explanation of Benefits (EOBs), medication receipts, or other forms of acceptable substantiation. Any and all unapproved or unsubstantiated purchases will be owed back to the organization administering the program.

The plan involves the use of a Visa card to pay for services. The program has a substantiation policy that allows the organization to confirm acceptable use of the card. The organization reserves the right to ask a member of documentation to confirm that charges on the card were allowed and approved by the insurance network and counted toward the deductible and out-of-pocket tracking. The policy states that documentation typically includes an EOB. If a member cannot substantiate charges and/or have not been approved by the insurer, the organization may request that the member repay the amount that does not qualify for the MERP back into their employer's healthcare plan. If the organization does not receive documentation or repayment, the card may be suspended. If the member does not respond after the card has been suspended, their account may be sent to collection if they haven't made a required repayment and/or their debt isn't repaid via claims offsetting. Nothing in this policy requires a member to document the acceptable use of the card or make direct limitations, such as the decline of purchase on-site.

The appellants presented a copy of MassHealth's Eligibility Operations Memo (EOM) 25-06 which summarizes changes to MassHealth's Premium Assistance (PA) Program eligibility policies related to deductible thresholds and models such as health reimbursement accounts (HRAs) and similar instruments. The memo states, effective April 2025, employer-sponsored insurance (ESI) plans with certain HRAs or similar instruments that reduce the deductible below the PA deductible threshold, will be eligible for MassHealth PA. The memo notes a number of ESI plans use HRAs or similar instruments entirely funded by the employer or insurance plan, without member contributions, to lower member deductibles. Because these HRAs and similar instruments are not funded by members, they effectively lower members' out-of-pocket costs at no expense to the members, and they should be considered when determining whether a plan meets the basic benefit level (BBL). The appellants argue that the card presented by their employer lowers the deductible below the PA deductible threshold as it is entirely funded by the employer.

The PAU representative noted that the policy requires that the provider receive payment directly from the instrument and/or health insurance plan, and the health insurance policyholder and members of their household do not pay or require later reimbursement for any of the portion of the deductible reduced by the instrument. The PAU representative testified that the testimony and documents presented by the appellants do not clearly show that the card can only be used to pay providers directly and the appellants do not pay or require later reimbursement for any portion of the deductible reduced by the instrument.

The record was held open as at the hearing it appeared that the appellants may have sent other documents to the agency prior to the hearing that were not received by the Board of Hearings. (Exhibit 5). Documents submitted by the appellants during the record open period are incorporated into the hearing record as Exhibit 6. A response from MassHealth is incorporated into the hearing record as Exhibit 7.

In their submission, the appellants duplicate most of what was submitted prior to the hearing with some additional comments. Regarding language in EOM 25-06, the appellants state that the provider receives payment directly from the MERP instrument which is part of the health benefit plan and is never received or given to the policyholder or household member. The appellants note that the MERP is paying the bill directly so they do not receive any funds themselves. The appellants argue that they are not entitled to any funds on the MERP instrument nor are they entitled to use it for whatever they want. They note that it is highly monitored and in-line with all IRS regulations. The appellants do not cite any IRS regulations or note their relevance to this matter.

The appellants presented screenshots from the portal that administers the plan. The screenshots show the plan holder; beneficiaries; a list of purchases from various providers, pharmacies and stores; as well as a section from the letter of agreement with the MERP provider that shows how the employer contributes to funding the reserves and states that if there are funds remaining at the end of the year, the employer is eligible to receive two-thirds of the reserves based on actual and projected claims.

During the record open period, the PAU representative reviewed the documents presented by the appellant as well as agency policy. The PAU representative stated that the plan needs to make payments directly to the provider and if a member has a debit card that indicates that they are paying out-of-pocket, being reimbursed, or responsible for making payments that require reimbursement. This type of HRA does not reduce the deductible amount to qualify for premium assistance. The PAU representative stated that if the plan does not explicitly state that claims are received from the carrier by the HRA, then the HRA makes payments directly to the provider, it's not PA eligible under the regulations and the EOM.

Findings of Fact

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

1. The appellants have a family group of three.
2. The appellants' son is eligible for MassHealth CommonHealth with a premium.
3. The household income consists of \$950 each month from self-employment and \$5,597

from an employer.

4. The appellants' monthly adjusted gross income (MAGI) of \$6,436 is at 289.8% of the federal poverty level (FPL).
5. The appellants' have a monthly premium of \$28.
6. MassHealth determined that the appellants' employer-sponsored insurance does not meet the minimum credible coverage requirements.
7. The employer-sponsored insurance involves a high-deductible plan and a Medical Expense Reimbursement Plan (MERP).
8. The insurance plan itself has a deductible in the amount of \$16,100 per family.
9. The MERP covers certain out-of-pocket in-network services up to \$14,100 even before the individual or family meets the deductible.
10. The MERP involves the use of a Visa card for medical expenses.
11. The MERP has a substantiation policy that allows the organization to confirm acceptable use of the card.
12. The MERP organization reserves the right to ask a member of documentation to confirm that charges on the card were allowed and approved by the insurance network and counted toward the deductible and out-of-pocket tracking.
13. The MERP policy states that documentation typically includes an explanation of benefits (EOB).
14. The MERP policy states that If a member cannot substantiate charges and/or have not been approved by the insurer, the organization may request that the member repay the amount that does not qualify for the MERP back into their employer's healthcare plan.
15. If the MERP organization does not receive documentation or repayment, the card may be suspended.
16. If the member does not respond after the card has been suspended, their account may be sent to collection If they haven't made a required repayment and/or their debt isn't repaid via claims offsetting.

Analysis and Conclusions of Law

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 PBF; 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). (130 CMR 506.012(B)).

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) MassHealth reserves the right to set its own annual deductible and maximum out-of-pocket limits. If MassHealth 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).² 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)).

Both parties reference Eligibility Operations Memo (EOM) 25-06 regarding changes to MassHealth's Premium Assistance (PA) Program eligibility policies related to deductible thresholds and models such as health reimbursement accounts (HRAs) and similar instruments. Effective April 2025, employer-sponsored insurance (ESI) plans with certain HRAs or similar instruments that reduce the deductible below the PA deductible threshold, as described below, will be eligible for MassHealth PA. (MassHealth EOM 25-06). A number of ESI plans use HRAs or similar instruments entirely funded by the employer or insurance plan, without member contributions, to lower member deductibles. (MassHealth EOM 25-06). Because these HRAs and similar instruments are

² For calendar year 2025, 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.

not funded by members, they effectively lower members' out-of-pocket costs at no expense to the members, and they should be considered when determining whether a plan meets the basic benefit level (BBL). (MassHealth EOM 25-06). The appellants argue that the plan offered by their employer falls within the parameters of what is set forth in this EOM. The PAU representative responded that the HRA needs to pay directly to the provider. The PAU representative states if the plan documents don't explicitly state that claims are received from the carrier by the HRA, then the HRA makes payments directly to the provider, it's not PA eligible per the regulations and EOM 25-06.

In July 2025, MassHealth issued EOM 25-11 which supersedes EOM 25-06. In both memoranda, MassHealth states that the regulations defining BBL specifically list instruments that cannot be used to reduce the health insurance deductible, such as an HRA, because of concerns that members and MassHealth could pay excessive out-of-pocket costs beyond the deductible threshold. Both memoranda require the provider to receive payment directly from the benefit and/or health insurance plan, and the health insurance policyholder and members of their household do not pay or require later reimbursement for any of the portion of the deductible reduced by the benefit. In this case, the appellant's use of a debit card to pay the provider is not a direct payment from the HRA to the provider as one cannot determine whether the card is used appropriately until there is a review of claims, similar to an individual paying out-of-pocket and then seeking reimbursement. The policy specifically states that the funds used under the MERP are to be substantiated with Medical Explanation of Benefits (EOBs), medication receipts, or other forms of acceptable substantiation. Any and all unapproved or unsubstantiated purchases will be owed back to the organization administering the program. If the MERP reserves the right to ask a member of documentation to confirm that the charges on the card are allowed, that is equivalent to a member paying for services or require later reimbursement for a portion of the deductible reduced by the benefit.

The appellants did not demonstrate that their employer-sponsored health insurance met the criteria described at 130 CMR 506.012. (130 CMR 505.005(B)(2)(b)2.a.). The decision made by MassHealth to end premium assistance 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 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: Justine Ferreira, Taunton MassHealth Enrollment Center, 21 Spring St., Ste. 4, Taunton, MA 02780, 508-828-4616
MassHealth Representative: Premium Assistance Unit