

## Blowing a Hole in the Health Safety Net: EOHHS Notice of Proposed Rules

EOHHS has released proposed rules that will significantly restrict eligible services in the Health Safety Net as early as April 1. The rules can take effect only after a public notice and comment period. This FAQ describes the HSN program, the proposed cuts, the rationale for the cuts to the extent they have been explained, and the reasons why the cuts are a bad idea that will hurt low income people, safety net hospitals and community health centers. We hope this information will be helpful to you and your organization in preparing testimony or submitting comments opposing the proposed changes.

A public hearing is scheduled for Feb. 26, 2016 in Quincy.

Written comments can be submitted by email until 5 pm on Feb 26 to: [ehs-regulations@state.ma.us](mailto:ehs-regulations@state.ma.us) with 101 CMR 613.00 Health Safety Net Eligible Services in the subject line. Include along with your comments your full name, mailing address and organization name if applicable.

The notice of Public Hearing and comment deadline is here:

<http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/101-cmr-613-public-hearing.pdf>

The proposed rules are here: <http://www.mass.gov/eohhs/docs/eohhs/eohhs-regs/hsn-613-redline.pdf>

### What is the Health Safety Net (HSN)?

- A program to encourage safety net hospitals and health centers to care for the uninsured and underinsured and equalize the financial burden among hospitals.
- It protects eligible individuals from medical debt to hospitals and CHCs, but **it is not insurance**.
- In recent years, about 93 percent of HSN spending is funded by hospitals, users of hospital services (surcharge payers) and inter-governmental transfers. In these years, the HSN has received \$30 million gross from the General Fund (\$15 million in state dollars net of federal revenue).<sup>1</sup>
- The hospital contribution to the HSN currently generates over \$150 million in federal revenue but it is paid into the General Fund not the HSN Trust fund.

### What are the proposed changes that will restrict HSN payments to hospitals and health centers?

- **Lowering the income eligibility standards.** The proposed rules would lower the income limit for full HSN from 200% of the Federal Poverty Level (FPL) (\$23,544 for one

person) to 150% FPL (\$17,664 for one person) and lower the upper income limit for partial HSN from 400% FPL to 300% FPL.

- **Imposing charges on the working poor.** The proposed rules would charge people with income over 150% FPL up to 200% FPL, an annual deductible of \$516 (in 2016 for one person) before a hospital can be reimbursed from HSN, and lower the CHC reimbursement by 20% per visit (to be collected from the patient as a co-payment) until the deductible is met.
  - The \$516 amount is based on the annual premium for insurance through ConnectorCare (with no deductible) for someone with income between 150-200% FPL. But people who pay \$516 for HSN, unlike those in ConnectorCare, will still be uninsured.
- **Limiting the billing period.** For patients who are not eligible for MassHealth or ConnectorCare, the proposed HSN rules would reduce the period in which hospitals and CHC can bill the HSN for services from up to 6 months prior to the date the patient completes an application to only 10 days prior regardless of the reason an application may not have been filed earlier.
- **Eliminating the \$30 million General Fund contribution in FY 2017.** The Governor's budget for 2017 does not propose to continue the \$30 million fund transfer to the HSN fund.

### **Are these changes because the Health Safety Net Care Pool is expiring in FY 2018?**

According to the Administration, the answer is **NO**. Recent reports of the Health Safety Net Care Pool funding mechanism in the 1115 demonstration expiring June 30, 2017 have no direct bearing on the proposed changes to the Health Safety Net program. While similar in name and related, the Health Safety Net program and the Safety Net Care Pool within the 1115 demonstration Medicaid Waiver are two different things.<sup>2</sup>

### **What is EOHHS's rationale for cutting the Health Safety Net?**

The agency has given several reasons for these change: Saving money, updating the partial HSN income range, better aligning HSN with MassHealth and the Connector, and encouraging HSN applications at the time of service. However, none of the changes appreciably accomplish the stated goals.

### **Why are the HSN cuts a bad idea?**

- **The cuts "update" the income range for HSN partial to lower income levels when the FPL has fallen far behind actual living costs over time**
  - The 200-400% FPL income range for partial HSN where people are expected to pay a portion of the hospital or CHC bill was established in the 1980s based on analysis of the cost of living for people at these income ranges.
  - EOHHS had conducted no new cost of living studies to "update" this income range.
  - Since the 1980s annual cost of living increases in the FPL have fallen further behind the actual costs of living in a high cost state like Massachusetts.

- The federal poverty guidelines do not reflect geographic differences in housing costs, but the Census Bureau has developed supplemental poverty measures that do look at housing costs and they show:
      - Measures that take into account housing costs have increased at a faster rate than updates in the official poverty level from 1999 to 2014; and
      - Using measures that take into account geographic differences in housing costs, the poverty threshold for renters in the Greater Boston area was 23% higher than the supplemental poverty measure for the US as a whole in 2014.<sup>3</sup>
    - If EOHHS were really updating the income range at which Massachusetts residents can afford to pay more of their hospital bill it would have increased the partial HSN income range to a higher percent of the FPL not lowered it.
- **The cuts aim to align HSN rules with rules for MassHealth and the Health Connector when HSN is nothing like MassHealth or coverage through the Connector**
  - Both MassHealth and the ConnectorCare program charge premiums (with no annual deductible) for individuals with income over 150% FPL, but these people are getting actual insurance coverage for their payment. There is no equity in aligning HSN charges for being uninsured with the costs of comprehensive insurance coverage.
  - HSN is not insurance.
    - Individuals eligible for HSN are still at risk of state and federal tax penalties for being uninsured
    - HSN does not entitle eligible individuals to any defined set of benefits the way insurance does.
    - HSN does not protect eligible individuals from debt to any providers but acute hospitals or CHCs.
      - HSN cannot be used by ambulance companies, private physicians or physician groups, chronic/rehab hospitals or nursing facilities, commercial pharmacies or specialists or any other provider who is not directly employed by a hospital or CHC.
      - The annual deductible will be particularly hard on individuals from 150-200% FPL who have paid a premium to enroll in ConnectorCare and are only using HSN until their ConnectorCare enrollment begins on the first of the next month or the following month. Historically, 22% of HSN claims were for this kind of temporary coverage.<sup>4</sup>

- **The cuts limit the billing period to encourage Hospitals and Health Centers to complete HSN applications for patients at the time of service when Hospitals and Health Centers already do this if they can**
  - Hospitals and CHC already have every incentive to help uninsured and underinsured patients complete an application for HSN benefits. Annual reports on hospital responsiveness to enrolling patients verify this.<sup>5</sup> In 2015, 562 of 1610 “certified application counselors” (CACs) were from acute care hospitals. All of the 61 hospitals that bill claims to the HSN employ CACs. The state provides no reimbursement for the work of CACs in helping people to apply and enroll.
  - Nonetheless, there are many reasons that some patients cannot complete an application within 10 days of receiving services:
    - Patients may not realize they are not insured or underinsured until getting a hospital bill or an explanation of benefits from the insurance company;
    - Patients are seen on evenings and weekends when CACs may not be available;
    - Due to limitations related to childcare, work, available transportation, etc. patients are unable to spend the hour or more it requires to create an email address, pass identity proofing and complete an online application on the date of service;
    - Inpatients may be too ill to complete an application within 10 days of admission, and
    - Once they leave the hospital, it may be impossible for the hospital to find them again –poor people move, their phones are disconnected, their minutes run out and they can’t access voicemail, etc.
  - The 6-month window (reduced from 12 months in 2004) provides a buffer against the practical difficulties of completing an application within 10 days of the date of service
- **The cuts selectively apply the alignment rationale to some billing periods and not others**
  - Recent IRS rules implementing the Affordable Care Act require nonprofit hospitals to provide patients a 240 day retroactive period to apply for a hospital’s financial assistance program. Aligning HSN billing periods with the ACA would mean increasing the six month window not reducing it to a 10 day period.<sup>6</sup>
  - The 10 day period does not even align with all MassHealth programs. The HSN proposes to reduce the retroactive period to 10 days for the elderly even though the elderly are eligible for up to three months of retroactive coverage in MassHealth.
- **The cuts reduce spending by shifting costs to providers and consumers and achieve no added state savings.**
  - These reductions will hurt the bottom line of safety net providers, reduce access to care and increase medical debt for the working poor, but save no additional state dollars.

- EOHHS says the proposed rule changes and enforcement of existing rules will reduce demand on the HSN Trust Fund by \$59 million. The state contribution to the HSN Trust Fund is only \$30 million gross, thus the most that can be saved from HSN cuts is \$15 million in net state dollars. However, enforcing existing rules alone is projected to reduce demand by more than \$30 million. Thus, reduced spending attributable to the proposed rule changes contributes no additional state savings.
  - Existing rules provide that individual eligible for ConnectorCare but not enrolled have only a time-limited period on HSN to allow them time to enroll. The HIX system has not had the capacity to enforce this limitation. In February 2016, EOHHS began to enforce this rule. It projects \$37 million in reduced spending for this enforcement of an existing rule alone.
  - Reduced spending attributed to the proposed rules are \$5 million (200%-150% FPL change); \$10 million (400%-300% FPL change); and \$8 million (6-month to 10 day billing period). These changes are projected to adversely affect almost 60,000 people.<sup>7</sup>

#### **How do the proposed changes hurt elders and the working poor?**

- **Twenty percent of HSN claims are made on behalf of elders (age 65 or older)<sup>8</sup>**
  - Most elders have Medicare, but the HSN is important in helping lower income elders who can't afford supplemental coverage pay for Medicare deductibles, coinsurance and copays owed for services at hospitals and CHCs.
    - The cost of the most popular Medicare supplemental insurance is \$3800 which is over 20% of the income of an elder just over 150% FPL. Nationally about 14% seniors do not have any supplemental coverage to pay Medicare costs.<sup>9</sup>
  - Not all elders have Medicare; some elders are uninsured. In 2014, 46,000 elders had a period without insurance in the prior 12 months, HSN is available to fill the gap during these periods.
- **Changing the income range for partial HSN hurts the working poor with no other affordable insurance options**
  - Individuals with income over 150% FPL to 400% FPL are likely working and rely on the HSN because they have no affordable insurance options. They may not have affordable insurance at work and may not qualify for ConnectorCare or premium tax credits for one of many reasons. Or they may be insured for only part of the year or underinsured.
    - Some immigrants who live and work in Massachusetts may not qualify to even purchase insurance at full cost from the Connector because they have no pathway to a legal immigration status under existing immigration laws. Other immigrants may be temporarily ineligible for ConnectorCare or premium tax credits while waiting to apply for asylum or other protection.

- Because of the so-called “family glitch” family members will not be eligible for ConnectorCare if the employer’s insurance is affordable for the worker even if it is not affordable for family coverage.
- Veteran’s enrolled with the VA health care system are not eligible for ConnectorCare.
- People who decline an offer of insurance with high deductibles or otherwise not affordable, will not be eligible for ConnectorCare and unable to enroll with their employer until the following year.
- As of 2013 there were still 7.6% of working age adults without insurance in Massachusetts for a period of time during the year, and 4.8% without insurance for the entire year.<sup>10</sup> These percentages are higher among those with income under 300% of poverty: 12.8% insured for only part of the year and 8.2% uninsured all year. Further the statewide rate of 4.8% uninsured masks much higher rates in many communities that will disproportionately suffer from HSN cuts.<sup>11</sup>
  - Everett, 11.5%
  - Lawrence 10.1%
  - Malden, 7.5%
  - New Bedford, 7.1%
  - Lynn, 6.8%
  - Chelsea, 10.8%
  - Barnstable, 8%
  - Framingham, 7.4%
  - Lowell, 6.8%

- **Reducing the upper income level harms people with high medical costs.** People with income over 300% FPL are better off than people with lower income, but HSN Partial accounts for that by imposing a substantial deductible. For a one person household, the deductible at the 300-400% FPL income level is an amount between \$4700 and \$9400. The HSN is only available after the patient has assumed liability for the deductible amount. Thus the reduction in the upper income level will only harm those with high medical expenses
- **There is no system for tracking when a deductible is met.** The state does not currently track costs incurred toward the deductible, and it is not proposing to do so. This means the only way for a hospital to know when it can stop billing the consumer and bill the HSN instead is if consumers understand the process and collect and supply all their bills to each hospital or health center where they get care during the year. Using this so-called “shoebox method” doesn’t work well for anyone but is a particularly unfair burden to place on families struggling to get by on incomes between 150-200% FPL.

- **The burden of medical debt negatively affects families in many ways**

- A January 2016 national survey reports that over 50% of the uninsured and 20 % of those with insurance report difficulty paying for medical bills<sup>12</sup>
  - Over 4 in 10 with medical bill problems reported a major impact on their families
    - Over one third reported being unable to meet basic needs for food, heat and housing due to medical bills
    - Over 62% reported difficulty paying other bills due to medical bills

- Those with medical bill problems reported delaying or skipping needed care at two to three times the rate of those without medical bills
- The 2013 Massachusetts Health Reform Survey shows that even with insurance, lower income is associated with unmet health needs due to costs. Among insured adults 48% of those with income under 300% FPL reported problems related to medical bills compared to 30% of those with higher incomes. Working age adults over Medicaid income thresholds (138% up to 200% FPL) were 4.7 percentage points more likely to experience unmet health needs due to costs.

**EOHHS is proposing fundamental changes to the basic structure of the HSN with no prior consultation with stakeholders and only one public hearing in Quincy**

G.L. c. 118E, §65(b)(ix) authorizes EOHHS to promulgate regulations governing the efficient use of monies from the HSN Trust Fund, but requires it to first consult with stakeholder organizations including the board of the commonwealth health insurance connector, representatives of the Massachusetts Hospital Association, the Massachusetts Council of Community Hospitals, the Alliance of Massachusetts Safety Net Hospitals, the Conference of Boston Teaching Hospitals and the Massachusetts League of Community Health Centers. To the best of our knowledge no such consultation regarding these proposed changes occurred with providers or in any public meeting with the Board of the Connector before the promulgation of these regulations.

For questions or comments please email Vicky Pulos at [vpulos@mlri.org](mailto:vpulos@mlri.org). After Feb. 20, 2016, please email Neil Cronin at [ncronin@mlri.org](mailto:ncronin@mlri.org)

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<sup>1</sup> G.L. c. 118E, §§65-69; Ch. 46, § 149, Acts of 2015

<sup>2</sup> BCBS Foundation Massachusetts, Summary of the Massachusetts 1115 Waiver, Feb. 2015  
<http://bluecrossfoundation.org/publication/summary-masshealth-1115-waiver>

<sup>3</sup> <http://www.census.gov/hhes/povmeas/index.html>

<sup>4</sup> Massachusetts Division of Health Care Finance and Policy, Health Safety Net 2011 Annual Report, Sept. 2012  
<http://www.mass.gov/eohhs/docs/masshealth/hsn/hsn11-ar.pdf>

<sup>5</sup> EOHHS, Health Safety Net Annual Report, Fiscal Year 2015

<sup>6</sup> IRS final regulations issued Dec. 29, 2014; 26 CFR §1.501(r)-1(3) Definition of “application period” for financial assistance as period within 240 days of date of service. See also, 26 CFR §1.501(r)-6 (3) hospitals must make reasonable efforts to notify patients of financial assistance policies within 120 days from the first billing statement.

<sup>7</sup> MLRI interview with MassHealth Chief Financial Officer and Deputy Medicaid Director, Feb. 9, 2016

<sup>8</sup> EOHHS, Health Safety Net Annual Report, Fiscal Year 2015

<sup>9</sup> BCBS Foundation Massachusetts, Minding the Gaps: The State of Coverage to Supplement Medicare in Massachusetts, Sept. 2015 <http://bluecrossfoundation.org/publication/minding-gaps-state-coverage-supplement-medicare-massachusetts>

<sup>10</sup> BCBS Foundation Massachusetts, 2013 Massachusetts Health Reform Survey, Nov. 2014  
<http://bluecrossfoundation.org/publication/2013-massachusetts-health-reform-survey>

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<sup>11</sup> BCBS Foundation Massachusetts, The Geography of Uninsurance in Massachusetts, 2009-13, April 2015,

<http://bluecrossfoundation.org/publication/geography-uninsurance-massachusetts-2009-2013>

<sup>12</sup> The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey, Jan. 2016, kff.org