HEALTH CARE FOR ALL

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August 18, 2017

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

Submitted by email

Re: Comments for Demonstration Amendment

Dear Secretary Sudders and Assistant Secretary Tsai,

Health Care For All (HCFA) appreciates the opportunity to provide comments on the MassHealth 1115 Demonstration Waiver Amendment ("1115 waiver amendment"), released on July 20, 2017. We share your commitment to a sustainable MassHealth program and to maintaining the gains Massachusetts has made in access to affordable health coverage for low-income residents, but we are concerned that many of the proposals included in the 1115 waiver amendment will likely decrease access to affordable coverage and care for low-income consumers.

With this waiver amendment, the Executive Office of Health and Human Services (EOHHS) requests broad flexibility to make significant changes to the MassHealth program. However, the draft document does not include a level of specificity needed to ascertain the intent and impact of the proposed changes. We ask that you make available more information on the estimated impact of these proposals in terms of the number of people affected, associated costs and cost savings, as well as more details about how the changes will be implemented and administered. In addition, the proposal seeks broad authority to waive important protections in the Medicaid Act without committing to the kinds of safeguards necessary to mitigate harm to affected populations. Before any of the proposed changes referenced below are submitted for approval, clear and strong safeguards should be included as part of the request and in any authorizing legislation.

ESI and Student Health Insurance "Gate"

MassHealth proposes to preclude otherwise eligible residents from qualifying for MassHealth if they have access to "affordable" employer sponsored insurance (ESI) or student health insurance. In a recent public presentation, MassHealth stated that it intends to apply their current thinking on affordability: the employee share of premiums and the deductible for the ESI is less than 5% of family income.[1] While this is a welcome change from the original proposal of using a 9.69% of income affordability test, taking into account only the premium cost, this metric does not account for other forms of cost-sharing, including copays and coinsurance, that may present substantial access barriers to low-income workers. Nor is even 5% of income affordable for adults with income below the poverty level given the high costs for housing and other life necessities. In addition, individuals who are locked out of MassHealth coverage will not have access to the same level of benefits as people at the same income levels who have access to unaffordable ESI and thus can qualify for MassHealth Premium Assistance.

[1] EOHHS and Health Connector, *MassHealth and Health Connector Requests for Federal Flexibility*, August 4, 2017. Available at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/masshealth-innovations/masshealth-1115-waiver-hearing-slides.pdf.

There is no precedent for this type of restriction in MassHealth; access to other health insurance has never been a bar to MassHealth coverage. Rather, MassHealth acts as a secondary or tertiary payer when other coverage is available, which protects low-income members from unaffordable medical bills and reduces MassHealth spending. In addition, many of the concerns outlined below regarding to the proposal to shift eligibility for non-disabled adults between 100-133% FPL also apply to the ESI and SHIP gate policy, particularly with regards to affordability of cost-sharing and access to certain benefits. We urge MassHealth to remove the ESI and SHIP "gate" from its proposed 1115 waiver amendment.

Instead, we support increased participation in the MassHealth Premium Assistance program as the best way to leverage employer contributions and reduce state spending while also ensuring that low-income workers have affordable and comprehensive coverage. Through programs like Premium Assistance, MassHealth has remained an important support for low-income families striving to work themselves out of poverty. We are hopeful that the use of the Health Insurance Responsibility Disclosure (HIRD) form to streamline the Premium Assistance process for MassHealth, consumers, and employers alike.

MassHealth Eligibility Changes for Non-Disabled Adults

MassHealth proposes to shift coverage for non-disabled adults ages 21 to 64 with incomes over 100% of the federal poverty level (FPL) to ConnectorCare as of January 1, 2019, including 100,000 parent and caretakers currently eligible for MassHealth Standard and 40,000 childless adults enrolled in MassHealth CarePlus.[2] ConnectorCare is a valuable program, integral to Massachusetts' health coverage system, as it offers more affordable coverage than even the federal Advanced Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs) alone would provide. However, ConnectorCare coverage provides fewer benefits, is more costly to consumers and presents more enrollment barriers than MassHealth coverage.

We strongly urge MassHealth to reconsider shifting non-disabled adults with incomes over 100% FPL from MassHealth to ConnectorCare, as this will result in:

- *Loss of benefits*:
    - *Dental care*: While the Health Connector offers stand-alone dental plans, the cost of these plans is not subsidized, and would be out of reach for most. In addition, the Health Safety Net – which provides "wrap" dental coverage to ConnectorCare enrollees – already has long wait times for patients to receive dental services, and adding more people to ConnectorCare will exacerbate this problem. Many people will have no choice but to seek services at hospital emergency departments, which are ill-equipped to provide comprehensive dental care.
    - *Behavioral health:* ConnectorCare plans are required to cover inpatient and outpatient mental health and substance use disorder services; however, not all ConnectorCare plans offer the same range of behavioral health services as MassHealth. In particular, access to diversionary services, such as Community Support Programs (CSPs) and Emergency Services Programs (ESPs), are not a part of traditional commercial insurance benefit packages and therefore may not be available to individuals covered through ConnectorCare plans.
    - *Prescription drugs*: ConnectorCare plans are able to implement more restrictive formularies than current MassHealth rules allow, and may impose more utilization management techniques, which create barriers to both obtaining needed medications and continuing on a course of treatment.
- *Higher premiums for consumers for all but one MCO*: In MassHealth, only members with incomes above 150% FPL are charged a premium. In ConnectorCare, anyone eligible for a plan with no premium contribution who does not switch to the new lowest cost plan at next year's open enrollment will be

[2] EOHHS Presentation: *FY18 MassHealth and Commercial Market Reform Package*, July 25, 2017. Available at: http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/1115-waiver.html.

assessed a premium and terminated after ninety days of non-payment of premiums.[3] Unlike Medicaid or the former Commonwealth Care program, in ConnectorCare there is no legal requirement that the Connector continue to offer a $0 premium contribution plan to low-income individuals. The premiums for plan options other than the lowest cost plan are substantial – up to $174 per month in 2017.[4] Many MassHealth members transitioning to ConnectorCare will not be able to continue enrollment in their current health plan or maintain continuity of care due to the higher cost. Data from the 2017 open enrollment period showed that nearly 3,000 members with no premium in December 2016 who did not switch to the new lowest cost plan in 2017 were terminated for non-payment of premiums on March 31, 2017.[5]

- *Higher copays:* ConnectorCare copays for enrollees in Plan Type 2A are substantially higher than those in MassHealth, impacting access to services for members. For example, MassHealth copays for prescription drugs are $1 or $3.65 per medication, and MassHealth members cannot be turned away for inability to pay.[6] ConnectorCare Plan Type 2A members are required to pay between $10-40 to fill each prescription. ConnectorCare imposes copays for a wider range of services than MassHealth, including $10 for a primary care or mental health/substance use disorder visit, $18 for a specialist visit, and $50 for emergency room and other hospital services.[7]
- *Splitting up families*: With the introduction of MassHealth Accountable Care Organizations (ACOs), and the re-procurement of MassHealth MCOs in 2018, there may be less overlap between MassHealth and ConnectorCare provider networks. Different networks will disrupt continuity of care and may split up care for families who currently receive care in the same provider system.
- *Reconciliation and tax debts*: ConnectorCare enrollees must reconcile the federal APTC portion of their subsidies, which can lead to a tax debt if the advance credit amount was incorrect or loss of coverage if ConnectorCare members failed to file the right forms with their taxes to reconcile for the prior year.
- *Loss of work incentives for the working poor.* MassHealth has work support programs like Premium Assistance to enable low income individuals to afford ESI and Transitional Medical Assistance to allow working poor parents whose earnings put them over 133% FPL to qualify for twelve months of transitional MassHealth Standard to help them work their way out of poverty without an abrupt increase in the cost of coverage. ConnectorCare does not offer these programs.
- *Enrollment barriers:* MassHealth allows continuous open enrollment throughout the year, and individuals are covered back to the date of application prior to enrolling in a health plan. The former Commonwealth Care program under Chapter 58 also allowed continuous open enrollment. However, the ConnectorCare program is partially governed by federal Exchange rules, and does not allow for continuous enrollment. Being determined newly eligible for ConnectorCare is considered a qualifying event and allows individuals a 60-day special enrollment period, but this does not mitigate enrollment barriers for those who have previously been determined eligible.
- *Increased number of uninsured*: Unlike MassHealth, Connector enrollees must take the step of choosing a plan and paying a premium before their coverage is effectuated. In fact, the most recent numbers provided by the Health Connector for a point in time show that 40% of people eligible for ConnectorCare Plan Type 2A remain unenrolled. ConnectorCare, unlike MassHealth, does not automatically enroll eligible individuals into a health plan. In addition, ConnectorCare has eligibility rules that would bar certain people from qualifying, such as those who have access to employer

[3] Connector Policy #NG-6B, available at: https://www.mahealthconnector.org/wp-content/uploads/policies/Policy_NG_6B.pdf.
[4] 2017 ConnectorCare Member Contributions, available at: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-09-08/ConnectorCare-Placemat-090816.pdf.
[5] Health Connector presentation, *Recap of Open Enrollment and Community Outreach*, April 13, 2017. Available at: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2017/04-13-2017/OE2017-Outreach-Update-041317.pdf.
[6] 130 CMR §506.016 and 506.017.
[7] See: https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare_Overview-2017.pdf.

sponsored insurance (ESI) with a premium that costs less than 9.69% of their family income in 2017; veterans with access to the VA Health System; Deferred Action Childhood Arrivals; and married couples living apart filing taxes separately (with limited exceptions).

In recent years, Connecticut, Maine, and Rhode Island attempted to shift parents from Medicaid to the Marketplace. Before the eligibility change, all three states covered parents at higher income levels than Massachusetts; after the shift, parents in Connecticut and Maine continue to be eligible at higher income levels than Massachusetts eligibility rules currently allow. Despite efforts on the part of these neighboring New England states to mitigate impacts, a substantial number of parents lost coverage. Rhode Island reduced parent eligibility for RIteCare from 175% FPL to 138% FPL beginning January 1, 2014. Of the 6,574 affected parents, 1,921 (29%) likely became uninsured – 650 chose a Qualified Health Plan (QHP) through the Exchange but never made a payment and 1,271 never submitted an application to enroll in a QHP.[8] In 2015, Connecticut reduced eligibility for the HUSKY program from 200% FPL to 150% FPL. Of the parents who lost coverage, just one in four enrolled in a QHP. [9] Maine reduced eligibility for MaineCare for working parents from 133% FPL to 105% FPL in 2012. As Marketplace coverage was not yet available, 28,500 parents lost coverage.[10] Based on Connecticut and Rhode Island's experiences and the fact that Maine has not restored coverage for parents nor expanded Medicaid, it is likely that the majority of these parents became uninsured.

Children are also impacted by interruptions in coverage for their parent(s). Children in low-income families are three time more likely to be uninsured if their parents are uninsured.[11] Data shows that children with uninsured parents have a greater risk of gaps in coverage, and are less likely to receive check-ups, preventative care and are other health services.[12]

MassHealth Premium Assistance "Wrap" Benefits

The MassHealth Premium Assistance program has always provided a benefit "wrap" in addition to assistance with the cost of ESI premiums and cost-sharing. Commercial health insurance coverage is often not sufficient to meet the needs of low-income families, especially with regards to behavioral health and other community-based services. Thus, these "wrap" benefits are critical to ensuring MassHealth-eligible individuals and families enrolled in commercial coverage have access to the same level of benefits as if they were enrolled in MassHealth as a primary payer.

We are concerned that MassHealth seeks "flexibility not to provide any additional benefit wrap, except for a limited number of services not typically covered by commercial" in the 1115 waiver amendment. We request that MassHealth amend the proposed waiver language to provide more specificity regarding the flexibility requested, and preserve the benefit wrap currently offered in the Premium Assistance program.

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[8] Community Catalyst, *Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned*, September 2015. Available at: https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?tr=y&auid=15902172.

[9] 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. Available at: http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf.

[10] Maine Children's Alliance, Ensuring Coverage for Maine Children with Families in 2014. Available at: http://www.mekids.org/assets/files/issue_papers/healthcoverage_children_2014.pdf.

[11] Connecticut Voices for Children, quoting Schwartz K, *Spotlight on uninsured parents: How a lack of coverage affects parents and their families,* Washington 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, 2008 Jan; 46(1): 3-8.

[12] Maine Children's Alliance, quoting Sara Rosenbaum and R.P.T. Whittington, Parental Health Insurance Coverage as Child Health Policy: Evidence from the Literature, 5-6 (George Washington University 2007).

MassHealth Limited and ConnectorCare Coverage

MassHealth proposes to eliminate MassHealth Limited coverage 90 days after an individual is determined eligible for ConnectorCare, as is done with access to the Health Safety Net. We understand the purpose of this change and believe it may help mitigate confusion for individuals currently enrolled in both coverage types. However, we are concerned that those who remain eligible for ConnectorCare but unenrolled will not have access to even emergency coverage after 90 days, and will be foreclosed from enrolling. Therefore, we suggest that MassHealth amend its request to provide that MassHealth Limited coverage is terminated only when the coverage is truly redundant; that is, after an individual has successfully enrolled in ConnectorCare. We support the proposed plan to open a special enrollment period for individuals enrolled in MassHealth Limited and eligible for – but unenrolled in – ConnectorCare.

Prescription Drug Benefit Changes

We understand that prescription drugs are a key driver of increasing health care costs and must be managed. However, we are concerned that more limited specialty pharmacy networks and a closed formulary, as proposed in the 1115 waiver amendment, would impose unnecessary barriers to needed medications and supplies. Unlike several of the other proposed changes, these changes apply to all MassHealth members, including people with disabilities, children, and seniors.

Closed Formulary

The move to a closed formulary with as few as one drug available per therapeutic class would create access barriers for members. Currently, MassHealth is required to cover any drug for which the manufacturer participates in the federal Medicaid rebate program. This requirement ensures that patients have access to the highest standard of care available and allows physicians to prescribe the course of treatment they and their patients believe is most appropriate, taking into account clinical indications, side effects, coexisting conditions, ease of adherence and interactions with other medications. The closed formulary removes this flexibility, which may lead to pushing patients into regimens not suited for their needs, resulting in more costly treatment, such as emergency room visits, hospitalizations or procedures. Even with an exceptions process, a closed formulary may unduly delay or limit the effectiveness of treatment.

HCFA is also concerned about the potential use of step therapy or "fail first" policies incorporated as part of the closed formulary, which may pose an insurmountable obstacle to certain drugs and may undermine the stability of a member's condition that has been managed well long-term with a certain medication regime. We suggest "grandfathering in" MassHealth members who are currently taking medications that will not be included in the closed formulary to ensure continuity of treatment.

In the event that MassHealth moves forward with a closed formulary, it is extremely important that there are strong consumer protections in place, including non-discrimination policies and an exceptions process reflective of individual need, perhaps building off of protections afforded to Medicare Part D and Medicare Advantage enrollees. Any exceptions process should include rapid turnaround to ensure timeliness of starting or continuing needed treatment. Expedited exceptions process must also be in place, especially for individuals who need a particular medication, but have a negative reaction to the MassHealth-approved drug. Access to medications obtained through the exceptions process should remain in effect throughout the course of treatment.

In addition, Massachusetts has historically recognized the unique status and needs of people mental health and substance use disorders and the need for collaboration between EOHHS and the Department of Mental Health (DMH) with regards to provision of behavioral health services. Section 113 of Chapter 58 of the Acts of 2006 requires EOHHS and MassHealth to consult with the commissioner of the DMH before making any changes to MassHealth behavioral health services. This intent should continue as MassHealth considers changes to its prescription drug benefits.

Selective Specialty Pharmacy Network
MassHealth's proposal to procure a selective specialty pharmacy network may impose barriers for members who do not live in the geographic area of the selected pharmacies. The mail order or home delivery option may also not be workable for MassHealth members. Specialty drugs are often delivered during the day when members may be working, and may need to take time off from work to ensure the medication is not stolen or does not go bad because it needs to be refrigerated. In addition, MasssHealth members who are homeless or face housing instability may not be able to access their medications through a mail order or home delivery system, and may not have transportation to pick up medication at the selected pharmacies.

Primary Care Clinician (PCC) Plan Network
MassHealth proposes to implement narrower networks in the PCC Plan to encourage enrollment in Accountable Care Organizations (ACOs) and MCOs. While the differential is decreasing, people with complex medical needs frequently choose the PCC Plan over MCOs. Most often, applicants choose the PCC Plan because their preferred providers are not all included in Managed Care Organization (MCO) networks, or are not included in the same network. We request that MassHealth provide more detail about how the narrower PCC Plan networks will be established, identify impacts on people with complex needs or disabilities, and demonstrate how the narrower networks will continue to meet Medicaid network adequacy requirements.

Managed Care Options
Similar to the proposed PCC Plan network changes, we request more details about the proposal to waive the requirement for multiple managed care options in certain areas of the state. Which areas of the state will be impacted? What are the implications for member choice and continuity of care? Without this information we cannot assess this proposal.

Premiums and Cost-Sharing

Cost-sharing greater than 5% for CommonHealth members
In this waiver request, MassHealth proposes to implement cost-sharing greater than 5% of income for members over 300% FPL, which would impact adults and children with disabilities enrolled in the CommonHealth program. We request that MassHealth amend its waiver proposal to include more specificity about how this change would be implemented. We have questions about how this policy will be implemented, and request that MassHealth include more details in its proposal. For CommonHealth members with other primary insurance, will the new cost-sharing levels take into account the cost of the primary coverage? What percentage of income does MassHealth anticipate using for enrollees with incomes over 300% FPL? Slides from the August 4th hearing indicate that cost-sharing will remain below the state affordability schedule as determined by the Health Connector. However, the affordability schedule only takes into account premiums. How does MassHealth anticipate accounting for copays?

Annual 5% cost-sharing limit
MassHealth proposes to implement the 5% cost-sharing limit on an annual basis rather than a quarterly or monthly basis. This change may impose barriers to seeking services for members who need to use care more often in one month or quarter compared to their usual yearly use. For example, someone may need recurring physical therapy visits for a few months, and then not for the rest of the year. We also urge MassHealth to put in place an automated system to track copays that is transparent to members and providers before making any changes to the copay structure.

Broad-based premium and copay changes
In the 1115 waiver amendment and extension approved on November 4, 2016, MassHealth received authority to charge higher cost-sharing to PCC plan members than those enrolled in ACOs, MCOs or fee-for-service (FFS). MassHealth also plans to raise premiums for all enrollees above 150% FPL to 3% of

income and cap copays at 2% of income, while exempting members below 50% FPL from copays, beginning January 1, 2019. MassHealth also plans to charge copays for more services.

Raising premiums to 3% of income for enrollees above 150% FPL will result in substantial premium increases, with the largest increases for the lowest income individuals and families. The proposed premium increase would result in Massachusetts families paying among the highest premiums of any state.[13] The proposed MassHealth premium at 3% of income for a family at 200% FPL will be at least $60 per month, which would give Massachusetts the second highest premium charge of any state, after Missouri.[14]

Instead of implementing premiums of 3% of income across the board, we urge MassHealth to institute a progressive premium schedule, with a percentage of income that starts below 3% of income for individuals and families at 150% FPL and increases at higher incomes. In addition, we ask MassHealth to consider capping the amount premiums increase from current levels, especially for members at the lower end of the income range. For example, a family of two (one adult, one child) between 150-200% FPL would see their premium increase from $12 per month to $45 per month, an 80% increase. Families earning between 150-300% FPL in a high cost state like Massachusetts cannot afford steeply increased health care costs and keep up with the cost of other necessities, particularly housing.

In addition, copays can add up quickly for low-income populations. Some consumers already face barriers in affording prescription medications, especially when they take more than one drug. Additionally, certain services, such as outpatient therapy (physical, speech and occupational therapy), are often utilized intensely for a relatively short period of time (although they may be ongoing for certain populations). Specialist copays may be onerous for people with complex conditions, who sees their specialist more often than their primary care physician (PCP) or designate a specialist as their PCP. One possible strategy to mitigate the impacts here is to institute sub-caps on copays for these services. MassHealth could also exempt from copay charges people with complex care needs who see a specialist as their PCP.

We appreciate that MassHealth proposes to eliminate copays for the lowest income members; maintain copays at a nominal level; continue to exempt currently exempt populations, including children and pregnant women; and ensure that a member's inability to pay a does not result in denial of service in any delivery system. We encourage MassHealth to continue to educate providers and pharmacies about these consumer protections.

We appreciate the dialogue the Administration has opened to discuss our concerns, and look forward to working with you to ensure that any changes to MassHealth do not adversely impact members. Should you have any questions or wish to discuss these comments further, please contact me at (617) 275-2977 or scurry@hcfama.org. Thank you for your time and consideration.

Sincerely,

Suzanne Curry
Associate Director, Policy and Government Relations

Cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services
Robin Callahan, Deputy Director, MassHealth

[13] Kaiser Family Foundation, *Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2017: Findings from a 50-State Survey*. Available at: http://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-tables/.
[14] Ibid.