FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

December 26, 2019

The Honorable Alex Azar
Secretary Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Re: Comments on Amendment 42 of the TennCare II Section 1115 Demonstration Waiver
Submitted electronically via *Medicaid.gov*

Dear Secretary Azar:

Families USA appreciates the opportunity to provide comments on Tennessee's proposed amendment to its Section 1115 Demonstration Waiver, known as TennCare II Demonstration. Families USA is a national, non-partisan health care policy and advocacy organization that supports policies and programs at the state and federal levels to ensure the best health and health care are equally accessible and affordable to all, with a particular focus on actions that affect lower-income individuals. Please note that in addition to my current role at Families USA, I was formerly the group director for the State Demonstrations Group at the Centers for Medicare and Medicaid Services.

Under this amendment to its Section 1115 Waiver, Tennessee proposes a dramatic restructuring of its Medicaid program and we urge you to reject the proposal in its entirety. A change of this magnitude necessitates a clear and detailed description to allow the public a chance to meaningfully provide comment. Unfortunately, this proposal does not meet this standard. Tennessee's proposal is unreasonably vague, preventing us from providing meaningful comment on key components of this proposal. As such, these comments will– at a high level – focus on the provisions that are legally problematic and poor policy choices. The provisions that fail to meet federal requirements and would harm TennCare beneficiaries are discussed in greater detail below.

Comments on Specific Provisions in the Amendment Request

1. The Block Grant Puts Families at Risk

Families USA is seriously concerned with Tennessee's proposal to end the 50-plus year federal guarantee of matching each states' actual Medicaid spending, passing risk and costs onto the state government, taxpayers, and TennCare beneficiaries. A basic concept of the Medicaid program is that it provides federal funds that match a state's needs and spending. The federal matching structure protects children, pregnant women, seniors, people with disabilities, and working families who rely on Medicaid from being caught in the middle of political, public health, or financial showdowns. Tennessee's proposed block grant caps the amount of federal funds available for four categories of beneficiaries: children, adults, elderly people, and disabled people, affecting nearly all of the 1.4 million TennCare enrollees. The state's proposal forgoes the protections of a federal

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matching structure in favor of a defined federal contribution or "block grant amount" that places the state in the position of having to pay any Medicaid expenditures above the cap with state-only funds. If the state exceeds this cap, it is forced to decide between cutting benefits and coverage or raising taxes to cover the additional cost.

The state's proposed "shared savings mechanism" component of the block grant further incentivizes the state to cut beneficiaries' benefits and coverage. As described in greater detail below, this financial gimmick would award half of all unspent federal dollars below the capped block grant amount to the state. The state is requesting new "flexibilities" that would be better described as an unchecked authority to cut enrollment, services, and benefits in order to reduce spending below the capped block grant amount and generate savings. The clear loser here is TennCare beneficiaries.

This proposal puts the health and wellness of Tennesseans in jeopardy, is contrary to federal law, and is not in the state or federal government's best interest. CMS should not approve this request.

Per Capita Adjustment Does Not Protect Against Financial and Public Health Vulnerabilities

Unlike a traditional block grant, Tennessee's proposal includes a one-way "per capita adjustment" for changes in enrollment levels. This provision would increase the block grant amount if enrollment exceeds the 3-year average, but would not reduce funds if enrollment decreases. In conjunction with the "shared savings mechanism," this structure presents the state with a perverse incentive to hold down or reduce enrollment levels in order to keep spending below the capped block grant amount and generate shared savings. The result will likely be a "fox guarding the henhouse" scenario, in which the state uses its well-established pattern of paperwork barriers to cut enrollment and generate savings. Tennessee has a history of non-compliance with Medicaid requirements that resulted in over 150,000 people losing coverage in 2018.[1]

The one-way per capita adjustment does attempt to address *upward* fluctuations in enrollment levels, but it insufficiently protects the state from variabilities in the health care system, such as cost increases, workforce changes, or public health crises. Right now, federal support automatically changes to match a state's spending and needs. Federal support increases if a state's per capita costs go up, like with an opioid epidemic, natural disaster, or in the event a state decides to cover new medical treatments for its residents. In contrast, Tennessee will face an awful choice in the event of health care cost trends that exceed their proposed inflation rate or a public health crisis under this proposal. This problem is likely to get worse once an inflation rate is negotiated with CMS, given the Trump administration's clearly stated goal of using block grants to drastically cut federal Medicaid spending.

This scenario is not theoretical. Puerto Rico's experience with capped Medicaid funds shows that it is a dangerous proposition for Medicaid beneficiaries. Hurricanes Maria and Irma showcased the harms of a block grant. But it is not just natural disasters. The block grant approach has disadvantaged Puerto Rico and forced financial hardship as they address issues such as workforce shortages, escalating costs, aging populations, and public health crises.

[1] https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf

Given Tennessee's intent to relinquish federal financial support that protects against these types of fluctuations in the health care system, the state should have acknowledged this vulnerability and explained how they would address it. However, the state remained silent on this issue in their application, never conducting analyses, such as:

- A comprehensive cost-benefit analysis of the proposal;
- A plan that demonstrates how the state would address common scenarios to which it would be vulnerable, such as a public health crisis that increases utilization of benefits/services or an unexpected increases in health care costs; and
- A detailed plan outlining the state's approach to maintaining services, benefits, and enrollment.

2. The Proposal is Full of Financial Gimmicks and Perverse Incentives

This proposal creates major new risks for state taxpayers, federal taxpayers, and TennCare beneficiaries. In an attempt to build in financial protections for the state, the proposal includes a number of gimmicks and perverse incentives that fail to advance the objectives of the Medicaid program.

<u>Shared Savings Mechanism Offers Impermissible Federal Funding Without a State Match</u>

If Tennessee can reduce Medicaid spending dramatically under a block grant using its new "flexibilities" to make cuts, the state's proposed "shared savings mechanism" would award half of the federal dollars saved to the state, which would essentially be used for state budget relief (described in more detail in the next section). The federal funds awarded to the state as part of the shared savings arrangement can be considered an unmatched bonus payment. CMS is awarding these funds in response to limited state spending that is already matched at the regular rate. Put simply, the federal government is awarding the state 50% of its own federal savings, while the state retains its own state savings. This amounts to 100% federal medical assistance, which violates the non-waivable section 1905(b)(1) of the Social Security Act, which states that "the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum." This provision is inconsistent with federal law and should be removed from the application along with the many other provisions that are contingent on approval of this provision.

<u>Uses "Costs Not Otherwise Matchable (CNOMs)" to Fill Budget Gaps</u>

As part of the "shared savings mechanism" described above, the state is proposing that it be awarded half of the federal dollars saved for state budget relief. On paper, Tennessee proposes to use those savings to re-invest into health within a few priority areas. In practice, states like Vermont have used this type of authority to cover existing spending not typically covered by Medicaid: that is, to save money in other parts of the state budget. Notably, the state does not provide details about these proposed investments. The fact that Tennessee is simply asking for a blank check with no strings attached from the federal government is problematic on its own terms. In this context, where the state has strong incentivizes to cut benefits and/or enrollment, the proposed "shared

savings mechanism" makes an already bad problem worse by intensifying the fiscal incentive to cut insurance eligibility and benefits.

Expends State Resources to Administer the New Approach

Tennessee is volunteering to change the way it administers Medicaid funds, which will require new expertise and resources. The state will need to manage its budget neutrality costs on an annual basis instead of a five-year basis. Shortening the budget time horizon exposes the state to annual costs that will likely not be recouped over a five-year period since it is unlikely that CMS will approve the "shared savings" approach described above. The state also is proposing to waive its ability to increase the per member per month spending and receive a federal match. These changes will not manage themselves. New efforts will require additional resources from state officials. These costs should be transparent, there should be a plan to evaluate these costs, and these costs should have been included in the budget neutrality analysis.

3. The Proposal Incentivizes and Streamlines the Process for Tennessee to Cut Benefits and Enrollment

The budget gimmicks described above give the state a significant incentive to cut benefits and enrollment. Tennessee says that "it is not the state's intention to reduce the benefits received by TennCare members" and further suggests "the state would not be permitted to use this authority to make reductions to its benefits package." However, this assurance is meaningless without significant oversight and accountability written into the waiver. The lack of a federal mechanism to review and approve changes and enforce violations makes this assurance hollow. At the same time, the state is using this waiver to gut existing federal oversight and accountability, requesting unprecedented "flexibilities" to limit benefits and impact enrollment without a transparent oversight process. The combination of financial incentives and limited oversight represents a major threat to beneficiaries in the state.

Allows Modification of Core Components of the Medicaid Program without Transparency or Oversight

The state proposes "flexibilities" to alter several elements of its Medicaid program "without seeking additional CMS approvals via State Plan amendments or demonstration amendments." Essentially, the state is requesting a blank check from CMS to make additional unspecified changes to its Medicaid program without complying with processes for federal oversight. Allowing the state to limit benefits without a transparent oversight process is dangerous. If the state exceeds their allotted block grant budget, this provision gives the state an "out" to cut or limit benefits. Given that CMS will continue to cover a majority of the cost of the state's Medicaid program, CMS should not relinquish its oversight of the state's program. We recommend CMS reject this provision.

Eliminates Oversight into the Managed Care Program

The state is requesting a blanket waiver of federal requirements related to Medicaid managed care in 42 CFR Part 438 to restructure its managed care delivery system. A waiver of all Medicaid managed care requirements in 42 CFR Part 438 would give the state authority to waive

requirements designed to protect beneficiaries' and their providers, such as prohibition of provider discrimination, network adequacy standards, actuarial soundness, beneficiary support systems, grievance and appeals processes, program integrity safeguards, sanctions, and parity in mental health and substance use disorder benefits.

As stated above, the "shared savings mechanism" incentivizes the state to generate savings at the expense of beneficiaries. A blanket waiver of Medicaid managed care requirements would allow the state to generate savings by cutting the infrastructure that protects managed care enrollees and by compromising their access to care.

The state provides *examples* of "unnecessary" federal requirements that could be waived with approval of this amendment, but does not explicitly list the specific requirements it would waive if the proposed amendment is approved by CMS. Because the state does not name the specific waived requirements, the impact on beneficiaries, providers, and managed care entities remains unknown. We request that CMS reject this request to eliminate managed care oversight.

Allows Adding or Eliminating Optional State Plan Benefits without Oversight

The state is requesting a waiver to cut or limit optional state plan benefits and place additional limits on mandatory benefits without federal oversight or approval. Waiving federal protections and unilaterally limiting benefits without a transparent oversight process is worrisome, especially given the state's proposal to share federal savings as part of its block grant. Under a "shared savings mechanism" the state is incentivized to generate savings by spending less than the allotted block grant amount. This "shared savings mechanism" incentivizes the state to cut benefits to spend less per beneficiary and thereby generate savings. At the same time, if the state exceeds the block grant amount, this provision offers the state with a pathway to cut or limit benefits and avoid assuming additional financial risk.

The state does not specify which state plan benefits would be added or eliminated if this waiver amendment is approved. As such, the impact on beneficiaries as well as the implications for federal and state funding remain unknown. Tennessee did not provide details on how its proposed waiver of 1902(a) would modify the "amount, duration, and scope" of specific optional and mandatory state plan benefits, how it would affect beneficiaries, and the impact on state and federal expenditures, limiting the public's ability to provide meaningful comment. As such, CMS should reject this proposal to cut state benefits without federal approval.

Permits Targeting Benefits for Certain Populations, but Doesn't Take Advantage of Existing Flexibilities

Tennessee proposes to waive 1902(a)(10)(B) comparability standards to provide targeted benefits to certain TennCare populations. The state justifies its request with an example that the state cannot provide targeted and limited dental benefit to pregnant women "unless the state has sufficient funds to provide dental services to all adults, the federal government will not allow the state to implement such a targeted benefit" and describes the 1115 waiver application process as "unnecessarily long and onerous." However, the state does not need a block grant or an 1115 waiver to provide a dental benefit to pregnant beneficiaries. Instead, the state can simply submit a

State Plan Amendment (SPA), as Virginia did in 2015.[2] We strongly encourage the state to pursue a SPA to provide dental benefits to pregnant women. Given that Tennessee is one of the few states that does not cover dental services for all adults in its Medicaid program, we also encourage the state to expand its Medicaid dental services benefit to cover adults.

A waiver of comparability to provide targeted benefits can potentially address or exacerbate health inequities among TennCare beneficiaries. Targeted benefits could focus on vulnerable populations that experience specific health inequities and require certain services, or targeted benefits could exclude certain populations that need those services the most. Additionally, since the state is proposed to "use block grant funds on public health initiatives that are not specifically targeted at the TennCare population," this could create a scenario in which TennCare beneficiaries receive limited benefits, while other populations (such as higher-income Tennesseans who earn too much to qualify for TennCare) benefit from the state's flexible use of federal funds. But again, since the state has not actually proposed a targeted benefits package or eligible populations, the effect of such a waiver remains unknown. The state failed to provide additional detail on what specific benefits and populations would be subject to the proposed waiver of comparability, limiting the public's ability to provide meaningful comment. As such, CMS should reject this proposal.

Allows Enrollment and Delivery Systems Changes without Oversight

The state is requesting flexibility to "modify enrollment processes, service delivery systems, and comparable program elements" without submitting additional waiver applications or state plan amendments to CMS for approval. This flexibility also represents a major threat to beneficiaries in the state given the state's proposal to share federal savings as part of its block grant. As stated above, the "shared savings mechanism" incentivizes the state to generate savings by spending less than the allotted block grant amount, which is based on projected enrollment. This incentivizes the state to reduce enrollment so that spending falls below the block grant amount, thereby generating savings.

Over the years, Tennessee's enrollment processes have failed to comply with federal regulations, which has resulted in massive drops in enrollment. Between 2013 and 2016, the state failed to update its eligibility system to comply with federal regulations, which caused thousands of Tennesseans to lose their Medicaid coverage, despite being eligible.[3] From 2016 until just recently, redeterminations could not be processed online, and the state attempted to mail and process lengthy paper renewal packets, which created paperwork barriers to enrollment for parents and their children.[4] Also contrary to federal law, the state failed to screen children for eligibility under other Medicaid categories before disenrolling them, resulting in children losing coverage despite qualifying under another category.[5] According to the Tennessee Justice Center's review of state records, paperwork-driven terminations ended health coverage for 220,000 children between 2016

[2] https://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/VA/VA-15-001.pdf
[3] https://familiesusa.org/sites/default/files/product_documents/Return_of_Churn_Analysis.pdf
[4] https://familiesusa.org/sites/default/files/product_documents/COV_Child%20Health%20Emergency_Report%20Part%20I.pdf
[5] https://ccf.georgetown.edu/2019/04/08/whos-minding-the-store-for-tennessees-children-who-rely-on-medicaid-and-chip/

and 2018.[6] Based on state Medicaid enrollment data, nearly 150,000 fewer beneficiaries were enrolled in Medicaid between December 2017 and December 2018.[7] New flexibilities to modify enrollment processes without federal approval will allow the state to continue its well-established pattern of cutting enrollment to generate savings.

The state notes that it contracts with multiple managed care organizations and health plans for the delivery of services, but provides no additional detail regarding what specific modifications would be made if granted these flexibilities, limiting the public's ability to provide meaningful comment. In any event, flexibility to make cuts does not promote the objectives of the Medicaid program. CMS should reject this proposal to modify enrollment processes and "comparable program elements" without federal approval.

Changes Requirements for Hospitals to Receive Uncompensated Care Funds

The state requests flexibility to "modify the participation criteria and distribution methodology associated with the state's two uncompensated care funds" without submitting additional waiver applications or state plan amendments to CMS for approval. Once again, the state provides an *example* of a possible modification: "condition a hospital's participation in one or both uncompensated care funds on its participation in outcomes- or quality-based payment initiatives," which could ultimately improve quality of care and outcomes for beneficiaries. However, the state does not commit to any specific modifications regarding how hospitals receive payments from uncompensated care funds, limiting the public's ability to provide meaningful comment. As such, CMS should reject this proposal.

Includes Extra Statutory Provision on Fraud Tied to Eligibility Loss

The state's new waiver proposal includes loss of eligibility for fraud. The state proposes to develop policies, but does not include those details in the proposal. It is concerning that the state is asking for a blank check to lock individuals out of the Medicaid program. There is not statutory basis for using Medicaid eligibility as a penalty for fraud.

4. Other Concerning Provisions

Offers Unprecedented Permanent Approval of TennCare 1115 Waiver

The state's amendment application includes a proposal for "CMS to approve of the TennCare 1115 demonstration waiver on a permanent basis and only require amendments to the waiver to go through the approval process." At the same time, as indicated above, the state is requesting to make additional changes to its waiver without submitting an amendment to CMS for approval. In combination, the state is effectively eliminating federal oversight of its waiver permanently, despite proposing a new funding structure that includes enhanced federal financial participation.

[6] https://www.tnjustice.org/wp-content/uploads/2019/07/How-Tennessee-Became-an-Outlier-in-the-Rising-Number-of-Uninsured-Children-and-What-Must-Happen-to-Reverse-the-Trend-1.pdf
[7] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html

To date, no Section 1115 waiver has received permanently approval as it runs counter to the very nature of the concept of a demonstration. On November 6, 2017, CMS released an informational bulletin[8] indicating that it "may approve the extension of routine, successful, non-complex section 1115(a) waiver and expenditure authorities in a state for a period up to 10 years." Given this proposal's variety of new requests, its lack of success in terms of complying with federal regulations, its intention to make additional changes without federal oversight, the complexity and novelty of its proposed block grant funding structure, and the fact that the state's proposal is an amendment and not an extension, the waiver can hardly be considered routine, successful, or non-complex. A permanent approval would be unprecedented and irresponsible. CMS should reject this proposal.

Attempts to Adopt a Closed Drug Formulary

The state is proposing to adopt a closed formulary to limit the number of drugs covered by Medicaid, particularly new drugs and drugs without "clinical benefit." The state proposes to negotiate with manufacturers to provide them with an "essentially guaranteed volume" of drugs in exchange for a larger drug rebate. This request will limit beneficiaries' access to beneficial drugs, is unlikely to generate a costs savings, and is should not receive CMS approval.

The state is requesting to waive 1902(a)(54) insofar as it incorporates section 1927. But section 1115 statute does not reference section 1927 (outpatient drugs), a statutory limitation that Tennessee's proposal simply ignores. The existence of 1902(a)(54) does not render 1927 non-existent or subject to 1115 waiver, which means section 1115 authority cannot be used to waive section 1927.
Even on its own legally dubious terms, Tennessee's proposal does not make sense from a policy standpoint. Massachusetts requested a similar 1115 waiver amendment in 2018 and was denied.[9] In its decision not approve Massachusetts' request, CMS noted that for a state to adopt a closed Medicaid drug formulary, it would have to first drop optional State plan drug coverage under section 1902(a)(54) of the Social Security Act and "forgo all manufacturer rebates available under the federal Medicaid Drug Rebate Program." Forgoing manufacturer rebates eliminates the possibility of the state controlling drug costs and generating savings by negotiating with manufacturers.

It is unlikely that any significant cost savings would result from adopting a closed formulary in Medicaid. For instance, Medicare Part D prescription drug plans can, with the exception of certain protected classes of drugs, implement closed formularies, but this has resulted in rebates that are much smaller than those in the Medicaid Drug Rebate Program. Additionally, though states cannot currently implement a closed formulary, they can use similar tactics to negotiate directly with manufacturers for supplemental rebates. Yet, such tactics have resulted in only small rebates on

[8] https://www.medicaid.gov/federal-policy-guidance/downloads/cib110617.pdf
[9] https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ma/MassHealth/ma-masshealth-demo-amndmnt-appvl-jun-2018.pdf

top of the required rebates.[10] This means that if this waiver were to result in significant savings, it could only do so by overly restricting access to needed and possibly even lifesaving medications for Medicaid beneficiaries.

The state proposes to implement a closed formulary to exclude new drugs that "have not yet demonstrated actual clinical benefit" from coverage new drugs with "limited or inadequate clinical efficacy." Although it is important that pharmaceutical manufacturers are incentivized to produce new and innovative drugs that meet critical health and public health needs, there is often therapeutic value in having multiple drugs for a given condition. Two drugs may have essentially the same effectiveness at a population level, but individual consumers may need or prefer to take one medication over another due to side effects, interactions with other medications or health conditions, or ease of adherence. Additionally, much of the evidence used to demonstrate a drug's clinical benefit is based on studies with overwhelmingly white participants, and there may be important differences in drug efficacy for people of color.[11] Therefore, we recommend CMS reject this provision, which does not promote Medicaid objectives.

Removes Beneficiary Notification and Communication Requirements

The state is requesting assurances from CMS that there will be no negative enforcement action taken against the state should it stop mailing minimum essential coverage notices to beneficiaries. The state claims that, because the individual mandate is effectively no longer enforced, these minimum essential coverage notices "no longer serve any useful purpose." However, minimum essential coverage notices still serve a useful purpose by informing beneficiaries of whether, depending on the type of Medicaid coverage they receive, they are eligible for premium tax credits or other savings to enroll in Marketplace insurance plans. For example, medically needy beneficiaries who qualify for coverage after incurring and spending down medical expenses as well as beneficiaries who receive limited benefits may qualify for subsidies to enroll in Marketplace coverage and should be made aware of their coverage options. For this reason, the state should continue to mail minimum essential coverage notices to beneficiaries. We therefore recommend CMS reject this proposal.

Conclusion

Overall, the state's vague application lacks a coherent, data supported rationale for its proposal; Tennessee has not shown how approval of the proposal will further the objectives of the Medicaid program. Indeed, it poses a grave threat to Medicaid coverage in Tennessee. The proposal would create overwhelming financial incentives for the state to cut TennCare eligibility and benefits.

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[10] Edwin Park, Center for Children & Families (CCF) of the Georgetown University Health Policy Institute, Trump Administration Medicaid Drug Rebate Proposal Raises Serious Concerns for Beneficiaries, Unlikely to Reduce Costs (Washington, DC: CCF, April 2, 2018), available online at https://ccf.georgetown.edu/2018/04/02/trump-administration-medicaid-drug-rebate-proposal-raises-serious-concerns-for-beneficiaries-unlikely-to-reduce-costs/.

[11] Esteban Burchard, Sam Oh, Marilyn Foreman, and Juan Celedón, "Moving toward True Inclusion of Racial/Ethnic Minorities in Federally Funded Studies. A Key Step for Achieving Respiratory Health Equality in the United States," American Journal of Respiratory and Critical Care Medicine191, no. 5 (January 2015), available online at https://www.atsjournals.org/doi/abs/10.1164/rccm.201410-1944PP?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed.

Furthermore, the proposal fails to address significant issues facing the state's program and misses an opportunity to make much needed improvements. This proposal:

- *Does Not Expand Coverage*: Tennessee is one of fourteen states that has not expanded Medicaid. The state could achieve a 90% federal match for 244,000 people rather than basing a block grant on their current 65.21% federal match rate. Instead of providing cost-effective coverage to more Tennesseans in need, the state's proposal incentivizes cuts to enrollment, benefits, or access for its current population.

- *Does Not Address Tennessee's History of Poor Program Management*: As discussed in greater detail below, Tennessee has history of aggressive policies that led to thousands of eligible beneficiaries losing their Medicaid coverage, including a large proportion of children.[12] These massive declines in coverage can be attributed to poor program management. Removing or limiting federal oversight into the Tennessee Medicaid program could allow this poor program management to continue, with disastrous consequences for beneficiaries.

- *Waives parts of Medicaid Law* **not** *Subject to Waiver*: Section 1115 waivers gives states broad authority to waive provisions. However, this proposal makes at least two requests that fall outside of the authority of the 1115 waiver authority. First, the language defining the matching rate appears in a section of the Social Security Act—section 1903—that the Secretary does not have the authority to waive. Second, in no way does the block grant proposal "assist in promoting the objectives" of the Medicaid program. Therefore, the Secretary cannot legally approve this request.

Instead of moving forward with this legally questionable waiver request that would result in devastating coverage and benefit losses, the state should focus on improving its Medicaid program by pursuing Medicaid expansion, improving its enrollment practices, and addressing health inequities and social determinants of health. We urge you to reject Amendment 42 in its entirety.

Thank you for your consideration of these comments. If you have any questions, please contact Emmett Ruff at ERuff@familiesusa.org or Joe Weissfeld at JWeissfeld@familiesusa.org or call 202-628-3030.

Respectfully submitted,

Eliot Fishman
Senior Director of Health Policy at Families USA

[12] https://familiesusa.org/wp-content/uploads/2019/09/Return_of_Churn_Analysis.pdf