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Sarah Iselin, Commissioner
Division of Health Care Finance and Policy
Two Boylston Street
Boston, MA 02116-4704

RE: Comments on 114.6 CMR 13.00: Health Safety Net Eligible Services

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Dear Commissioner Iselin:

Health Law Advocates (“HLA”) submits these written comments in connection with 114.6 CMR 13.00, Health Safety Net Eligible Services (“HSN”). HLA is the state’s only non-profit, public interest law firm devoted solely to helping consumers overcome barriers to health care access. HLA helps numerous low and moderate-income clients annually overcome unaffordable medical debt.

HLA appreciates the commitment and dedication of the Division of Health Care Finance and Policy (the “Division”) in ensuring successful implementation of health care reform. The HSN continues to be an invaluable resource for many residents in the Commonwealth as a payer of last resort, increasing access to medical care while protecting residents from the heavy burden of paying for medical care. We urge the Division to consider all proposed regulations in light of this purpose.

I. Protecting Patients’ Rights

With the proposed amendments to “Patient Rights and Responsibilities” in Section 13.08(2) the regulations place new significant responsibilities on patients but overly deemphasize patients’ rights. For that reason, we urge the Division to adopt additional patient rights under Section 13.08(2)(a) and (b). Above all, this section should confirm that Providers are restricted in collection efforts against Low Income Patients pursuant to Section 13.08(3)(c). This is important because the proposed regulations govern situations in which a Provider is required to repay the HSN and then may turn to the consumer for reimbursement.

The regulations should also protect Low Income Patients from collection efforts by The Division as long as they cooperate with the Division and there is a third party in a position to pay. This provision would protect disadvantaged consumers and their families from being held accountable for a third party’s fulfillment of its responsibility. The Division should also be prevented from collecting against a consumer more than six years after the date of service.

Thus, we encourage the Division to adopt the following subparagraph at the beginning of Section 13.08(2):

(a) Patient rights

1. Low Income Patients are exempt from Collection Action for any Eligible services rendered by a Provider receiving payments from the Health Safety Net Office for services received during the period for which they have been determined Low Income Patients except for co-payments and deductibles, pursuant to 13.08(3).
2. If a Low Income Patient cooperates with the Division as described in 13.08(2)(c)(4) [NOTE: this section is created in proposed regulations discussed below], but the Division fails to obtain payment from a third party, the Low Income Patient has no duty to repay.
3. The Division may not collect against Low Income Patients after six years from the date of service.

II. Burdensome Reporting Requirements

The HSN regulations at Section 13.08(2)(b)(2) should not require Patients to provide to MassHealth or their Provider information relevant to their eligibility status beyond the requirement of MassHealth's own regulations. MassHealth's regulations at 130 CMR 501.010(B) provide that "(t)he applicant or member must report to MassHealth, within 10 days or as soon as possible, changes that affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability." By imposing additional requirements under the HSN regulations that differ from MassHealth's requirements, Patients are not provided fair and clear notice of what their responsibilities are under the law in terms of reporting information to MassHealth. Unnecessary requirements for financial disclosures to Providers are of particular concern because, in the absence of HSN coverage, Patients and Providers may be in adversarial legal positions.

III. Patient and Provider Responsibilities

The proposed new Sections 13.04(6)(d) and 13.08(2)(b)(4) impose obligations on Patients that are complicated, burdensome, and in some instances inconsistent with the rights and duties defined elsewhere in the regulations. Our primary concern, from a Patient's perspective, is that if these changes were to be implemented, Patients would be obliged to assign their rights to third-party recovery to both the Division and the Provider (see also section 13.08(1)(g)). That double assignment would likely create confusion over who was entitled to payment from a third-party recovery. We join in the recommendation of the Massachusetts Law Reform Institute (MLRI) and the Massachusetts Hospital Association that the Division adopt the third-party recovery model used by MassHealth following Atlanticare Medical Center v. Commissioner, 439 Mass. 1 (2003). In short, the primary responsibility to collect from third-party payers should fall to Providers, who bear a duty to be diligent in investigating whether any such third party payers may exist. (See MLRI's comments for further discussion of Atlanticare and MassHealth policy.) We respectfully suggest that this provision also make clear that regardless of the diligence of the Provider and

the Division's possible right to repayment, the protection of low-income consumers codified in section 13.08(3)(c), Populations Exempt from Collections, remain in force.

Because the Provider will be pursuing its own inquiry into whether or not a third party exists that will pay for the services provided, the Patient should not bear an independent duty to inform the Division of Provider claims. Instead, the Patient's duty should be limited to reasonable cooperation with the efforts of the Provider and/or the Division to identify and collect payment from such third parties. Should the Patient choose to file a lawsuit against a third party seeking medical damages, the Patient should be required to report such a filing to the Division within a reasonable period of time.

Several other provisions of the proposed new Sections 13.04(6)(d) and 13.08(2)(b)(4) are troubling to us as well. We suggest alternate language below, reflecting the following policies: First of all, the Patient's duty to inform the Division of loss that may result in a lawsuit or insurance claim should be limited to cases in which the patient may recover a cash settlement. As currently phrased, the Patient would bear a duty to inform the Division of every illness that might result in a claim being filed with his or her health insurer, which would be essentially every illness or injury suffered by any patient at any time. Next, the Patient's duty to inform the Division of his or her own lawsuit should not include a requirement that such notification be in writing and within 10 days, as indicated in Section 13.04 (6)(d)(4) and 13.08 (2)(b)(4)(b)(3). The Patient should be responsible for reporting his/her claims orally or in writing and within a reasonable length of time. In a similar vein, the requirement that a Patient "must file a claim for compensation" should be limited to meritorious cases and to claims with relevant insurers so that the regulation does not, in its plain language, mandate the filing of lawsuits and frivolous claims.

With those suggestions in mind, we respectfully encourage the Division to adopt the following in place of the proposed section 13.08(2)(b)(4), in addition to consistent language in 13.04(6)(d).

4. Inform the Division when the Patient is involved in an accident, or suffers from an illness or injury that may result in a lawsuit or insurance claim. The Patient must:
 - a. Cooperate with the Provider's and the Division's reasonable efforts to identify and receive reimbursement for the accident or illness from a Third Party.
 - b. Notify the Division within a reasonable time if the Patient files a lawsuit or claim relating to the Patient's accident or illness.
 - c. Repay the Health Safety Net from money received in a settlement relating to the Patient's illness or accident for all Eligible Services provided as a result of the accident or illness, provided that the Health Safety Net has not been reimbursed by a Provider and is not pursuing such reimbursement and that such repayment shall be proportionate to repay the settlement that is allocated to medical costs.

IV. AVAILABILITY OF “AFFORDABLE” INSURANCE

HLA urges the Division to delay implementation of Section 13.04(4)(b) entitled “Affordable Insurance” until further caveats and protections for consumers are considered. At present, this provision has not yet been effectuated due to operational issues. If the provision continues to be inoperational, then we suggest that the Division incorporate into the regulations a future effective date. As is, Section 13.04(4)(b) becomes effective October 1, 2009. The Affordable Insurance provision will deny certain HSN benefits to residents who have access to private insurance or employer-sponsored health plans and do not enroll.

Employer sponsored insurance and other sources of health insurance are not always affordable in the day-to-day lives of disadvantaged consumers. Low and moderate income consumers who are faced with unaffordable insurance either opt not to enroll in the health plan or are terminated from the plan for nonpayment. They should not be penalized by the Division with the loss of access to HSN medical services.

- The Division should make an independent determination of affordability based on the consumer’s specific circumstances for purposes of implementing Section 13.04(4)(b)

The Division should implement an independent affordability determination based on specific circumstances, as to whether available insurance is actually affordable to the consumer, before rendering the consumer ineligible for HSN benefits under the Affordable Insurance provision. Any affordability review should be based on the gross income of the entire household and household size. As an example, the MassHealth Medical Benefit Request requires an applicant to disclose and provide proof of all household sources of income. MassHealth and all state subsidized health care assistance programs calculate eligibility based on household income and household size. Eligibility notices, including HSN benefits, are sent to the head of household for all household members. Actual household income and household size, as is used by MassHealth in its eligibility reviews, is a better indicator of consumer ability to pay and affordability.

- The Division should undertake a searching review of affordability and not rely on the Affordability Schedule when ending HSN benefits for certain consumers

The Division imputes the definition of “affordable,” as determined annually by the Connector Authority’s Affordability Schedule, 956 C.M.R. 6.00, into the HSN regulations. For the reasons set forth below, the Affordability Schedule is an inadequate tool for the Division to adopt in ending HSN benefits for certain consumers.

“Affordable” for consumers is not simply the cost of monthly premium payments. Any determination of what is affordable should take into account out-of-pocket expenses and additional health care costs, such as co-payments, deductibles, and cost sharing. A total cost basis, rather than a premium payment amount, is a better indicator of what is affordable to Massachusetts residents.

The Affordability Schedule classifies households as individual, couple (married couple without children), or family (at least one adult and at least one child). 956 C.M.R. 3.04. “Family” is defined as a “couple or head of household and their dependents.” Id. For example, the Affordability Schedule deems that a family can afford to pay \$820 monthly for private insurance if the taxpayer’s adjusted gross income is \$93,601 to \$114,400. It makes no difference under the Affordability Schedule if this is a family of two, e.g., one parent/guardian and child versus a family of eight.

The Affordability Schedule fails to include a ceiling on total consumer out-of-pocket health care costs by setting an overall cap on the maximum dollar amount that consumers can be expected to incur.

Because certain consumers will lose eligibility for necessary medical services pursuant to the Affordable Insurance section, the Division should not adopt the 956 C.M.R. 6.00 Affordability Schedule in assessing what is affordable for the consumer. HLA respectfully requests that the Division undertake a more searching review of affordability before terminating any HSN benefits to this disadvantaged population.

While HLA acknowledges the underlying policy herein is to encourage consumers to take up affordable health care insurance, it is fundamentally unfair that low or moderate income consumers be penalized twice, e.g., both taxed for being uninsured and also precluded from certain HSN benefits under Section 13.04(4)(b).

Health Law Advocates remains deeply appreciative of our ongoing collaboration with the Division on this and other matters, and we would be more than happy to respond to any questions that these comments may raise. Please feel free to contact any of the undersigned if we can clarify or expand on any of the issues addressed above.

Sincerely,



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