August 25, 2017

Audrey Morse Gasteier, Chief of Policy and Strategy
Emily Brice, Deputy Chief of Policy and Strategy
Massachusetts Health Connector
100 City Hall Plaza, 6th Floor
Boston, MA 02108

Submitted by email to StateInnovations@MassMail.State.MA.US

Re: Comments on 1332 Waiver Request

Dear Ms. Gasteier and Ms. Brice:

On behalf of Health Care For All, Health Law Advocates, and the Massachusetts Law Reform Institute, thank you for the opportunity comment on the Commonwealth's proposed Waiver for State Innovation under Section 1332 of the Affordable Care Act (ACA), released on July 24, 2017. We share the Health Connector's commitment to maintaining access to affordable health coverage for Massachusetts residents, and believe that the 1332 waiver request largely aims to further this goal. Our comments focus on ensuring that the appropriate protections are in place for low and moderate income Massachusetts residents eligible for subsidized health coverage.

1332 Waiver Request: Premium Stabilization Fund in Lieu of Cost-Sharing Reductions

Cost-sharing reductions (CSRs), along with Advanced Premium Tax Credits (APTCs), are the key mechanisms in the ACA that make coverage more affordable for low and moderate income individuals and families. CSR payments are made to health insurers with members below 250% of the federal poverty level (FPL) who purchase Silver-level plans through the Marketplace, as health insurers are required to increase the actuarial value, thereby reducing cost-sharing, for these enrollees.[1] Massachusetts leverages CSRs and APTCs, and invests additional state dollars, to provide even more affordable coverage than federal CSRs and APTCs alone through the ConnectorCare program.

Recent uncertainty about whether the federal government will continue to make CSR payments has introduced significant risk for both insurers and consumers in the Massachusetts health insurance market. Failure to make CSR payments would result in fewer insurers participating in Marketplaces, including the Health Connector; coverage disruptions for consumers; and significant premium increases. In turn, the premium increases would increase federal and state liability for APTCs and supplemental subsidies. The Health Connector estimates that Massachusetts carriers would need to increase their premium rates by 16% to 20% due to CSR uncertainty alone.[2] Similarly, the Congressional Budget Office and Joint Committee on Taxation recently reported that ending CSRs would lead to gross premium increases of 20% for Silver-level

[1] 42 USC § 18071.
[2] Massachusetts Health Connector, *Requests for State Flexibility to Support Commercial Insurance Market Stability and Reforms*, July 24, 2017. Available at: https://www.mahealthconnector.org/about/policy-center/state-innovation-waiver.

plans as well as increase federal APTC obligations, and thereby the federal deficit by $194 million from 2017 through 2026.[3]

The instability caused by the federal government's failure to make CSR payments would lead to increases in the uninsurance rate as premiums increase for these plans.[4] To address uncertainty around the CSR payments, and thus the market as a whole, the Health Connector proposes to establish a Premium Stabilization Fund in lieu of CSRs. The Commonwealth would receive federal APTC savings, which will accrue through moderation of premium increases for Silver-level plans, in the form of a "pass-through," to be deposited into the Commonwealth Care Trust Fund.

HCFA supports the Health Connector's efforts to ensure continued affordability and continuity of coverage for consumers purchasing coverage through the Health Connector. We understand that with this proposal the Health Connector intends to hold consumers harmless by keeping premiums and cost-sharing stable for ConnectorCare members. As such, we request that the Health Connector clarify this intent by providing specific language in the 1332 waiver request, and including a written analysis of how the Commonwealth will continue to meet the ACA guardrails requiring that coverage be as affordable and comprehensive as coverage absent the waiver.[5]

We also ask the Health Connector to consider language in state law or regulation to ensure that the pass-through funding is used as intended – to shield consumers from increased costs and to reimburse insurers for meeting their obligations under the ACA and ConnectorCare with regards to cost-sharing levels. This is especially important as the Commonwealth's past several General Appropriations Acts have allowed a substantial transfer from the Commonwealth Care Trust Fund to the General Fund.[6] In addition, should the Commonwealth implement the proposed transition of 140,000 non-disabled adults from MassHealth to ConnectorCare, the Commonwealth must ensure that there is enough funding to at least maintain – and potentially improve – affordability of ConnectorCare premiums and cost-sharing.

1115 Waiver Amendment Request: Health Connector-Related Provisions

MassHealth released their 1115 waiver proposal on a parallel track with the 1332 waiver request. We ask you to also consider HCFA's comments on the Health Connector-related provisions in the MassHealth proposal.

MassHealth Eligibility Changes for Non-Disabled Adults

MassHealth proposes to shift coverage for non-disabled adults ages 21 to 64 with incomes over 100% FPL to ConnectorCare as of January 1, 2019. This transition would impact 100,000 parent and caretakers currently eligible for MassHealth Standard and 40,000 childless adults enrolled in MassHealth CarePlus.[7] ConnectorCare is a valuable program, integral to Massachusetts' health coverage system, as it offers more affordable coverage than even the federal APTCs and CSRs alone would provide. However, ConnectorCare coverage provides fewer benefits, is more costly to consumers, and presents more enrollment barriers than MassHealth coverage.

---

[3] Congressional Budget Office, *The Effects of Terminating Payments for Cost-Sharing Reductions*, August 2017. Available at: https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53009-costsharingreductions.pdf.

[4] See, Declaration of Hannah Dyer Frigand (Health Care For All HelpLine Director) in Support of the States' Motion to Intervene, *United States House of Representatives v. Price*, submitted to the U.S. Court of Appeals for the District of Columbia Circuit, Case 16-5202, p. A-50. Available at: http://news.delaware.gov/files/2017/05/2017-05-18-States-Motion-to-Intervene-FILED-time-stamped.pdf.

[5] 42 USC § 18052(b).

[6] Section 106 of the FY2018 state budget allows the Secretary of the Executive Office of Administration and Finance to request a transfer of up to $185,000,000 from the Commonwealth Care Trust Fund to the General Fund.

[7] 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.

We strongly urge the Commonwealth 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% of the federal poverty level (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 assessed a premium and terminated after ninety days of non-payment of premiums.[8] 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.[9] 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.[10]
- *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.[11] 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.[12]
- *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

[8] Connector Policy #NG-6B, available at: https://www.mahealthconnector.org/wp-content/uploads/policies/Policy_NG_6B.pdf.
[9] 2017 ConnectorCare Member Contributions, available at: https://www.mahealthconnector.org/wp-content/uploads/board_meetings/2016/2016-09-08/ConnectorCare-Placemat-090816.pdf.
[10] 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.
[11] 130 CMR §506.016 and 506.017.
[12] See: https://www.mahealthconnector.org/wp-content/uploads/ConnectorCare_Overview-2017.pdf.

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 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 its RIteCare program 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.[13] In 2015, Connecticut reduced eligibility for its HUSKY program from 200% FPL to 150% FPL. Of the parents who lost coverage, just one in four enrolled in a QHP. [14] 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.[15] 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.

---

[13] 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.

[14] 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.

[15] 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.

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.[16] 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.[17]

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 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 the Commonwealth 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.

We appreciate the opportunity to provide written comments and enter into dialogue regarding the Commonwealth's proposed 1332 waiver and related issues. Should you have any questions or wish to discuss these comments further, please contact Suzanne Curry at (617) 275-2977 or scurry@hcfama.org. Thank you for your time and consideration.

Sincerely,

Suzanne Curry
Associate Director
Policy and Government Relations
Health Care For All

Michelle Virshup
Staff Attorney
Health Law Advocates

Victoria Pulos
Senior Health Law Attorney
Massachusetts Law Reform Institute

[16] 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.

[17] 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).