FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

October 2, 2015

The Honorable Sylvia Matthews Burwell, Secretary
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Submitted online via Medicaid.gov

Re: Comments on Healthy Michigan 1115 Waiver Amendment

Dear Secretary Burwell:

Thank you for this opportunity to comment on Michigan's waiver amendment application for its Healthy Michigan demonstration.

Families USA is a national organization representing the interests of health care consumers, with a particular focus on low-income consumers. We are extremely supportive of Michigan's decision to extend Medicaid coverage under the Affordable Care Act (ACA) through the Healthy Michigan Plan.

Healthy Michigan provides important health insurance coverage to approximately 600,000 low-income Michigan residents. By extending Medicaid coverage, the state has ensured access to care, including important primary and preventive care, along with the financial security that comes with having health insurance for over half a million of its residents.

We are pleased that the state is interested in continuing this important program and we understand that this request is pursuant to state law (PA 107). However, we have serious concerns about some elements of the state's request. There is no policy rationale for the changes outlined in either the request or in PA 107. Additionally, the request includes elements that we believe are inconsistent with the intent of the Medicaid program and the ACA's Medicaid expansion, as well as the state's goals of "improving health, increasing the quality, reliability, availability and continuity of care" as articulated in PA 107.[1]

[1] Act No. 107, Public Acts of 2013, available online at http://www.legislature.mi.gov/documents/2013-2014/publicact/pdf/2013-PA-0107.pdf.

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We urge CMS and the state to work together to address these concerns so that the Healthy Michigan Plan will continue to provide vital health coverage to hundreds of thousands of Michigan residents.

Our comments on specific aspects of the request are outlined below.

General lack of detail.

The application lacks clarity regarding how the requested changes will be administered, how the 48-month trigger will be calculated, specifics of healthy behavior programs mentioned, how transitions between programs (premium assistance and Medicaid managed care) will be handled, and even the exact structure of premium assistance cost-sharing and out-of-pocket maximums. These are critical issues to consider when evaluating this request, yet the request lacks detail needed for full evaluation.

In our comments below, we note some areas where greater detail is needed for a complete program evaluation. However, this lack of detail hampers our ability to fully evaluate all aspects of the request.

Lack of stated demonstration purpose.

The state fails to provide stated demonstration purposes that this amendment will serve; such purposes should be provided prior to any approval.

- ***The amendment fails to meet the requirements of Section 1115 of the Social Security Act.*** Section 1115 of the Social Security Act gives the Secretary authority to approve demonstration projects which, in her judgement, are "likely to assist in promoting the objectives of title……XIX……"[2]

  The request fails to articulate any demonstration purpose that the amendment will serve that will assist in promoting the objectives of the Medicaid program. As presented, it seems unlikely that the request will, in fact, promote either the objectives of the Medicaid program or of the Healthy Michigan Plan.

  We understand that this an amendment and not a new demonstration application. However, the changes requested are of such magnitude that greater specificity, and a stated demonstration purpose for these changes, should be provided.

Changes to enrollees' options after 48 cumulative months of Healthy Michigan coverage (48-month trigger) sets a bad precedent.

The state's request to change Medicaid health plan cost sharing and premiums for individuals above 100 percent of poverty who have been in Healthy Michigan for 48

[2] Social Security Act Sec. 1115. **[**42 U.S.C. 1315**]** (a).

cumulative months and who do not elect to move to marketplace coverage (premium assistance) should not be approved as requested.[3]

- ***Penalizing enrollees for time on program does not further Medicaid goals.*** The Medicaid program is a health coverage program for individuals who meet income and other eligibility criteria. The amount of time that an individual needs coverage should have no bearing on an enrollee's cost-sharing, result in any coverage limits, or in any way result in a penalty to an enrollee. Penalizing individuals who need the program for a particular period of time, regardless how long or short that time and regardless of the enrollee's income level, is inconsistent with Medicaid's fundamental purpose of providing affordable health coverage to low-income people. This is true for Medicaid writ large and for the Medicaid expansion. This would be the first time, to our knowledge, that CMS has ever approved any such changes tied solely to time receiving Medicaid. Such a dramatic change is not properly undertaken at the administrative level.

- ***The "choice" of marketplace coverage is not a true choice.*** The state presents the 48-month trigger program changes (increased premiums and cost-sharing limits) as a choice that enrollees can make between marketplace coverage (premium assistance), with lower premiums, or remaining enrolled in a Medicaid health plan and seeing premiums increase.[4] This is not a choice that individuals should have to make simply because they have been enrolled in Healthy Michigan for a particular period of time. It forces enrollees to choose between higher (potentially unaffordable) premiums, or leaving their current coverage and provider network.

- ***The request will disrupt enrollees' care.*** All enrollees who would be affected by this provision will have had Healthy Michigan coverage for at least 48 months. Even though these months may not be continuous, many of these enrollees, if not most, will have established relationships with Medicaid health plan providers who participate in Healthy Michigan.

  Those who find the increased premiums unaffordable will have no choice but to switch to marketplace coverage, in many cases severing established relationships with their health care providers. There are cost and health consequences associated with moving from one type of coverage to another ("churn"), particularly for low-

[3] We recognize that Michigan refers to monthly payments as "contributions," however they function as premiums (monthly payments associated with coverage) and we refer to them as such.

[4] The request lacks clarity on the cost-sharing and out-of-pocket maximums for individuals who elect to move into premium assistance. As a result, we cannot assess the exact financial choice that enrollees will be confronting. This is covered in greater detail in our discussion of Option 1, later in these comments.

income health care consumers.[5] Forcing individuals to make this choice because they have received Medicaid coverage for a particular period of time is not only inconsistent with the goals of the Medicaid program but also potentially increases program costs.

- ***There is no stated demonstration purpose.*** There is no policy rationale or demonstration purpose for the 48-month trigger offered in the state's application. It is unclear how the trigger serves any legitimate demonstration purpose that further Medicaid's goals.

- ***Approving penalties based on time on program sets a bad precedent.*** If approved, this request would be the basis for subsequent requests from states that may go further in placing time limits on Medicaid coverage, limits that would severely undermine the purpose of the program. For example, Arizona is developing a waiver amendment request to limit individuals' time on Medicaid.[6]

  We understand that Michigan is not requesting to disenroll individuals from Medicaid after 48 months cumulative coverage; nevertheless, adding penalties based on time enrolled sets a bad precedent and should not be approved.

Option 1 (premium assistance through the marketplace) lacks critical details. The request lacks critical details about this option. CMS should clarify that this option is premium assistance consistent with CMS guidance, and that all Medicaid rights and protections, including those pertaining to cost-sharing and out-of-pocket limits, are maintained.

- ***Structure of marketplace coverage and out-of-pocket cost limits is unclear; CMS should follow existing guidance regarding premium assistance through 1115 waivers in Medicaid expansion***. The application seems to suggest that cost sharing for Option 1 Medicaid enrollees would mirror QHP cost sharing for people at a similar poverty level. The out of pocket cap for individuals between 100 percent and 150 percent of poverty in a QHP receiving a cost-sharing reduction subsidy (CSR) is $2,200 is 2015. For an individual at 100 percent FPL, this would represent 18 percent of her annual income. For individual at 138 percent of poverty, 14 percent of her annual income. These amounts are inconsistent with Medicaid rules and with CMS guidance regarding premium assistance in Medicaid expansions.

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[5] Matthew Buettgens, et al, *Churning under the ACA and State Policy Options for Mitigation* (Washington, D.C.: Urban Institute, June 2012) available online at http://www.urban.org/sites/default/files/alfresco/publication-pdfs/412587-Churning-under-the-ACA-and-State-Policy-Options-for-Mitigation.PDF

[6] Arizona's draft Medicaid expansion 1115 waiver request, which has been through a state comment period, is available at http://www.azahcccs.gov/shared/Downloads/WaiverTemplateDRAFT8-18-15.pdf

CMS should follow existing guidance regarding premium assistance in Medicaid expansions when approving Michigan's waiver amendment.[7] CMS must clarify that cost-sharing will be in line with ***Medicaid*** limits, as premium assistance enrollees are still Medicaid beneficiaries.

- ***It is unclear whether Medicaid cost-sharing requirements are met.*** Furthermore, cost-sharing "consistent with the Affordable Care Act…. Administered through the QHP" must meet Medicaid requirements for nominal cost-sharing under 42 CFR § 447.54, Section 1916A of the Social Security Act. Individuals below 150 percent of poverty on the marketplace receive a silver plan with cost sharing reductions that amount to 94 percent Actuarial Value (AV). For many services, 94 percent AV will not be the same as nominal Medicaid cost-sharing as detailed in 42 CFR § 447.54.[8] In order to charge in excess of this nominal cost-sharing, the state must request a Section 1916(f) waiver, which it has failed to do. Any approval CMS should clarify that Option 1 enrollees will only be charged nominal Medicaid cost-sharing.

- ***The state has not requested a benefit waiver, yet it is not clear from the application that full ABP benefits will be provided to enrollees in premium assistance***. The proposed amendment states that: "All beneficiaries will remain eligible for services consistent with the ABP as described in the Medicaid State Plan. *Individuals selecting coverage through the Marketplace will receive the essential health benefits through their QHP's*" (emphasis added, p. 3).

  While we are pleased that the state does not seem to be requesting any specific benefit waivers, the proposal is unclear as there is no guarantee that the benefits provided through a QHP are consistent with Medicaid benefits. Attachment D compounds the confusion. Following a question as to whether wrap-around services will be provided for beneficiaries who choose to receive their health coverage through the marketplace (Option 1), the attachment states that "MDHHS expects that beneficiaries who maintain Healthy Michigan Plan eligibility would continue to receive comprehensive services consistent with the State Plan."

  However, given the aforementioned differences in benefits under Medicaid and QHPs, it is unclear how the state would ensure that all benefits are provided. Any approval should clarify that the state will provide all ABP benefits and specify how the state will ensure that those benefits are provided.

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[7] CMS FAQs "Medicaid and the Affordable Care Act: Premium Assistance," March 2013 available online at http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf

[8] For easy reference to allowable cost-sharing in Medicaid, see Medicaid.gov at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing-out-of-pocket-costs.html

Option 2: Premium and cost-sharing levels requested for enrollees who remain in Medicaid managed care are excessive.

The request to increase certain enrollees' costs based on time covered if they elect to remain in Medicaid managed care is not only inconsistent with the Medicaid program, but the premium amounts and aggregate cost-sharing limits requested are excessive, beyond what CMS has approved in any other Medicaid expansion, and serve no demonstration purpose.

- ***We continue to oppose the imposition of monthly premiums in Medicaid expansions because premiums present a real and substantial barrier to care which is contrary to the objectives of the Medicaid program.*** There is ample evidence that monthly payments make it difficult for low-income individuals to retain coverage.[9] When Wisconsin's Medicaid program, Badgercare, added a 3 percent of income premium on enrollees with incomes between 133 and 150 percent of poverty, among that group there was a 24 percent enrollment reduction due to non-payment of premiums.[10] Compared to Michigan's request, Wisconsin's program entailed a lower financial burden on a higher income groups of enrollees. There is no doubt that many enrollees will not be able to retain Medicaid managed care coverage.

  The impact of premiums on enrollees' ability to retain coverage is so well documented that there is no demonstration purpose to be served by increasing premiums to 3.5 percent.

- ***The premiums requested are higher than CMS has approved for this income group for other states and exceeds marketplace premiums*.** All prior 1115 demonstrations for the Medicaid expansion population have limited premiums for beneficiaries with incomes above the poverty line to 2 percent of income on the rationale that they would pay similar premiums in the marketplace.

  Allowing the state to charge beneficiaries selecting this option premiums of 3.5 percent would result in them paying *higher* premiums than those with similar incomes in the marketplace. There is no reasonable demonstration purpose or policy rationale for this. Instead, it seems that the purpose is to punish people for remaining eligible for and staying enrolled in Medicaid coverage, a rationale that is inconsistent with the purpose of the Medicaid program, the ACA's Medicaid

[9] Bill Wright, et al, "The Impact of Increase Cost-Sharing on Medicaid Enrollees," *Health Affairs,* 24, no.4, (2005): 1106-1116.

[10] See Wisconsin Department of Health Services Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings," available online at: http://www.dhs.wisconsin.gov/MAreform/report12.11.12.pdf Wisconsin Council on Children and Families, "Evaluation of Last Year's BadgerCare Changes Makes Strong Case Against New Waiver," September 4, 2013, available online at: http://wccf.org/pdf/BadgerCare_changes_evaluation.pdf.

expansion, and the purpose of 1115 demonstration waivers under the Social Security Act.

- ***Increasing aggregate cost-sharing limits to 7 percent of income will result in a financial hardship on enrollees*.** Per 42 CFR 447.78, the total aggregate amount of cost sharing (premiums and copays) may not exceed 5 percent of a family's income on a monthly or quarterly basis. Michigan is seeking, in an unprecedented move, to waive this provision of Sec. 1916 of the Social Security Act and lift the aggregate cap to 7 percent. This will result in significant financial hardship for low income Medicaid enrollees. The enrollees who will be most affected by this are those who are the sickest and therefore use (and need) health care services the most.

  The effect of cost-sharing in Medicaid, and its disproportionate impact on those who need care the most, was discussed and documented as recently as July of this year in a report from the Department of Health and Human Services Office of the Assistant Secretary of Planning and Evaluation.[11] We urge CMS to consider the findings of that report and not allow an increase of total cost-sharing to 7 percent.

- ***Responding to public comments on hardship exemptions.*** The request fails to note whether hardship exemptions will be allowed for premiums and cost-sharing limits. Several commenters at the state level suggested inclusion of hardship exemptions and that has been part of demonstrations in other states. For example, in Iowa's 1115 Medicaid expansion waiver enrollees who are charged premiums can self-attest to financial hardship by checking a box on a form. The state's request should respond to those comments and include a broad hardship exemption in this program, covering both premiums and aggregate cost-sharing limits.

- ***Wellness programs:*** The amendment notes that cost-sharing requirements "may be reduced" if healthy behavior activities criteria are met, but scant detail is provided about what these criteria would be. We urge CMS to ensure that any final agreement establishes specific criteria for how cost sharing requirements are reduced through healthy behavior incentives. Further, these incentives ought to be based on proven methods of improving health outcomes in Medicaid and/or explain the demonstration rationale for new approaches.[12] We strongly object to measures tied to enrollees' health care costs or meeting particular health measures (e.g.,

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[11] Lauren Frohlich, et al, *Financial Conditions and Health Care Burdens of People in Deep Poverty* (Washington, D.C.: Department of Health and Human Services, July 2015) available online at http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty.

[12] See for example J. Schubel and J. Solomon, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility," Center on Budget and Policy Priorities, April 9, 2015, available at http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing.

target BMI or cholesterol levels). Additional detail should be provided on the measures that will be considered, how they will affect cost-sharing, and program evaluation.

Additional areas where more detail is necessary.
There are many areas that lack critical details around program operation.

- ***It is unclear how the 48-month trigger will be calculated or administered.*** As outlined above, we believe that the 48-month trigger is inconsistent with the Medicaid statute and approval of this change is outside of CMS's authority. That said, the proposal as submitted lacks detail as to how the state will administer the 48-month trigger.

    - Calculation of the 48-month trigger. The waiver application does not clearly outline how the state will calculate the 48-month trigger. It is unclear whether the trigger refers to enrollees who have met both criteria for 48 months, i.e., both had an income between 100 and 138 percent and been enrolled in the Healthy Michigan program; or, enrollees who happen to be in that income level when they reach 48 cumulative enrollment months. This should be clarified. Requiring that enrollees meet both conditions simultaneously for 48-months can be supported by and is consistent with the legislation.[13]

    - Impact of income changes. Similarly, it is unclear what happens to an enrollee in Option 1 or Option 2 if their income falls below the target range. The state is not asking to change cost-sharing, premiums, or use premium assistance for enrollees with incomes below 100 percent of poverty. This indicates that once an individual's income falls below 100 percent of poverty, they will be immediately transferred into the standard Healthy Michigan program. That should be clarified. If that is not the case, additional waivers will be needed.

    - Opportunities to switch options. There is a considerable lack of detail surrounding this process of passive enrollment in Option 2 and affirmative choice between Option 1 and Option 2. The request is not clear on whether, or

[13] The enabling legislation appears to anticipate that both requirements be met for 48 months. It reads: "individuals who are between 100% and 133% of the federal poverty guidelines *and* who have had medical assistance coverage for 48 cumulative months beginning on the date of their enrollment into the program described in subsection (1) to choose 1 of the following options…" (emphasis added). Use of the word "and" indicates that the intent is for individuals to meet both the income and the time-on-program requirements simultaneously, with "beginning on the date…." simply clarifying that the 48-months applies to enrollment in Healthy Michigan, as opposed to other medical assistance programs. In the drafting, it appears that the realities of income fluctuations among low-income individuals were not considered.

if, after being passively enrolled into Option 2 an individual would be able to switch again to Option 1, and the timeframe for doing so. Generally, Medicaid managed care enrollees may switch at between plans any time during the first 90 days of enrollment and the states open enrollment period. However, for this program, where low-income enrollees may experience unexpected financial hardship if their health care needs change, more flexible opportunities to switch plans should be allowed. Options for switching should be clarified.

- ***Insufficient detail on application of the aggregate cost-sharing limit.*** While we do not believe that CMS should approve the requested increase in the aggregate cost-sharing limit, we note that the request lacks needed detail. It fails to specify whether the cap will be applied monthly or quarterly. Out-of-pocket limits tend to disproportionately affect those with high health care needs. Those with chronic conditions are affected throughout the year. Calculating the cap monthly will give individuals relief from cost-sharing sooner and is in line with longstanding Medicaid law.

- ***Budget neutrality*****.** It is likely that Michigan's proposed amendment would have significant budget consequences. Extensive tracking of income, beneficiary education counseling, the adverse effects of moving between Medicaid and marketplace coverage, and other consequences of the proposed changes to Healthy Michigan will likely increase administrative costs and could increase health care costs, as well. GAO cited HHS for failing to ensure budget neutrality in the approval of Arkansas 1115 premium assistance demonstration, and we believe HHS is showing similar lax application of budget neutrality rules by not requiring more detailed documentation from Michigan.[14] While not strictly required for a waiver amendment, we believe the change proposed represents a fundamental change to the waiver. It warrants a budget analysis specific to this option that is part of the public request.

- ***Evaluation.*** There is no mention of separate evaluation of this program to ascertain the impact on enrollees' coverage retention, continuity of care, ability to afford care, understanding of the program, understanding of and ability to access wellness options, and overall satisfaction. The changes proposed are of such import that they should be separately evaluated.

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[14] Memorandum from Katherine M. Iritani, GAO Director, Health Care to Hon. Orrin Hatch and Hon. Fred Upton, "Medicaid Demonstrations: HHS's Approval Process for Arkansas's Medicaid Expansion Waiver Raises Cost Concerns," August 8, 2014 available online at http://www.gao.gov/assets/670/665265.pdf

Michigan's proposed waiver amendment would make considerable changes to the highly successfully Health Michigan Plan. We have several concerns with some of the specific requests which we have outlined in these comments. Additionally, the request lacks the detail needed for complete comments, and the planning and evaluation components necessary for full public engagement. We have outlined areas where greater detail is required in any approval.

We urge CMS to work with Michigan to arrive at a waiver agreement that continues the state's Medicaid expansion while maintaining the integrity of the Medicaid program, both for the state of Michigan and other states considering Section 1115 Medicaid expansion waivers.

Thank you for your consideration. Should you have any questions, please don't hesitate to contact Dee Mahan, Medicaid Program Director, at dmahan@familiesusa.org or Andrea Callow, Senior Policy Analyst, acallow@familiesusa.org.

Sincerely,

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