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June 22, 2017

The Honorable Robert DeLeo
Speaker of the House
Massachusetts State House, Room 356
Boston, MA 02133

The Honorable Stanley Rosenberg
Senate President
Massachusetts State House, Room 332
Boston, MA 02133

The Honorable Brian Dempsey
Chair, House Committee on Ways and Means
Massachusetts State House, Room 243
Boston, MA 02133

The Honorable Karen Spilka
Chair, Senate Committee on Ways and Means
Massachusetts State House, Room 212
Boston, MA 02133

Re: Governor Baker's June 20 MassHealth Reform Proposals

Dear Speaker DeLeo, Senate President Rosenberg, Rep. Dempsey, and Senator Spilka,

This letter is submitted by the Massachusetts Law Reform Institute on behalf of our low-income clients who rely on the MassHealth program for access to care. On Tuesday we saw for the first time the Governor's new proposals related to MassHealth which we understand the administration is asking the conference committee to adopt within a matter of days as part of the FY 2018 budget.

While some ideas, such as the employer assessment, were first proposed in January and have received intense scrutiny, other ideas, such as changes in MassHealth eligibility that will affect many thousands of beneficiaries never saw the light of day before two days ago. Reducing MassHealth eligibility from 133% to 100% of the poverty level, denying coverage to the working poor with access to employer-sponsored insurance, and authorizing cuts in any optional benefits is going too far too fast.

We appreciate the strong support of Massachusetts' elected officials for the commitment to universal coverage and the difficulties of the job before you. There are good ideas in the proposal such as reintroducing an employer assessment, increasing participation in the MassHealth premium assistance program, and expanding the scope of practice for lower-cost providers. However, we urge you not to include the following proposals in the FY 18 budget.

1. The ESI Lock-Out (Section 40)

Section 40 authorizes the MassHealth agency to deny or terminate MassHealth eligibility for non-disabled persons who have access to affordable employer sponsored health insurance (ESI) as defined by the agency (the ESI lock-out). In its supporting fact sheet, the agency identifies the ESI lock-out, the reintroduction of employer reporting (Sections 41 and 42) and steps to

maximize participation in MassHealth's premium assistance program as together generating $76.5 million in net FY 18 savings.

We support increased participation in MassHealth Premium Assistance as the best way to leverage employer contributions and reduce state spending while also assuring that low income workers have affordable and comprehensive coverage. Through programs like Premium Assistance, MassHealth has been an important support for low income families striving to work themselves out of poverty. The Medicaid Director has told us that most of the $76.5 million nry savings derive from better employer reporting and increased participation in Premium Assistance not the ESI lock-out. However, he refused to disclose how many MassHealth beneficiaries would be terminated due to the ESI lock-out or what portion of the FY 18 savings the lock-out represents.

The MassHealth agency says it intends to define "affordable" ESI for MassHealth eligible adults with income under the poverty level the same way that the Affordable Care Act (ACA) defines affordable ESI for purposes of eligibility for premium tax credits for those with income over the poverty level and up to 400% of poverty. Under the ACA, if an employee can purchase coverage for less than 9.66% of household income, the ESI is affordable and the employee is not eligible for subsidized coverage. The only limit on deductibles, coinsurance and other cost sharing is that affordable ESI must have a 60% minimum value. Under the ACA, group insurance cost sharing can be as high as $7,150 for individual coverage or $14,300 for family coverage in 2017.

Federal Medicaid law and MassHealth regulations, as well as the Connector's affordability scale for both ConnectorCare premiums and for the individual mandate, recognize that NO premium contribution is "affordable" for individuals and families with income under 150% of the poverty level. Yet the Governor's ESI lockout proposal will deny or terminate MassHealth for individuals under 100% of the poverty level if they have an offer of ESI that will charge monthly premiums for coverage with high deductibles or other cost-sharing.

Under the proposal, low income parents, grandparents raising grandchildren, and childless adults with income under $1334 per month (100% of poverty for a household of two) offered ESI at a monthly premium of $130 (9.66% of income) will no longer be eligible for MassHealth. A full-time worker making minimum wage ($1668 per month) in a household size of three will be denied MassHealth if the cost of ESI for her own coverage is $164 per month or less. The costs of deductibles, coinsurance and copays will add thousands more to the cost of ESI. The administration says this is to "promote the uptake of employer sponsored insurance." However, the more likely result is that families will have to forego insurance coverage in order to pay the rent or keep food on the table.

This is not a return to the way it was under chapter 58. This will affect low income families with children who from 1997 until today have been able to rely on MassHealth as a work support. If ESI is cost-effective, families are required to participate in Premium Assistance which reimburses premium costs and cost sharing and provides services, like dental, that might not be in the employer plan. If a working family on MassHealth has an increase in earnings that puts them over the 133% income standard, they are entitled to a further 12 months of transitional

medical assistance as a work incentive. The ESI lock-out undermines a successful and important support for working families as well as childless adults.

We strongly oppose the ESI lockout in MassHealth and urge the conference committee not to add section 40 to the FY 18 budget.

2. Cutting optional services (Section 55 and 56)

Section 55 authorizes MassHealth to restructure pharmacy benefits and Section 56 temporarily authorizes "restructuring or eliminating *any* optional covered services under Medicaid in order to generate savings." The fact sheet includes these changes along with other changes for which it is not seeking legislative authority as together contributing $38.1 million in net savings in FY 18. We have not been able to obtain a breakdown of what share of savings are attributable to the different components, what populations will be affected, or any detail on the changes envisioned by sections 55 and 56. With so little information forthcoming on changes to benefits that will affect the entire MassHealth population of children, individuals with disabilities, low income parents, childless adults and the elderly we urge the Committee not to give the agency the unbridled authority it seeks. Some restructuring of pharmacy may be appropriate to reduce spending but not without added safeguards to assure access to care.

3. Cutting income eligibility and benefits for adults (Section 58)

Section 58 provides that non-disabled adults with income over 100% of poverty (excepting pregnant women, HIV positive adults, and adults with breast or cervical cancer) will be eligible for subsidized insurance through the Connector only starting on January 1, 2019. The fact sheet states that this will affect 140,000 people. The MassHealth agency informs us that this group represents 100,000 parents or other relatives caring for minor children with income from 100-133% of poverty and 40,000 childless adults with income from 100-133% of poverty. The fact sheet also states that 230,000 nondisabled parents and caretaker relatives with income under 100% of poverty will change coverage from MassHealth Standard to MassHealth CarePlus which has fewer benefits. Together these changes are expected to save $88.3 million net in FY 2019.

Parents and caretaker relatives have been eligible for full Medicaid benefits (MassHealth Standard) at 133% of the poverty level since 1997. We strongly oppose the reduction in this long standing 133% of poverty income standard for parents as well as the roll back in eligibility for childless adults. For a family of two, the difference is between $1334 per month (100% of poverty) and $1800 per month (133% of poverty). For a single parent working full time at minimum wage, it's the difference between MassHealth with nominal drug copays, dental coverage, and transitional Medicaid if she gets a raise that brings her income over $1800 to ConnectorCare Plan Type 2B. In ConnectorCare, she will still have at least one plan choice with no premium contribution but her cost sharing will be much greater than MassHealth such as: $10 for an office visit, $50 for the ER, and drug costs of $10-$40 up to a $500 annual drug maximum. ConnectorCare is also a more difficult program to understand and use. One can enroll only at certain times of year or after a qualifying event. There is no automatic enrollment; if eligible people do not select a plan by the deadline they will remain uninsured. The subsidy is in

the form of a tax credit that must be reconciled at the end of the year, and errors, even inadvertent errors, may create a tax debt.

These changes are slated for 2019. There is no reason to rush through a change in basic eligibility standards in 2019 for 140,000 people without knowing whether the program to which they are supposed to transition –subsidized insurance through the Connector –will bear any resemblance to the ConnectorCare of today. Within a few months, or even sooner, we may all have a better idea of what to expect in 2019 based on the status of the American Health Care Act (AHCA). The AHCA as passed by the House would eliminate all cost sharing reduction subsidies and provide lower tax credits for the poor. It is not at all clear whether the added state subsidies that underpin ConnectorCare will continue to be eligible for federal reimbursement in the future. On the other hand, the AHCA is not immediately ending the enhanced match for the Medicaid expansion, instead the phase-out is triggered by a break in coverage. Under the proposal, 40,000 childless adults will also lose eligibility for MassHealth at enhanced federal matching rates and along with low-income parents face an uncertain future in 2019.

While no legislation addresses it, the fact sheet also describes a shift of 230,000 parents and caretaker relatives with income under the newly lowered 100% poverty limit to MassHealth Care Plus, a program with fewer benefits than MassHealth Standard. CarePlus does not include long term services and supports. Parents who need such supports should be able to establish disability but in the process they will have necessary care delayed. They will also lose access to non-emergency medical transportation in CarePlus. The MassHealth agency has already begun the process of amending the 1115 waiver to make this change. The legislature did not intervene when the change was slated to affect only the Medicaid expansion group of childless adults, however, its scope is now significantly different with a core Medicaid population, low income parents, slated to lose this otherwise mandatory benefit. Few use NEMT, but for those who do, research has shown it to be a low cost, high value benefit.

4. ConnectorCare and MassHealth Limited (Section 57)

Lawfully present immigrants who do not meet the stricter immigrant eligibility rules of MassHealth are eligible for both ConnectorCare and MassHealth Limited. MassHealth Limited covers only emergency care which is also included in ConnectorCare and this is redundant. However, MassHealth Limited and Health Safety Net (HSN) now also provide access to limited care during the temporary period before ConnectorCare enrollment begins. We understand from the agency that there was no intent to change this period of MassHealth Limited eligibility which reduces claims that would otherwise be made on the HSN Trust Fund. Further, if individuals do not enroll in ConnectorCare, their HSN ends but Limited is available to reimburse hospitals for ER services. We believe a technical change to the language of section 57 is needed to make clear that individuals should remain eligible for Limited in those circumstances where it is not redundant with ConnectorCare.

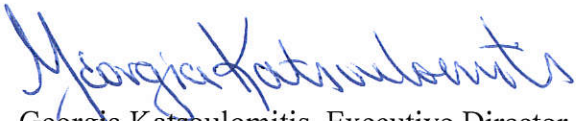
5. The targeted employer assessment for workers enrolled in public coverage (Section 49)

We support the concept of employer shared responsibility for public insurance costs, one of the underpinning of Chapter 58. While we have taken no position on the specific features of the employer assessment, we do have concerns with section 49. First, we fear that the targeted

assessment may lead to employers refusing to hire applicants on public coverage or pressuring employees with public coverage to drop their coverage or cease work. Protections against this sort of retaliation will be difficult to enforce, but should be included in any legislation. Second, we are concerned that some direct care workers who provide services to MassHealth members, may themselves qualify for MassHealth and that this provision may jeopardize the ability of smaller MassHealth provider organizations to serve the elderly and individuals with disabilities.

Thank you for taking these concerns into consideration. Please let us know if we can provide you with any additional information.

Yours truly,



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