MHA MASSACHUSETTS HOSPITAL ASSOCIATION

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Audrey Morse Gasteier, Director Policy and Outreach
Emily Brice, Senior Advisor on State Innovation Waivers
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, MA 02108

Dear Ms. Gasteier and Ms. Brice:

On behalf of our member hospitals and the patients they care for, the Massachusetts Hospital Association (MHA) appreciates the opportunity to offer comments as the commonwealth considers pursuing a Section 1332 waiver to the Affordable Care Act (ACA). MHA appreciates the Connector's thorough education on the Section 1332 process and potential effects on Massachusetts health insurance offerings, as well as your consideration of the many issues the healthcare community has offered.

Subsidy Structure and Tax Credits

MHA strongly supports the approach the Connector has made to ensure health insurance premiums and out-of-pocket expenses are affordable for low-income patients. MHA supports and appreciates the Connector's creative approach to provide additional state subsidies so that premiums and cost sharing mirror prior Commonwealth Care amounts.

One of the issues raised in the stakeholder meetings is to modify the insurance subsidy/tax credit structure and adopt a state-specific approach to how the federal subsidies are used. Specifically, the state approach that is preferred by many would be more aligned with the Commonwealth Care model. While MHA is pleased that the commonwealth has maintained affordability through the ConnectorCare program, we believe the tax credit reconciliation process eventually will expose low-income patients to unanticipated additional financial costs after the tax year has ended, and this could have an effect on their ability to maintain health insurance coverage. There are also opportunities to better align subsidized coverage eligibility rules with the MassHealth eligibility determination process.

Under Commonwealth Care, an applicant's eligibility was based on the income information provided at the time of the application. This afforded the subsidized insured with greater predictability in their healthcare expenses during the year. The one-time determination also

aligned with the MassHealth income determination, which is important for consumers since people often can move between the programs and families can have individual members in each program. Using such an approach would also allow for consistency between the two programs, which currently use different ways of counting an applicant's household. A state approach to subsidized insurance would also allow greater flexibility related to continuous open enrollment for low-income patients as well as for enrollee payment plans and co-pay waivers, which had previously been available to Commonwealth Care enrollees.

Like the MassHealth process, program integrity can be achieved with state income data matches as well as a requirement that the applicant update income information during the year. In both cases, such a determination makes changes to an enrollee's coverage going forward, thereby not exposing low-income enrollees retro-actively to additional premium costs that may prevent them later from being able to afford health insurance coverage. MHA supports modifying the subsidized offering in the Health Connector to a model that is similar to the previous Commonwealth Care program.

Continuity of Coverage Related to the Premium Payment Grace Period

Moving to a Commonwealth Care-like model would also make it easier to address a significant gap in coverage that is related to the ConnectorCare and the Advance Premium Tax Credit (APTC) grace period. (We also believe this can be addressed in the ConnectorCare model as well.) While the Health Connector has done an exceptional job to maintain comparable insurance premium and out-of-expenses for those in ConnectorCare, one key difference affecting beneficiaries of the new program is the issue of retroactive loss of coverage.

As you know, Commonwealth Care did not retroactively deny an enrollee's health insurance coverage for failure to pay premiums. Instead, a person received an effective 60-day grace period before being terminated with no loss of prior coverage. Under current rules, the Connector provides a ConnectorCare enrollee with a three-month grace period if the person is delinquent in his or her payment. If payment is not made during that time, the person loses coverage retroactively to the end of first month of the grace period, thereby leaving the person with no coverage in months two and three.

The consequence of retroactive denial of health insurance coverage places significant financial burdens on patients. As patients are ultimately responsible for the cost of any services provided, the current policy will increase patient debt and represents a backwards step in the state's effort to alleviate this financial burden on low-income individuals.

The retroactive loss of insurance coverage also places a significant financial burden on healthcare providers. Since the denial is retroactive, providers have no way of knowing at the time services are provided whether a patient's coverage is in jeopardy. The effect is compounded by the fact that most retroactive denials by insurers do not indicate the basis for a retroactive denial. As a result,

providers are forced to spend considerable time reviewing claims in an effort to determine the cause, track down patients to verify the problem, and then seek payment accordingly. The current policy puts healthcare providers in an untenable position; collecting payment from a low-income patient is not an ideal or realistic situation, and in most cases will result in bad debt for the healthcare provider.

MHA believes the commonwealth should continue insurance during any period of payment delinquency – and thus reverse the policy of retro-active denials that has been put into place. We are also supportive of reasonable rules to prevent such a policy from being abused and used as an incentive to not pay premiums. MHA strongly encourages the Connector to establish a policy that ensures program integrity while protecting low-income patients from the retro-active loss of health insurance offered in the Health Connector. We believe this can be done through the Section 1332 waiver or a different state-based solution. This important protection existed for seven years under the Commonwealth Care program and it should be re-established.

Metallic Tiers and Actuarial Value

Another key effect the ACA had on the Connector's insurance offerings related to the actuarial value of the health plans within the various metallic tiers. Most of the Connector's previous Commonwealth Choice products would be considered Platinum and Gold category health plans under today's ACA actuarial standards. Commonwealth Choice Bronze plans were more like today's Silver and the current Bronze health plans would not have been permitted given the significant patient cost sharing. Of concern, the 2016 Bronze plans were further revised downward to comply with the ACA's 60-percent actuarial value target, further adding to the out-of-pocket expenses of consumers.

In our view, the current Bronze products include too much financial exposure for most people, especially since they do not have a companion requirement of possessing a Health Savings Account (HSA). Current Bronze health plan annual deductibles run as high as $3,350 for an individual and $6,700 for a family. Hospital "co-payments" defy the historical co-payment assumptions as they are typically $1,000 for emergency department visits, inpatient stays, and certain outpatient services. High cost imaging including CT/PET scans and MRIs are also $1,000. In some cases, 30% co-insurance applies. The annual out-of-pocket maximum costs are $6,550 for an individual and $13,100 for a family.

Affordability was a key principal in the 2006 Massachusetts health coverage reform as well the ACA. Related to both the state and federal individual mandate to have health insurance, affordability is unfortunately measured solely on the price of premiums relative to one's income, thereby ignoring significant costs that ultimately make it unaffordable for many. For example, a 40-year-old single individual making $50,000 per year living in Boston can expect to pay on average $312.99 a month for Bronze coverage. The $3,755 annual cost of the premium is affordable under the ACA definition as it represents 7.5% of the person's income. However, this

health coverage becomes unaffordable by that definition if the person needs one MRI. It becomes significantly unaffordable if the person has to pay their whole deductible as healthcare expenses would then represent 14% of their income (before taxes). Bronze coverage could put a person in medical debt if they have a significant illness and are forced to pay up to their out-of-pocket expense cap, making their healthcare expenses more than 20 percent of their gross income.

The downstream effect of high patient cost sharing is serious. Products with high deductibles and co-pays most affect those with the greatest medical needs, can discourage people from seeking needed care, and increase consumer bad debt. On the provider side, the administrative burden of collecting and processing these claims is costly and inefficient. Such substantial fragmentation of payment responsibility significantly raises billing costs, increases the potential for bad debt, and causes confusion and frustration for consumers. Hospital bad debt does not end with individual hospitals; it affects their communities. Other employers and individuals purchasing insurance either make up the unpaid amounts, or hospitals absorb that debt and are unable to reinvest in their facilities or, worse, are forced to reduce services.

Since 2006, the Connector has done a commendable job in striving to ensure health insurance is affordable while providing people with sufficient choices in shopping for health insurance. However, the new requirements of the ACA metallic tier actuarial values have forced the Exchange to offer products that the commonwealth previously would have not have promoted to consumers given the unaffordability of the cost-sharing. MHA believes the Connector should use the Section 1332 waiver to adjust the actuarial values so that they align with Massachusetts principals of affordable coverage. If the Connector is committed to high-deductible and co-insurance concepts, we believe that their use should be limited to only those that can afford them through an HSA. We also hope that at some point the actuarial value of a typical person's out-of-pocket expenses should factor into the measurement of health insurance affordability, which would be a better representative of the true cost of a health insurance product.

MHA appreciates the opportunity to offer these comments and for your consideration. We look forward to continuing this important partnership with the administration, the legislature, and other stakeholders to continue to make the ACA successful for Massachusetts residents and the healthcare providers that care for them.

Sincerely,

Daniel J. McHale
Sr. Director, State Government Finance & Policy
Massachusetts Hospital Association