Commonwealth of Massachusetts
Executive Office of Health and Human Services
Office of Medicaid
600 Washington Street
Boston, MA 02111
www.mass.gov/masshealth

MassHealth
Eligibility Letter 171
November 15, 2007

TO: MassHealth Staff

FROM: Tom Dehner, Medicaid Director TD

RE: **Revisions to Regulations about MassHealth Premiums**

MassHealth is revising the regulations about MassHealth premiums.

MassHealth will no longer charge premiums to individuals who have family group income at or below 150 percent of the federal-poverty level (FPL). This change will apply to members in MassHealth Standard, CommonHealth, and the Breast and Cervical Cancer Program.

Children who have a parent or guardian in the home who is paying a Commonwealth Care health-plan premium are exempt from paying MassHealth premium payments.

MassHealth will assume responsibility for collection of Children's Medical Security Plan premiums. The regulations at 130 CMR 506.011 are being revised to support this change.

These emergency regulations were effective July 1, 2007.

MANUAL UPKEEP

Insert	**Remove**	**Trans. By**
501.001 (6 of 6)	501.001 (6 of 6)	E.L. 116
506.000	506.000	E.L. 112
506.001	506.001	E.L. 77
506.006	506.006	E.L. 165

Insert	**Remove**	**Trans. By**
506.011 (1 of 6)	506.011 (1 of 6)	E.L. 121
506.011 (2 of 6)	506.011 (2 of 6)	E.L. 121
506.011 (3 of 6)	506.011 (3 of 6)	E.L. 133
506.011 (4 of 6)	506.011 (4 of 6)	E.L. 148
506.011 (5 of 6)	506.011 (5 of 6)	E.L. 148
506.011 (6 of 6)	506.011 (6 of 6)	E.L. 148
506.012 (5 of 5)	506.012 (5 of 5)	E.L. 164
522.004 (1 of 3)	522.004 (1 of 3)	E.L. 149

Person Who Is HIV Positive – a person who has submitted verification that he or she has tested positive for the human immunodeficiency virus (HIV).

Premium – a charge for payment to the MassHealth agency that may be assessed to members of MassHealth Standard, MassHealth CommonHealth, MassHealth Family Assistance, or the Children's Medical Security Plan (CMSP).

Premium Assistance Payment – an amount contributed by the MassHealth agency toward the cost of employer-sponsored health-insurance coverage for certain MassHealth members.

Presumptive Eligibility – a time-limited period of conditional eligibility for children based on the applicant's declaration of family group gross income.

Primary-Care Clinician (PCC) Plan – a managed-care option administered by the MassHealth agency through which enrolled members receive primary care and other medical services. See 130 CMR 450.118.

Qualified Employer – a small employer who:

(1) purchases health insurance that meets the Basic-Benefit Level;

(2) contributes at least 50 percent of the cost of employees' health-insurance premiums; and

(3) has completed an Employer Application form and been approved by the MassHealth agency or its contractor(s) as a qualified employer pursuant to 130 CMR 650.010(A).

Quality Control – a system of continuing review to measure the accuracy of eligibility decisions.

Senior Care Organization – an organization that participates in MassHealth under a contract with the MassHealth agency and the Centers for Medicare and Medicaid Services to provide a comprehensive network of medical, health-care, and social-service providers that integrates all components of care, either directly or through subcontracts. Senior care organizations are responsible for providing enrollees with the full continuum of Medicare- and MassHealth-covered services.

Small Business – see definition for small employer.

Small Employer – an employer that has no more than 50 employees who work 30 hours or more a week, or a self-employed individual.

Substantial Gainful Activity – generally, employment that provides a set amount of gross earnings as determined by the Social Security Administration (SSA) under Title XVI of the Social Security Act.

Third Party – any individual, entity, or program that is or may be responsible to pay all or part of the expenditures for medical benefits.

Trans. by E.L. 171

MASSHEALTH
FINANCIAL REQUIREMENTS **Chapter 506**
Rev. 07/01/07 **Page 506.000**

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, Family Assistance, and the Children's Medical Security Plan (CMSP) Premiums
506.012: Family Assistance Premium Assistance Payments

506.001: Introduction

(A) 130 CMR 506.000 describes the rules governing financial eligibility for MassHealth. These rules are based on the size of the family group and countable income.

(B) The formula for income standards used in the determination of financial eligibility, the deductible income standards, the premiums for Family Assistance, CommonHealth, and the Children's Medical Security Plan (CMSP), and the Family Assistance premium assistance payment formulas are also contained in 130 CMR 506.000.

506.002: Financial Responsibility

In determining eligibility for MassHealth, the gross income of all family group members is counted and compared to an income standard based on the family group size. Caretaker relatives and parents of children under age 19 who are pregnant or who are parents may choose whether or not to be part of the child's family group. Family groups are comprised of families, couples, or individuals, as defined in 130 CMR 501.001.

506.003: Countable Income

Eligibility is based on the family group's gross countable earned and unearned income as defined in 130 CMR 506.003, except as described in 130 CMR 506.003(C) below.

(A) Gross Earned Income.

(1) Gross earned income is the total amount of compensation received for work or services performed without regard to any deductions.

(2) Gross earned income for the self-employed is the total amount of business income listed or allowable on a U.S. Tax Return.

(3) Seasonal income is income derived from an income source that is associated with a particular time of the year. Annual gross income is divided by 12 to obtain a monthly gross income with the following exception: if the applicant or member has a disabling illness or accident during or after the seasonal employment period that prevents the person's continued or future employment, only current income will be considered in the eligibility determination.

(B) Gross Unearned Income.

(1) Gross unearned income is the total amount of income that does not directly result from the individual's own labor before any income deductions are made.

(2) Unearned income includes, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, federal veterans' benefits, and interest and dividend income.

(C) Rental Income. Rental income is the total amount of gross income less any deductions listed or allowable on an applicant's or member's U.S. Tax Return.

506.006: Transfer of Income

All family group members are required to avail themselves of all potential income.

(A) If the MassHealth agency determines that income has been transferred for the primary purpose of establishing eligibility for MassHealth, the income is counted as if it were received.

(B) If the MassHealth agency is unable to determine the amount of available income, the family group remains ineligible until such information is made available.

506.007: Calculation of Financial Eligibility

(A) The financial eligibility for various MassHealth coverage types is determined by comparing the family group's gross monthly income with the applicable income standard for the specific coverage. In determining gross monthly income, the MassHealth agency multiplies average weekly income by 4.333.

(B) Generally, eligibility is based on 100 percent of the federal-poverty level for long-term unemployed adults; 133 percent of the federal-poverty level for parents and disabled nonworking adults; 200 percent of the federal-poverty level for pregnant women, persons who are HIV positive, and children who are special status aliens; and 300 percent of the federal-poverty level for children who are citizens, nationals, or qualified aliens, as well as for adults working for qualified employers. Disabled persons with income in excess of these applicable standards may be eligible for MassHealth CommonHealth. There are no income caps for premium-based CommonHealth and the Children’s Medical Security Plan (CMSP).

(C) The monthly federal-poverty-level income standards are determined according to annual standards published in the *Federal Register* using the following formula. The MassHealth agency adjusts these standards in March of each calendar year.

(1) Divide the annual federal-poverty-level income standard as it appears in the *Federal Register* by 12.

(2) Multiply the unrounded monthly income standard by the applicable federal-poverty-level standard.

(3) Round up to the next whole dollar to arrive at the monthly income standards.

506.008: Cost-of-Living Adjustment (COLA) Protections

Applicants and members whose income increases each January as the result of a cost-of-living adjustment (COLA) will have their eligibility determined using their social security income just before the COLA, if such income can be verified, until the subsequent federal-poverty-level adjustment.

506.011: MassHealth Standard, CommonHealth, Family Assistance, and the Children's Medical Security Plan (CMSP) Premiums

(A) MassHealth Standard, CommonHealth, Family Assistance, and the Children's Medical Security Plan (CMSP) Premiums. MassHealth may charge a premium to certain MassHealth CommonHealth and Family Assistance members, and to certain women with breast or cervical cancer who receive MassHealth Standard in accordance with 130 CMR 505.002(H) who have incomes above 150 percent of the federal-poverty level. MassHealth may charge a premium to members of the Children's Medical Security Plan (CMSP) who have incomes at or above 200 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 for women with breast and cervical cancer are based on family group gross countable income and family group size as it relates to the federal-poverty guidelines.

(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) CMSP premiums are based on family group countable income and family group size as it relates to the federal-poverty level income guidelines.

(5) When the family group contains members in more than one coverage type or program, including CMSP, 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. MassHealth may charge monthly premiums to persons described in 130 CMR 501.006; 505.002(C)(2), (F)(2), and (H); 505.004(B), (C), (D), and (E); 505.005(B)(3), (E), (F), and (G); and 522.004(C).

(1) Persons described in 130 CMR 501.006, 505.002(C)(2), (F)(2), and (H), 505.004(B), (C), (D), and (E), 505.005(B)(3), (E), (F), and (G), and 522.004(C) who are assessed a premium are responsible for monthly premium payments beginning with the calendar month following the date of MassHealth'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, Family Assistance, or CMSP are not charged a premium for the calendar month in which the coverage type changes or thereafter.

(C) Delinquent Premium Payments. If MassHealth 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 will be sent 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 MassHealth. After such a payment plan has been established, MassHealth 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) or 522.004(H), after the member has paid in full all payments due, or has established a payment plan with MassHealth, MassHealth will reactivate coverage.

(2) If a waiting list has been established, children (through age 18) eligible for CMSP or adults (aged 19 or older) 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 MassHealth is able to reopen enrollment for those placed on the waiting list. When MassHealth 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.

(1) Extreme financial hardship means that the member has shown to the satisfaction of the MassHealth agency that the member:

(a) is homeless, or is more than 30 days in arrears in rent or mortgage payments, or has received a current eviction or foreclosure notice;

(b) has a current shut-off notice, or has been shut off, or has a current refusal to deliver essential utilities (gas, electric, oil, water, or telephone);

(c) has medical and/or dental expenses, totaling more than 7.5% of the family group's gross annual income, that are not subject to payment by the Uncompensated Care Pool, and have not been paid by a third-party insurance, including MassHealth (in this case "medical and dental expenses" means any outstanding medical or dental services debt that is currently owed by the family group, regardless of the date of service); or

(d) has experienced a significant, unexpected increase in essential expenses within the last six months.

(2) If the MassHealth agency determines that the requirement to pay a premium results in extreme financial hardship for a member, the MassHealth agency may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a particular family.

(3) Hardship waivers will be authorized for six months. The six-month time period begins in the month after a documented hardship request is granted. At the end of the six-month period, the member may submit another request. Requests for premium relief should be addressed to the MassHealth agency.

(G) Voluntary Withdrawal. If a member wishes to voluntarily withdraw from receiving MassHealth coverage, it is the member's responsibility to notify the MassHealth agency of his or her intention by phone or, preferably, in writing. Coverage continues through the end of the calendar month of withdrawal. The member is responsible for the payment of all premiums up to and including the calendar month of withdrawal.

(H) Change in Premium Calculation. The premium amount is recalculated when the MassHealth agency is informed of changes in income, family group size, or health-insurance status, and whenever an adjustment is made in the CommonHealth premium schedule, the Standard premium schedule for women with breast or cervical cancer, the Family Assistance premium amount for the purchase of medical benefits schedule, or the CMSP premium schedule.

(I) The Monthly MassHealth Standard, CommonHealth, and Certain Family Assistance Members Premium Schedules. 130 CMR 506.011(I) provides the formulas that the MassHealth agency 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 MassHealth agency 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) Monthly Full Premium Formula for CommonHealth Children with Income Above 150 Percent to 300 Percent of the Federal-Poverty Level. The premium formula is provided below. If income is above 300% of the federal-poverty level, refer to the "Full Premium Formula" chart in 130 CMR 506.011(I)(1).

FULL PREMIUM FORMULA	
% of Federal-Poverty Level (FPL)	**Premium Cost**
Above 150% to 200%	$12 per child ($36 per family group maximum)
Above 200% to 250%	$20 per child ($60 per family group maximum)
Above 250% to 300%	$28 per child ($84 per family group maximum)

(3) Monthly Supplemental Premium Formula. A lower supplemental payment is required of members who have health insurance to which the MassHealth agency 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

(4) Monthly Premium Schedule for Standard for Women with Breast or Cervical Cancer (BCC). Women with breast or cervical cancer who are described at 130 CMR 505.002(H) and have income above 150 percent of the federal-poverty level in accordance with DPH requirements as certified by DPH to the MassHealth agency are assessed a monthly premium in accordance with the following premium schedule.

BCC PREMIUM SCHEDULE	
% of Federal-Poverty Level (FPL)	**Premium Cost**
Above 150% to 160%	$15
Above 160% to 170%	$20
Above 170% to 180%	$25
Above 180% to 190%	$30
Above 190% to 200%	$35
Above 200% to 210%	$40
Above 210% to 220%	$48
Above 220% to 230%	$56
Above 230% to 240%	$64
Above 240% to 250%	$72

(J) Monthly Family Assistance Premiums for the Purchase of Medical Benefits for Children. MassHealth Family Assistance members for whom the MassHealth agency purchases medical benefits under 130 CMR 505.005(B)(3) and (E) are assessed a monthly premium in accordance with the following premium schedule.

FAMILY ASSISTANCE PREMIUM SCHEDULE	
% of Federal-Poverty Level (FPL)	**Premium Cost**
Above 150% to 200%	$12 per child ($36 family group maximum)
Above 200% to 250%	$20 per child ($60 family group maximum)
Above 250% to 300%	$28 per child ($84 family group maximum)

(K) Children's Medical Security Plan (CMSP) Premiums.

CMSP PREMIUM SCHEDULE	
% of Federal-Poverty Level (FPL)	**Premium Cost**
Greater than or equal to 200%, but less than or equal to 300.9%	$7.80 per child per month; family group maximum $23.40 per month
Greater than or equal to 301.0%, but less than or equal to 400.0%	$33.14 per family group per month
Greater than or equal to 400.1%	$38.99 per child per month

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

(1) MassHealth Family Assistance members under age 19 who are American Indians or Alaska Natives, as defined in 130 CMR 501.001;

(2) MassHealth members with family group income at or below 150 percent of the federal-poverty level;

(3) pregnant women and children under age one receiving MassHealth Standard; and

(4) children when a parent or guardian in the family group is paying a premium for and is receiving Commonwealth Care. The premiums for children will be waived after the parent or guardian has enrolled in a Commonwealth Care health plan and is paying a Commonwealth Care health-plan premium, but the premiums for children will not be waived before the parent or guardian has enrolled in a Commonwealth Care health plan.

(2) Estimated Member Share of Premium.

(a) The monthly premium amount for which premium assistance adults are responsible is determined as follows. These premium amounts apply except when a covered adult is eligible for MassHealth Standard or CommonHealth. Covered adults eligible for MassHealth Standard or CommonHealth are assessed a member share according to 130 CMR 506.011(I).

MEMBER SHARE OF PREMIUM	
% of Federal-Poverty Level (FPL)	**Premium Cost**
Above 150% to 200%	$27 per covered adult in the family group
Above 200% to 250%	$53 per covered adult in the family group
Above 250% to 300%	$80 per covered adult in the family group

(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 MassHealth agency, that the MassHealth agency contributes per insured adult toward the policyholder's share of the health insurance premium when the health insurance plan is offered through a MassHealth-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 MassHealth agency contributes per insured adult who is HIV positive.

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

(D) Premiums. The premium schedule and payment policies for CMSP are described in 130 CMR 506.011.

(E) Copayments. Members are required to pay copayments for certain covered services. There are no required copayments for preventive and diagnostic services. No member will be exempt from copayment requirements.

(1) The copayments for prescription drugs are:

(a) $3 for each generic drug prescription; and

(b) $4 for each brand-name drug prescription.

(2) The copayments for dental services are:

(a) $2 for members with income equal to or below 199.9% of the federal-poverty level (FPL);

(b) $4 for members with income 200.0% to 400.0% FPL; and

(c) $6 for members with income equal to or greater than 400.1% FPL.

(3) The copayments for medical (nonpreventive visits) and mental health services are:

(a) $2 for members with income equal to or below 199.9% FPL;

(b) $5 for members with income 200.0% to 400.0% FPL; and

(c) $8 for members with income equal to or greater than 400.1% FPL.

(F) Medical Coverage Date. Except as provided at 130 CMR 522.004(H), coverage begins on the date of the final eligibility determination. The time standards for determining and redetermining eligibility are described at 130 CMR 502.005 and 502.007.