FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

October 15, 2015

The Honorable Sylvia Mathews Burwell, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Montana's Section 1115 Waiver Application, Health and Economic Livelihood Partnership (HELP) Program

Dear Secretary Burwell,

Thank you for the opportunity to comment on Montana's Section 1115 Medicaid expansion HELP program waiver.

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 Montana's decision to extend Medicaid coverage under the Affordable Care Act (ACA) through the HELP program to cover as many as 70,000 Montanans. However, the proposal includes provisions that would place an undue financial burden on enrollees, particularly those below the poverty line.

We hope that CMS and Montana can successfully negotiate a waiver agreement that allows HELP program implementation such that enrollees– especially those with incomes below the poverty line – do not face undue financial burden, and which is compatible with the goals and objectives of the Medicaid program.

There are provisions in Montana's enabling legislation, SB 405, that are not included in its waiver application and that are deeply concerning to us.[1] Specifically, the application does not address either the "taxpayer integrity fee," which appears to apply a substantial premium to some HELP enrollees based on assets, or the "lock-out" period for individuals above poverty who are dis-enrolled for failure to pay premiums. Both of those provisions are in the HELP legislation. Because these provision were not included in Montana's application, we are not commenting on them in detail and are assuming that they will not be part of Montana's Medicaid expansion. In its approval, CMS should make clear that its approval relates *only* to the

[1]Montana SB 405 http://leg.mt.gov/bills/2015/billpdf/SB0405.pdf

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Medicaid program elements submitted and that any changes, modifications or additions must go through the waiver application process.

Should Montana seek to implement either of these provisions, a waiver application would be required for the reasons outlined below.

- ***The taxpayer integrity fee.*** For the following reasons, we believe that a waiver application is required before the state can implement the integrity fee.

    - The integrity fee outlined in the legislation is a monthly payment, based on assets, that is triggered by receipt of Medicaid benefits. Regardless of the name applied to the fee, as a monthly fees that would only apply to individuals enrolled in Medicaid through HELP, it is essentially a premium.[2] Other states that have monthly fees not labeled as premiums appropriately submitted those fees for review and approval prior to implementation (e.g., Indiana's POWER Account Contribution and Michigan's MI Health Plan co-pay contribution.)
    - Even though the fee is not a condition of eligibility and non-payment does not result in disenrollment, approval is still required. Iowa, Arkansas and Michigan sought approval for monthly fees based on Medicaid enrollment that accrue as a debt to the state upon non-payment but do not implicate disenrollment from the program for failure to pay, similar to the provision outlined in the HELP legislation. Should Montana seek to implement such a program element it must likewise gain approval from CMS.

- ***"Lock-Out" provisions.*** Montana's enacting legislation also includes a provision that would allow for disenrollment of individuals above 100 percent FPL for failure to pay premiums, and would not allow them to re-enroll until those back premiums were collected. This potentially indefinite "lock-out" period raises grave reasonable promptness concerns and cannot be implemented without CMS approval. Both Pennsylvania and Indiana sought lock-out periods for non-payment of premiums and we refer to our comments on those state waivers regarding the policy and legal implications of lock out periods.[3]

Our specific comments on the components of the proposed waiver follow:

[2] Section 1916A of the Act 42 USC 1396o-1 "Premium.—The term "premium" includes any enrollment fee or similar charge."

[3] See Families USA's comments on 1115 Medicaid expansion waiver proposals for Pennsylvania and Indiana (filed April 10, 2014 and September 19, 2014)

Charging premiums and maximum nominal co-pays to expansion enrollees at all levels of poverty serves no demonstration purpose and is incompatible with the goals of the Medicaid program

Montana's waiver seeks to impose a 2 percent premium on ALL enrollees coupled with maximum out of pocket cost sharing. Such cost-sharing will represent a serious financial hardship for Medicaid enrollees, and is not in keeping with the purposes of the Medicaid program to provide health insurance and access to health care for low income people.

The imposition of premiums serves no demonstration purpose and is not in keeping with the goals of the Medicaid program. As we have noted in our comments on 1115 waivers in Iowa[4], Arkansas[5], Michigan,[6] Pennsylvania[7] and Indiana[8], premiums do not serve a demonstration purpose. The impact of premiums on low-income people is well documented.[9] Even assuming there is a hypothesis and demonstration purpose behind assessing premiums on Medicaid expansion enrollees, this hypothesis is already being tested in several states.

Montana's proposed out-of-pocket expenses are significantly higher than has been approved in any other state for people below poverty. In Iowa and Arkansas, approval of a $5 monthly contribution was approved for people between 50 and 100 percent of poverty. In Indiana, individuals down to 0 percent of poverty may pay a monthly premium of two percent. But, they are given the option of enrolling in a zero premium benefit plan option. In Montana, by contrast, all enrollees are subject to a 2 percent premium payment AND maximum cost-sharing. This will set a dangerous precedent for out-of-pocket cost sharing that could foreseeably lead

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[4]Families USA Comments on Section 1115 Waiver related to Iowa Health and Wellness and Iowa Marketplace Choice Plans (Sept. 26,2013) http://familiesusa.org/sites/default/files/documents/Families%20USA%20Iowa%201115%20Comments%209-26-13.pdf

[5]Families USA Comments on Section 1115 Waiver related to Arkansas Health Care Independence Program (Sept. 7, 2013) http://familiesusa.org/sites/default/files/documents/Families%20USA%20AR%201115%20Comments%209-7-13.pdf

[6]Families USA comments on Michigan Section 1115 Waiver Healthy Michigan Program (December 18, 2013) http://familiesusa.org/sites/default/files/documents/Families%20USA%20comments%20Michigan%201115%20Adult%20Benefit%20Waiver%20amendment.pdf

[7] Families USA comments on Pennsylvania Section 1115 Healthy Pennsylvania Program (April 10, 2014) http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20Healthy%20Pennsylvania%201115%20waiver%20request.pdf

[8]Families USA Indiana Section 1115 Waiver HIP 2.0 Program (September 19, 2014) http://familiesusa.org/sites/default/files/documents/Families%20USA%20Comments%20HIP%202%200%201115%20waiver.pdf

[9]Office of the Assistant Secretary for Planning and Evaluation, "Financial Condition and Health Care Burdens of People in Deep Poverty," July 16, 2015, http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty

to efforts in other states to scale back critical enrollee financial protections in Medicaid expansions.

***High out of pocket costs for those below poverty, especially those below 50 percent of poverty, will pose a significant financial hardship to Medicaid enrollees*.** A recent ASPE report showed that people living in poverty, particularly deep poverty (below 50 percent FPL) tend to be less healthy and need more medical care than people with higher incomes.[10] Montana's premium structure would directly impact those in deep poverty. The report states

> "When subject to copayments and premiums, low-income individuals must decide whether to go to the doctor, fulfill prescriptions, or pay for other basic needs like child care and transportation. As a result of these daily tradeoffs, low-income individuals are especially sensitive to modest and even nominal increases in medical out-of-pocket costs." (p. 5)

Given the ample research on the harmful effect of cost sharing on low income people, particularly those in deep poverty, charging maximum premiums and cost sharing to all enrollees serves no demonstration purpose and is antithetical to the purposes of the Medicaid program.

Any final waiver approval that includes the requested premiums and cost sharing to all enrollees must include elements that will mitigate the financial hardship caused by premiums, cost-sharing and disenrollment penalties

We strongly disagree that high out of pocket cost sharing in the form of premiums and co-pays serves a demonstration purposes or is in keeping with the goals of the Medicaid program. However, should the requested premiums and cost-sharing be approved, we urge CMS to ensure there are adequate beneficiary safeguards and a robust evaluation process to document the effect such policies have on enrollment and access to care.

- The final waiver should include a program that will allow third parties to make premium payments on behalf of individuals

As was approved in Indiana's HIP 2.0 waiver, third parties should be permitted to contribute towards a beneficiaries premiums with no limits on the amount a third party may contribute. These third parties should include, but not be limited to, employers, foundations, hospitals, health clinics and other providers. We urge CMS to issue guidance to providers clarifying how premium contribution programs should be structured, and details on premium contributions interaction with Stark anti-kickback laws.

- The final waiver should include a hardship exemption for individuals unable to pay their premiums

[10] *Id.*

Families and individuals below the poverty line are, by definition, already living in economic hardship. If they are unable to pay premiums, they should have the opportunity to attest to that hardship and have premiums waived. Furthermore, there is precedent for hardship waivers in other states. Iowa provides a broad exemption, under which each monthly invoice sent to a beneficiary includes the opportunity to attest to financial hardship.[11] We recommend shaping an exemption application similar to Iowa's program; namely a simple application and monthly invoice to attest hardship. This allows for minimum administrative costs and resources and provides an easy to use and understand process for consumers.

- <u>The final waiver should include clarification on the "wellness program" individuals can engage in to receive an exemption from disenrollment.</u>

The Montana proposal says that certain populations with incomes above the poverty line "may be exempt from disenrollment if they engage in a wellness program" (page 2), but there is no information on how such a program would work. We urge CMS and Montana to develop a wellness protocol that is achievable by most people, like that in Michigan, in which beneficiaries have their co-payment obligations reduced if they see a primary care physician at some point during the year.

- <u>Cost-sharing should be calculated by household, not individual, and the five percent monthly cap should be calculated monthly, not quarterly.</u>

In an effort to minimize the impact of very high cost sharing on people in poverty and deep poverty, CMS should require the state to calculate the five percent aggregate household cap on a monthly rather than quarterly basis. Based on the unprecedented nature of the cost sharing scheme proposed in Montana, CMS should be proscriptive in its requirements for calculation of the cap to minimize harm done to very low-income people.

As the recent HHS ASPE report points out, people living in deep poverty are more likely to report fair or poor health, need multiple prescriptions and have multiple annual doctor and hospital visits.[12] By requiring the aggregate cap be calculated monthly, the state will ensure that those low-income individuals with high health care needs that meet their cap early will be able to access necessary care and medication in months two and three of the quarter.

<u>The application lacks specifics on who is an individual with "exceptional health care needs."</u>

Montana's proposal says that individuals who have a medical, mental health, or developmental condition, live in an area where there are an insufficient number of providers (such as an Indian reservation), or need coverage that cannot be delivered in the demonstration, will not be enrolled and instead get coverage in the state's regular Medicaid program (page 6). Such an exemption is a critical feature of this demonstration, and the special terms and conditions

[11] Iowa Health and Wellness Plan p. 41

[12] *Supra at Note 9*

should more clearly define what qualifies as an "exceptional" need and the process for determining when someone meets the standard.

We fully support the state's decision to implement the Medicaid expansion and, as stated at the outset of our comments, we hope that CMS and Montana can successfully negotiate a waiver agreement.

However, as proposed, Montana's waiver would set a new precedent for beneficiary cost-sharing and, as such, raises concerns. Additionally, the request lacks the detail needed for complete comments, and the planning and evaluation necessary for full public engagement. We have outlined some program elements that could mitigate some of the more troubling aspects of the state's requested cost-sharing and premium structure, should CMS consider approving that structure. These suggestions should in no way be considered an endorsement of the requested premium and cost-sharing.

Finally, as indicated earlier, we have not commented on those items included in Montana's enabling legislation that are not included the waiver. We believe that an additional waiver is required before such programs can be implemented. Any approval should be clear that it is limited to the program as submitted for approval.

Thank you for the opportunity to comment on this important program. Should you have any questions, please don't hesitate to contact Dee Mahan, Medicaid Program Director dmahan@familiesusa.org or Andrea Callow, Senior Policy Analyst acallow@familiesusa.org .

Respectfully submitted,

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