



Commonwealth of Massachusetts
Executive Office of Health and Human Services
Division of Medical Assistance
600 Washington Street
Boston, MA 02111
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MassHealth
Eligibility Letter 112
November 1, 2003

TO: Division Staff

FROM: Beth Waldman, Acting Commissioner *Beth Waldman*

RE: Premium Increases for MassHealth CommonHealth and Family Assistance Members and Premiums for MassHealth Standard Members

Currently, the Division charges monthly premiums to MassHealth CommonHealth and Family Assistance members whose income is above 150 percent of the federal poverty level. These revised regulations will now allow the Division to charge premiums to MassHealth CommonHealth and Family Assistance members whose income is above 100 percent of the federal poverty level.

Currently, the Division does not charge monthly premiums to MassHealth Standard members. These revised regulations will now allow the Division to charge premiums to:

- disabled adult MassHealth Standard members who are not parents, and whose income is above 114 percent of the federal poverty level; and
- all other MassHealth Standard members (except pregnant women and children under the age of six) whose income is at or above 133 percent of the federal poverty level.

These regulations are effective November 1, 2003.

MANUAL UPKEEP

<u>Insert</u>	<u>Remove</u>	<u>Trans. By</u>
504.002 (2 of 3)	504.002 (2 of 3)	E.L. 104
505.004	505.004	E.L. 106
505.005 (3 of 10)	505.005 (3 of 10)	E.L. 100
505.005 (7 of 10)	505.005 (7 of 10)	E.L. 100
505.005 (8 of 10)	505.005 (8 of 10)	E.L. 108
505.005 (9 of 10)	505.005 (9 of 10)	E.L. 108
505.005 (10 of 10)	505.005 (10 of 10)	E.L. 108
506.000	506.000	E.L. 62
506.009 (1 of 2)	506.009 (1 of 2)	E.L. 53
506.011 (1 of 4)	506.011 (1 of 4)	E.L. 100
506.011 (2 of 4)	506.011 (2 of 4)	E.L. 108
506.011 (3 of 4)	506.011 (3 of 4)	E.L. 106
506.011 (4 of 4)	506.011 (4 of 4)	E.L. 100
506.012 (5 of 5)	506.012 (5 of 5)	E.L. 100

Trans. by E.L. 112

	MASSHEALTH		
	CITIZENSHIP AND IMMIGRATION	Chapter	504
Rev. 11/01/03	(2 of 3)	Page	504.002

(g) Aliens granted deferred action status.

(h) Aliens living under orders of supervision.

(i) Aliens who have entered and continuously lived in the United States since before January 1, 1972.

(j) Aliens granted suspension of deportation, and whose departure the DHS does not contemplate enforcing.

(k) Any other aliens living in the United States with the knowledge and consent of the DHS, and whose departure the DHS does not contemplate enforcing. (These include permanent nonimmigrants as established by Public Law 99-239, and persons granted Extended Voluntary Departure due to conditions in the alien's home country based on a determination by the Secretary of State.)

(2) Persons described below who are not otherwise defined as qualified aliens under 130 CMR 504.002(B) are the following.

(a) Persons admitted for legal permanent residence (LPR) under the INA.

(b) Persons granted parole for at least one year under section 212(d)(5) of the INA.

(c) Conditional entrants under section 203(a)(7) of the INA as in effect before April 1, 1980.

(E) Nonqualified Alien. Aliens whose status is not described in 130 CMR 504.002(B), (C), or (D) are considered nonqualified aliens.

(F) Applicable Coverage Types.

(1) Citizens, qualified aliens, and protected aliens may receive MassHealth under any coverage type if they meet the eligibility requirements described in 130 CMR 505.000 et seq.

(2) Aliens with special status may not receive coverage under MassHealth Standard. However, they may be eligible for:

(a) MassHealth CommonHealth, if they are under age 19, disabled, and meet the categorical requirements and financial standards of MassHealth Standard as described at 130 CMR 505.002(F) or MassHealth CommonHealth if they are under age 19 and meet the categorical requirements and financial standards as described at 130 CMR 505.004;

(b) MassHealth Family Assistance, if they are children under age 19, parents under age 19, or pregnant women under age 19 who meet the categorical requirements and financial standards of MassHealth Standard as described at 130 CMR 505.002(C), (D), or (E). If they meet these requirements and have health insurance, they are also eligible for MassHealth Limited;

Trans. by E.L. 112**MASSHEALTH
COVERAGE TYPES****Chapter 505
Page 505.004**

Rev. 11/01/03

(4) be ineligible for MassHealth Standard.

(C) Disabled Adults. Disabled adults must meet the following requirements:

- (1) be aged 19 through 64;
- (2) be permanently and totally disabled, as defined in 130 CMR 501.001;
- (3) be ineligible for MassHealth Standard; and
- (4) meet a one-time-only deductible in accordance with 130 CMR 506.009.

(D) Disabled Children Under Age 18. Disabled children under age 18 must meet the following requirements:

- (1) be permanently and totally disabled based on the disability criteria for children under age 18, as defined in 130 CMR 501.001; and
- (2) be ineligible for MassHealth Standard.

(E) Disabled 18-Year-Olds. Disabled 18-year-olds must meet the following requirements:

- (1) (a) be ineligible for MassHealth Standard; and
 - (b) if not working, be permanently and totally disabled based on the disability criteria for adults and 18-year-olds, as defined in 130 CMR 501.001; or
- (2) if working, be permanently and totally disabled based on the disability criteria for adults and 18-year-olds (except for engagement in substantial gainful activity), as defined in 130 CMR 501.001.

(F) Determination of Disability. Disability is established by:

- (1) certification of legal blindness by the Massachusetts Commission for the Blind (MCB);
- (2) a determination of disability by the SSA; or
- (3) a determination of disability by the Division's Disability Determination Unit (DDU).

(G) MassHealth CommonHealth Premium. Disabled adults, disabled working adults, and disabled children who meet the requirements of 130 CMR 505.004 may be assessed a premium in accordance with the premium schedule provided in 130 CMR 506.011(I). No premium is assessed during a deductible period.

Trans. by E.L. 112**MASSHEALTH
COVERAGE TYPES****Rev. 11/01/03****Chapter 505
Page 505.005**

(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.

(b) The begin date for the benefits described in 130 CMR 505.005(B)(3)(a) is established in accordance with 130 CMR 505.005(E)(4). Premiums are established in accordance with 130 CMR 506.011(J).

(c) 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.

(d) 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).

(e) The medical benefits described in 130 CMR 505.005(B)(3)(d) 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.

(f) 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);

Trans. by E.L. 112

**MASSHEALTH
COVERAGE TYPES**

Rev. 11/01/03

**Chapter 505
Page 505.005****(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(J). 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(J).

(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:

Trans. by E.L. 112**MASSHEALTH
COVERAGE TYPES****Rev. 11/01/03****Chapter 505
Page 505.005**

- (i) are under the age of 65;
- (ii) have family group gross income that is less than or equal to 133 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(I).

(3) Medical Coverage Date.

(a) Except as provided in 130 CMR 501.003(E)(2)(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) Except as provided in 130 CMR 501.003(E)(2)(a), 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 these 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 133 percent of the federal poverty level; and
- (iii) are ineligible for MassHealth Standard or MassHealth CommonHealth.

Trans. by E.L. 112

**MASSHEALTH
COVERAGE TYPES**

Rev. 11/01/03

**Chapter 505
Page 505.005**

(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 provided.

(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(I).

(e) Medical Coverage Date.

(i) Except as provided in 130 CMR 501.003(E)(2)(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.

(ii) Except as provided in 130 CMR 501.003(E)(2)(a), 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 these 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 133 percent of the federal poverty level;

Trans. by E.L. 112

**MASSHEALTH
COVERAGE TYPES**

Rev. 11/01/03

**Chapter 505
Page 505.005**

- (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 provided. 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(I).
- (e) Medical Coverage Date.
 - (i) Except as provided in 130 CMR 501.003(E)(2)(b), 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) Except as provided in 130 CMR 501.003(E)(2)(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 these 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.

Trans. by E.L. 112

**MASSHEALTH
FINANCIAL REQUIREMENTS**

**Chapter 506
Page 506.000**

Rev. 11/01/03

TABLE OF CONTENTS

Section

- 506.001: Introduction
- 506.002: Financial Responsibility
- 506.003: Countable Income
- 506.004: Noncountable Income
- 506.005: Verification of Income
- 506.006: Transfer of Income
- 506.007: Calculation of Financial Eligibility
- 506.008: Cost-of-Living Adjustment (COLA) Protections
- 506.009: The One-Time Deductible
- 506.010: Verification of Medical and Remedial-Care Expenses
- 506.011: MassHealth Standard, CommonHealth, and Family Assistance Premiums
- 506.012: Family Assistance Premium Assistance Payments

Trans. by E.L. 112

**MASSHEALTH
FINANCIAL REQUIREMENTS**

Rev. 11/01/03

Chapter 506
(1 of 2) Page 506.009

506.009: The One-Time Deductible

(A) Eligibility Requirements. Disabled adults described in 130 CMR 505.004(C) may establish eligibility for MassHealth CommonHealth by meeting a one-time-only deductible. Once a deductible has been met, the person may be assessed a premium in accordance with the premium schedule in 130 CMR 506.011(I). Once the deductible has been met, the person is not required to meet another deductible if there is a lapse in CommonHealth coverage.

(B) Definition of the Deductible. The deductible is the total dollar amount of incurred medical expenses that an applicant, whose family group gross income exceeds 133 percent of the federal-poverty level, must be responsible for before MassHealth eligibility is established.

(C) The Deductible Period. The deductible period is a six-month period beginning on the date established in accordance with 130 CMR 505.004(I).

(D) Calculating the Deductible. The amount of the deductible is determined by comparing the gross monthly income of the family group to the MassHealth CommonHealth Monthly Deductible Income Standards provided in the chart below and multiplying the difference by six.

**THE MASSHEALTH COMMONHEALTH
MONTHLY DEDUCTIBLE INCOME STANDARDS**

Family Group SizeIncome Standards

1	542
2	670
3	795
4	911
5	1036
6	1161
7	1286
8	1403
9	1528
10	1653
	+ 133 for each additional person

Trans. by E.L. 112**MASSHEALTH
FINANCIAL REQUIREMENTS****Rev. 11/01/03****Chapter 506
(1 of 4) Page 506.011**

506.011: MassHealth Standard, CommonHealth, and Family Assistance Premiums

(A) MassHealth Standard, CommonHealth, and Family Assistance Premiums. The Division may charge a premium to certain disabled MassHealth Standard members with incomes above 114 percent of the federal poverty level, and to certain other MassHealth Standard members with incomes above 133 percent of the federal poverty level. The Division may charge a premium to certain MassHealth CommonHealth and Family Assistance members with incomes above 100 percent of the federal poverty level. Only one premium per family group will be assessed. Certain members are exempt from paying premiums, in accordance with 130 CMR 506.011(K).

(1) MassHealth Standard premiums are based on family group gross countable income, family group size as it relates to the federal poverty level guidelines, and whether or not the member has other health insurance.

(2) MassHealth 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 health insurance.

(3) MassHealth 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.

(4) When the family group contains members in more than one coverage type who are responsible for a premium or member share, the family group is responsible for only the higher premium amount or member share.

(B) Premium Payments. The Division may charge monthly premiums to persons described in 130 CMR 501.006, 505.002(C)(2) and (F)(2), 505.004(B), (C), (D), and (E), and 505.005(B)(3), (E), (F), and (G).

(1) Persons described in 130 CMR 501.006, 505.002(C)(2) and (F)(2), 505.004(B), (C), (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 Standard, CommonHealth, or Family Assistance are not charged a premium for the calendar month in which the coverage type changes or thereafter.

Trans. by E.L. 112**MASSHEALTH
FINANCIAL REQUIREMENTS****Rev. 11/01/03****Chapter 506
(2 of 4) Page 506.011**

(C) 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.

(D) Reactivating Coverage Following Termination Due to Delinquent Payment.

- (1) If no waiting list has been established pursuant to 130 CMR 501.003(C) and (D), after the member has paid in full all payments due, or has established a payment plan with the Division, the Division will reactivate coverage.
- (2) If a waiting list has been established, adults (aged 19 and over) whose eligibility has been terminated due to nonpayment of premiums will be placed on the waiting list upon payment of all payments due. They will not be allowed to reenroll until the Division is able to reopen enrollment for those placed on the waiting list. When the Division is able to open enrollment for those on the waiting list, their eligibility will be processed in the order they were placed on the waiting list.

(E) 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.

(F) 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.

(G) 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.

(H) 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.

Trans. by E.L. 112

**MASSHEALTH
FINANCIAL REQUIREMENTS**

Rev. 11/01/03

Chapter 506
(3 of 4) Page 506.011

(I) The Monthly MassHealth Standard and CommonHealth Premium Schedule. 130 CMR 506.011(I) provides the formulas that the Division uses to determine the monthly premiums for people who are receiving MassHealth Standard or CommonHealth, and for certain MassHealth Family Assistance members who are HIV positive.

(1) Monthly Full Premium Formula for CommonHealth and Certain Family Assistance Members Receiving Benefits under 130 CMR 505.005(F) and (G). 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 100% to 150%	\$15 per family group	\$15
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) Monthly 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 100% to 150%	60% of full premium
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

(3) Monthly Premium Schedule for Standard Disabled (Not Applicable for Parents and Children).

% of Federal Poverty Level (FPL)	Premium Cost
Up to 114%	No premium
Above 114%	\$12 per family group
Supplemental Premium	60% of full premium

Trans. by E.L. 112

**MASSHEALTH
FINANCIAL REQUIREMENTS**

Rev. 11/01/03

**Chapter 506
Page 506.011**(4) Monthly Premium Schedule for Standard Children.

% of Federal Poverty Level (FPL)	Premium Cost
Above 133% to 150%	\$12 per child to \$15 maximum per family group
Supplemental Premium	60% of full premium

(J) Monthly Family Assistance Premiums for the Purchase of Medical Benefits.

(1) MassHealth Family Assistance members with income greater than 150 percent up to 200 percent of the federal poverty level 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.

(2) MassHealth Family Assistance members with income between 100 and 150 percent of the federal poverty level 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 \$15 per family.

(K) Members Exempted from Premium Payment. The following members are exempt from premium payments.

(1) Members who are eligible under section 1634 of the Social Security Act as a disabled adult child or as a disabled widow or widower, or who are eligible under the provisions of the Pickle Amendment, as described in 130 CMR 519.003.

(2) Pregnant women and children under the age of six who are receiving MassHealth Standard.

(3) MassHealth Family Assistance members who are American Indians or Alaska Natives, as defined in 130 CMR 501.001.

Trans. by E.L. 112

**MASSHEALTH
FINANCIAL REQUIREMENTS**

Rev. 11/01/03

**Chapter 506
Page 506.012**

(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 is the same as the premium described at 130 CMR 506.011(I)(1). The maximum contribution amount is 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.