GREATER BOSTON
LEGAL SERVICES
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August 31, 2007

Commissioner Sarah Iselin
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Re: Comments on Health Safety Net Trust Fund: Eligible Services - 114.6 CMR 13.00

Dear Commissioner Iselin:

We submit these comments on behalf of our individual clients who receive services at the hospitals and health centers affected by these proposed changes. Greater Boston Legal Services (GBLS) provides free civil (non-criminal) legal assistance to low-income people in Boston and thirty-one surrounding cities and towns to help them secure some of the most basic necessities of life. The help we offer ranges from legal advice to full case representation, depending on client need. Our clients are all low-income, such as poor families with no income, low-wage workers, elders and people with disabilities. GBLS's Health & Disability Unit has represented numerous clients who have depended on the uncompensated care pool to receive necessary medical care. We also have many clients who have faced problems of medical debt.

The Uncompensated Care Pool was established by the legislature in 1985 "as a financing mechanism to distribute the burden of bad debt and of providing free care . . . more equitably among acute care hospitals."[1] The Pool was to "help pay for the costs of providing care to the uninsured, and also to eliminate financial disincentives that a hospital might have to providing such care." *Id.* The Pool has enabled low income uninsured individuals and families to access health care that was often not available to them before 1985. Under the proposed regulations, the health care access which the pool had opened up for many patients, is closing for some. While many of our clients who have relied on the uncompensated care pool will be served by Commonwealth Care, there are others who will still need to look to the Health Safety Net Trust Fund for access to health care.

We join in the comments filed by the Massachusetts Law Reform Institute and the ACT!! Coalition. We appreciate the effort that DHCFP has made to draft regulations that will maintain a true safety net and appreciate the changes that were announced at the hearing in response to providers' and advocates' concerns. However, in a number of areas, we disagree with the policy

[1]Uncompensated Care Pool PFY03 Annual Report, p.3, Mass. D.H.C.F.P. (June 2004)

decisions that DHCFP has made. We are filing these additional comments to highlight the areas that we fear will have an adverse impact on our clients.

1. Exclusions from the Definition of Low Income Patient

13.04(1)(b) excludes many low income individuals from designation as a "Low Income Patient" thereby making them ineligible for Health Safety Net services except through the medical hardship provisions. It is our position that the current policy, which provides pool eligibility to anyone who meets residence and financial eligibility criteria should be maintained. There are too many situations, not all of which can be foreseen, where these proposed regulations could prevent access to medically necessary services. They also complicate an eligibility process that is already too complex for many low income individuals.

a. 13.04(1)(b)(2). Excludes from coverage individuals determined eligible for any MassHealth program who have failed to apply and enroll. We understand that you propose to amend this regulation to allow for HSN coverage for 10 days prior to and 90 days after an application for benefits for individuals determined eligible for Commonwealth Care, MassHealth Essential and MassHealth Basic and for cases pending citizenship and identity documentation. These are positive changes but they do not go far enough.

There are many situations where individuals who may be eligible for Commonwealth Care or a Masshealth program could be left without access to medically necessary care. One fairly common situation is the individual who has been receiving MassHealth Standard based on disability and whose income increases to above 133% of the federal poverty level[2]. This person will be sent a notice terminating MassHealth Standard and informing them of potential eligibility for either MassHealth CommonHealth upon meeting a deductible or for Commonwealth Care. Currently the notice will also inform the individual of free care pool eligibility. Will HSN coverage be immediately available to someone in this situation? It does not appear so under your proposed regulations. For many individuals with disabilities, this termination notice is a traumatic event. For these individuals access to medical care is not a theoretical concept but a necessary part of daily life. They may be undergoing chemotherapy, dependant on life sustaining medication, or in need of personal care assistance. The decision as to whether to enroll in Commonwealth Care or attempt to meet the MassHealth deductible is complicated and will involve learning the differences in coverage of these two programs. HSN coverage should be available during this transition.

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[2]The increase in come could occur either due to initial approval for Social Security disability benefits or due the annual COLA adjustment.

HSN services should also be available during other gaps resulting from MassHealth terminations due to income changes or other changes which make MassHealth coverage unavailable . Examples include the former MassHealth member who turns 19 or the long term unemployed individual who finds a job. While 13.03(c)(7) provides for HSN eligibility when someone is enrolled in a Commonwealth Care program and are awaiting coverage, it is unclear whether HSN coverage is available prior to enrollment. MassHealth eligibility periods and Commonwealth Care eligibility periods are not aligned. MassHealth coverage can begin at any time and end at any time of the month with 10 days advance notice. Commonwealth Care eligibility is on a monthly basis and may require payment of a premium by the 20th of the previous month. Gaps in coverage are inevitable as these two programs are not synchronized.

Another example of a potential gap in coverage is the situation that was reported recently on the Community Partners Website:
http://www.compartners.org/talk/2007/08/27/who-is-responsible-when-systems-collide/
There is a report of an individual, enrolled in Commonwealth Care who was cut off in the middle of a month without notice due to an application for EAEDC benefits. This is yet another situation where HSN services should be available for needed for hospital care.

We also urge that individuals, who apply for MassHealth based on disability and who often wait 3 to 6 months for a disability determination, should be provided access to HSN services pending the disability determination. If disability is ultimately approved, MassHealth coverage would be retroactive to 10 days prior to the application. However, this retroactive eligibility does not provide access to health care while the disability determination is pending.

b. 13.04(1)(b)(4) denies Low Income Patient status to individuals whose enrollment in MassHealth or Commonwealth Care has been terminated due to failure to pay premiums. We object to this restriction. We believe that access to medically necessary care should be available even to people who have failed to pay a premium, as the potential consequences of lack of access to care are too severe both to the individual and to public health. An article in today's New York Times is pertinent. The Times reports: "In a stark departure from past practice, the American Cancer Society plans to devote its entire $15 million advertising budget this year not to smoking cessation or colorectal screening but to the consequences of inadequate health coverage. The campaign was born of the group's frustration that cancer rates are not dropping as rapidly as hoped, and of recent research linking a lack of insurance to delays in detecting malignancies. . . While the decline in death rates is accelerating, studies have shown that if cancer was diagnosed more in its early stages, the rates would fall faster. And new research is confirming that insurance status often determines whether a person's cancer is diagnosed early or late."

Individuals who fail to pay their premiums may have complicated and difficult lives. While hardship waivers can be requested, MasssHealth's criteria for a waiver is restrictive and MassHealth does not grant retroactive waivers. In our experience, our clients who have been terminated for failing to pay a premium, were either individuals in financial crisis or cases where MassHealth had terminated benefits in error. They did not choose to stop paying premiums so that they could access the free care pool. Rather they stopped paying premiums because they could not afford them or did not know that they were subject to a premium. In one case, a severely disabled child was terminated for non-payment of a premium after family income had dropped below the level at which premiums are charged. Fortunately free care covered his care during the bureaucratically difficult process of restoring his coverage. In another case, a recently disabled mother, who could no longer work, was so overwhelmed with debts and her own medical treatment needs that she was unable to pay her asthmatic daughter's premium. For these families, loss of insurance coverage was already a penalty. Free care services should remain available as a safety net.

c. 13.04(1)(b)(5) denies Low Income Patient status to individuals with access to affordable employer sponsored insurance based on the affordability standards of the Connector, while 13.03(1)(c)(7)b provides that services are reimbursable for such individuals if they have been determined ineligible for Commonwealth Care due to access to insurance, but cannot enroll until the open enrollment period. As most employers have open enrollment only once a year, it would seem that in most cases of employer sponsored insurance, Low Income Patient status will not in fact be denied. Given the enormous complexity of the eligibility requirements for MASSHEALTH, Commonwealth Care and HSN services, we recommend that 13.04(1)(b)(5) be deleted as it serves little purpose and adds an additional level of confusion to an already confusing structure.

2. Section 13.04(5) Retroactive coverage.

Until 2004 a patient could apply for free care up to one year after obtaining services, or longer if there had been continuous collection action or patient payments. As of January 2005, this was limited to six months prior to the date of MassHealth eligibility or a determination of pool eligibility. Your proposed regulations maintain the six months of retroactive coverage for individuals who are granted Low Income Patient status. But, there is a proposal to limit this period to 10 days prior to application for individuals who are found eligible for Commonwealth Care, MassHealth Essential or MassHealth Basic and to provide no retroactive HSN coverage for people enrolled in other MassHealth programs. This is a drastic change from the current practice. It is unnecessary and will result in more instances of unwarranted medical debt. We do not see a justification for treating individuals and families who are approved for MassHealth coverage differently from those who are only approved for HSN coverage. While, in an ideal

world, individuals would know enough to complete an MBR before or at the time of services, in our real world this does not always happen. Sometimes the information that is needed to submit an application takes time to gather. Other individuals do not realize that they are uninsured until they get a bill from the hospital or a notice from a collection agency. This can take more than 60 days as the hospital will bill the putative insurance first. Also, there have been problems with lost and misplaced MBRs, verifications and eligibility review forms, all of which could result in the need for retroactive coverage. As discussed below, medical debt can have severe and long lasting consequences. There is no reason to create a system that will increase medical debt for the low income population of Massachusetts.

3. 13.04(3) Grievance Process - right to a fair hearing

We again reiterate our support for the MLRI comments on a right to a fair hearing, not simply a paper review conducted by the agency. A right to a fair hearing is a fundamental right to due process. We believe that the MassHealth Board of Hearings is experienced at conducting face to face hearings for individuals who have been denied a MassHealth benefit; many such individuals go to the hearings *pro se.* There is no need to create a new agency to handle such hearings, but rather use an existing system. Face to face hearings, particularly for this population, can enable individuals to explain why the decision made by the agency was wrong. It also provides an opportunity that many people cherish: the right to be heard. In our experience, people are more willing to accept the denial or termination if they have had the opportunity to present their side of the issue in person. For a program that is trying to build public support, this is no small consideration. In person fair hearings can ensure that the public sees the process as fair, and not arbitrary.

4. 13.08 Debt Collection Protections

GBLS has had a long standing interest in these protections. In 1988, along with Health Care For All, we conducted a survey of acute care hospitals signage policies concerning the availability of free care, and issued a report. Perhaps not surprisingly, there was room for lots of improvement on the part of the hospitals concerning notice even back then. Here, we are concerned that the draft regulation, 13.08 (1)(d), disclosing some personal medical billing information to an employer, may be very problematic given the Notice of Free Rider surcharge that will be instituted. We again endorse the written comments from MLRI, on this topic, previously submitted. Further, the protection from collection action should clearly be extended during the eligibility period, as pointed out in the MLRI comments. We request that you adopt the alternate language suggested in those comments (at page 12).

Medical debt is a barrier to access to medically necessary care, so these debt collection protections have grown in importance over the years. In a Massachusetts survey published in

2004, The Access Project found that 41% of its respondents reported having medical debt.[3] Hospitals were listed most frequently as the source of debt.[4] Further, 59% of those in debt said it caused a significant barrier to them getting health care, and caused them to delay getting needed care. Further, such debt follows people and has an impact on their ability to get credit, jobs, and housing.[5] So protection from collection action is not simply an academic exercise for the individuals and families who use the acute care hospitals here in Massachusetts. The provisions which exempt those who qualify for free care from collection actions should be maintained.

In addition, the prohibition on execution on a primary residence or first motor vehicle which are currently available, are limited to those individuals who have been determined Low Income Patients, under 114.6 CMR 13.08(1)(b). These provisions were added after examples of excessive collections actions were brought to light, and should remain available to other individuals, such as those who are excluded from the HSN under your draft proposal. We request that you drop this limitation.

Thank you for the opportunity to submit these comments.

Respectfully submitted,

Sarah J. Anderson

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Nancy Lorenz
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Greater Boston Legal Services

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[3]"Getting Care But Paying The Price: How Medical Debt Leaves Many in Massachusetts Facing Tough Choices,", p. 15, Carol Pryor & Deborah Gurewich, The Access Project (Feb. 2004). Available at http://www.accessproject.org .

[4]*Id.* at 17.

[5]*Id. at 19-20. See also Borrowing to Stay Healthy: How Credit Card Debt is Related to Medical Expenses,* by Mark Rukavina & Cindy Zeldin, (2007), available at http://www.accessproject.org