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HealthLawAdvocates

Fighting for Health Care Justice

COMMENTS RELATIVE TO

956 CMR 3.00 and 956 CMR 6.00

Before the

Commonwealth Health Insurance Connector Authority Board

February 4, 2008

Testimony of Health Law Advocates

Regarding

EXECUTIVE DIRECTOR
Barbara Anthony

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S. Stephen Rosenfeld

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OFFICE MANAGER
Irene Nicolaidis

ADMINISTRATIVE ASSISTANT
Laura Healey

By
Georgia J. Maheras, Esq
Staff Attorney
Health Law Advocates

Good Morning. My name is Georgia Maheras and I am a staff attorney at Health Law Advocates. Health Law Advocates represents low-income clients who encounter problems accessing health care. We are affiliated with Health Care For All and a member of the ACT!! Coalition. I am here today to tell you the story of my client, L.J. L.J. could not be here today, but wants me to share her story so other people do not end up in the position she is in.

L.J. is a 41 year old woman living in Edgartown. L.J. works and goes to school and her income puts her in the 250-300% FPL income bracket. By February, 2007, she was successfully enrolled in Commonwealth Care Plan Type 3 for \$105 per month and dutifully paid her premiums each month. From April to July, she worked approximately four hours a week at another job and was paid a lump sum at the end for this work.

As required, L.J. immediately notified MassHealth of this additional pay by sending in her pay stubs, time sheets and a letter explaining that the income was not for one month, but for four months of work. Unfortunately, MassHealth mis-calculated her income and deemed her ineligible for Commonwealth Care by calculating her income monthly, not as spread out over four months. L.J. received a bill for her

September premium and paid it on time not knowing that her Commonwealth Care would be inactive for September.

The story would end there, if L.J. did not need surgery in the beginning of September. She discovered her insurance was inactive after her surgery, while trying to fill a prescription. L.J. was able to reinstate her coverage beginning in October, but was left with thousands of dollars in medical debt.

L.J. is now in serious medical debt because there is no retroactive coverage in the Commonwealth Care programs.

Commonwealth Care needs retroactive coverage capacity to correct and provide accountability for erroneous denials or termination of assistance. Even if a member is successful in a Board of Hearings decision, there is no mechanism for corrective action due to the prospective nature of Commonwealth Care.

Furthermore, the regulation does not have any references to “aid pending”. This means that someone appealing a decision can go without coverage during the appeal as well as be subjected to the mandate during an extended appeal process. The regulation also writes, “Enrollees who have brought an appeal must continue to pay

all required Enrollee Premium Contributions during the pendency of the appeal.”

Again, we think the Connector should presume the correctness of a claim by allowing for coverage during the appeals period.

Medicaid fair hearing regulations require the agency to make corrective payments retroactive to the date an incorrect action was taken. 42 C.F.R. § 431.246. The Medicaid fair hearing regulations adopt the constitutional requirements of due process of law as enunciated in *Goldberg v. Kelly*, 397 U.S. 254 (1970). The Connector must develop some way to allow for retroactive enrollment and/or reimbursement for expenses incurred between an erroneous denial and reinstatement into Commonwealth Care. The policies of retroactive coverage and aid pending during appeals are equitable and complementary. MassHealth is able to retroactively enroll members in its MMCOs and has aid pending for its enrollees. Commonwealth Care should be able to do likewise.

I urge the Connector to create a balanced, fair appeals process to facilitate enrollment and access to the care that people like L.J. need. Thank you.