

**Office of Medicaid
BOARD OF HEARINGS**

Appellant Name and Address:



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|-------------------------|------------|-----------------------|------------|
| Appeal Decision: | Denied | Appeal Number: | 2515071 |
| Decision Date: | 1/15/2026 | Hearing Date: | 11/18/2025 |
| Hearing Officer: | Emily Sabo | | |

Appearance for Appellant:



Appearances for MassHealth:

Sherianne Paiva, Taunton MEC; Gladys Pacheco, 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

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|----------------------------|--|--------------------------|--------------------|
| Appeal Decision: | Denied | Issue: | Premium Assistance |
| Decision Date: | 1/15/2026 | Hearing Date: | 11/18/2025 |
| MassHealth's Reps.: | Sherrienne Paiva, Gladys Pacheco | Appellant's Rep.: | Parent/guardian |
| Hearing Location: | Taunton MassHealth Enrollment Center (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 dated October 8, 2025, MassHealth notified the Appellant's father that he was no longer eligible for premium assistance and that MassHealth had stopped the household's premium assistance payments. 130 CMR 506.012 and Exhibit 1. The Appellant's representative filed this appeal in a timely manner on October 15, 2025. 130 CMR 610.015(B) and Exhibit 2. Denial of assistance is valid grounds for appeal. 130 CMR 610.032.

Action Taken by MassHealth

MassHealth terminated the Appellant's premium assistance payments.

Issue

The appeal issue is whether MassHealth was correct, pursuant to 130 CMR 506.012, in determining that the Appellant is not eligible for premium assistance.

Summary of Evidence

The fair hearing request included information on the Appellant's household's [REDACTED] which states that the plan year is from October 1, 2025, to September 30, 2026. Exhibit 2 at 7. It states that the deductible is "\$4,000 per Individual/Maximum of \$8,000 per Family (*Individual Responsibility: \$2,700; Last \$1,300 reimbursed by HRA*) (*Family Responsibility: \$5,400; Last \$2,600 reimbursed by HRA*)." *Id.* It also states that that the out-of-pocket maximum is "\$5,000/Individual up to a Maximum of \$10,000/Family)." *Id.* The Premium Assistance Review Form states that the Appellant is enrolled in the [REDACTED] family plan, along with her parents, that the total monthly premium is \$2,753.51, that the monthly employer contribution is \$1,514.43, and the monthly employee contribution is \$1,239.08. *Id.* at 9. By letter dated October 1, 2025, the Appellant's father's employer stated that the "Ultimate Annual Family Responsibility towards deductible: [is] \$5,400." *Id.* at 22.

The hearing was held virtually. MassHealth was represented by an eligibility specialist and a Premium Assistance representative. Their testimony is summarized as follows: the Appellant is [REDACTED] and is a MassHealth Standard member, whose benefit is active through the Social Security Administration. The Appellant has been eligible for Premium Assistance since 2016. The Appellant is enrolled in a family plan through her father's employer-sponsored insurance, [REDACTED]. The Premium Assistance representative testified that the plan's deductible is greater than the eligibility limits for MassHealth premium assistance. The Premium Assistance representative testified that the Appellant's plan has an individual deductible of \$4,000.00, and a family deductible of \$8,000.00. The Premium Assistance representative testified that the MassHealth Premium Assistance maximum deductible for 2025 is \$2,950.00 for an individual and \$5,900.00 for a family. The Premium Assistance representative testified that the MassHealth Premium Assistance maximum deductible starting in January 2026 is \$3,200.00 for an individual and \$6,400.00 for a family. The Premium Assistance representative testified that the reduction in the ultimate family responsibility by the HRA did not meet any exceptions.

The Appellant was represented by her mother and guardian, who verified the Appellant's identity. The Appellant's representative testified that the Appellant had been on Premium Assistance for years, and that the family just went through open enrollment for the [REDACTED]. The Appellant's representative testified that if the Appellant was no longer eligible for Premium Assistance, the Appellant would need to be covered solely by MassHealth. The Appellant's representative testified that the Appellant has extensive medical issues and that she has tens of thousands of dollars' worth of claims.¹ The Appellant's representative testified that the Appellant's list of prescriptions is two pages long, and that she is due for a number of procedures in early 2026 including an MRI, an endoscopy, and eye surgery. The Appellant's representative explained that it has been stressful trying to figure out what to do. The Appellant's representative testified that the Appellant could be reimbursed less by Premium Assistance so that it balanced out the difference between the HMO deductible and the Premium Assistance deductible limit. The Appellant's

¹ Prior to the hearing, the Appellant's representative submitted supporting documentation. Exhibit 8.

representative stated that she hoped that an exception could be made because it would be beneficial to all parties to have the Appellant continue with [REDACTED] with Premium Assistance. The Appellant's representative testified that she had tried to work with the employer's Human Resources Director to see if the medical providers could receive payment directly through the health reimbursement arrangement, but that that was not possible.

After the hearing, the Premium Assistance representative sent an email citing the specific regulation that she referenced at the hearing and the 2025 and 2026 deductible limits. Exhibit 5. The Appellant's representative submitted an email stating that she was attaching Eligibility Operations Memo 25-11: *Updated—Changes to MassHealth Premium Assistance Plan Eligibility and Deductible Threshold Guidance* (July 2025). Exhibit 6. The Appellant's representative also stated that she could reimburse MassHealth directly through a health reimbursement arrangement (HRA) or "it could be taken out of our reimbursement to make it meet the qualifications." *Id.* at 1. The Appellant's representative sent a subsequent email stating that based on information in the Appellant's Harvard Pilgrim portal, the Appellant was \$662.00 away from having Harvard Pilgrim pay the rest of the Appellant's health claims at 100%, and that the plan runs from October 1, 2025, to September 30, 2026. Exhibit 7. What was included indicated that the Appellant had met the \$4,000.00 deductible and was \$662.44 away from meeting the \$5,000.00 in-network, out-of-pocket spending threshold where [REDACTED] would pay her remaining services in full for the rest of the plan year. *Id.* at 4. The Appellant wrote "Keeping [Appellant] on her private insurance and allowing us to have premium assistance would make financial sense for all parties. Our current insurance deductible is \$800 over the eligibility for [Appellant], I would want that amount to be taken out of our reimbursement so we are compliant." *Id.* at 1. The Premium Assistance representative responded that "the plan still does not meet the guidelines." *Id.*

Findings of Fact

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

1. The Appellant is [REDACTED] years old. Testimony, Exhibit 4.
2. The Appellant is a MassHealth Standard member, whose benefit is active through the Social Security Administration. Testimony.
3. For an employer-sponsored health plan to meet the basic benefit level, and qualify for premium assistance, for 2025, it cannot have an annual deductible greater than \$2,950.00 for an individual plan and \$5,900.00 for a family plan. For 2026, the limits are \$3,200.00 for an individual plan, and \$6,400.00 for a family plan. Testimony, Exhibit 5.²

² The administrative bulletins are available at [Administrative Information Bulletin 02-24](#) and [Administrative Information Bulletin 01-25](#).

4. [REDACTED] plan has an annual deductible of \$4,000.00 for an individual and \$8,000.00 for a family plan for the plan year of October 1, 2025, to September 30, 2026. Testimony, Exhibit 2.
5. By notice dated October 8, 2025, MassHealth notified the Appellant's father that he was no longer eligible for premium assistance and that MassHealth had stopped the household's premium assistance payments. Exhibit 1.
6. The Appellant's representative filed this appeal with the Board of Hearings in a timely manner on October 15, 2025. Exhibit 2.
7. The Appellant's mother, and appeal representative, testified that she had tried to work with the employer's Human Resources Director to see if the family's medical providers could receive payment directly through the health reimbursement arrangement, but that that was not possible.

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 premium assistance 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 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).³

130 CMR 506.012(B).

In this appeal, MassHealth argues that Appellant does not qualify for premium assistance payments because her employer sponsored insurance plan [REDACTED] does not meet the criteria specified in subsection (B)(1), above. Specifically, MassHealth determined that Appellant's plan does not meet the basic benefit level (BBL) because the plan's annual deductible exceeds the maximum limit. MassHealth defines the BBL as follows:

(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.

130 CMR 501.001.

³ Subsection (C) of 130 CMR 506.012 includes employer sponsored insurance as one of the enumerated qualifying policy types.

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), and MassHealth does not allege that Appellant’s insurance plan stopped covering the core services cited above. Rather, MassHealth’s decision to terminate Appellant’s premium assistance benefit is based solely on the deductible amount. The central issue on appeal, therefore, turns to the second inquiry posited under the BBL definition and whether the Appellant’s deductible is in line with the regulations set by the Health Connector. See 130 CMR 501.001.

956 CMR 5.03(2) and (3) provide:

(2) A Health Benefit Plan, or the aggregate of multiple Health Benefit Plans, that otherwise meets the requirements of 956 CMR 5.03(1) may incorporate the following and continue to be considered as providing minimum creditable coverage:

(a) A Health Benefit Plan may impose reasonable exclusions and limitations, including different benefit levels for in-network and out-of-network providers. Exclusions and limitations on benefits should be identified in plain language and non-discriminatory in their design and application. For a Health Benefit Plan that does not have a network design, the overall Health Benefit Plan design must meet the requirements of 956 CMR 5.03(1) to be considered as providing minimum creditable coverage.

(b) A Health Benefit Plan may impose varied levels of Co-payments, Deductibles and Co-insurance, provided that:

1. the plan must disclose to Covered Persons the Deductible, Co-payment and Co-insurance amounts applicable to in-network and out-of-network Covered Services;
2. any Deductible(s) for in-network Covered Services that are provided as part of the plan benefits shall not in combination exceed \$2,000 for an individual and \$4,000 for a family;
3. 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). Such amounts are typically published by the Secretary in the annual Notice of Benefit and Payment Parameters regulations. If the amount of any adjustment is not a multiple of \$50, such adjustment shall be rounded down to the next lowest multiple of \$50. The dollar amounts for a family specified in 956 CMR 5.03(2)(b)2. shall be increased each year to an amount equal to twice the amount in effect for an individual, as adjusted pursuant to 956 CMR 5.03(2)(b)3.; and
4. the dollar amount of any separate Deductible imposed for prescription drug coverage shall, unless the Connector Board establishes otherwise for a given calendar year, not exceed an amount equal to 12.5% of the total Deductible limits for individuals and families, respectively, as determined by 956 CMR 5.03(2)(b)3. If the amount of any adjustment is not a multiple of \$10, such adjustment shall be rounded down to the

nearest multiple of \$10.

(c) 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.

1. The Out-of-pocket Maximum for in-network Covered Services, or the sum of the Out-of-pocket Maximums for in-network Covered Services, shall not exceed the dollar amounts in effect under the Internal Revenue Code § 223(c)(2)(A)(ii) for self-only and family coverage, respectively, for each taxable year.

2. The dollar amounts for individuals specified in 956 CMR 5.03(2)(c)1. shall refer to the dollar amount in effect under the Internal Revenue Code § 223(c)(2)(A)(ii) during the tax year 2014, adjusted 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. If the amount of any increase is not a multiple of \$50, such increase shall be rounded to the next lowest multiple of \$50. The dollar amounts for a family specified in 956 CMR 5.03(2)(c)1. shall be increased to an amount equal to twice the amount in effect for individuals as described in 956 CMR 5.03(2)(c)2.

(d) A Health Benefit Plan with Deductibles exceeding 956 CMR 5.03(2)(b) and/or Out-of-pocket Maximums for in-network Covered Services exceeding 956 CMR 5.03(2)(c) may be combined with a health reimbursement arrangement, or HRA, so that, together, the "net" Deductible amount (i.e., the annual Deductible less the annual HRA funding) and Out-of-pocket Maximum of the combined Health Benefit Plans satisfy 956 CMR 5.03(2)(b) and (c).

(e) A Health Benefit Plan that does not meet the standards for minimum creditable coverage under 956 CMR 5.03(1) and (2) on its own may be combined with additional Health Benefit Plans so that, together in the aggregate, the combined health benefit plans (the net result thereof) satisfy 956 CMR 5.03(1) and (2). For purposes of aggregating multiple Health Benefit Plans under 956 CMR 5.03, the following are examples of permissible aggregations:

1. A Health Benefit Plan that excludes prescription drug coverage may be combined with a separate prescription drug-only Health Benefit Plan so that, together in the aggregate, the combined Health Benefit Plans satisfy 956 CMR 5.03(2)(b).

2. A Health Benefit Plan that excludes coverage for mental health services may be combined with a separate mental health services Health Benefit Plan so that, together in the aggregate, the combined Health Benefit Plans satisfy the standards of minimum creditable coverage.

(3) Notwithstanding any other requirement under 956 CMR 5.03, the following shall be deemed to provide minimum creditable coverage:

(a) a Catastrophic Health Plan as defined in 42 U.S.C. § 18022(e);

(b) any health benefit coverage defined as "creditable coverage" in M.G.L. c. 111M, § 1(b) through (l);

(c) a high deductible health plan ("HDPH") which:

1. complies with federal statutory and regulatory requirements under 26 U.S.C. § 223;

and

2. complies with 956 CMR 5.03(1)(a), (c), (d) and (e) (to the extent the requirements of 956 CMR 5.03(1) are not inconsistent with federal statutory and regulatory requirements for an HDHP under 26 U.S.C. § 223); and either

3. the carrier or plan sponsor facilitates access to an HSA administrator (i.e., financial institution) to enable a Covered Person to establish and fund an HSA in combination with a federally compliant HDHP; or

4. the plan sponsor establishes and maintains a Health Reimbursement Arrangement ("HRA") in combination with a federally compliant HDHP.

(d) any health arrangement provided by an established religious organization comprised of individuals with sincerely held beliefs, provided that the organization:

1. is not a for-profit organization;

2. does not make any direct or indirect representation that the organization has sufficient financing to meet members' anticipated financial or medical needs or that it has had a successful history of meeting members' financial or medical needs, provided that this requirement shall not apply to any financial statement that the organization is otherwise required to disclose by law;

3. does not use compensated sales agents, sales tactics, or deceptive marketing practices to solicit or enroll members, including that it does not use common insurance terms, such as "health plan," "coverage," "copay," "copayment," "deductible," "premium," and "open enrollment," or refer to itself as "licensed" in advertisements, marketing material, brochures, or other materials related to the arrangement;

4. does not use funds paid by members for medical needs to cover administrative costs;

5. provides disclosure that the organization is not an insurance company and does not guarantee that medical bills will be paid by the organization or any other individuals; such disclosure must be made at initial contact with a prospective member, at the time of any material modification to the terms of the sharing arrangement, and in all advertising, brochures, and marketing materials;

6. reports annually to the Connector any information about membership, operations, and finances as the Connector may require; and

7. meets such other criteria that the Connector may deem appropriate to ensure that individuals participating in such arrangements participate only in those operating in a manner consistent with the requirements described in 956 CMR 5.03(3)(d)(1)-(6).

(e) any currently operating U.S. Veterans Administration healthcare program administered by the U.S. Veterans Administration;

(f) any health plan offered or approved by the Corporation for National and Community Service for members of the AmeriCorps National Service Network (i.e., AmeriCorps State, AmeriCorps National, Volunteers in Service to America (VISTA), and National Civilian Community Corps (NCCC)), pursuant to the Domestic Volunteer Service Act (42 U.S.C. § 4950 et seq.) or the National and Community Service Act (42 U.S.C. § 12501 et seq.); and

(g) a Health Benefit Plan that does not meet every element of minimum creditable coverage

required under 956 CMR 5.03(1), but which the Connector, in its discretion, has determined:

1. conforms with the regulatory requirements under 956 CMR 5.00 relating to Core Services (without limitation) and a "broad range of medical benefits";
2. does not fail the standards of minimum creditable coverage established in 956 CMR 5.03(1)(c)3; and
3. has an actuarial value equal to or greater than any Bronze-level plan offered through the Connector as certified by an actuary.

Eligibility Operations Memo 25-11: *Updated—Changes to MassHealth Premium Assistance Plan Eligibility and Deductible Threshold Guidance* (July 2025) states that:

This memo supersedes MassHealth Eligibility Operations Memo 25-06. It also summarizes changes to MassHealth's Premium Assistance (PA) Program eligibility policies related to deductible thresholds and models, such as health reimbursement arrangements (HRAs) and similar benefits. These changes reflect revisions to 130 CMR 506.012 and 130 CMR 501.001 that are currently in progress.

Effective April 2025, employer-sponsored insurance (ESI plans with certain HRAs or similar benefits that reduce the deductible below the PA deductible threshold, as described below, are eligible for MassHealth PA.

A number of ESI plans use HRAs or similar benefits funded by the employer or insurance plan to reduce the effective deductible for the member. Because portions or all of these HRAs and similar benefits are not funded by members, they effectively lower members' out-of-pocket costs, and should be considered when determining whether a plan meets the basic benefit level (BBL).

Explanation of Interaction Between HRAs and Deductible Thresholds

Certain types of benefits receive financial contributions from the employer or insurance plan; providers receive payment from these benefits directly. These HRAs or similar benefits pose no financial risk to either the member or MassHealth and truly reduce the member's effective deductible.

....

Effective April 2025, the MassHealth PA Program may approve ESI plans for PA eligibility if an HRA or similar benefit reduces the deductible below the maximum deductible threshold, provided that the benefit meets the following two criteria.

- 1. The benefit is entirely funded by the employer and/or health insurance plan, with no financial contribution to the benefit by the health insurance policyholder or members of their household.**

This criterion refers only to a benefit or the portion of a benefit that reduces the annual deductible for an individual's health insurance plan below the current PA

maximum annual deductible threshold of \$2,950 for an individual plan and \$5,900 for a family plan. The health insurance policyholder or members of their household may provide a financial contribution to the benefit as long as this financial contribution would not result in the individual or family contributing out of pocket toward their annual deductible an amount exceeding the MassHealth PA maximum annual deductible thresholds. . . .

- 2. The provider receives 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 portion of the deductible reduced by the benefit.**

Exhibit 6 at 3-5.

Here, the Appellant's representative agreed that the HRA does not meet the second criterion of EOM 25-11, whereby the provider would be paid directly from the benefit and/or health insurance plan. Therefore, the exception allowed for by EOM 25-11 does not apply in the present case. Because the [REDACTED] deductibles of \$4,000.00 and \$8,000.00 exceed the 2025 and 2026 Premium Assistance thresholds, the Appellant did not establish that MassHealth erred in its October 8, 2025 notice.⁴

I understand the Appellant's representative's testimony, that based on the specifics of the Appellant's situation that it may be more cost-effective for MassHealth to have the Appellant remain enrolled in the [REDACTED] with Premium Assistance and that there may be policy benefits to making an exception on a case-by-case basis. However, I am responsible for interpreting the regulations as written and as interpreted by MassHealth. To the extent that the Appellant's request for an exception is a challenge to the legality of the MassHealth regulations, in accordance with 130 CMR 610.082(C)(2), as the hearing officer, I

must not render a decision regarding the legality of federal or state law including, but not limited to, the MassHealth regulations. If the legality of such law or regulations is raised by the appellant, the hearing officer must render a decision based on the applicable law or regulation as interpreted by the MassHealth agency. Such decision must include a statement that the hearing officer cannot rule on the legality of such law or regulation and must be subject to judicial review in accordance with 130 CMR 610.092.

130 CMR 610.082(C)(2).

The appeal is denied.

⁴ I have no information in the record before me to indicate that the Harvard Pilgrim HMO is a high-deductible plan as described in 956 CMR 5.03(3)(c).


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.

Emily Sabo
Hearing Officer
Board of Hearings


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

cc: MassHealth Representative: Premium Assistance, 519 Somerville Avenue, #372, Somerville, MA 02145