December 18, 2013

The Honorable Kathleen Sebelius
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

By E-Mail to: Kathleen.Sebelius@hhs.gov

Re: Comments on Michigan amendment to the state's Section 1115 Adult Benefits Waiver Demonstration Program

Dear Secretary Sebelius:

Families USA greatly appreciates this opportunity to comment on Michigan's requested amendment to its 1115 Adult Benefit Waiver Demonstration Program. We recognize that, as an amendment to an existing waiver, you are not technically required to provide an opportunity for public comment. We want to thank you for opening the process to public comment, particularly given the magnitude of the program changes proposed and the large number of Michigan residents who will be affected.

We are a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans, particularly those with the lowest incomes. We are committed to seeing Michigan expand Medicaid eligibility. We support Michigan's decision to accept federal funding to extend Medicaid coverage to more low-income parents and adults.

We commend the state on many aspects of its waiver application.

We are pleased to see that Michigan plans to use its existing Medicaid structure to provide benefits to those who will gain eligibility. We agree with the state's assessment that using the existing Medicaid structure for Healthy Michigan will reduce the disruptions in care that can occur as individuals move from one Medicaid coverage category to another. We also believe that, over the long-term, this approach will be more cost-effective than alternatives, such as premium assistance.

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We are extremely pleased with the depth and breadth of the coverage that Michigan is choosing to offer to those gaining eligibility. The state has developed an Alternative Benefit Plan that will increase the likelihood that enrollees will have access to the services that they need to lead healthier, higher quality lives.

We are very supportive of Michigan's proposed enrollment strategy. Because Michigan's Medicaid expansion will not be in sync with open enrollment for the new Marketplace, the state will have enrollment challenges. We are pleased to see the state's proposal to identify applicants back to October 1, 2013 and mine that data for people who may have been denied but would be eligible for Healthy Michigan. We are also pleased that the state appears to have given considerable thought to transitioning individuals currently covered by the adult waiver program so that disruptions in care will be minimized.

However, we have some concerns with certain aspects of Michigan's program design. Specifically, we are concerned with the Michigan Health Account structure, the imposition of monthly payments on individuals no matter how low their income, and the lack of detail on both the penalties for non-payment of the monthly cost-sharing and the elements of the wellness incentives. Our concerns are discussed more fully below.

Michigan Health Account

We have concerns with the proposed use of Michigan Health Accounts and the potential impact on enrollees' use of care.

We are pleased that individual accounts will be funded so that enrollees will receive the health services that they need. However, we are concerned that the account structure establishes a framework that could, in the future, lead to health savings accounts that do not include the assurance that all costs of care will be covered. We recognize that is not the case with this proposal. We wish, however, to place on record our concerns about the potential evolution of this approach, and to urge CMS to be vigilant in guarding against future proposals that would result in higher-out-of-pocket costs on low-income beneficiaries.

Regarding the specific elements of the Michigan Health Account in this waiver application, we have the following concerns.

Account statements may negatively affect appropriate service use. We agree that moving toward price transparency is important to reduce health care spending. However, most individuals without medical training do not have the knowledge to appropriately manage their medical care and health care costs, nor should they be expected to. For most consumers, the majority of health care decisions, particularly those involving use of high-cost procedures, are driven by choices of referring or treating physicians rather than consumer choice. While it is important that consumers *and* treating providers have price information, we are skeptical that the proposed account structure will result in consumers using health care services more wisely. We are concerned that the proposed quarterly account statements could create anxiety and confusion among enrollees that might cause them to delay or avoid necessary care.

From the description in the waiver application, it appears that the quarterly statements will include not only information on enrollee cost sharing, but also information on the cost of services used to date and "amounts available in the account…" (waiver application page 8). The presentation of "amounts available" might lead some enrollees to believe that they are responsible for managing their health care spending within that amount and that they will be financially responsible for costs exceeding account amounts. This could cause some enrollees to forego necessary treatment. Such decisions could ultimately increase, rather than decrease, the cost of care. We therefore propose some mitigation strategies below.

Incorporate enrollee education and require evaluation of the impact of the accounts. We urge CMS to work with the state to develop statements designed to minimize enrollee confusion and ensure that enrollees understand that they will not be responsible for costs of care in excess of account amounts. Statements should include a clear and conspicuous statement (bold, larger font, boxed/colored text) indicating that individuals will not be financially responsible for costs of care that is in excess of the account amounts. The state should also make available a toll free number for enrollees to call if they have questions about their account statement.

We also urge CMS to require the state to include a strong education component as part of the enrollment process to help ensure that enrollees understand their monthly statements, use that information appropriately, and understand that needed health care will be covered. As part of program evaluation, we recommend that the state be required to evaluate the impact of the health accounts. Such an evaluation should include an assessment of enrollees' understanding of the account information and the effect of the accounts on enrollees' health care use.

Premiums and Monthly Cost-Sharing Contributions

As a rule, we oppose the imposition of premiums and cost-sharing on very low-income individuals. Monthly premiums can make it difficult for individuals to retain coverage. Cost-sharing can cause individuals to limit needed care.[1]

We continue to have concerns with the impositions of premiums on Medicaid enrollees below 150 percent of poverty. We are pleased that program termination will not be a penalty for non-payment of premiums. Nevertheless, we are concerned that the imposition of premiums for enrollees with incomes from 100 to 138 percent of poverty may lead some individuals to drop coverage.

There is ample evidence that monthly payments make it difficult for low-income individuals to retain coverage. 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.[2] The 3 percent of income premium for this slightly higher income group is an amount roughly comparable in financial impact to the 2 percent premiums proposed for the 100 to 138 percent of poverty group in Healthy Michigan. We suggest that the Special Terms and Conditions include requirements for the state to evaluate the impact of premiums on individuals' ability to retain coverage.

Monthly cost-sharing is comparable to premiums. As noted above, we have serious concerns with monthly contribution requirements for low-income individuals, and particularly for individuals with incomes below the poverty level.

The proposal's monthly cost-sharing obligations function, in effect, like premiums regardless of what they are called. It is a long-standing Medicaid policy to not impose premiums on individuals with incomes below the poverty level.

Recurring monthly payment obligations can make it difficult for individuals to keep coverage. Yet this proposed program would impose monthly payment obligations on individuals at all income levels, even those with no income at all. Because payment requirements will increase as individuals use more care, the financial strain will be most severe on individuals with the greatest health care needs.

We recognize that this proposal does not include disenrollment as a penalty for non-payment. Nevertheless, the mere presence of monthly payment requirements can deter

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

[2] 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.

very low-income individuals from enrolling or staying in the program. Furthermore, we are concerned that the proposed change in the application of cost-sharing sets a framework for moving to premiums with disenrollment penalties for these very low-income Medicaid enrollees at some point in the future.

Careful evaluation of the impact of monthly cost-sharing should be required. If this approach is approved, we suggest that there be some requirements and clarifications to minimize the potential negative impact on enrollee access to care.

- **Clarify that the state will not charge beneficiaries cost sharing in excess of what the state could have charged without the waiver.** We are pleased that Michigan's proposed cost-sharing amounts fit within the limits of section 1916 of the Social Security Act and the July 2013 cost-sharing regulations.[3] We would have greater concerns if Michigan were proposing cost-sharing amounts that exceeded those limits. Because added cost-sharing can impose a burden on Medicaid enrollees, Congress included additional safeguards and requirements state must meet if they want to use more onerous forms of cost-sharing. These additional safeguards are outlined in section 1916(f)(1) through (5) of the Social Security Act. Michigan is not proposing to follow those requirements. Therefore, we urge that waiver approval include an assurance that Michigan will not increase cost sharing beyond what the state could charge without a waiver.

- **Require a careful evaluation of the impact of this cost-sharing structure on access to care and coverage retention.** We urge CMS to require the state to incorporate a rigorous evaluation of the impact of the monthly cost-sharing contribution. We recommend that such an evaluation include an assessment of:

    - Enrollees' understanding of both their cost-sharing obligation and the fact that failure to meet cost-sharing payments would not result in program termination.
    - The impact of monthly cost-sharing on enrollees' service use. This should include an evaluation of any negative impact on access, such as delays in necessary care, and a comparison with service use and access under point-of-service cost-sharing.
    - The financial burden that monthly payment requirements place on enrollees, and a comparison with traditional point-of-service cost-sharing.
    - The impact of the monthly payment obligations on program enrollment and retention, including gathering information from individuals who drop coverage to ensure that individuals are not leaving the programs because they cannot meet monthly cost-sharing obligations.

    We recommend that the evaluation look at how the proposed monthly payment

[3] Medicaid and Children's Health Insurance Program, 78 Fed. Reg. 42160, 42307 (July 15, 2013).

structure affects individuals at different income levels and with different levels of medical need. We urge that evaluation results be reviewed after one year of monthly cost-sharing and that the program structure be revisited at that time based on evaluation findings.

Minimize the non-payment penalty. As stated above, we are please that there is not a disenrollment penalty for non-payment of monthly cost-sharing obligations. However, we have concerns with the range of penalties noted in the waiver application, which included withholding tax refunds or placing an individual's name on a list. Depending on circumstances, either option could have a significant adverse effect on low-income individuals.

We strongly urge CMS to obtain clarification regarding non-payment penalties prior to approving the waiver. Penalties should not place extremely low-income individuals at a further financial disadvantage, which would clearly be the case if the state were allowed to seize tax refunds. Additionally, penalties should not be structured in any way that might create a record that could make it more difficult for individuals to obtain or retain employment, get credit, execute a lease for housing, or otherwise take steps that might improve their personal financial situation.

Ensure that the health plans do not disenroll individuals for non-payments. The proposal removes cost-sharing collection from providers and places that responsibility with the managed care plans. The waiver indicates that the state will assure that no enrollee is terminated from the program for failure to meet monthly cost-sharing obligations. However, we suggest that safeguards be in place to ensure that plans do not terminate individuals for non-payment. We urge CMS to require that Michigan's managed care contracts include specific language stating that plans cannot terminate Healthy Michigan enrollees for failure to meet their cost-sharing obligations. All plan-generated notices to enrollees must clearly and conspicuously state that no Healthy Michigan enrollee can be terminated from the program for failure to pay monthly cost-sharing amounts.

Ensure that the health plans do not aggressively seek cost-sharing payments*.* We also urge CMS to stipulate that Michigan's contracts with its Medicaid managed care plans clearly state that plans are not authorized to pursue any collection procedures that would pose additional hardships on enrollees. This includes turning accounts over to collection agencies or other actions that could have a negative impact on enrollees' future financial status, or actions that would increase the likelihood that enrollees will terminate coverage..

Clarify treatment of cost-sharing for individuals with chronic conditions and for wellness requirements. Page 12 of the waiver application states that wellness incentives will be designed to "address the current health status of all beneficiaries….including those dealing with chronic conditions." This implies that cost-

sharing might be waived for treatments related to chronic conditions, such as heart disease or diabetes. We support such a policy, and believe it should be an explicit component of the waiver. Waiving cost-sharing for treatments related to chronic conditions will increase the likelihood that enrollees will comply with treatment regimes which can reduce overall health care costs.

Similarly, it is unclear whether cost-sharing will be waived for visits or other services that are required to meet the wellness program requirements. We understand that there is no cost sharing for preventive services. However, to the extent that services required to meet the "healthy behaviors" requirements are outside of the definition of preventive services, we strongly urge that cost-sharing be waived, and that this policy be explicitly stated in the final waiver approval.

Incentives for Healthy Behavior

We appreciate that the state trying to encourage healthful behaviors among enrollees. Nevertheless, designing wellness incentives that truly work can be difficult. Programs that are not properly designed can create barriers to care. Therefore, we urge that you require Michigan to submit a detailed protocol outlining the wellness program requirements before this aspect of the waiver goes into effect.

Healthy behaviors should be defined. We are please that the Michigan Department of Community Health plans to work with stakeholders to define standards of healthy behavior. Additionally, we are pleased that the waiver request indicates that incentives will be "innovative, evidence-based and population focused." However, more detail about the potential requirements for meeting the "healthy behaviors" should be provided.

We support encouraging all beneficiaries to have a health risk assessment, to identify unhealthy behaviors, and to take steps to improve health status. However, a program based on outcomes measures, such as successful weight loss (as opposed to participating in a weight-loss program) is unwise, particularly for low-income people.

Using outcome measures can create barriers to care. Individuals with the most significant health care and personal challenges will generally have the most difficulty meeting the measures. As a result, they may become discouraged and avoid contact with the health care system. This can result in health problems becoming worse, rather than improving.

We urge CMS to work with the state to develop an incentive program that is based on things like participation in education and health improvement programs rather than

outcomes measures.[4]

Alternatives to financial rewards may result in greater compliance. Michigan is proposing to reward individuals who meet the program's healthy behaviors measures by reducing their monthly payments. We believe that there are approaches other than financial penalties that will better encourage individuals to engage in behaviors that will benefit their health. These approaches tend to reward individuals with specific health risks for engaging in specific behaviors that should improve their health, rather than penalize a general population for non-compliance with generic obligations.

Promising examples of such programs include those under development through the Medicaid Incentives for the Prevention of Chronic Disease Grant Program. For example, Minnesota Medicaid's Medicaid Incentives for Diabetes Prevention Program offers Medicaid patients diagnosed with pre- diabetes or with a history of gestational diabetes the opportunity to participate in an evidence-based Diabetes Prevention Program offered in a community based setting. Child care and transportation are provided. Participants can earn incentives like cash uploaded onto a debit card or membership to the YMCA for attending classes and meeting weight loss goals.[5] Connecticut Medicaid's Incentives to Quit Smoking program provides cash incentives to encourage enrollees to use tobacco cessation services and quit smoking.[6]

If Michigan retains its wellness plan structure that is based on cost-sharing reductions as reward, we urge that CMS work with the state to see that positive rewards can also be incorporated into the program.

Program evaluation should assess effectiveness. We recommend including in the program evaluation an assessment of the effectiveness or lack thereof of the wellness incentives. This evaluation could be conducted in part through enrollee surveys. Enrollees who do complete the wellness requirements should be surveyed to determine if the possibility of paying premiums was a factor to encourage them to complete the requirements. Enrollees who do not complete the wellness requirements should be surveyed to determine why they did not or could not complete the requirements.

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[4] Lydia Mitts, *Wellness Programs: Evaluating the Promises and the Pitfalls,* (Washington, D.C., Families USA, June 2012), available online at http://familiesusa2.org/assets/pdfs/health-reform/Wellness-Programs.pdf.

[5] Minnesota Department of Human Services, *RFP for Qualified Grantees to Offer Diabetes Prevention Program to Eligible Medicaid Recipents as part of the Minnesota Medicaid Incentives for Diabetes Prevention Program.* (August 6, 2012). Available online at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_170774.pdf Minnesota Department of Human Services, *Appendix 4a (Reading Level 6.9) We Can Prevent Diabetes in Minnesota Consent Form.* Available online at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_171439.pdf.

[6] Center for Medicare and Medicaid Innovation, *MIPCD State Summary: Connecticut*. Available online at: http://innovation.cms.gov/Files/x/MIPCD-CT.pdf.

Thank you for considering our comments, and again, thank you for the opportunity to comment on this important waiver amendment. If you have any questions or would like additional information, please contact Dee Mahan, at dmahan@familiesusa.org, or 202-626-0622.

Respectfully submitted,

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