Part 1

Overview of MassHealth

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1 What is MassHealth?

"MassHealth" is the name of the health coverage programs administered by a state agency called the Executive Office of Health and Human Services Office of Medicaid to benefit certain groups of low- and moderate-income people. MassHealth includes the federal-state Medicaid program under Title XIX of the Social Security Act and the State Children's Health Insurance program under Title XXI of the Social Security Act, as well as programs created and funded entirely by Massachusetts with no federal assistance.

MassHealth provides comprehensive health coverage to financially needy people who fit into an eligibility group such as families with children, the disabled, and the elderly. Most people eligible for MassHealth get a plastic MassHealth card that enables them to get health care services from participating providers at little or no cost. The federal government pays half the costs of Medicaid expenditures in Massachusetts, and state government pays for most of the remaining costs.

MassHealth provides health coverage to over one million people representing over 15 percent of Massachusetts residents. While the number of seniors on MassHealth has remained stable over the years, enrollment of people under 65 has steadily grown. Most of this growth is attributable to the 1997 implementation of a comprehensive Medicaid demonstration project under Section 1115 of the Social Security Act referred to in this Guide as Medicaid reform.

In 2006 Massachusetts enacted a wide-ranging health reform law, Chapter 58 of the Acts of 2006, designed to increase health insurance coverage for almost all state residents. Key components of the plan include expanding MassHealth coverage to uninsured children from 200 percent to 300 percent of poverty, and creating a new program called Commonwealth Care to assist uninsured adults under 300 percent of poverty to purchase insurance from participating plans. Starting in July 2007, an individual mandate requires all adults to be insured or face a state tax penalty. While questions remain about the affordability and sustainability of the health reform plan, the need for informed health advocates is greater than ever.

2 Medicaid reform in Massachusetts

Under Section 1115 of the Social Security Act, a state can apply for a comprehensive research and demonstration project in order to get certain federal rules waived that otherwise would apply to its Medicaid program, and to get federal Medicaid matching funds to expand coverage and services. The Massachusetts Medicaid program has been operating under a Section 1115 waiver since July 1, 1997.

The overall goals of the initial demonstration project in Massachusetts were to expand access to insurance to more people under age 65 while also controlling costs by streamlining the eligibility process, saving on the Uncompensated Care Pool (now called the Health Safety Net) and expanding the use of managed care. The waiver expands eligibility to higher income levels for existing eligible groups of children, parents, and people with disabilities, extends coverage to a new group of long-term unemployed adults and people who are HIV positive, and subsidizes premiums for certain workers and small employers.

The most recent renewal of the demonstration also provides funds for a new subsidized insurance program called Commonwealth Care that began on October 1, 2006 for adults not otherwise eligible for MassHealth. While funded under Title XIX, Commonwealth Care operates much differently than the MassHealth programs.

The demonstration generally does not affect people age 65 and older, people requiring long-term nursing home care, and certain other groups for whom eligibility is still governed by traditional Medicaid rules. One key difference is that traditional Medicaid considers asset ownership as well as income in determining financial eligibility, but Medicaid reform only considers income.

In addition to different rules about assets, Medicaid reform and traditional Medicaid have different rules about counting income, when benefits begin, the use of managed care, premium charges, and options available to people who exceed financial eligibility limits.

Under the terms of the most recent renewal of the demonstration, the MassHealth agency may apply to amend the waiver in order to impose enrollment caps in MassHealth Basic, Essential, and Family Assistance. The state also has statutory authority to cap enrollment in Commonwealth Care. Currently, there are no enrollment caps.

3 The 2006 health reform law and the individual mandate

The 2006 health reform law required all individuals age 18 or older to have "creditable" health insurance coverage if it is available at an "affordable" cost or incur state tax penalties. In 2008 and later years, the penalty is assessed based on one-half the lowest cost available coverage. A new entity called the Health Insurance Connector Authority was created to define minimum creditable coverage and affordability and hear appeals on hardship grounds from those assessed the penalty, and to create more affordabled insurance options through subsidized and unsubsidized plans. The new subsidized health insurance program is called Commonwealth Care, and is described in Part 10 of this Guide.

For purposes of the individual mandate, all comprehensive MassHealth programs and Commonwealth Care itself count as "creditable" coverage, but the Health Safety Net does not. The affordability schedule corresponds to the minimum premium schedule in Commonwealth Care for individuals with income under that program's 300 percent of poverty upper limit. Individuals whose income does not exceed 150 percent of poverty can obtain Commonwealth Care with no minimum premium contribution and, accordingly, are not subject to individual mandate penalties if they remain uninsured. Higher-income individuals who were uninsured complete a series of tax worksheets to determine if insurance was affordable, and may appeal the assessment of a penalty on hardship grounds.

G.L. c. 111, § 2 (individual mandate); 956 C.M.R. § 5.00 (definition of creditable coverage); 956 C.M.R. § 6.00 (affordability and hardship standards; the annual affordability schedule is published separately); Dept. of Revenue, TIR-07-18 and 09-01 (tax penalties for Tax Year 2008 and proposed penalties for Tax Year 2009).

4 The main types of MassHealth coverage

There are several different kinds of MassHealth coverage. See Table 1 and Figure 1, below. Coverage types differ in their eligibility criteria, the scope of covered benefits, the premiums or other costs charged to beneficiaries, when

coverage begins, and whether beneficiaries must enroll in managed care in order to be eligible for coverage. People in traditional Medicaid receive coverage under MassHealth Standard or MassHealth Limited. People eligible under Medicaid reform may qualify under any one of five MassHealth coverage types or in Commonwealth Care.

In determining whether a person is eligible for MassHealth, the eligibility system tries to provide the MassHealth coverage type with the most comprehensive benefits for which the individual is eligible. Only individuals not eligible for MassHealth are considered for Commonwealth Care. The coverage types in the order in which eligibility is determined are:

First: MassHealth Standard

Second: MassHealth CommonHealth

Third: MassHealth Family Assistance

Fourth: MassHealth Basic

Fifth: MassHealth Essential

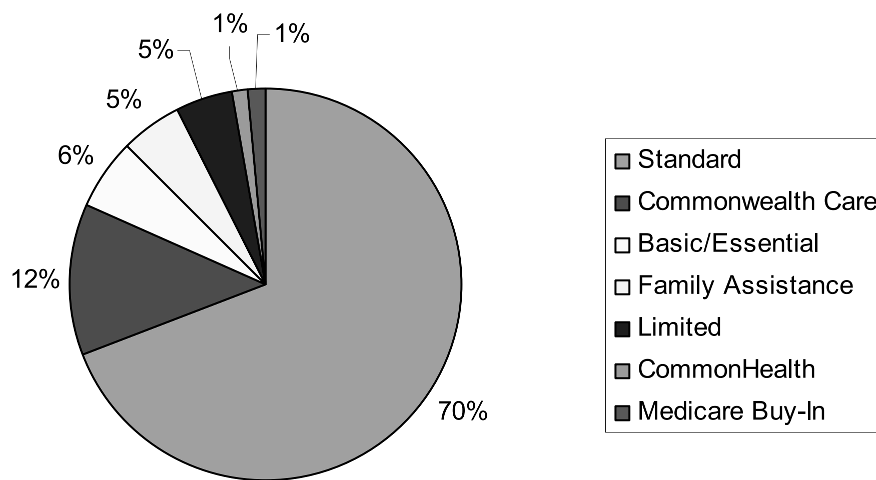
Sixth: Commonwealth Care

The features of the five main MassHealth coverage types and of Commonwealth Care are summarized below. MassHealth also administers four other health coverage programs: MassHealth Limited (also known as emergency Medicaid); Medicare Savings Programs (help paying Medicare premiums and Medicare cost sharing); the Healthy Start Program (prenatal care for pregnant women); and the Children's Medical Security Plan (primary and preventive care for children). In addition, the MassHealth agency makes eligibility determinations for the Health Safety Net (formerly called the Uncompensated Care Pool or Free Care) that is administered by the Division of Health Care Finance and Policy. These other programs are described in Part 15 (MassHealth Limited), Part 11 (Medicare Savings Programs), and Part 19 of this Guide.

Table 1: Numbers Enrolled on October 31, 2008

Coverage type	Number enrolled
Standard	908,094
Commonwealth Care	162,721
Basic/Essential	76,622
Family Assistance	63,804
Limited	61,873
CommonHealth	18,929
Medicare Buy-In	18,334
Total	1,310,377

Figure 1: Enrollment in Commonwealth Care & MassHealth



5 How MassHealth is administered

Federal law requires a "single state agency" to be responsible for Medicaid. In Massachusetts, that agency is the Executive Office of Health and Human Services (EOHHS).[1] Within EOHHS, the Office of Medicaid is responsible for much of the

[1] G.L. c. 118E, § 1; 42 C.F.R. § 431.10.

day-to-day administration of MassHealth. The Department of Elder Affairs and the Office of Long Term Care (both under EOHHS) oversee MassHealth services for the elderly and disabled. This Guide will generally refer to the state agency administering MassHealth as the MassHealth agency or the agency. The MassHealth agency has a central office in Boston and four regional MassHealth Enrollment Centers (MECs) in Revere, Taunton, Tewksbury, and Springfield.[2]

The demonstration authorized a new entity called the Health Insurance Connector Authority (the Connector) to administer the Commonwealth Care program. However, the Connector has arranged for the MassHealth agency to make initial eligibility determinations for Commonwealth Care. The organization and operation of the Connector is discussed in more detail in Part 10.

The MassHealth agency relies on its computer system to make most eligibility determinations. Applications are entered into the system at the central processing unit of the MassHealth agency in Boston. Incomplete applications and renewals are handled by one of the four regional MECs.

Clinical decisions about approving payment for specific services are made by the prior approval unit at the MassHealth agency central office in Boston, not at the MECs. For members in managed care, such decisions are made by the managed care organizations and the behavioral health and substance abuse vendor under contract with the MassHealth agency.

In addition, the MassHealth agency has contracts with many private and public entities to perform specific functions for it. For example, it has contracts with the University of Massachusetts Medical Center to do disability evaluations and drug utilization review. The agency contracts with a national for-profit company called Maximus for a variety of functions including: provider services, managed care enrollment assistance, and operation of the Customer Service Center.

The federal agency that oversees both the Medicaid and the State Children's Health Insurance components of MassHealth and Commonwealth Care is the Centers for Medicare and Medicaid Services (CMS), formerly called the Health Care Financing Administration. It has a regional office in Boston and central offices in Baltimore, and is part of the U.S. Department of Health and Human Services.

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[2] Part 20 of this Guide lists the address and telephone number for the offices described here.

6 How to obtain MassHealth or Commonwealth Care

There are four main ways to apply for MassHealth or Commonwealth Care: by mail; in person at a MassHealth Enrollment Center; over the Internet at a hospital, health center, or other site authorized to submit applications via the "Virtual Gateway"; or by applying for and obtaining certain cash assistance programs including SSI, TAFDC, and EAEDC. See Part 4 for more about how to apply for MassHealth.

There are two main MassHealth application forms: the Medical Benefit Request (MBR) used primarily by people under age 65, and the Senior Medical Benefit Request form (S-MBR) used by most people age 65 and older, people of any age seeking payment for long-term nursing home care, and certain people seeking MassHealth for services to live at home instead of in a nursing home. There is also a separate form to apply for the Medicare Savings Program (also called the Medicare Buy-In).

The MBR and S-MBR constitute an application for almost all programs for which the MassHealth agency makes an eligibility determination. This includes all types of MassHealth coverage described below, as well as MassHealth Limited, the Medicare Savings Programs, the Children's Medical Security Plan (CMSP), the Healthy Start Program (HSP), the Health Safety Net (formerly called the Uncompensated Care program/Free Care), and starting October 1, 2006, the new Commonwealth Care program.

However, applications must go through an intermediary in order to be considered for certain MassHealth programs: Women's Health Network sites for the Breast and Cervical Cancer Treatment program; and an employer participating in the Insurance Partnership program for certain premium assistance programs.

7 The role of advocates

The Section 1115 demonstration greatly expanded eligibility and simplified the eligibility process by eliminating an asset test, but it also complicated the work of

advocates by creating many different coverage types with different eligibility criteria and different benefits. Advocates have an important role to play in helping low-income people navigate the MassHealth system in order to obtain access to necessary health care services. With the introduction of Commonwealth Care and the tax penalties for adults who do not enroll in affordable insurance, the role of advocates is more important than ever.

Advocates commonly represent people with two kinds of problems with MassHealth and Commonwealth Care:

- they are denied initial or continuing eligibility for the programs; or
- they are eligible but are denied coverage for a particular service.

Advocates will need consent from their clients to obtain information from the MassHealth agency or the Connector. If a client is not present to give oral consent, a written release form must be on file with the agency. MassHealth has developed a form called the “Permission to Share Information” (PSI) that complies with federal health insurance privacy law known as HIPAA and is available on the MassHealth website. The PSI authorizes both the MassHealth agency and the Connector to release information. An Eligibility Representative form also authorizes the release of information and allows the representative to apply on behalf of someone else.

Legal services programs have trained advocates who may be able to represent clients with health access problems. While many problems can be resolved informally, some can only be solved by an administrative appeal to the appropriate agency. Lawsuits are another way to resolve problems that cannot be fixed any other way. A list of legal services programs is included in Part 20 of this Guide.

8 Sources of information for advocates

The first place to look to resolve a MassHealth problem is in the state regulations. The regulations for MassHealth, CMSP, and HSP are written by the MassHealth agency and are found in Chapter 130 of the Code of Massachusetts Regulations (130 C.M.R.). Eligibility regulations for the Medicaid reform population are in Sections 501–508; regulations for the 65 and older and nursing home population

and for CMSP and HSP are in Sections 515–521. The regulations are posted on the MassHealth website along with a wealth of additional information about MassHealth at www.mass.gov/MassHealth. Look for citations to relevant regulations throughout this Guide.

The regulations of Commonwealth Care are written by the Connector and are found in Chapter 956 of the Code of Massachusetts Regulations (956 C.M.R. 3.00). The Commonwealth Care regulations, administrative bulletins, descriptions of benefits, copayments and premium schedules along with other information are posted on the Connector website at www.mahealthconnector.org.

In some cases, it will be necessary to look beyond the state regulations to state statutes, agency policy materials, provider manuals, and contracts with managed care plans, as well as federal laws, regulations, and sub-regulatory materials such as Dear State Medicaid Director letters and the CMS State Medicaid Manual. Most federal resources and many state resources are available on the Internet.[3]

9 Summary of the main types of MassHealth coverage

Summary 1: MassHealth Standard

1. Overview

MassHealth Standard is the traditional type of full Medicaid coverage. It has the broadest scope of benefits. The vast majority of people enrolled in MassHealth have MassHealth Standard. It covers most of those who fall within the groups of low-income people typically eligible for Medicaid: pregnant women, families with children, and people who are disabled or elderly.

[3] Part 20 of this Guide lists legal citations and websites for many of the resources described here.

2. Eligible groups

Medicaid Reform: Parents or caretaker relatives living with children under age 19, children under age 19, pregnant women, disabled individuals, women with breast or cervical cancer who have been screened through the Women's Health Network, youth under age 21 who have aged out of foster care.

Traditional Medicaid: People age 65 and over, certain disabled individuals, individuals of any age living in nursing homes or other medical institutions, foster children, certain adoptive children, and certain refugees. Also recipients of cash assistance from SSI or TAFDC.

3. Eligibility of Noncitizens

Only noncitizens eligible for Medicaid under federal rules (qualified aliens) and certain people who were already on Medicaid in 1997 (protected aliens) are eligible for MassHealth Standard. Noncitizens who satisfy all the eligibility criteria for MassHealth Standard except for immigration status receive instead MassHealth Limited, and some may receive state-funded Family Assistance, CommonHealth, Essential, or Commonwealth Care.

4. Financial Eligibility

Medicaid Reform: For parents or caretaker relatives with children: gross family income cannot exceed 133 percent of the federal poverty level. For children age 1–18: gross family income cannot exceed 150 percent of poverty. For pregnant women and infants, gross family income cannot exceed 200 percent of poverty. For disabled individuals under age 65: gross family income cannot exceed 133 percent of poverty. For women with breast or cervical cancer, gross family income cannot exceed 250 percent of poverty. For youth aging out of foster care, there are no income limits. There are no eligibility criteria related to asset ownership.

Traditional Medicaid: For people age 65 and over: adjusted family income cannot exceed 100 percent of poverty and countable assets cannot exceed $2,000 for an individual or $3,000 for a couple. Seniors with income in excess of 100 percent of poverty can become eligible after meeting a recurring six-month deductible.

For people of any age living in a nursing home or medical institution there is no upper income limit but there is a required contribution to the costs of care based on income, and asset limits apply.

In addition, people who satisfy the eligibility criteria of other agencies for certain cash assistance programs such as SSI or TAFDC automatically qualify for MassHealth Standard.

5. Coverage begin date

Medicaid Reform: Coverage begins 10 days prior to the date the MassHealth agency receives the application form.

Traditional Medicaid: Coverage begins up to three months prior to the month of application if the individuals satisfied the eligibility criteria in the prior months.

6. Covered services

MassHealth Standard provides the most comprehensive coverage of any MassHealth coverage type. MassHealth Standard is the only coverage type that provides long-term care to adults living in nursing homes or other medical institutions. See Table 18 for a list of covered services.

7. Premiums & copayments

Most people in MassHealth Standard have no premium charge, but women eligible throught the Breast and Cervical Cancer Treatment program (BCCTP) with gross family income over 150 percent of poverty are charged premiums on a sliding scale. See Table 18. Adults, regardless of income, are also charged a copayment for drugs.

8. Managed Care

Medicaid Reform: Unless an exemption applies, managed care is required.

Traditional Medicaid: Managed care is not required for the elderly or residents of nursing homes. Voluntary managed care is available for some elderly individuals through Senior Care Options (SCO) plans and PACE plans.

Summary 2: CommonHealth

1. Overview	CommonHealth began as a state-funded program for disabled children and working people with disabilities with income in excess of traditional Medicaid limits, but is now part of MassHealth under Medicaid reform. Many disabled people use CommonHealth to supplement the limitations of private health insurance plans. The Section 1115 waiver expanded CommonHealth to include nonworking adults under age 65 who have met a one-time deductible/spenddown.
2. Eligible groups	Children under 19 with disabilities, working adults with disabilities (including those 65 and over), and nonworking disabled adults (under age 65 only) who are not eligible for MassHealth Standard may be eligible for CommonHealth.
3. Eligibility of noncitizens	As in MassHealth Standard, "qualified" and "protected" aliens are eligible for CommonHealth. In addition, disabled children under age 19 who are not "qualified" but are in the United States legally during a five-year bar period (special status) or "under color of law" (PRUCOL) may be eligible for CommonHealth.
4. Financial Eligibility	There is no upper income limit. However, nonworking disabled adults must meet a one-time deductible: such adults will be eligible only after incurring medical expenses that equal or exceed the amount of the deductible.
5. Coverage begin date	Coverage begins ten days prior to the date the MassHealth agency received the application.
6. Covered services	CommonHealth covers the same types of services as MassHealth Standard but some of the rules relating to the amount, duration and scope of services are more limited in CommonHealth. See Table 18 for a list of covered services.
7. Premiums & copayments	Premiums are charged for all individuals with family income over 150 percent of poverty based on a sliding scale. See Table 18. Adults are also charged a copayment for drugs.
8. Managed Care	Managed care is not currently required, but starting in July 2009 may be required where CommonHealth is the primary coverage (no other insurance).

Summary 3: Family Assistance

1. Overview

MassHealth Family Assistance combines several programs:

- a non-Medicaid health coverage program for children created pursuant to the federal-state State Children's Health Insurance Program (Title XXI);
- a program to encourage employer-sponsored health insurance under the Section 1115 waiver; and
- coverage for people who are HIV positive.

There are two types of Family Assistance: direct coverage and premium assistance toward the cost of private insurance. The Section 1115 waiver also created a program called the Insurance Partnership that pays a subsidy to small employers to encourage them to offer health insurance to low- and moderate-income employees who in turn are eligible for premium assistance toward the cost of coverage.

2. Eligible groups

Direct Coverage: Children under age 19 who are uninsured and currently without access to cost-effective, employer-sponsored insurance; and people under age 65 who are HIV positive may be eligible. Starting July 1, 2006 children with income between 201 and 300 percent of poverty are eligible but only if they have been uninsured for the past six months prior to application.

Premium Assistance: Children under age 19 with access to cost-effective, employer-sponsored insurance, individuals under age 65 who are HIV positive with access to cost-effective insurance, and employees (and their spouses) of "qualified" employers participating in the Insurance Partnership program. Starting July 1, 2006 children with income between 201 and 300 percent of poverty with access to cost-effective insurance are eligible but only if they have been uninsured for the past six months prior to application. See Table 2 in Part 5. Starting October 1, 2006 employees of employers in the Insurance Partnership program will be eligible only if they did not have insurance in the past six months.

All family members may benefit from family coverage if at least one member of the family is eligible for Family Assistance Premium Assistance. It is not necessary that all members of the family be eligible.

3. Eligibility of noncitizens

Qualified immigrants and children who are special status or PRUCOL are eligible. Immigrant children who would be eligible for MassHealth Standard but for special status/PRUCOL are instead provided Family Assistance.

4. Financial Eligibility

For employees of qualified employers, starting October 1, 2006, gross family income cannot exceed 300 percent of the federal poverty level. For uninsured children, starting July 1, 2006 income cannot exceed 300 percent of poverty. For HIV-positive individuals, insured children, and special status/PRUCOL children income cannot exceed 200 percent of poverty. There is no asset test.

5. Coverage begin date

Direct Coverage begins 10 days prior to the MassHealth agency's receipt of the application. Children will receive direct coverage while premium assistance is being investigated. Under **Premium Assistance**, payroll withholding and premium reimbursement payments should begin in the month in which eligibility is determined and coverage through the employer begins the following month.

6. Covered services

Direct Coverage is less extensive than MassHealth Standard; it excludes nonemergency transportation, personal care attendants, private duty nursing, and certain other services. See Table 18 for a list of covered services. With **Premium Assistance**, employer-sponsored insurance benefits will vary based on the employer's plan. However, to be eligible for the subsidy, the employer's policy must provide "minimum creditable coverage."

7. Premiums & copayments

Direct Coverage for children with family income over 150 percent of poverty requires a premium charge per child with a family maximum for the cost of three children. See Table 18.

Employer-sponsored insurance for a child subsidized by **Premium Assistance** will cost at least as much as direct coverage but may cost up to 5 percent of gross family

income. Childless employees of a qualified employer in the Insurance Partnership with income over 150 percent of poverty pay a monthly premium that varies by income; the maximum premium assistance amount is also capped. See Table 8 for Premium Assistance Upper Payment Limits. For adults, additional copayments and other cost-sharing will depend on the employer's plan.

For HIV-positive adults with income over 150 percent of poverty, there is a monthly premium based on income, and a higher premium assistance cap. See Tables 8 and 19. Adults with **Direct Coverage** in the HIV program are also charged a copayment for drugs.

8. Managed are

Unless an exemption applies, managed care is required in Direct Coverage. In Premium Assistance, the terms of coverage are determined by the employer's insurance plan, not by MassHealth.

Summary 4: MassHealth Basic

1. Overview

MassHealth **Basic** was created by the Section 1115 waiver for childless unemployed adults not traditionally eligible for Medicaid. In 2003, it was limited to unemployed adults who are also clients of the Department of Mental Health (DMH), and to recipients of a cash assistance program called EAEDC. The **Basic Buy-In** offers premium assistance toward the purchase of private health insurance instead of direct coverage through MassHealth Basic.

2. Eligible groups

Adults under age 65 who are either chronically (long term) unemployed and clients of the Department of Mental Health or receive cash assistance from EAEDC are eligible. To be a client of DMH, a person with a serious mental illness must apply for DMH services and be determined eligible by DMH, and then apply to the MassHealth agency for Basic. To receive EAEDC, a person must apply to the Department of Transitional Assistance (DTA), and, if eligible, he or she will automatically receive Basic. There are five groups eligible for EAEDC including adults having a disability expected to last at least 60 days.

3. Eligibility of Noncitizens	Noncitizens must be qualified to be eligible for Basic as long-term unemployed DMH clients. Noncitizens who are subject to the five-year bar or PRUCOL may be eligible for EAEDC, but most will receive MassHealth Essential instead of MassHealth Basic.
4. Financial Eligibility	For EAEDC recipients, eligibility is determined by DTA, income levels depend on living arrangements and there is an asset test. For the long-term unemployed DMH clients: gross family income cannot exceed 100 percent of the federal poverty level, and there is no asset test.
5. Coverage begin date	For the long-term unemployed under age 65, coverage begins only after the MassHealth agency has enrolled the individual with a primary care provider/managed care plan. For EAEDC recipients, a limited EAEDC benefit is available from the point of eligibility for EAEDC until enrollment into MassHealth Basic.
6. Covered services	**MassHealth Basic** is less extensive than MassHealth Family Assistance, CommonHealth or MassHealth Standard. It excludes nonemergency transportation and eight other services that primarily benefit people with disabilities or chronic illness. See Table 18 for a list of covered services. The **Basic Buy-In** does not specify any minimum scope of coverage for private plans.
7. Premiums & copayments	There are no premiums for **MassHealth Basic**, but there are copayments for drugs. Under the **Basic Buy-In**, MassHealth will contribute toward the costs of a health insurance premium and the recipient pays any balance as well as any other cost-sharing required by the private plan.
8. Managed Care	Unless exempt, people under age 65 enrolled in MassHealth Basic are required to use managed care.

Summary 5: MassHealth Essential

1. Overview	In 2003, MassHealth Essential coverage replaced coverage under Basic for long-term unemployed adults who are not clients of DMH. In 2004 state-funded MassHealth Essential also became available to certain elderly and disabled special status and PRUCOL noncitizens. Currently there are no enrollment caps in Essential.
2. Eligible groups	Essential is available to unemployed adults under age 65 who have been unemployed for the past 12 months or earned less than $3,300 (FY 2009) in the past 12 months. It is also available to special status/PRUCOL adults under age 65 who are disabled, and to special status/PRUCOL adults who are age 65 or older.
3. Eligibility of Noncitizens	Qualified noncitizens are eligible for MassHealth Essential based on long-term unemployment alone. Immigrants who are subject to the five-year bar or PRUCOL are eligible for Essential only if they are also disabled or are age 65 or older.
4. Financial Eligibility	Gross family income cannot exceed 100 percent of poverty. There is no asset test except for elderly five-year bar/ PRUCOL immigrants who must have countable assets less than $2,000 for an individual or $3,000 for a couple.
5. Coverage begin date	For adults under age 65, coverage begins only when the MassHealth agency has enrolled an individual in a managed care plan. Elderly five-year bar/PRUCOL noncitizens may be covered for up to three months prior to the month of application.
6. Covered services	MassHealth Essential covers fewer services than MassHealth Basic or the other coverage types. See Table 18 for a list of covered services.
7. Premiums & copayments	There is no premium charge for Essential, but there are copayments for drugs.
8. Managed Care	Unless exempt, managed care is required for individuals under age 65. Elderly five-year bar/PRUCOL immigrants are in fee-for-service rather than managed care.

Summary 6: Commonwealth Care

1. Overview	This is a new program created by the 2006 health reform law to provide affordable coverage to uninsured adults who are not otherwise eligible for MassHealth and have gross family income under 300 percent of poverty. It is administered by the Health Insurance Connector Authority, but uses a common application form with MassHealth and the MassHealth agency makes the eligibility determination.
2. Eligible groups	Individuals who are uninsured and not eligible for MassHealth, the Children's Medical Security Plan (CMSP), Medicare, the Medical Security Plan, the Fishing Partnership, TRICARE or Qualifying Student Health Insurance (QSHIP) and are not offered insurance in which an employer pays at least 33 percent of the cost of an individual premium or 20 percent of the cost of a family premium may be eligible for Commonwealth Care. Individuals paying the full cost of insurance as self-employed or COBRA or in a waiting period for employer coverage may be eligible for Commonwealth Care.
3. Eligibility of Noncitizens	To be eligible, non-U.S. citizens must be "qualified," subject to the five-year bar or PRUCOL.
4. Financial Eligibility	Gross family income cannot exceed 300 percent of the poverty level. There is no asset test.
5. Coverage begin date	Coverage begins on the first of the month after an eligible individual has chosen a health plan, and paid the first month's premium if due. If choice of plan or receipt of the premium occurs after a cut-off date in the current month, enrollment will be delayed until the first of the second following month.
6. Covered services	Only those under the poverty level are covered for dental care. Otherwise, covered services are similar to MassHealth Family Assistance or Basic. See Table 18.

7. Premiums & copayments	Premiums are charged to anyone over 150 percent of poverty, and also to those from 101 to 150 percent of poverty who choose any Managed Care Organization (MCO) other than the lowest cost MCO. Premiums vary by income, region, and MCO choice. See Table 18. There are three plan types that charge different levels of copayments based on income. Copayments are the same as MassHealth for those under the poverty level, similar to copayments in small group commercial plans for those over 200 percent of poverty, and somewhat lower for those from 101 to 200 percent of poverty. See Table 9.
8. Managed Care	All services are provided only through participating MCOs.