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506.001: Introduction

(A) 130 CMR 506.000 describes the rules governing financial eligibility for MassHealth. Financial eligibility includes household composition, countable income, deductibles, calculation of premiums, and copayments for all coverage types described in 130 CMR 505.000: *Coverage Types*.

(B) Financial eligibility for MassHealth Senior Buy-In and Buy-In is determined in accordance with 130 CMR 519.010: *MassHealth Senior Buy-In*, 519.011: *MassHealth Buy-In*, and 520.000: *Financial Eligibility*.

506.002: Household Composition

(A) Determination of Household Composition. MassHealth determines household size at the individual member level. MassHealth determines household composition in two ways.

(1) MassHealth Modified Adjusted Gross Income (MAGI) Household Composition. MassHealth uses the MassHealth MAGI household composition rules to determine member eligibility for the following benefits:

(a) MassHealth Standard, as described in 130 CMR 505.002(B), (C), (D), (F), and (G);
(b) MassHealth CommonHealth, as described in 130 CMR 505.004(F) and (G);
(c) MassHealth CarePlus, as described in 130 CMR 505.008: *MassHealth CarePlus*;
(d) MassHealth Family Assistance, as described in 130 CMR 505.005(B) through (E);
(e) MassHealth Limited, as described at 130 CMR 505.006: *MassHealth Limited*;
(f) MassHealth Small Business Employee Premium Assistance, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*; and
(g) Children's Medical Security Plan (CMSP), as described in 130 CMR 522.004: *Children's Medical Security Plan (CMSP)*.

(2) MassHealth Disabled Adult Household. MassHealth uses the MassHealth Disabled Adult household composition rules to determine member eligibility for the following benefits:

(a) MassHealth Standard, as described in 130 CMR 505.002(E): *Disabled Adults*;
(b) MassHealth CommonHealth, as described in 130 CMR 505.004(B) through (E); and
(c) MassHealth Family Assistance, as described in 130 CMR 505.005(F): *Eligibility Requirement for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100 Percent of the Federal Poverty Level*.

(B) MassHealth MAGI Household Composition.

(1) Taxpayers Not Claimed as a Tax Dependent on His or Her Federal Income Taxes. For an individual who expects to file a tax return for the taxable year in which the initial determination or renewal of eligibility is being made and who is not claimed as a tax dependent by another taxpayer, the household consists of

(a) the taxpayer; including his or her spouse, if the taxpayers are married and filing jointly regardless of whether they are living together;

(b) the taxpayer's spouse, if living with him or her regardless of filing status;

(c) all persons the taxpayer expects to claim as tax dependents; and

(d) if any woman described in 130 CMR 506.002(B)(1)(a) through (c) is pregnant, the number of expected children.

(2) Individuals Claimed as a Tax Dependent on Federal Income Taxes.

(a) For an individual who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which the initial determination or renewal of eligibility is being made and who does not otherwise meet the Medicaid exception rules as described in 130 CMR 506.002(B)(2)(b)(i), (ii), or (iii), the household consists of

(i) the individual;

(ii) the individual's spouse, if living with him or her;

(iii) the taxpayer claiming the individual as a tax dependent;

(iv) any of the taxpayer's tax dependents; and

(v) if any woman described in 130 CMR 506.002(B)(2)(a)(i) through (iii) is pregnant, the number of expected children.

(b) Medicaid Exceptions. Household size must be determined in accordance with non-tax filer rules for any of the following individuals

(i) individuals other than the spouse or natural, adopted, or stepchild who expect to be claimed as a tax dependent by the taxpayer;

(ii) individuals younger than 19 years old who expect to be claimed by one parent as a tax dependent and are living with both natural, adopted or stepparents, but whose natural, adopted, or stepparents do not expect to file a joint tax return;

(iii) individuals younger than 19 years old who expect to be claimed as a tax dependent by a noncustodial parent. For the purpose of determining custody, MassHealth uses a court order or binding separation, divorce, or custody agreement establishing physical custody controls or, if there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

(3) Individuals Who Do Not File a Federal Tax Return and Are Not Claimed as a Tax Dependent on a Federal Tax Return. For an individual who does not expect to file a federal tax return and who does not expect to be claimed as a tax dependent on a federal tax return or when any of the exceptions described at 130 CMR 506.002(B)(2)(b)(i), (ii), or (iii) apply, the household consists of the individual and, if living with the individual,

(a) the individual's spouse;
(b) the individual's natural, adopted, and stepchildren younger than 19 years old;
(c) for individuals younger than 19 years old, the individual's natural, adoptive, or stepparents and natural, adoptive, or stepsiblings younger than 19 years old; and
(d) if any woman described in 130 CMR 506.002B(3)(a) through (c) is pregnant, the number of expected children.

(C) MassHealth Disabled Adult Household. The household consists of

(1) the individual;
(2) the individual's spouse if living with him or her;
(3) the individual's natural, adopted, and stepchildren younger than 19 years old if living with him or her; and
(4) if any woman described in 130 CMR 506.002(C)(1), (2), or (3) is pregnant, the number of expected children.

506.003: Countable Household Income

Countable household income includes earned income described in 130 CMR 506.003(A) and unearned income described in 130 CMR 506.003(B) less deductions described in 130 CMR 506.003(D).

(A) Earned Income.

(1) Earned income is the total amount of taxable compensation received for work or services performed less pretax deductions. Earned income may include wages, salaries, tips, commissions, and bonuses.

(2) Earned taxable income for the self-employed is the total amount of taxable annual income from self-employment after deducting annual business expenses listed or allowable on a U.S. Individual Tax Return. Self-employment income may be a profit or a loss.

(3) Earned income from S-Corporations or Partnerships is the total amount of taxable annual profit (or loss) after deducting business expenses listed or allowable on a U.S. Individual Tax Return.

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

(B) Unearned Income.

(1) Unearned income is the total amount of taxable income that does not directly result from the individual's own labor after allowable deductions on the U.S Individual Tax Return.

(2) Unearned income may include, but is not limited to, social security benefits, railroad retirement benefits, pensions, annuities, certain trusts, interest and dividend income, state or local tax refund for a tax you deducted in the previous year, and gross gambling income.

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

(D) Deductions. The following are allowable deductions from countable income when determining MAGI:

(1) educator expenses;
(2) reservist/performance artist/fee-based government official expenses;
(3) health savings account;
(4) moving expenses;
(5) self-employment tax;
(6) self-employment retirement account;
(7) penalty on early withdrawal of savings;
(8) alimony paid to a former spouse;
(9) individual retirement account (IRA);
(10) student loan interest; and
(11) higher education tuition and fees.

506.004: Noncountable Household Income

The following types of income are noncountable in the determination of eligibility for individuals described at 130 CMR 506.002:

(A) TAFDC, EAEDC, or SSI income;

(B) sheltered workshop earnings;

(C) federal veteran benefits that are not taxable in accordance with IRS rules;

(D) income-in-kind;

(E) roomer and boarder income derived from persons residing in the applicant's or member's principal place of residence;

(F) most workers' compensation income;

(G) pretax contributions to salary reduction plans for payment of dependent care, transportation, and certain health expenses within allowable limits;

(H) child support received;

(I) taxable amounts received as a lump sum, except in the month received;

(J) income received by independent foster-care adolescents described at 130 CMR 505.002(H): *Eligibility Requirements for Former Foster-Care Individuals*;

(K) income from children and tax dependents who are not expected to be required to file a tax return under section 6012(a)(1) of the Internal Revenue code for the taxable year in which eligibility for MassHealth is being determined, whether or not the children or the tax dependents files a tax return; and

(L) any other income that is excluded by federal laws other than the Social Security Act.

506.005: Verification of Income

Verification of income is mandatory. Income may be verified either through electronic data matches or paper verification.

(A) Electronic Data Matches.

(1) Data Matches. MassHealth electronically matches with federal and state data sources described at 130 CMR 502.004: *Matching Information* to verify attested income.

(2) Reasonable Compatibility. The income data received through an electronic data match is compared to the attested income amount to determine if the attested amount and the data source amount are reasonably compatible. If these amounts are reasonably compatible, the attested income is considered verified for purposes of an eligibility determination. To be considered reasonably compatible

(a) both the attested income and the income from the data sources must be above the applicable income standard for the individual; or

(b) both the attested income and the income from the data sources must be below the applicable income standard for the individual; or

(c) the attested income and the income from the data sources must be within a ten percent range of each other.

(3) When self-attested income is reasonably compatible with the electronic data, the income amount used to determine eligibility is the self-attested amount.

(B) Paper Verification. If the attested income and the income from the electronic data source are not reasonably compatible, or if the electronic data match is unavailable, paper verification of income is required.

(1) Paper verification of monthly earned income includes, but is not limited to

(a) recent paystubs;

(b) a signed statement from the employer; or

(c) the most recent U.S. Individual Tax Return.

(2) Verification of monthly unearned income is mandatory and includes, but is not limited to

(a) a copy of a recent check or paystub showing gross income from the source;

(b) a statement from the income source, where matching is not available; or

(c) the most recent U.S. Individual Tax Return.

(3) Verification of gross monthly income may also include any other reliable evidence of the applicant's or member's earned or unearned income.
(4) For reasonably predictable fluctuating income, as described at 130 CMR 506.003(A)(4), verification may also include documentation of a contract for employment or clear history of predictable fluctuations in income.

506.006: Transfer of Income

All household 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

To calculate financial eligibility for an individual, the MassHealth agency will construct a household as described in 130 CMR 506.002 for each individual who is applying for or renewing coverage. Different households may exist within a single family, dependent on the family members' familial and tax relationships to each other. The rules at 130 CMR 506.003 and 506.004 describing countable income and noncountable income apply to both MassHealth MAGI households and MassHealth Disabled Adult households. Countable income includes earned income described in 130 CMR 506.003(A) and unearned income described in 130 CMR 506.003(B) less deductions described in 130 CMR 506.003(C). Income of all the household members forms the basis for establishing an individual's eligibility. A household's countable income is the sum of the MAGI-based income of every individual included in the individual's household with the exception of children and tax dependents who are not expected to be required to file a return as described in 42 CFR 435.603 and 130 CMR 506.004(K).

(A) Financial eligibility for coverage types that are determined using the MassHealth MAGI household rules and the MassHealth Disabled Adult household rules is determined by comparing the sum of all countable income less deductions for the individual's household as described at 130 CMR 506.002 with the applicable income standard for the specific coverage type. In determining monthly income, the MassHealth agency multiplies average weekly income by 4.333. Five percentage points of the current federal poverty level (FPL) is subtracted from the applicable household total countable income to determine eligibility of the individual under the coverage type with the highest income standard.

(B) The financial eligibility standards for each coverage type may be found in 130 CMR 505.000: *Health Care Reform: MassHealth: Coverage Types*.

(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 annually.

(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.

(D) Safe Harbor Rule. The MassHealth agency will provide a safe harbor for individuals whose household income determined through MassHealth MAGI income rules results in financial ineligibility for MassHealth but whose household income determined through Health Connector income rules as described at 26 CFR 1.36B-1(e) is below 100 percent FPL. In such case, the individual's financial eligibility will be determined in accordance with Health Connector income rules.

(1) MassHealth uses current monthly income and the Health Connector uses projected annual income amounts.

(2) MassHealth MAGI household uses exceptions to tax household rules and the Health Connector uses the pure tax filing household.

(E) MAGI Protection for Individuals Receiving MassHealth Coverage on December 31, 2013. Notwithstanding 130 CMR 506.007(A) through (D), in the case of determining ongoing eligibility for individuals determined eligible for MassHealth coverage to begin on or before December 31, 2013, application of the MassHealth MAGI Household Income Calculation methodologies as set forth in 130 CMR 506.007 will not be applied until March 31, 2014, or the next regularly scheduled annual renewal of eligibility for such individual under 130 CMR 502.007: *Continuing Eligibility*, whichever is later, if the application of such methodologies would result in a downgrade of benefits.

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.

506.009: The One-Time Deductible

(A) Eligibility Requirements. Disabled adults described in 130 CMR 505.004(C)(5)(a) and disabled young adults described in 130 CMR 505.004(E)(3)(a)(i) 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(B). 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 MassHealth Disabled Adult household income, as described in 130 CMR 506.003, 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(M): *Medical Coverage Date*.

(D) Calculating the Deductible. The amount of the deductible is determined by comparing the MassHealth Disabled Adult household income as described in 130 CMR 506.003 to the MassHealth CommonHealth Monthly Deductible Income Standards provided in the following chart and multiplying the difference by six.

THE MASSHEALTH COMMONHEALTH MONTHLY DEDUCTIBLE INCOME STANDARDS

MassHealth Disabled Adult Household Size	Income 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

(E) Notification of the Deductible.

(1) The applicant who has excess monthly income will be informed that he or she is currently ineligible for MassHealth, but may establish eligibility by meeting the deductible. The applicant will be informed in writing of the following:

(a) the deductible amount; and

(b) the start and end dates of the deductible period.

(2) A person who meets a deductible will be eligible for MassHealth CommonHealth effective with the begin date of the deductible period.

(F) Persons Deemed to Have Met a Deductible. The following disabled adults will be considered to have met a deductible:

(1) those who were receiving MassHealth on July 1, 1997 as the result of meeting a deductible; and

(2) those who were denied eligibility with a deductible before July 1, 1997, but who submit medical bills on or after July 1, 1997 to meet the deductible.

(G) Submission of Bills to Meet the Deductible.

(1) Criteria. To establish eligibility, the applicant must submit verification of medical or remedial bills whose total equals or exceeds the deductible and that meets the following criteria.

(a) The bill must not be subject to further payment by health insurance or other liable third-party coverage, including the Health Safety Net.

(b) The bill must be for an allowable medical or remedial expense as provided in 130 CMR 506.009(G)(2). A remedial expense is a nonmedical support service made necessary by the medical condition of any individual in the family group.

(c) The bill must be unpaid and a current liability, or, if paid, was paid during the six-month deductible period.

(d) The bill may not be for one of the following services:

(i) cosmetic surgery;

(ii) rest-home care;

(iii) weight-training equipment;

(iv) massage therapy;

(v) special diets; and

(vi) room and board charges for individuals in residential programs.

(2) Meeting the Deductible.

(a) Bills to meet the deductible are applied in the following order:

(i) Medicare and other health-insurance premiums credited prospectively for the cost of six months' coverage;

(ii) expenses incurred by any member of the MassHealth Disabled Adult household for necessary medical and remedial-care services that are recognized under state law but are not covered by MassHealth, including guardianship fees and related expenses as defined at 130 CMR 515.001: *Definition of Terms*, and described in and allowed under 130 CMR 520.026(E)(3): *Guardianship Fees and Related Expenses*; and

(iii) expenses incurred by any member of the MassHealth Disabled Adult household for necessary medical and remedial-care services that are covered by MassHealth.

(b) Premiums for Qualified Health Plans can be applied to meet the deductible as they are incurred.

(c) Any bills or portions of bills that are used to meet the deductible are not paid by the MassHealth agency and remain the responsibility of the applicant.

506.010: Verification of Medical and Remedial-Care Expenses

(A) Medical or remedial-care expenses must be verified by a bill or written statement from a health-care provider with the exception of expenses for nonprescription drugs, which must be verified by a receipt from the provider of the drug.

(B) Verifications must include all of the following information:

(1) the type of service provided;

(2) the name of the person for whom the service was provided;

(3) the amount charged for the service including the current balance; and

(4) the date of service.

506.011: MassHealth and the Children's Medical Security Plan (CMSP) Premiums

The MassHealth agency may charge a monthly premium to MassHealth Standard, CommonHealth, or Family Assistance members who have income above 150 percent of the federal poverty level (FPL), as provided in 130 CMR 506.011. The MassHealth agency may charge a monthly premium to members of the Children's Medical Security Plan (CMSP) who have incomes at or above 200 percent of the FPL. MassHealth and CMSP premiums amounts are calculated based on a member's household modified adjusted gross income (MAGI) and their household size as described in 130 CMR 506.002 and 506.003 and the premium billing family group (PBFG) rules as described in 130 CMR 506.011(A). Certain members are exempt from paying premiums, in accordance with 130 CMR 506.011(J).

(A) Premium Billing Family Groups.

(1) Premium formula calculations for MassHealth and CMSP premiums are based on premium billing family groups (PBFG). A PBFG is comprised of

(a) an individual;

(b) a couple who are two persons married to each other according to the rules of the Commonwealth of Massachusetts and are living together; or

(c) a family who live together and consist of

(i) a child or children under the age of 19, any of their children, and their parents;

(ii) siblings under the age of 19 and any of their children who live together, even if no adult parent or caretaker is living in the home; or

(iii) a child or children under the age of 19, any of their children, and their caretaker relative when no parent is living in the home.

(2) A child who is absent from the home to attend school is considered as living in the home.

(3) A parent may be natural, adoptive, or a stepparent. Two parents are members of the same PBFG as long as they are mutually responsible for one or more children who live with them.

(4) In a family with more than one child, any child with a MAGI household income that does not exceed 300% FPL will have its premium liability determined based on the MAGI household income of the child in the family PBFG with the lowest percentage of the FPL. If a child in the PBFG has an income percentage of the FPL at or below 150 percent of the FPL, premiums for all children in the PBFG are waived.

(5) MassHealth and CMSP premiums for children with a MassHealth MAGI household income greater than 300 percent of the FPL and all premiums for young adults and adults are calculated using the individual's FPL and the corresponding premium amount as described in 130 CMR 506.011.

(6) For individuals within a PBFG that is approved for more than one premium billing coverage type, except where application of 130 CMR 506.011(A)(4) will result in a lower premium for children in the PBFG, the following apply.

(a) When the PBFG contains members in more than one coverage type or program, including CMSP, and who are responsible for a premium or required member contribution, the PBFG is responsible for only the higher premium or required member contribution.

(b) When the PBFG includes a parent or caretaker relative who is paying a premium for and is receiving Qualified Health Plan with Premium Tax Credits, the premiums for children in the PBFG are waived once the parent or caretaker relative enrolls in and pays for a QHP.

(B) MassHealth and Children's Medical Security Plan (CMSP) Premium Formulas.

(1) The premium formula for MassHealth Standard members with breast or cervical cancer (BCC) whose eligibility is described at 130 CMR 505.002(F): *Individuals with Breast or Cervical Cancer* is as follows.

Standard Breast and Cervical Cancer Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly 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

(2) The premium formulas for MassHealth CommonHealth members whose eligibility is described in 130 CMR 505.004(B): *Disabled Working Adults* through (G): *Disabled Children Younger than 18 Years Old* are as follows.

(a) The premium formula for children with MassHealth MAGI household income between 150 and 300 percent of the FPL is provided as follows.

CommonHealth Full Premium Formula Children between 150% and 300%	
% of Federal-Poverty Level (FPL)	**Monthly Premium Cost**
Above 150% to 200%	$12 per child ($36 PBFG maximum)
Above 200% to 250%	$20 per child ($60 PBFG maximum)
Above 250% to 300%	$28 per child ($84 PBFG maximum)

(b) The full premium formula for young adults with household income above 150 percent of the FPL, adults with household income above 150 percent of the FPL, and children with household income above 300 percent of the FPL is provided as follows. The full premium is charged to members who have no health insurance and to members for whom the MassHealth agency is paying a portion of their health-insurance premium.

CommonHealth Full Premium Formula Young Adults and Adults above 150% of the FPL and Children above 300% of the FPL		
Base Premium	**Additional Premium Cost**	**Range of Monthly 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

(c) The supplemental premium formula for young adults, adults, and children is provided as follows. A lower supplemental premium is charged to members who have health insurance to which the MassHealth agency does not contribute. Members receiving a premium assistance payment from the MassHealth agency are not eligible for the supplemental premium rate.

CommonHealth Supplemental Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly 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

(d) CommonHealth members who are eligible to receive a premium assistance payment, as described in 130 CMR 506.012, that is less than the full CommonHealth premium receive their premium assistance payment as an offset to the CommonHealth premium assistance bill and are responsible for the difference.

(3) The premium formula for MassHealth Family Assistance children whose eligibility is described at 130 CMR 505.005(B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 Percent and Less than or Equal to 300 Percent of the Federal Poverty Level* and (E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level* is as follows.

Family Assistance for Children Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly Premium Cost**
Above 150% to 200%	$12 per child ($36 PBFG maximum)
Above 200% to 250%	$20 per child ($60 PBFG maximum)
Above 250% to 300%	$28 per child ($84 PBFG maximum)

(4) The premium formulas for MassHealth Family Assistance HIV-positive adults whose eligibility is described at 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level* are as follows.

(a) The full premium formula for Family Assistance HIV-positive adults between 150 and 200 percent of the FPL is charged to members who have no other health insurance and to members for whom the MassHealth agency is paying a portion of their health-insurance premium. The full premium formula is provided as follows.

Family Assistance for HIV+ Adults Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly 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

(b) The supplemental premium formula for Family Assistance HIV-positive adults is charged to members who have other health insurance to which the MassHealth agency does not contribute. A lower supplemental premium is charged to these members. Members receiving a premium assistance payment from the MassHealth agency are not eligible for the supplemental premium rate. The supplemental formula is provided as follows.

Family Assistance for HIV+ Adults Premium Formula Supplemental Premium Formula	
% of Federal Poverty Level (FPL)	**Monthly Premium Cost**
Above 150% to 200%	60% of full premium

(5) The premium formula for MassHealth Family Assistance for nonqualified PRUCOL (NQP) adults, as described in 130 CMR 505.005(D): *Eligibility Requirements for Adults and Young Adults Aged 19 and 20 Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300 Percent of the Federal Poverty Level* is based on MassHealth MAGI household income and MassHealth MAGI household size as it relates to the FPL income guidelines and PBFG rules, as described at 130 CMR 506.011(B). The premium formula can be found at 956 CMR 12.00: *Eligibility, Enrollment and Hearing Process for Connector Care*.

(6) The premium formula for Children's Medical Security Plan (CMSP) members, as described in 130 CMR 522.004: *Children's Medical Security Plan (CMSP)* is as follows.

CMSP Premium Schedule	
% of Federal-Poverty Level (FPL)	**Monthly Premium Cost**
Greater than or equal to 200%, but less than or equal to 300%	$7.80 per child per month; PBFG maximum $23.40 per month
Greater than or equal to 300.1%, but less than or equal to 400.0%	$33.14 per PBFG per month
Greater than or equal to 400.1%	$64.00 per child per month

(C) Premium Payment Billing.

(1) With the exception of persons described in 130 CMR 505.004(C): *Disabled Adults*, MassHealth members who are assessed a premium are responsible for monthly premium payments beginning with the calendar month following the date of the MassHealth agency's eligibility determination.

(2) Persons described in 130 CMR 505.004(C): *Disabled Adults* 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:

(a) with the calendar month following the reported change if the premium is increased; or

(b) with the calendar month of the reported change if the premium is decreased or no longer assessed.

(4) Members who have been assessed premiums but who are subsequently determined eligible for MassHealth benefits that do not require a premium will not be charged a premium for the calendar month in which the coverage type changes or thereafter.

(5) If the member contacts the MassHealth agency by telephone, in writing, or online and requests a voluntary withdrawal within 60 calendar days from the date of the eligibility notice and premium notification, MassHealth premiums are waived.

(D) Delinquent Premium Payments.

(1) Termination for Delinquent Premium Payments. If the MassHealth agency has billed a member for a premium payment, and the member does not pay the entire amount billed within 60 days of the date on the bill, the member's eligibility for benefits is terminated. 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

(a) pays all delinquent amounts that have been billed;

(b) establishes a payment plan and agrees to pay the current premium being assessed and the payment-plan-arrangement amount;

(c) is eligible for a nonpremium coverage type;

(d) is eligible for a MassHealth coverage type that requires a premium payment and the delinquent balance is from a CMSP benefit; or

(e) requests a waiver of past-due premiums as described in 130 CMR 506.011(G).

(2) Default on a Payment Plan.

(a) 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 payment plan is terminated and the past due balance is due in full.

(b) If the member is in a premium-paying coverage type and does not pay the past due amount within 60 days of the date on the bill, the member's eligibility is terminated.

(c) If a member has defaulted on a payment plan twice within a 24-month period, the member must pay in full any past due balances before they can be determined eligible for a coverage type that requires a premium payment.

(d) A member may be granted additional payment plans if the member has been approved for a hardship waiver as described at 130 CMR 506.011(F).

(3) Referral to State Intercept Program for Collection of Delinquent Payment. The MassHealth agency may refer a member who is 150 days or more in arrears to the State Intercept Program (SIP) in compliance with 815 CMR 9.00: *Collection of Debts*. Members will not be referred to SIP for collection of a past due balance if they have and are currently paying on the payment-plan arrangement that was approved by the MassHealth agency.

(E) Reactivating Coverage Following Termination When a Member Has a Past-Due Balance.

(1) Except as provided in 130 CMR 506.011(E)(2), after the member has paid in full all payments due, has established a payment plan with MassHealth, or has been granted a waiver of past-due balance as described in 130 CMR 506.011(G), the MassHealth agency will reactivate coverage.

(2) For children younger than 19 years old, coverage may be reactivated after 90 days from the date termination upon request, regardless of any outstanding payments due.

(F) Waiver of Outstanding Premium Payments. Outstanding premium balances that are older than 24 months are waived.

(G) Waiver or Reduction of Premiums for Undue Financial Hardship.

(1) Undue financial hardship means that the member has shown to the satisfaction of the MassHealth agency that at the time the premium was incurred or when the individual is seeking to reactivate benefits, 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 Health Safety Net, 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, unavoidable increase in essential expenses within the last six months.

(2) If the MassHealth agency determines that the requirement to pay a premium results in undue financial hardship for a member, the MassHealth agency may, in its sole discretion,

(a) waive payment of the premium or reduce the amount of the premiums assessed to a particular family; or

(b) grant a full or partial waiver of a past due balance. Past due balances include all or a portion of a premium accrued before the first day of the month of hardship; or

(c) both 130 CMR 506.011(H)(2)(a) and (b).

(3) Hardship waivers may be authorized for 12 months. At the end of the 12-month period, the member may submit another hardship application.

(a) The 12-month time period begins on the first day of the month in which the hardship application and supporting documentation is received by the MassHealth agency.

(b) The 12-month time period may be retroactive to the first day of the third calendar month before the month of hardship application.

(4) If a hardship waiver is granted and past-due balances are not waived, the MassHealth agency will automatically establish a payment plan for the member for any past-due balances.

(a) The duration of the payment plan will be determined by the MassHealth agency. The minimum monthly payment on the payment plan will be $5.

(b) The member must make full monthly payments on the payment plan for the hardship waiver to stay in effect. Failure to comply with the established payment plan will terminate the hardship waiver.

(H) 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 telephone, in writing, or online. Coverage may continue 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, unless the request for voluntary withdrawal is made in accordance with 130 CMR 506.011(C)(5).

(I) Change in Premium Calculation. The premium amount is recalculated when the MassHealth agency is informed of changes in the household's MAGI, household composition, or health-insurance status, and whenever an adjustment is made to any of the MassHealth premium formula tables in 130 CMR 506.011(B) or in Federal Poverty Levels.

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

(1) MassHealth members who have verified that they are American Indians or Alaska Natives who have received or are eligible to receive an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or by a non-Indian health-care provider through referral, in accordance with federal law;
(2) MassHealth members with MassHealth MAGI household income or MassHealth Disabled Adult household income at or below 150 percent of the federal poverty level;
(3) pregnant women and children under age one receiving MassHealth Standard;
(4) children when a parent or guardian in the PBFG is eligible for a Qualified Health Plan (QHP) with Premium Tax Credits (PTC) who has enrolled in and has begun paying for a QHP;
(5) children for whom child welfare services are made available under Part B of Title IV of the Social Security Act on the basis of being a child in foster care and individuals receiving benefits under Part E of that title, without regard to age;
(6) individuals receiving hospice care;
(7) independent former foster care children younger than 26 years old; and
(8) Members who have accumulated premium and copayment charges totaling an amount equal to five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter do not have to pay further MassHealth premiums during the quarter in which the member reached the five percent cap.

506.012: Premium Assistance Payments

(A) Coverage Types. Premium assistance payments are available to MassHealth members who are eligible for the following coverage types:

(1) MassHealth Standard, as described in 130 CMR 505.002: *MassHealth Standard*;
(2) MassHealth Standard for Kaileigh Mulligan, as described in 130 CMR 519.007: *Individuals Who Would Be Institutionalized*;
(3) MassHealth CommonHealth, as described in 130 CMR 505.004: *MassHealth CommonHealth*;
(4) MassHealth CarePlus, as described in 130 CMR 505.008: *MassHealth CarePlus*;
(5) MassHealth Family Assistance for HIV-positive adults and HIV-positive young adults, as described in 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level*;

(6) MassHealth Family Assistance for disabled adults whose Disabled Adult MassHealth household income is at or below 100 percent of the FPL and who are qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 Percent of the Federal Poverty Level*;

(7) MassHealth Family Assistance for children younger than 19 years old and young adults 19 and 20 years of age whose household MAGI is at or below 150 percent of the FPL and who are nonqualified PRUCOLs, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 Percent of the Federal Poverty Level*;

(8) MassHealth Family Assistance for children younger than 19 years old whose household MAGI is between 150 percent and 300 percent of the FPL and who are citizens, protected noncitizens, qualified noncitizens barred, nonqualified individuals lawfully present, and nonqualified PRUCOLs, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 Percent of the Federal Poverty Level*; and

(9) MassHealth Small Business Employee Premium Assistance Program, the rules and requirements of which are described at 130 CMR 506.013.

(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*.

(2) The health-insurance policy holder is either in the PBFG or resides with the individual who is eligible for the premium assistance benefit.

(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).

(C) Eligibility. Eligibility for MassHealth premium assistance is determined by the individual's coverage type and the type of private health insurance the individual has or has access to. MassHealth has two categories of health insurance for which it may provide premium assistance.

(1) Employer-Sponsored Insurance (ESI) 50% Plans are employer-sponsored health-insurance plans to which the employer contributes at least 50% towards the monthly premium amount. MassHealth provides premium assistance for individuals with ESI 50% Plans who are eligible for MassHealth coverage types as described in 130 CMR 506.012(A).

(2) Other Group Insurance Plans are employer-sponsored health-insurance plans to which the employer contributes less than 50% towards the monthly premium amount, Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage, and other group health insurance. MassHealth provides premium assistance for individuals with Other Group Health Insurance Plans who are eligible for MassHealth coverage types as described in 130 CMR 506.012(A), except for individuals described in 130 CMR 506.012(A)(8).

(3) Non-group unsubsidized Health Connector individual plans for children only.

(4) Members enrolled in any of the following types of health-insurance coverage are not eligible for premium assistance payments from MassHealth:

(a) Health Savings Accounts;

(b) Medicare supplemental coverage, including Medigap and Medex coverage;

(c) Medicare Advantage coverage;

(d) Medicare Part D coverage; and

(e) Qualified Health Plans (QHP) with Premium Tax Credits.

(5) The following MassHealth members are not eligible for premium assistance payments as described in 130 CMR 506.012(C)(5) from MassHealth:

(a) MassHealth members who have Medicare coverage as MassHealth provides premium assistance-benefits in the form of Medicare A and/or B Buy-In benefits as described in 130 CMR 505.002(O): *Medicare Premium Payment*. Medicare beneficiaries who are eligible for the benefits described in 130 CMR 505.002(O): *Medicare Premium Payment* are also deemed eligible for the Low Income Subsidy (LIS) benefit which provides Medicare Part D coverage;

(b) all nondisabled nonqualified PRUCOL adults, as described in 130 CMR 505.005(D): *Eligibility Requirements for Adults and Young Adults 19 and 20 Years of Age Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 300 Percent of the Federal Poverty Level*; and

(c) disabled nonqualified PRUCOL adults with MassHealth Disabled Adult household income above 100% of the FPL, as described in 130 CMR 505.005(F): *Eligibility Requirements for Disabled Adults Who Are Qualified Noncitizens Barred, Nonqualified Individuals Lawfully Present, and Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth Disabled Adult Household at or below 100 Percent of the Federal Poverty Level*.

(D) Required Member Contribution. The calculation of the MassHealth required member contribution is as follows.

(1) MassHealth may require that a member contribute towards the cost of their health-insurance coverage. MassHealth refers to this amount as the MassHealth required member contribution. The MassHealth required member contribution is based on MassHealth MAGI household income and size and/or the MassHealth Disabled Adult household income and size, as described in 130 CMR 506.002 and 506.003, as it relates to federal poverty guidelines and PBFG rules described at 130 CMR 506.011(A).

(2) The following members are responsible for a required member contribution.

(a) MassHealth CommonHealth premium-assistance eligible members who have MassHealth MAGI household income or MassHealth Disabled Adult household income greater than 150 percent of the FPL have the following required member contribution amounts.

(i) The required member contribution formula for children younger than 19 years old with household MAGI between 150 and 300 percent of the FPL is provided as follows.

CommonHealth Required Member Contribution Formula Children between 150% and 300% FPL	
% of Federal Poverty Level (FPL)	**Estimated Member Share**
Above 150% to 200%	$12 per child ($36 per PBFG maximum)
Above 200% to 250%	$20 per child ($60 per PBFG maximum)
Above 250% to 300%	$28 per child ($84 per PBFG maximum)

(ii) The required member contribution for adults with household MAGI above 150 percent of the FPL and children with household MAGI above 300 percent of the FPL is provided as follows.

CommonHealth Required Member Formula Adults above 150% FPL and Children above 300% FPL		
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

(iii) CommonHealth members who are eligible to receive a premium assistance payment as described in 130 CMR 506.012 that is less than the CommonHealth required member contribution receive their premium assistance payment as an offset to the CommonHealth monthly premium bill and are responsible for the difference.

(b) The required member contribution formula for MassHealth Family Assistance premium assistance eligible children, as described in 130 CMR 505.005 (B): *Eligibility Requirements for Children with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 150 Percent and Less than or Equal to 300 Percent of the Federal Poverty Level*, whose household MAGI is between 150 percent and 300 percent of the FPL is as follows.

Family Assistance Member Contribution for Children Required Member Contribution Formula	
% of Federal Poverty Level (FPL)	**Member Monthly Contribution Amount**
Above 150% to 200%	$12 per child ($36 PBFG maximum)
Above 200% to 250%	$20 per child ($60 PBFG maximum)
Above 250% to 300%	$28 per child ($84 PBFG maximum)

(c) The required member contribution formula for MassHealth Family Assistance premium assistance for HIV-positive adults, as described in 130 CMR 505.005(E): *Eligibility Requirements for HIV-Positive Individuals Who Are Citizens or Qualified Noncitizens with Modified Adjusted Gross Income of the MassHealth MAGI Household Greater than 133 and Less than or Equal to 200 Percent of the Federal Poverty Level* is as follows.

Family Assistance for HIV+ Adults Member Contribution Formula	
% of Federal Poverty Level (FPL)	**Member Monthly Contribution Amount**
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

(3) The following members do not have a required member contribution:
(a) MassHealth Standard premium assistance eligible members described at 130 CMR 505.002: *MassHealth Standard*;
(b) MassHealth CommonHealth premium assistance eligible members, as described in 130 CMR 505.004: *MassHealth CommonHealth*, who have household MAGI at or below 150 percent of the FPL;
(c) MassHealth CarePlus premium assistance eligible members, as described in 130 CMR 505.008: *MassHealth CarePlus*;

(d) MassHealth Family Assistance premium assistance eligible members, as described in 130 CMR 505.005(C): *Eligibility Requirements for Children and Young Adults Who Are Nonqualified PRUCOLs with Modified Adjusted Gross Income of the MassHealth MAGI Household at or below 150 Percent of the Federal Poverty Level*, who household MAGI is at or below 150 percent of the FPL; and

(e) MassHealth members who have verified that they are American Indians or Alaska Natives who have received or are eligible to receive an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or by a non-Indian health-care provider through referral, in accordance with federal law. These members receive premium assistance payments totaling the full employee share, to the extent that it is cost effective for the MassHealth agency. If it is not cost effective for the MassHealth agency, these members may choose to accept a premium assistance amount that is lower than the full-employee share or they may choose to enroll in direct coverage under MassHealth Family Assistance.

(E) MassHealth Premium Assistance Payment Amount Calculation.

(1) Formulas. MassHealth uses two formulas to calculate the premium assistance payments. The formulas are based on the category of assistance a member is enrolled in.

(a) The monthly premium assistance formula for ESI 50% Plans is described in 130 CMR 506.012(E)(2).

(b) The monthly premium assistance formula for Other Group Insurance Plans is described in 130 CMR 506.012(E)(3).

(2) MassHealth Premium Assistance Payment Amount Calculation — ESI 50% Plans.

(a) Determination of Actual Premium Assistance Payment Amount. In order to determine the actual premium assistance payment amount, MassHealth must review and compare the estimated premium assistance payment amount and the cost-effective amount. The estimated premium assistance payment amount and cost-effective amount are compared to calculate the actual premium assistance payment amount.

(i) Estimated Premium Assistance Premium Payment Amount. The estimated premium assistance payment amount is calculated by subtracting the employer share of the policyholder's health-insurance premium and the MassHealth required member contribution of the health-insurance premium, as described in 130 CMR 506.012(D), from the total cost of the health-insurance premium.

(ii) Cost-Effective Amount. The ESI 50% Plans cost-effective amount is the MassHealth agency's cost of providing direct MassHealth benefits to the premium billing family group (PBFG) who are beneficiaries of the ESI.

(b) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and cost-effective amount to determine the actual premium assistance payment amount.

(i) If the estimated premium assistance payment amount is less than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

(ii) If the estimated premium assistance payment amount is equal to or greater than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the cost-effective amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.

(c) Example. A parent and two children apply for MassHealth. The two children are eligible for MassHealth, but the parent is not eligible. Their health insurance is an ESI 50% plan.

(i) The total monthly cost of the health-insurance premium = S.

(ii) The employer's monthly share of the health-insurance premium = T.

(iii) The MassHealth estimated member share of the monthly health-insurance premium = U.

(iv) Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (employer's share of the cost)
V = (employee's share of the cost)
- U = (the MassHealth estimated member share of the cost)
W = (estimated premium assistance payment amount)

ESI 50% Plans cost-effective amount: W is compared to the MassHealth cost of covering the three individuals (X).

If W is less than X, the MassHealth agency sets the actual premium assistance payment amount at W.

If W is equal to or greater than X, the MassHealth agency sets the actual premium assistance payment amount at X.

(3) MassHealth Premium Assistance Payment Amount Calculation — Other Group Insurance Plans.

(a) Determination of Actual Premium Assistance Payment Amount. In order to determine the actual premium assistance payment amount, MassHealth must review and compare the estimated premium assistance payment amount and the cost-effective amount. The estimated premium assistance payment amount and cost-effective amount are compared to calculate the actual premium assistance payment amount.

(i) Estimated Premium Assistance Payment Amount. The estimated premium assistance payment amount is calculated by subtracting both the MassHealth required member contribution, as described in 130 CMR 506.012(D), and any contribution amount from an employer a person covered by this plan is eligible for from the total cost of the health-insurance premium.

(ii) Cost-Effective Amount. The Other Group Insurance Plans cost-effective amount is the MassHealth agency's cost of covering MassHealth-eligible premium billing family group (PBFG) who are beneficiaries of the Other Group Insurance Plan.

(b) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and cost-effective amount to determine the actual premium assistance payment amount.

(i) If the estimated premium assistance payment amount is less than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.

(ii) If the estimated premium assistance payment amount is equal to or greater than the cost-effective amount, the MassHealth agency sets the actual premium assistance payment amount at the cost-effective amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.

(c) Example. A parent and two children apply for MassHealth. The two children are eligible for MassHealth, but the parent is not eligible. Their health insurance falls into Other Group Insurance Plans.

(i) The total monthly cost of the health-insurance premium = S.

(ii) The monthly contribution amount for an employer that a person covered by this plan is eligible for = T.

(iii) The MassHealth required member contribution toward the monthly health-insurance premium = U.

(iv) Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (monthly contribution from an employer)
V = (employee's share of the cost)
- U = (the MassHealth estimated member share of the cost)
W = (estimated premium assistance payment amount)

Other Group Insurance Plans cost-effective amount: W is compared to the cost of covering only those MassHealth eligible individuals = Z.

If W is less than Z, the MassHealth agency sets the actual premium assistance payment amount at W.

If W is equal to or greater than Z, the MassHealth agency sets the actual premium assistance payment amount at Z.

(F) MassHealth Premium Payment Administration.

(1) Premium Assistance Payments.

(a) The MassHealth agency makes only one premium assistance payment per policy.

(b) Premium assistance payments are made directly each month to the policyholder.

(c) Proof of health-insurance premium payments may be required.

(d) Premium assistance payments begin in the month of the MassHealth Premium Assistance eligibility determination or in the month that health-insurance deductions begin, whichever is later.

(e) Each monthly premium assistance payment is for health-insurance coverage in the following month.

(f) MassHealth reviews the cost effectiveness of the member's health insurance at least once every 12 months.

(2) Change in Premium Assistance Calculation.

(a) The premium assistance amount is recalculated when the MassHealth agency is informed of changes in the federal poverty level, health-insurance premium, employer contribution, and whenever an adjustment is made in the premium assistance payment formula.

(b) Members whose premium assistance amount changes as the result of a reported change or any adjustment in the premium assistance payment formula receive the new premium assistance payment beginning with the calendar month following the reported change.

(3) Termination of Premium Assistance Payments.

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

(b) If there is a change in the services covered under the policy that affects the Basic Benefit Level (BBL) requirements, the premium assistance payments end.

(c) Members who become eligible for a different coverage type in which they are not eligible to receive a premium assistance benefit receive their final premium assistance payment in the calendar month in which the coverage type changes.

(d) If a member voluntarily withdraws his or her MassHealth application for benefits, the MassHealth premium assistance payments end.

506.013: MassHealth Small Business Employee (SBE) Premium Assistance Program

(A) Introduction. 130 CMR 506.013 describes the rules and requirements for the Small Business Employee (SBE) Premium Assistance Program eligibility and the payment calculation for individuals who are eligible for this program, as described at 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.

(B) Premium Assistance Eligibility Criteria. MassHealth provides a premium assistance payment to eligible individuals as described at 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance* if such individuals have access to an employer-sponsored health insurance (ESI) that meets all of the following criteria.

(1) The ESI meets the Basic Benefit Level (BBL), as described at 130 CMR 501.001: *Definition of Terms*.
(2) The ESI policy holder is in the premium billing family group (PBFG).
(3) At least one person covered by the ESI policy is eligible for MassHealth SBE Premium Assistance benefits, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*.
(4) The ESI is from an employer that offers an individual health-insurance plan to the employee for which the employee contribution costs more than the Health Connector affordability schedule as defined at 956 CMR 6.05:*Determining Affordability* but less than 9.5% of the MassHealth MAGI income.
(5) The ESI does not cover any individuals who are eligible for or receiving a MassHealth premium assistance payment as described in 130 CMR 506.012.
(6) Effective January 1, 2015, the ESI is a small group health insurance plan purchased by the individual's employer through the Health Connector.

(C) Required Member Contribution. For individuals eligible for the MassHealth SBE Premium Assistance Program, as described in 130 CMR 505.009: *MassHealth Small Business Employee Premium Assistance*, whose household MassHealth MAGI income is between 133 percent and 300 percent of the federal poverty level (FPL) the required member contribution can be found at 956 CMR 12.00: *Eligibility, Enrollment and Hearing Process for Connector Care*.

(D) MassHealth SBE Premium Assistance Payment Amount Calculations.
(1) Calculation of Estimated Premium. MassHealth compares the estimated premium assistance payment amount and the maximum premium assistance amount to calculate the actual premium assistance amount.
(a) The estimated premium assistance payment amount is calculated by subtracting the employer share of the policyholder's health-insurance premium and the MassHealth required member contribution of the health-insurance premium, as described in 130 CMR 506.013(C), from the total cost of the health-insurance premium.
(b) The SBE maximum premium assistance amount is $150 per adult covered by the employer-sponsored plan in the PBFG and cannot exceed two adults.
(2) Comparison of Payment Amounts. MassHealth compares the estimated premium assistance payment amount and the SBE maximum premium assistance amount and uses the following formula to determine the actual premium assistance payment amount.
(a) If the estimated premium assistance payment amount is less than the SBE maximum premium assistance amount, the MassHealth agency sets the actual premium assistance payment amount at the estimated premium assistance payment amount.
(b) If the estimated premium assistance payment amount is equal to or greater than the SBE maximum premium assistance amount, the MassHealth agency sets the actual premium assistance payment amount at the SBE maximum premium assistance amount. The policy holder is responsible for payment of the remainder of the health-insurance premium, if any.

(3) Example. An adult applies for MassHealth and is determined eligible for SBE premium assistance. The adult has access to employer-sponsored insurance (ESI) that meets the requirements set out in 130 CMR 506.013(B). The adult has enrolled in ESI coverage from the employer.

(a) The total monthly cost of the health-insurance premium = S.

(b) The monthly contribution amount for an employer that a person covered by this plan is eligible for = T.

(c) The MassHealth required member contribution toward the monthly health-insurance premium = U.

(d) Calculating the estimated premium assistance payment amount:

S = (total cost of premium)
- T = (employer's share of the cost)
V = (employee's share of the cost)
- U = (the MassHealth SBE required member contribution)
W = (estimated premium assistance payment amount)

SBE premium assistance maximum contribution amount: X = $150 times the number of adults covered by the employer-sponsored plan in the PBFG, not to exceed two adults.

Actual SBE premium assistance amount: W is compared to X.

If W is less than X, the MassHealth agency sets the actual premium assistance payment amount at W.

If W is equal to or greater than X, the MassHealth agency sets the actual premium assistance payment amount at X.

(E) MassHealth SBE Premium Payment Administration.

(1) SBE Premium Assistance Payments.

(a) The MassHealth agency makes only one SBE premium assistance payment per policy.

(b) SBE premium assistance payments are made directly each month to the policyholder.

(c) Proof of health-insurance premium payments may be required.

(d) SBE premium assistance payments begin in the month of the MassHealth Premium Assistance eligibility determination or in the month that health-insurance deductions begin, whichever is later.

(e) Each monthly SBE premium assistance payment is for health-insurance coverage in the following month.

(f) MassHealth reviews the SBE maximum contribution amount and the cost of the member's health insurance at least once every 12 months.

(2) Change in SBE Premium Assistance Calculation.

(a) The SBE premium assistance amount is recalculated when the MassHealth agency is informed of changes in the federal poverty level, health-insurance premium, employer contribution, and whenever an adjustment is made in the premium assistance payment formula.

(b) Members whose SBE premium assistance amount changes as the result of a reported change or any adjustment in the SBE premium assistance payment formula receive the new SBE premium assistance payment beginning with the calendar month following the reported change.

(3) Termination of Premium Assistance Payments.

(a) If a member's health insurance terminates for any reason, the MassHealth SBE premium assistance payments end.

(b) If there is a change in the services covered under the policy such that the policy no longer meets the BBL requirements, the SBE premium assistance payments end.

(c) Members who become eligible for a different coverage type in which they are not eligible to receive an SBE premium assistance benefit receive their final SBE premium assistance payment in the calendar month in which the coverage type changes.

(d) If a member voluntarily withdraws his or her MassHealth application for benefits, the MassHealth SBE premium assistance payments end.

506.014: Copayments Required by MassHealth

The MassHealth agency requires its members to make the copayments described in 130 CMR 506.016, up to the maximum described in 130 CMR 506.018, except as excluded in 130 CMR 506.015. If the usual-and-customary fee for the service or product is less than the copayment amount, the member must pay the amount of the service or product, providing that this amount shall be no greater than the MassHealth payment minus one cent.

506.015: Copayment and Cost Sharing Requirement Exclusions

(A) Excluded Individuals.

(1) The following individuals do not have to pay the copayments described in 130 CMR 506.016:

(a) members younger than 21 years old;

(b) members who are pregnant or in the postpartum period that extends through the last day of the second calendar month following the month in which their pregnancy ends (for example, if the woman gave birth May 15th, she is exempt from the copayment requirement until August 1st);

(c) MassHealth Limited members;

(d) MassHealth Senior Buy-In members or MassHealth Standard members for drugs covered under Medicare Parts A and B only, when provided by a Medicare-certified provider;

(e) members who are inpatients in nursing facilities, chronic-disease or rehabilitation hospitals, or intermediate-care facilities for the mentally retarded or who are admitted to a hospital from such a facility or hospital;
(f) members receiving hospice services;
(g) persons receiving medical services through the Emergency Aid to the Elderly, Disabled and Children Program pursuant to 130 CMR 450.106: *Emergency Aid to the Elderly, Disabled and Children Program*, if they do not receive MassHealth Standard, MassHealth CarePlus, or MassHealth Family Assistance; and
(h) members who are American Indians or Alaska Natives who are currently receiving or have ever received an item or service furnished by the Indian Health Service, an Indian tribe, a tribal organization, or an urban Indian organization, or through referral, in accordance with federal law.

(2) Members who have accumulated copayment charges totaling the maximum of $250 per calendar year do not have to pay further MassHealth copayments on pharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for pharmacy services.
(3) Members who have accumulated copayment charges totaling the maximum of $36 per calendar year on nonpharmacy services do not have to pay further MassHealth copayments on nonpharmacy services during the calendar year in which the member reached the MassHealth copayment maximum for nonpharmacy services.
(4) Members who have accumulated premium and copayment charges totaling an amount equal to five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household, as applicable, in a given calendar quarter do not have to pay further MassHealth copayments during the quarter in which the member reached the five percent cap.
(5) Members who have other comprehensive medical insurance, including Medicare, do not have to pay MassHealth copayments on nonpharmacy services.
(6) Members who are inpatients in a hospital do not have to pay a separate copayment for pharmacy services provided as part of the hospital stay.

(B) Excluded Services. The following services are excluded from the copayment requirement described in 130 CMR 506.016:
(1) family planning services and supplies such as oral contraceptives, contraceptive devices, such as diaphragms and condoms, and contraceptive jellies, creams, foams, and suppositories;
(2) nonpharmacy behavioral-health services;
(3) emergency services; and
(4) provider-preventable services as defined in 42 CFR 447.26(b).

506.016: Services Subject to Copayments

MassHealth members are responsible for making the following copayments unless excluded in 130 CMR 506.015.

(A) Pharmacy Services. The copayment for pharmacy services is

(1) $1 for each prescription and refill for each generic drug and over-the-counter drug covered by the MassHealth agency in the following drug classes: antihyperglycemics, antihypertensives, and antihyperlipidemics; and

(2) $3.65 for each prescription and refill for all other generic and over-the-counter drugs, and all brand-name drugs covered by the MassHealth agency.

(B) Nonpharmacy Services. The copayment for nonpharmacy services is $3 for an acute inpatient hospital stay.

506.017: Members Unable to Pay Copayment

Providers may not refuse services to a member who is unable to pay at the time the service is provided. However, the member remains liable to the provider for the copayment amount.

506.018: Maximum Cost Sharing

Members are responsible for the MassHealth copayments described in 130 CMR 450.130(B): *Services Subject to Copayments*, up to the following maximums:

(A) $250 for pharmacy services per calendar year;

(B) $36 for nonpharmacy services per calendar year; and

(C) five percent of the member's MAGI income of the MassHealth MAGI household or the MassHealth Disabled Adult household per calendar quarter, including both copayments and any applicable premium payments.

506.019: Family Assistance Premium Plus Cap

(A) Copays, Coinsurance, and Deductibles. The MassHealth agency pays copays, coinsurance, and deductibles for children eligible for Family Assistance Premium Assistance as described in 130 CMR 505.005 (B)(2)(b)(i) provided

(1) the MassHealth agency has made a determination that the member was uninsured at the time of the eligibility determination, had access to employer-sponsored health insurance, and the MassHealth agency required the member's enrollment in the health insurance plan; and

(2) the policyholder's annualized share of the employer-sponsored health insurance premium, combined with copays, coinsurance, and deductibles incurred and paid by members, exceeds five percent of the MAGI of the child with the lowest federal poverty level in the PBFG in a 12-month period beginning with the date of eligibility for premium assistance. In such cases, the MassHealth agency pays for any copays, coinsurance, or deductibles incurred by the members during the balance of the 12-month period provided they have submitted proof of payment of bills equal to or exceeding five percent of the MAGI of the child with the lowest federal poverty level in the PBFG. Proof of payment may be submitted during or after the 12-month period, but no later than six months after the 12-month period ends. The five percent cap will be recalculated when there is any circumstance that changes the MAGI of the child with the lowest federal poverty level in the PBFG.