Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
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MassHealth
Eligibility Letter 100
March 1, 2003

TO: Division Staff

FROM: Douglas S. Brown, Acting Commissioner

RE: **Changes to MassHealth CommonHealth, MassHealth Family Assistance, and MassHealth Premium Assistance Premiums**

The monthly premiums for MassHealth CommonHealth, MassHealth Family Assistance, and MassHealth Premium Assistance are changing.

- For Family Assistance members who are HIV positive and for MassHealth CommonHealth members, there is a new premium schedule. Beginning with their March 2003 bill, members will be required to pay a premium based on their income and family size as it relates to the federal poverty level. Members for whom MassHealth is their only form of health insurance, or for whom MassHealth pays for all or part of their health insurance, including Medicare, will be charged the full premium. Members who have other health insurance that is not paid for by MassHealth will be charged a supplemental premium.
- For MassHealth Premium Assistance members, the amount they pay towards their employer-sponsored health insurance will increase: a) from $10 per child to $12 per child with a maximum of $36 per family; and b) from $25 per adult to $27 per adult if he or she has no children. If a member currently does not pay a premium, he or she will now be charged a premium based on these new figures. Members who are HIV positive will be required to pay the full premium from the CommonHealth premium schedule towards their employer-sponsored health insurance.
- The premium amount for MassHealth Purchase of Benefits members will increase from $10 per child to $12 per child with a maximum of $36 per family.
- Certain members who were previously enrolled in the Children's Medical Security Plan (CMSP) and were exempted from paying a premium will now be responsible for paying a monthly premium. Members who receive 60-day presumptive or time-limited eligibility under MassHealth Family Assistance will also now be responsible for paying a monthly premium.
- Family Assistance members who are HIV positive will no longer have their premiums waived.

These regulations are effective March 1, 2003.

MANUAL UPKEEP

Insert	**Remove**	**Trans. By**
501.006	501.006	E.L. 51
505.005 (3 of 10)	505.005 (3 of 10)	E.L. 81
505.005 (6 of 10)	505.005 (6 of 10)	E.L. 81
505.005 (7 of 10)	505.005 (7 of 10)	E.L. 81
505.005 (8 of 10)	505.005 (8 of 10)	E.L. 81
505.005 (9 of 10)	505.005 (9 of 10)	E.L. 81
505.005 (10 of 10)	505.005 (10 of 10)	E.L. 81
506.011 (1 of 4)	506.011 (1 of 6)	E.L. 83
506.011 (2 of 4)	506.011 (2 of 6)	E.L. 83
506.011 (3 of 4)	506.011 (3 of 6)	E.L. 53
506.011 (4 of 4)	506.011 (4 of 6)	E.L. 51
----	506.011 (5 of 6)	E.L. 51
----	506.011 (6 of 6)	E.L. 88
506.012 (2 of 5)	506.012 (2 of 5)	E.L. 88
506.012 (4 of 5)	506.012 (4 of 5)	E.L. 81
506.012 (5 of 5)	506.012 (5 of 5)	E.L. 81

(B) Families Who Have Met a Deductible. Families (including caretaker relatives) with children under 18 who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who were denied with a deductible before July 1, 1997, and subsequently meet a deductible on or after July 1, 1997, and whose family group gross income exceeds MassHealth standards will be eligible for MassHealth Standard for one year from the end of the deductible period, except in the following circumstances:

(1) the individual or family no longer lives in Massachusetts;

(2) the individual enters an institution;

(3) the individual turns 65;

(4) the individual or all members of the family are deceased; or

(5) the individual or family is no longer categorically eligible.

A determination of eligibility for MassHealth will be made toward the end of the one-year period.

(C) Disabled Individuals Who Have Met a Deductible. Disabled individuals who were receiving Medical Assistance on June 30, 1997, as a result of meeting a deductible, or who meet a deductible on or after July 1, 1997, will have their continuing eligibility for MassHealth determined in accordance with 130 CMR 506.009.

501.006: Children Receiving Benefits under the Children's Medical Security Plan on August 3, 1998

(A) Eligibility.

(1) Children who were receiving benefits under the Children's Medical Security Plan on August 3, 1998, as well as any siblings in their family group, will be treated as a protected status group under MassHealth if they:

(a) have submitted a complete Medical Benefit Request as defined in 130 CMR 502.001 by March 31, 1999;

(b) meet the eligibility requirements of MassHealth; and

(c) have a family group gross income less than or equal to 200 percent of the FPL.

(2) Families of children described in 130 CMR 501.006(A)(1) who are determined eligible for MassHealth Family Assistance will have the option of choosing purchase of medical benefits or premium assistance under MassHealth Family Assistance if the Division determines the child has access to health insurance from an employer other than the Commonwealth of Massachusetts.

(B) Loss of Protected Status. The protected status of a child described in 130 CMR 501.006(A) will end in the following circumstances:

(2) Waiver of Access Requirement. The Division may waive its requirement to access health insurance if the Division determines it is more cost effective to the Division to purchase medical benefits under MassHealth Family Assistance than to assist the family with payment of health-insurance premiums.

(3) Eligibility for a Limited Period of Time.

(a) The Division may determine a child who meets the requirements of 130 CMR 505.005(B)(1)(a)(ii) and (iii) eligible for medical benefits under MassHealth Family Assistance for a limited period of time if:

(i) the child is currently uninsured; and

(ii) a family group member has indicated employer-sponsored health insurance may be available.

The begin date for these benefits is established in accordance with 130 CMR 505.005(E)(4). Premiums are established in accordance with 130 CMR 506.011(I).

(b) During this limited period, the Division determines if the insurance that is available to the child meets the basic-benefit level as described at 130 CMR 501.001, and whether the employer contributes at least 50 percent of the premium cost.

(c) If the Division determines the child has access to insurance as described at 130 CMR 505.005(B)(1)(a)(i), the applicant is notified in writing of the child's eligibility for premium assistance and the need to enroll in such insurance. The child continues to be eligible for medical benefits for up to 60 days from the date of this notice to allow time for enrollment in the health-insurance plan. Once enrolled in the health-insurance plan, the child becomes eligible for premium assistance payments as described in 130 CMR 505.005(B)(4).

(d) The medical benefits described in 130 CMR 505.005(B)(3)(c) end when the child is covered under the health-insurance plan. Coverage also ends if the family group member fails to enroll the child in the health-insurance plan, or fails to submit proof of such enrollment within 60 days of being notified of this requirement.

(e) If the Division determines the available insurance does not meet the requirements of 130 CMR 505.005(B)(1)(a) or, if the Division is unable to complete its evaluation of the health insurance within 60 days of the Division's receipt of a complete MBR, the applicant is notified in writing of the child's eligibility for the purchase of medical benefits under MassHealth Family Assistance, as described in 130 CMR 505.005(E).

(4) Premium Assistance Payment.

(a) The Division makes monthly payments on behalf of a child toward the cost of the employer-sponsored health insurance premium if:

(i) the child meets the requirements of 130 CMR 505.005(B)(1);

(iv) either have or choose to purchase available health insurance that the Division has determined to be cost effective, in accordance with 130 CMR 505.005(D)(2).

(b) The Division establishes eligibility under the provisions of 130 CMR 505.005(D) for persons who are HIV positive and who also meet the requirements of 130 CMR 505.005(B) or (C).

(2) Cost Effectiveness Determination. The Division determines the cost effectiveness of the available insurance plan to establish the appropriate premium assistance payment amount, and notifies the applicant or member of its decision.

(3) Premium Assistance Payment. The Division makes monthly premium payments on behalf of members through its Health Insurance Premium Program (HIPP). Health insurance premium payments are made directly to the insurance carrier, the employer, or to the most appropriate party, as determined by the Division. If a direct payment is made to a family group member, proof of health-insurance payments may be required from the parent or member.

(4) Premium Assistance Payment Amount. The Division provides premium assistance in accordance with 130 CMR 506.012(F).

(5) Eligibility Date.

(a) Premium assistance payments begin in the month of the Division's eligibility determination or the month in which the insurance deductions begin, whichever is later. These payments are for the following month's coverage.

(b) Persons eligible under the provisions of 130 CMR 505.005(D) are also eligible for services provided under the purchase of medical benefits as described in 130 CMR 450.105(H)(3) to the extent these services are not covered by the individual's employer-sponsored health insurance. The medical coverage date for these services is established in accordance with 130 CMR 505.005(F)(3).

(6) Premium Assistance for Persons Who Have Not Yet Verified HIV-Positive Status. The Division also provides premium assistance, in accordance with 130 CMR 505.005(D), to persons meeting the requirements of 130 CMR 505.005(G)(1)(a) who would otherwise be eligible for premium assistance under 130 CMR 505.005(C).

(E) The Purchase of Medical Benefits for Children.

(1) Eligibility Requirements. Children under the age of 19 are eligible for the purchase of medical benefits under MassHealth Family Assistance if they meet all of the following requirements:

(a) the child's family group gross income is above 150 percent but does not exceed 200 percent of the federal-poverty level;

(b) the child is ineligible for MassHealth Standard or MassHealth CommonHealth; and

(c) the child is uninsured and does not have access to health insurance.

(2) Presumptive Eligibility Requirements. The Division may determine uninsured children presumptively eligible for medical benefits under MassHealth Family Assistance in accordance with the requirements of 130 CMR 502.003 if the self-declared gross income of the family group is above 150 percent but does not exceed 200 percent of the federal-poverty level.

(3) Premium. Families of children who meet the requirements of 130 CMR 505.005(E)(1) and (2) are assessed a monthly premium in accordance with 130 CMR 506.011(I). Children who are eligible for a limited period of time, as described at 130 CMR 505.005(B)(3), and children who meet the requirements at 130 CMR 501.006 are also assessed a monthly premium in accordance with 130 CMR 506.011(I).

(4) Medical Coverage Date.

(a) The medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site if all required verifications have been received within 60 days of the date of the Request for Information.

(b) If required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(E)(4)(a), the begin date of medical coverage is 10 days before the date on which the verifications were received if these verifications are received within one year of receipt of the Medical Benefit Request.

(c) The begin and end dates for medical coverage under presumptive eligibility are described in 130 CMR 502.003.

(F) The Purchase of Medical Benefits for Persons Who Are HIV Positive.

(1) Eligibility Requirements.

(a) Persons who are HIV positive may establish eligibility for the purchase of medical benefits if they:

(i) are under the age of 65;

(ii) have family group gross income that is less than or equal to 200 percent of the federal poverty level;

(iii) are ineligible for MassHealth Standard or MassHealth CommonHealth; and

(iv) do not have health insurance.

(b) The Division establishes eligibility under the provisions of 130 CMR 505.005(F) for persons who are under the age of 19 and are HIV positive, and who also meet the requirements of 130 CMR 505.005(E).

(2) Premium. Individuals who meet the requirements of 130 CMR 505.005(F) are assessed a monthly premium in accordance with 130 CMR 506.011(H).

(3) Medical Coverage Date.

(a) The medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site. However, the medical coverage date will in no event begin before April 1, 2001.

(b) If required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(G)(1)(b), the begin date of medical coverage is 10 days before the date on which the verifications were received if such verifications are received within one year of receipt of the Medical Benefit Request.

(G) Fee-for-Service Benefits for Persons Who Are HIV Positive.

(1) Persons Who Have Claimed on the MBR to be HIV Positive.

(a) Eligibility Requirements. Persons who have claimed on the MBR to be HIV positive may establish temporary eligibility for fee-for-service benefits if they:

(i) are under the age of 65;

(ii) have a verified family group gross income that is less than or equal to 200 percent of the federal poverty level; and

(iii) are ineligible for MassHealth Standard or MassHealth CommonHealth.

(b) Time Frames for Verification.

(i) Persons who have claimed on the MBR to be HIV positive must submit verification of their HIV-positive status within 60 days of their eligibility determination. If verifications are not submitted, the Division redetermines their eligibility as if they were not HIV positive.

(ii) Verification of HIV-positive status can be a letter from a doctor, qualifying health clinic, laboratory, or AIDS service provider or organization. The letter must indicate the member's name and his or her HIV-positive status.

(c) Members who have other health insurance must access those benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are rendered.

(d) Premium. Individuals who meet the requirements of 130 CMR 505.005(G) are assessed a monthly premium in accordance with 130 CMR 506.011(H).

(e) Medical Coverage Date.

(i) The medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site. However, the medical coverage date will in no event begin before April 1, 2001.

(ii) If required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(G)(1)(b), the begin date of medical coverage is 10 days before the date on which the verifications were received if such verifications are received within one year of receipt of the Medical Benefit Request.

(f) Premium Assistance for Persons Who Have Not Verified HIV-Positive Status. Persons who meet the requirements of both 130 CMR 505.005(G)(1)(a) and 505.005(C) receive benefits under 130 CMR 505.005(D). If verification of their HIV-positive status is not submitted within 60 days, they receive benefits under 130 CMR 505.005(C), if otherwise eligible.

(2) Persons Who Have Verified Their HIV-Positive Status.

(a) Eligibility Requirements. Persons who have verified their HIV-positive status, in accordance with 130 CMR 505.005(G)(1)(b), may establish eligibility for fee-for-service benefits if they:

(i) are under the age of 65;

(ii) have a family group gross income that is less than or equal to 200 percent of the federal poverty level;

(iii) are ineligible for MassHealth Standard or MassHealth CommonHealth; and

(iv) have declared that they have other health insurance.

(b) Members receive benefits on a fee-for-service basis:

(i) while the Division investigates the member's private health insurance to determine if premium assistance is available; or

(ii) if the Division determines the member's health insurance is not cost effective.

(c) Members who have other health insurance must access those benefits and must show both their private health insurance card and their MassHealth card to providers at the time services are rendered. The fee-for-service benefit applies only to services not covered by the member's private health insurance.

(d) Premium. Individuals who meet the requirements of 130 CMR 505.005(G) are assessed a monthly premium in accordance with 130 CMR 506.011 (H).

(e) Medical Coverage Date.

(i) The medical coverage date for the purchase of medical benefits under MassHealth Family Assistance begins on the 10th day before the date a Medical Benefit Request is received at any MassHealth Enrollment Center or received by a Division outreach worker at a designated outreach site. However, the medical coverage date will in no event begin before April 1, 2001.

(ii) If required verifications listed on the Request for Information are received after the 60-day period referenced in 130 CMR 505.005(G)(1)(b), the begin date of medical coverage is 10 days before the date on which the verifications were received if such verifications are received within one year of receipt of the Medical Benefit Request.

(H) Referral to Children's Medical Security Plan. The Division submits the names of children whose family group gross income exceeds 200 percent of the federal-poverty level to the Children's Medical Security Plan.

506.011: CommonHealth and Family Assistance Premiums

The Division may charge a premium to certain CommonHealth and Family Assistance members with incomes above 150 percent of the federal poverty level. CommonHealth premiums are based on family group gross countable income, family group size as it relates to the federal poverty level income guidelines, and whether or not the member has other insurance. Family Assistance premiums for the purchase of medical benefits as described in 130 CMR 505.005(E) are based on the number of eligible members in the family group. Only one premium per family group will be assessed. When the family group contains at least one CommonHealth-eligible member, and at least one member who is eligible for Family Assistance, the family group will be responsible for only the higher premium amount or member share.

(A) Premium Payments. The Division may charge monthly premiums to persons described in 130 CMR 501.006, 505.004(B), (C), (D), and (E), and 505.005(B)(3), (E), (F), and (G).

(1) Persons described in 130 CMR 501.006, 505.004(B), (D), and (E), and 505.005(B)(3), (E), (F), and (G) who are assessed a premium, are responsible for monthly premium payments beginning with the calendar month following the date of the Division's eligibility determination.

(2) Persons described in 130 CMR 505.004(C), who are assessed a premium, are responsible for monthly premium payments beginning with the calendar month following the date the deductible period ends, or the calendar month following the month in which the member has verified that the deductible has been met, whichever is later.

(3) Members who are assessed a revised premium as the result of a reported change, or any adjustment in the premium schedule are responsible for the new premium payment beginning with the calendar month following the reported change.

(4) Members who have been assessed premiums but who are subsequently determined eligible for a coverage type other than CommonHealth or Family Assistance are not charged a premium for the calendar month in which the coverage type changes or thereafter.

(B) Delinquent Premium Payments. If the Division has billed a member for a premium payment, and the member does not pay all of the amount billed within 60 days of the date on the bill, then the member's eligibility for benefits is terminated, except as provided below. The member receives a notice of termination before the date of termination. The member's eligibility will not be terminated if, before the date of termination, the member:

(1) pays all amounts that have been billed 60 days or more before the date such payment is made; or

(2) establishes a payment plan acceptable to the Division. After such a payment plan has been established, the Division bills the member for: (a) payments in accordance with the payment plan; and (b) monthly premiums due subsequent to the establishment of the payment plan. 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 eligibility is terminated. If the member

does not pay monthly premiums due subsequent to the establishment of the payment plan within 60 days of the date on the bill, the member's eligibility is terminated.

(C) Reactivating Coverage Following Termination Due to Delinquent Payment. After the member has paid in full all payments due, or has established a payment plan with the Division, the Division will reactivate coverage if the member is otherwise eligible.

(D) Waiver of Outstanding Premium Payments. If a member whose eligibility has been terminated due to nonpayment of premiums reapplies and is determined eligible for MassHealth after 24 months, the outstanding premium payments are waived.

(E) Waiver or Reduction of Premiums for Extreme Financial Hardship. If the Division determines that the requirement to pay a premium results in an extreme financial hardship for a MassHealth member, the Division may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a particular family. Requests for premium relief should be addressed to the Division.

(F) Voluntary Withdrawal. If a member voluntarily withdraws, coverage continues through the end of the calendar month of withdrawal. The member is responsible for the payment of all premiums through the calendar month of withdrawal.

(G) Change in Premium Calculation. The premium amount is recalculated when the Division is informed of changes in income, family group size, or health-insurance status, and whenever an adjustment is made in the CommonHealth premium schedule or the Family Assistance premium amount for the purchase of medical benefits.

(H) The Monthly CommonHealth Premium Schedule. 130 CMR 506.011(H) provides the formulas that the Division uses to determine the monthly CommonHealth premium for which CommonHealth members and certain MassHealth Family Assistance members who are HIV positive are responsible.

(1) Full Premium Formula. Full payment is required of members who have no health insurance and of members for whom the Division is paying a portion of their health-insurance premium. The full premium formula is provided below.

FULL PREMIUM FORMULA		
Base Premium	**Additional Premium Cost**	**Range of Premium Cost**
Above 150% FPL—start at $15	Add $5 for each additional 10% FPL until 200% FPL	$15 — $35
Above 200% FPL—start at $40	Add $8 for each additional 10% FPL until 400% FPL	$40 — $192
Above 400% FPL—start at $202	Add $10 for each additional 10% FPL until 600% FPL	$202 — $392
Above 600% FPL—start at $404	Add $12 for each additional 10% FPL until 800% FPL	$404 — $632
Above 800% FPL—start at $646	Add $14 for each additional 10% FPL until 1000%	$646 — $912
Above 1000% FPL—start at $928	Add $16 for each additional 10% FPL	$928 + greater

(2) Supplemental Premium Formula. A lower supplemental payment is required of members who have health insurance to which the Division does not contribute. The supplemental premium formula is provided below.

SUPPLEMENTAL PREMIUM FORMULA	
% of Federal Poverty Level (FPL)	**Premium Cost**
Above 150% to 200%	60% of full premium
Above 200% to 400%	65% of full premium
Above 400% to 600%	70% of full premium
Above 600% to 800%	75% of full premium
Above 800% to 1000%	80% of full premium
Above 1000%	85% of full premium

(I) Family Assistance Premiums for the Purchase of Medical Benefits. MassHealth Family Assistance members for whom the Division purchases medical benefits under 130 CMR 505.005(B)(3) and (E) are assessed a monthly premium of $12 per child, with a maximum of $36 per family.

(J) Members Exempted from Premium Payment. MassHealth Family Assistance members who are American Indians or Alaska Natives, as defined in 130 CMR 501.001, are exempt from premium payments.

(D) The Monthly Premium Assistance Payment Formula for Children. The premium assistance payment calculation in 130 CMR 506.012(D) provides a formula for determining the Division's premium assistance payment amount for children, and the monthly amount members are required to pay towards their health insurance premiums.

(1) Actual Premium Assistance Payment Amount. The actual premium assistance payment amount is calculated by using the following formula.

(a) The estimated premium assistance payment amount is first determined by subtracting the employer share of the policyholder's health insurance premium and the Division's estimated member share of the health insurance premium from the total cost of the health insurance premium. The estimated member share is $12 per child with a maximum of $36 per family.

(b) The resulting estimated premium assistance payment amount is then compared to the cost-effective amount, as described below:

(i) if the family member is employed by a small employer as described at 130 CMR 501.001, the estimated premium assistance payment amount is compared to the cost-effective amount, which is the Division's cost of covering the family group members who are beneficiaries of the insurance; or

(ii) if the family member is employed by a large employer as described at 130 CMR 501.001, the estimated premium assistance payment amount is compared to the cost-effective amount, which is the Division's cost of covering MassHealth-eligible children who would be covered by the insurance.

(c) If the estimated premium assistance payment amount is less than the cost-effective amount, then the Division sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

(d) If the estimated premium assistance payment amount is equal to or greater than the cost-effective amount, then the Division sets the actual premium assistance payment amount at the cost-effective amount.

(2) Member Assignment. If the Division determines that a policyholder's share of the health insurance premium including any remaining premium, as described in 130 CMR 506.012 (D)(3)(b), would exceed five percent of the family group's gross income, the member must enroll in the purchase of medical benefits under MassHealth Family Assistance. This assignment is limited to those uninsured members who have access to health insurance.

(3) Estimated Member Share of Premium.

(a) Families are responsible for paying $12 per Family Assistance-eligible child, with a maximum of $36 per family toward the cost of covering their Family Assistance-eligible children under their employer-sponsored health insurance.

(E) The Monthly Premium Assistance Payment Formula for Adults. The premium assistance payment calculation in 130 CMR 506.012(E) provides a formula for determining the Division's premium assistance payment amount for adults who are employed by qualified employers, and the monthly amount members are required to pay toward their health insurance premiums. Adults whose children receive premium assistance in accordance with 130 CMR 505.005(B) or (D), or Health Insurance Premium Program (HIPP) payments in accordance with 130 CMR 507.003 have their premium assistance payments determined in accordance with 130 CMR 506.012(D).

(1) Actual Premium Assistance Payment Amount. The actual premium assistance payment amount is calculated by using the following formula.

(a) The estimated premium assistance payment amount is first determined by subtracting the employer share of the policyholder's health insurance premium and the Division's estimated member share of the health insurance premium from the total cost of the health insurance premium. The estimated member share is $27 per covered adult.

(b) The resulting estimated premium assistance payment amount is then compared to the maximum contribution amount, which is the maximum amount the Division pays per insured adult toward employer-sponsored health insurance.

(c) If the estimated premium assistance payment amount is less than the maximum contribution amount, then the Division sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

(d) If the estimated premium assistance payment amount is equal to or greater than the maximum contribution amount, then the Division sets the actual premium assistance payment amount at the maximum contribution amount.

(2) Estimated Member Share of Premium.

(a) The monthly premium amount for which premium assistance adults are responsible is determined as follows.

(i) If the family group's gross income is over 100 percent of the federal-poverty level, the premium is $27 per covered adult, except when a covered adult is eligible for MassHealth Standard or MassHealth CommonHealth. In this instance, the covered adult is not assessed a member share.

(ii) If eligibility is determined in accordance with 130 CMR 505.005(C), the person or couple is not responsible for paying a share of the premium if the family group's gross income is at or below 100 percent of the federal poverty level, or if there are children in the family receiving MassHealth and the family income does not exceed 150 percent of the federal poverty level.

(b) If the actual premium assistance payment amount is set at the maximum contribution amount, the member is responsible for payment of the remainder of the health insurance premium, which is the difference between the estimated premium assistance payment and the maximum contribution amount.

(3) Maximum Contribution Amount. The maximum contribution amount is the maximum amount, as determined by the Division, that the Division contributes per insured adult toward the policyholder's share of the health insurance premium when the health insurance plan is offered through a Division-approved billing and enrollment intermediary, or the Insurance Partnership agent.

(F) Calculation of Monthly Premium Amount for Adults Who Are HIV Positive. The formula for HIV-positive adults who are described in 130 CMR 505.005(D) is the same as the formula described at 130 CMR 506.012(E) except that the estimated member share will be the same as the appropriate Full CommonHealth Premium described at 130 CMR 506.011(H)(1). The maximum contribution amount will be the maximum amount that the Division contributes per insured adult who is HIV positive.

(G) Termination of Health Insurance. If a member's health insurance terminates for any reason, the Division's premium assistance payments end.