health law advocates
Lawyers Fighting for Health Care Justice
HLA

One Federal Street, 5th Floor
Boston, MA 02110

T 617-338-5241
888-211-6168 (toll free)
F 617-338-5242
W www.healthlawadvocates.org

Board of Directors
Mala M. Rafik, *President*
Brian P. Carey, *Treasurer*
Lisa Fleming, *Clerk*
Michael S. Dukakis
Ruth Ellen Fitch
Paula Gold
Joshua Greenberg
Daniel J. Jackson
Wendy E. Parmet
S. Stephen Rosenfeld
Lauren A. Smith
Eleanor H. Soeffing

Executive Director
Matt Selig

Legal Staff
Senior Staff Attorney
Marisol Garcia

Staff Attorneys
Lauren Bentlage
Andrew P. Cohen
Caroline T. Donahue
Ashley Jones-Pierce
Lisa Morrow
Eliza L.M. Presson
Michelle Virshup
Wells Wilkinson

Paralegal/Intake Coordinator
Kimberly I. Romero

Administrative Staff
Chief Operating Officer
Robert MacPherson

Program and Development Associate
Emily Tabor

Development Assistant
Sharon N. Jaquez

August 21, 2017

Daniel Tsai
Assistant Secretary for MassHealth
Executive Office of Health and Human Services
One Ashburton Place, 11th Floor
Boston, MA 02108

Submitted via email to kaela.konefal@state.ma.us

Re: Request to Amend the MassHealth 1115 Demonstration Waiver

Dear Assistant Secretary Tsai,

Health Law Advocates (HLA) respectfully submits the following comments to the Massachusetts Executive Office of Health and Human Services (EOHHS) regarding the proposed changes to the MassHealth 1115 Demonstration Waiver.

HLA is a non-profit, public interest law firm that provides free legal assistance to low-income Massachusetts residents who face barriers to accessing health care and coverage. We appreciate the agency's willingness to work with advocates and listen to feedback as it begins to investigate possible changes to the MassHealth program. The financial strength of this program is a goal that we can all come together on, that we all agree is vital to the long-term stability of MassHealth. We also believe maintaining consumers' current level of access to health care is equally vital to preserve the strength of our Commonwealth and health of our residents.

We are concerned that the current proposed changes will impose considerable new obstacles for low-income Massachusetts residents' *access* to health care. If individuals are unable to access health care services – either due to the financial burden imposed by new cost-sharing and deductible amounts, or administrative hurdles described below – their health and wellbeing will inevitably suffer. Coverage without access is tantamount to no coverage at all.

Below, HLA highlights the three proposed changes by the Amendment request that we believe most threaten the ability of low-income Massachusetts residents to access health care: 1) Shifting non-disabled adults with incomes over 100% of the Federal Poverty Level (FPL) from MassHealth to the Health Connector; 2) Changing the MassHealth's Premium Assistance program and implementing a so-called "eligibility gate;"; and 3) Implementation of a closed prescription drug formulary and restricted availability of specialty pharmacies

While we strongly urge EOHHS against pursuing these policy proposals further, we have also included suggestions for implementation that may mitigate some of the possible negative outcomes. Finally, we have also included a list of other aspects of the proposed amendment that concern HLA, as well as areas where we tentatively support the changes put forward.

I. The proposed shift of non-disabled adults with incomes over 100% of the FPL into Health Connector plans endangers health care access for the affected members, particularly parents and caretakers, and their MassHealth-eligible children

EOHHS proposes five reforms to "align coverage for non-disabled adults with commercial plans."[1] This includes moving roughly 140,000 people with incomes between 100% FPL and 138% FPL from MassHealth to the Health Connector, and shifting roughly 230,000 individuals from MassHealth Standard into MassHealth CarePlus. We understand that the rationale behind this change is that this group is the most "economically mobile"[2] and does not require the "unique services" that Medicaid offers."[3] Many of HLA's clients fall into this category of non-disabled adults and we feel the proposals fail to account for numerous factors that distinguish this group and therefore justifies their access additional support from the MassHealth progam in regards to health insurance coverage.

We are especially concerned about those moving from MassHealth to the Health Connector. This group is still very poor even though many have employment income. At their income level, they are more likely to be working in part-time or seasonal positons in which employers do not offer health benefits. As you know, an individual at 138% FPL earns $16,656 a year, or $1,388 a month, and a family of four earns $33,960 a year or $2,830 a month. These amounts do not go very far in Massachusetts where essentials such as housing, food, transportation, and medical care are very expensive. Additional cost-sharing for health care would be a monumental impediment to meeting daily necessities for many of HLA's clients.

Under the current proposal, increased cost-sharing in terms of monthly premiums could reach up to 17% of income for individuals and 24% of income for couples. Higher cost-sharing in the form of out-of-pocket co-pay increases could represent 10% of income for an individual and 15% of income for couples at 100% FPL, or up to 7.7% of income for an individual and 11.5% of income for couples at 133% FPL. Certain essential services, such as primary care visits, mental and behavioral health services, and emergency room visits, will have co-pays where there are currently none under MassHealth. These costs could be devastating for an individual or a family on an already limited budget. HLA currently has clients for whom co-pays, no matter how small the amount, are unsurmountable barriers to accessing care. Additionally, there are certain services – such as dental and vision – which will not be covered at all. We are extremely concerned about the impact this increased cost-sharing will have on the ability of this population to access medically necessary health care. Massachusetts is one of the only states which has proposed going this far in increasing cost-sharing, which runs counter to the "culture of coverage" in the Commonwealth, and our historic commitment to provide coverage to all residents.

One population of particular concern to HLA are parents and caregivers of children who are eligible for MassHealth coverage. Under the current proposal, 100,000 parents and caretakers

---

[1] *MassHealth Section 1115 Demonstration Amendment Request (Waiver Amendment),* July 20, 2017, 3.
[2] *Id*. at 4.
[3] *Id*.

will be moved from MassHealth to the Health Connector. This means they will be on an entirely different health insurance system then their MassHealth-eligible children. We are concerned about the implications of this move on both the parents' and the children's ability to access health care. Even with abundant attempts at notice and messaging, and an extended transition period, it is likely that many parents will not take the necessary steps to enroll in a qualified health plan (QHP) through the Health Connector. Other states that have attempted this type of population shift have seen significant coverage reductions among parents who were moved from the state Medicaid system to the exchange.

In 2015, Connecticut eliminated eligibility for parents and relative caregivers of children in the HUSKY program.[4] The state undertook an extensive notice and marketing campaign, emphasizing that affordable health insurance was still available under the Access Health CT exchange, and even provided many parents with a year of transitional medical assistance (TMA).[5] Nonetheless, among the parents disenrolled from Husky Care, just one in four enrolled in a QHP through Access Health CT, including some who experienced gaps in coverage during the transition.[6] Most parents in the group (73.5%) did not enroll or have since dropped coverage and may be uninsured.[7]

In 2012, Maine reduced the Medicaid income eligibility level for parents from 133% FPL to 105% FPL, and about 28,500 working Maine parents lost regular Medicaid coverage in the following two years.[8] In Rhode Island, out of 6,574 parents affected when Medicaid eligibility was rolled back in 2014, roughly 20% never submitted an application to enroll in a QHP and likely became uninsured, while roughly 10% signed up for a plan but never made a payment and likely became uninsured.[9] These states had a high percentage of drop-off with a relative small population of parents; the outcome for the 100,000 parents and caretakers affected by the MassHealth proposal could be much worse, but even a loss of 20-30% of currently covered parents could be devastating. It could represent the first dramatic increase of the uninsured in Massachusetts in recent times.

HLA is particularly concerned about the impact on MassHealth-eligible children whose parents are moved to the Health Connector. Continuous coverage for low-income parents is likely to result in uninterrupted coverage for their children and more effective use of that coverage for addressing health care needs.[10] Conversely, children in low-income families are three times more likely to be uninsured if their parents are uninsured.[11] Data shows that children with uninsured

---

[4] Connecticut Voices for Children, *HUSKY Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligibility Cut Later in 2016 (Connecticut Voices)*, April 2016, 1.

[5] *Id*. at 1 – 2.

[6] *Id*. at 1.

[7] *Id*.

[8] *Ensuring Health Coverage for Maine Families with Children in 2014: A Health Policy Brief by the Maine Children's Alliance (Maine Health Policy Brief)*, 1.

[9] These numbers don't take into account 36% of parents who were unaccounted for at the time the date was collected, and likely became uninsured. Community Catalyst, *Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned (Roll-Back in Rhode Island)*, September 2015, 5.

[10] *Connecticut Voices*, 3; *quoting* Rosenbaum S, Whittington RPT, *Parental health insurance coverage as child health policy: Evidence from the literature*, Washington DC: George Washington University School of Public Health and Health Services, June 2007. Available at: http://publichealth.gwu.edu/departments/healthpolicy/CHPR/downloads/Parental_Health_Insurance_Report.pdf.

[11] *Id*.; *quoting* Schwartz K, *Spotlight on uninsured parents: How a lack of coverage affects parents and their families*, Washingington DC: Kaiser Commission on Medicaid and the Uninsured, June 2007; *see also* DeVoe JE, Krois L, Edlund C, Smith J, Carlson NE, *Uninsured but eligible children: are their parents insured? Recent findings from Oregon*, Medical Care, January 2008, 46(1): 3-8.

parents have a greater risk of gaps in coverage, and are less likely to receive check-ups, preventative care and other health services.[12] Particularly at risk are children with complex medical or behavioral health needs. In Maine, when the change in parent's eligibility occurred, 6,000 children who were eligible for Medicaid became unenrolled. This represents roughly 13% of children who lost coverage for which they were otherwise eligible.[13] Advocates hypothesized that some parents who received notice of their own termination from Medicaid believed, erroneously, that their children were also being terminated.[14] This is a probable outcome in Massachusetts, as well. Compounding this confusion is the prevalence of MassHealth MCOs and Health Connector plans with the same or similar names. Massachusetts has long been a champion of children's health care access, and this proposal threatens our commitment to maintaining quality health care coverage for vulnerable young people.

A subset of the parent population who are especially at risk are mothers of newborn children above 100% of the FPL. Shortly after they give birth, these women must navigate setting up their own health insurance while also ensuring they enroll in health coverage for their newborn child. Maintaining health coverage during the postpartum period is vital to maintain population health.[15]

HLA is strongly against shifting parents and caretakers from MassHealth to the Health Connector. However, if this change were to take place, there are several measures that have been used in other states that could mitigate potential harm. First, the Commonwealth could implement a redetermination process for any member who would lose MassHealth eligibility to identify those who may still be eligible under another coverage category (for example, pregnancy or disability). In Rhode Island, 24% of the affected parent population remained on Medicaid after an eligibility review.[16] Once people enroll in coverage through the Health Connector, a streamlined process for determining medical frailty, which confers access to MassHealth would be imperative to ensure individuals have access to the appropriate level of coverage for their circumstances. A long and vigorous notice period, as well as the availability of benefits during the transition and access to a robust network of assistors, will be imperative.

We recognize that Massachusetts has a "culture of coverage" not seen in many other states, but Massachusetts will likely suffer the same coverage drop-offs if residents do not have knowledge of and access to the resources to maintain coverage. Additionally, a plan made available on the Health Connector that closely resembles and mimics MassHealth (and the old Commonwealth Care coverage) – including $0 premiums and minimal cost-sharing – would greatly reduce disruptions in care. Automatic enrollment into a $0 premium Health Connector plan would greatly reduce barriers to access, although HLA recognizes that conversations would need to happen with the Health Connector, and possibly the legislature, to determine if such a change would be possible.

HLA is also concerned with the proposed shift of approximately 230,000 parents and caretakers from MassHealth Standard to MassHealth CarePlus due to the availability of CommonHealth and the medical frailty program. However, we emphasize the importance of a redetermination process to ensure that members are in the appropriate level of coverage, and the necessity of a

---

[12] *Maine Health Policy Brief*, 1; *quoting* Rosenbaum and Whittington, 5-6.
[13] *Maine Health Policy Brief*, 1, 3.
[14] *Id*. 3.
[15] *Id*. 4.
[16] *Roll-Back in Rhode Island*, 3.

streamlined exceptions and waiver process, so that members can easily move to more comprehensive coverage should their health care needs change.

II. Proposed changes to the Premium Assistance program, including introduction of an "ESI gate" and narrowing of the Medicaid wrap, endanger access to health care for MassHealth members

HLA is very supportive of the Premium Assistance program, and has been engaged with MassHealth over the past year to help improve the efficacy and visibility of Premium Assistance benefits. HLA supports some of the measures that MassHealth has suggested to improve the program, such as the reintroduction of the HIRD form. However, we are concerned that two proposed changes to the Premium Assistance program – the implementation of an "employer-sponsored insurance (ESI) gate" and the potential reduction of the MassHealth benefit wrap – may impose unneeded barriers to accessing health services.

HLA opposes the implementation of a gate that would bar access to MassHealth for individuals with access to "affordable" ESI. In the August 4th hearing on this proposal, MassHealth revealed that ESI would be considered "affordable" if the ESI premium plus deductibles totaled less than 5% of income.[17] The inclusion of deductibles in this calculation is new, though it is unclear what exactly is meant by "deductible" Is this the out-of-pocket maximum cost? Are co-pays included? How is this calculated when an individual notifies MassHealth that they have access to ESI? MassHealth estimates that with the new calculation, roughly 5,000 members would be affected. We believe that affected individuals will be among the poorest and most vulnerable in the state. The example that MassHealth included in the presentation exemplifies the dangers of this proposal: a single non-disabled adult earning $12,000 a year with ESI that costs less than $50 per month.[18] This member would likely be taking home less than $1,000/month – after rent, food, and other essentials, any new costs associated with health care, even at an amount of less than $50 a month, would be devastating. HLA has clients who are unable to go to scheduled medical appointments or have necessary tests done because of the associated costs, even where co-payments are as small as 10 or 20 dollars. This population needs the protections of Premium Assistance and MassHealth to allow them to access necessary and affordable health care. HLA urges MassHealth not to impose the gate, and to allow these members into the Premium Assistance program).

Also, HLA is concerned about the health care access implications of reducing the Medicaid "wrap" of commercial plans for MassHealth-eligible people. It is unclear based on available materials which benefits would potentially be reduced. We are heartened to see a commitment to cover programs not usually covered by commercial insurance. For many members with Premium Assistance, the wrap covers medically necessary services such as behavioral health services, and long-term services and supports. We would be very concerned if there were any effort to reduce access to any of these services, or to reduce the wrap-around coverage for co-payments and deductible that allows many in the Premium Assistance program to access crucial benefits. HLA requests additional information regarding which benefits EOHHS is requesting to reduce as part of the Premium Assistance MassHealth wrap. We oppose any changes and reductions to the program which would reduce access for low-income MassHealth members who rely on these benefits to access their health care.

---

[17] *MassHealth August Presentation*, Slide 14.
[18] *Id*.

III. Proposed changes to pharmacy benefits may reduce access to medically-necessary drugs for MassHealth members

HLA recognizes the need to manage the rapid growth of prescription drug costs to ensure the overall financial strength of the MassHealth program. We believe that an increase in MassHealth's bargaining power in relation to prescription drug companies is a tool that would have a positive impact on the pharmacy program. However, we are concerned by the proposals to implement a closed formulary and narrow the specialty pharmacy networks. HLA recognizes that there are a number of positive and reasonable outcomes that will be achieved by establishing a closed formulary, especially given the historical context where Medicaid programs have been forced to cover some low-value, high cost drugs if the manufacturer participates in the federal drug rebate program. A closed formulary that gives MassHealth the ability to exclude brand-name drugs from coverage in certain therapeutic categories – such as high cholesterol, high blood pressure, etc. - is very reasonable given available generic equivalents. Also, it would be helpful to protect financial resources where the cost of a drug spikes. HLA hopes that any savings generated would be put back into the pharmacy program to ensure greater access for members.

We are concerned about a closed formulary when it comes to specialty drugs, such as treatments for hepatitis-C and other chronic illnesses. While HLA supports the agency's ability to negotiate for rebates that allows MassHealth to lower the costs associated with these high-priced drugs, there must be a **truly expedited** exceptions process to permit access to drugs outside of the formulary. Such a process is necessary for affected individuals who have a negative indication or reaction to a MassHealth-preferred drug. HLA is also concerned about the rise of "fail first" policies introduced as part of the closed formulary, which may pose an undue obstacle to certain drugs and may undermine the stability of a member's condition that has been well-managed under a certain medication regime. Currently, our clients find it extremely difficult and cumbersome to navigate the MassHealth exceptions process for prescription drugs, particularly when an MCO is involved. We believe MassHealth should ensure access to an exceptions process that is streamlined and accessible if it plans to further restrict access to prescription drugs.

Additionally, HLA is concerned about overly restrictive language related to drugs that were "fast-tracked" under the 21st Century CURES Act. While it is true that many of the drugs that are coming to market through the FDA's accelerated approval pathway have not yet proven their efficacy on primary endpoints in clinical trials,[19] many of these drugs treat cancer and other chronic terminal illnesses and the affected members may not have time to wait. While we are encouraged by the language that would support coverage of "breakthrough" drugs,[20] we are concerned that the exclusion included in the waiver amendment is too broad and will prohibit MassHealth members from accessing potential life-saving treatments that their privately insured peers will be able to obtain.

Finally, we are troubled by the proposal to establish a more selective specialty pharmacy network. Language in the waiver refers to "selected pharmacy locations."[21] If MassHealth chooses only one pharmacy to manage and provide specialty drugs, then MassHealth members who do not live in a geographic area that houses one of the selected pharmacies may be unable to

---

[19] *Waiver Amendment*, 10.
[20] *Id.*
[21] *Id.*

access the medication they need. Many MassHealth members do not have reliable access to public transportation, particularly in the Western part of the state, and limiting where they can access medications may pose an insurmountable access barrier. Furthermore, "mail order or home delivery"[22] of drugs is not workable for many MassHealth members. Often, specialty drugs are delivered during the day and members may need to take time off from work to insure the medication is not stolen or does not go bad because it is not adequately refrigerated in time. Additionally, MassHealth members who face housing instability may not be able to access their medications at all through a mail order or home delivery system. HLA believes that restricting where and how MassHealth members can access specialty medication is not an effective way to manage pharmacy costs in the MassHealth program.

IV. Miscellaneous Comments and Concerns

- HLA supports EOHHS's request to waive federal payment restrictions on care provided in Institutions of Mental Disease (IMDs), as we believe this step will increase access to behavioral health services, including treatment for substance use disorders (SUD). However, the agency must clearly state that the waiver applies to *private hospitals only* -- not public institutions -- to avoid an overwhelming and unmanageable reliance on state institutions to provide behavioral health care.

- HLA cautiously supports the elimination of MassHealth Limited coverage for Health Connector-eligible individuals. Currently, many members are confused by the dual notices informing them that they are eligible for both MassHealth Limited and the Health Connector. Many of our clients do not understand that they must take action to choose and enroll in a plan after receiving the eligibility determination. However, if MassHealth Limited coverage were to be terminated for this population, MassHealth must engage in a comprehensive notice period and education effort to inform individuals how to access coverage from the Health Connector. Eligibility for the Health Safety Net (HSN) should be available to this population during the time between filing the application and enrolling in Connector Care. Additionally, HSN eligibility should be extended for this group once they are terminated from MassHealth Limited for a period of at least 6 months. This extension would minimize coverage gaps during the transition period, resulting in the accrual of unmanageable medical debt.

- HLA is concerned with MassHealth's proposal to limit and narrow MassHealth's Primary Care Clinician (PCC) plan, especially because it is unclear exactly how narrow the network would become. While we recognize the importance of coordinated, integrated care, and support MassHealth's move to the accountable care (ACO) model, many of our members are in the PCC plan for very specific reasons. Often, due to their medical needs, they require access to very specific and varied specialists, and none of the MCOs have provider networks adequate to meet their needs. We think that even after the move to the ACO model, there will still be MassHealth members who cannot access key specialists and who will need to enroll in the PCC plan to access medically appropriate care. In regards to network adequacy, especially in the face of a shrinking PCC plan, HLA is also concerned with MassHealth's proposal to waive the requirements for multiple managed care options in certain areas of the state.[23] We feel this could severely restrict access, particularly in western Massachusetts, Cape Cod, and the Islands.

---

[22] *Id.*
[23] *Waiver Amendment*, 12.

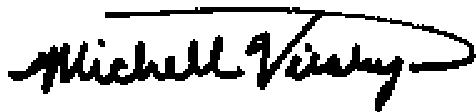
- HLA does not support the proposal to implement cost sharing greater than five percent of income for members over 300% FPL.[24] MassHealth members above 300% FPL are members who have disabilities or families with children with disabilities who are covered under the MassHealth CommonHealth program. While these members may have higher incomes, their cost of living is also much higher. Their housing and transportation costs, as well as many other aspects of everyday life, must be modified in relation to their disability. For example, families of children with complex medical or behavioral health needs face significant costs to keep them safely in the home. We have clients who are CommonHealth members who struggle to pay the 5% deductible and we have some clients who end up paying more than 5% income for their medical costs, regardless of the restriction. Increased cost sharing for this population could pose an insurmountable obstacle to accessing medical care and may have a detrimental impact on the wellbeing of vulnerable people with disabilities. We are especially concerned because MassHealth did not include the amount of the cost-sharing increase in the waiver amendment.

V. Conclusion

HLA would like to thank EOHHS for your willingness to engage in an open dialogue regarding MassHealth reforms and the agency's diligent efforts to ensure the ongoing strength of MassHealth. We share your goal of ensuring a MassHealth program that is financially strong in the long term. However, we believe that some of the Waiver proposals – in particular the population shift from MassHealth to the Health Connector, the changes to Premium Assistance program, and changes to the MassHealth pharmacy benefit – go too far by limiting access to health care for vulnerable residents of the CommonHealth. We look forward to working with EOHHS ensure the sustainability of MassHealth without endangering access for the thousands of low-income Massachusetts residents who rely on the program to access medically necessary health services.

Thank you again for the opportunity to comment on MassHealth's proposed 1115 Waiver Amendment. If you have any questions or need additional information, please do not hesitate to contact Andrew Cohen at 617-275-2891 or acohen@hla-inc.org.

Sincerely,



Michelle Virshup
Staff Attorney

Andrew P. Cohen
Staff Attorney

[24] *Id*. at 13.