April 10, 2014

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
330 Independence Avenue SW
Washington, DC 20201

Re: Proposed Healthy Pennsylvania 1115 Demonstration Project

Dear Secretary Sebelius:

The undersigned organizations appreciate the opportunity to comment on the proposed Healthy Pennsylvania demonstration project.

We support Pennsylvania's decision to accept federal Medicaid funding to extend coverage to low-income parents and adults. However, we have substantial concerns as to aspects of the proposal, which can and should be addressed during the approval process.

Pennsylvania's proposal to tie work-related activities to Medicaid participation should be rejected. The Pennsylvania proposal would charge different premiums to beneficiaries based on whether they are working or actively looking for work. This proposal is in lieu of the state's initial proposal that would have made work search a condition of eligibility for many adults who were not already working more than twenty hours a week. While the new proposal is obviously less harsh and punitive, it should still be rejected as being outside the scope of the Secretary's authority to approve demonstration projects under section 1115 of the Social Security Act.

Demonstration projects must assist in promoting the objectives of the Medicaid program. The key purpose of the Medicaid program is to provide health care services to low-income and vulnerable people who can't afford the costs of the health care services they need. Programs aimed at connecting people to employment, however laudable, have no connection to the purposes of the Medicaid program, and Pennsylvania's proposal should be rejected on this basis.

Moreover, as discussed in more detail below, we have significant concerns about the state's request to charge premiums to low-income Medicaid beneficiaries, so using lower premiums as an incentive to work is especially problematic. Reducing premiums for people who are able to work or comply with work search requirements and maintaining them at higher levels for people who cannot participate in work-related activities would be discriminatory and an inappropriate use of demonstration authority. The premise that a reduction in premiums would serve as a work incentive is also highly questionable.

CMS should not grant Pennsylvania's request to charge low-income Medicaid beneficiaries' premiums that are higher than beneficiaries at the same income range would pay on the marketplace. Pennsylvania has proposed premiums for adults with incomes above 100 percent of the poverty line of $25 per month ($300 per year) for households with one adult and $35 per month ($420 per year) for households with more than one adult. Pennsylvania's proposed premiums are much higher than the premiums adults at the same income level would pay on the marketplace. The expected contribution for coverage on the marketplace for one adult with an income at 101% of the FPL is $232 per year.[i] In many cases, people may have a choice of coverage on the marketplace that would cost them even less than the expected contribution used to calculate their premium credit. Pennsylvania's proposed premium is at least $70 more per year than the marketplace premium. Charging premiums to Medicaid beneficiaries has been shown to result in steep losses of coverage. We suggest, at a minimum, that CMS require that the premium in Medicaid for people above poverty cannot be higher than what they would be paying on the marketplace.

Allowing Pennsylvania open-ended authority to charge premiums for adults with incomes below the poverty line and raise premiums for other adult populations in future years would undermine the integrity of the Medicaid statute and the waiver process and set a dangerous precedent. Pennsylvania is requesting open-ended authority to charge premiums for adults with incomes up to 100 percent of the poverty line in year two of the demonstration. Such a vague request is not acceptable, and CMS should require the state to be more specific as to its plans. Pennsylvania would also like discretion to revise premium obligations for many adult populations at all income levels every year starting in demonstration year two. Charging premiums to Medicaid beneficiaries with incomes below 150 percent of the poverty line is inconsistent with the Medicaid statute. [ii] Allowing Pennsylvania open-ended authority through a waiver to impose premiums on new groups or raise premiums to unknown levels in future years would undermine the integrity of the waiver process. *We urge CMS to clearly state that premiums should not be charged in any circumstance to beneficiaries with incomes below the poverty line.* In addition, CMS should require Pennsylvania to seek a waiver amendment with public comment at both the state and federal levels, if the state wants to impose premiums on a new group or raise premiums for beneficiaries already covered through the demonstration project at a later date.

CMS should reject Pennsylvania's proposed lockout periods for non-payment of premiums. Pennsylvania has requested a waiver to lock people out of Medicaid for three, six and nine months—for the first, second and third times respectively -- that they fail to pay premiums. The lockouts would apply to people with incomes above the poverty line in year 2, but could apply to additional populations if CMS grants Pennsylvania discretion to add premiums for other groups. Pennsylvania would not allow people to re-enroll until the end of the three-month period. In Wisconsin's recent 1115 waiver approval, CMS limited the penalty for failure to pay a premium to a three-

month disqualification, and allowed beneficiaries to re-enroll any time during that three-month period when they pay any outstanding premiums.

The state's request to purchase private coverage is vague, lacks clear objectives, and is likely unwarranted*:* A central feature of Pennsylvania's proposal is the use of Medicaid funds to purchase "private coverage." While the proposal is said to be modeled on the Arkansas "private option," the proposal deviates significantly from the Arkansas approach in ways that are troubling.

The proposal does not clearly define the concept of purchasing private coverage. The state seeks approval of three options, including 1) purchasing QHPs in the marketplace; 2) purchasing coverage in the private health insurance market through an undefined procurement process; and 3) purchasing available employer sponsored coverage.

We urge CMS to work with Pennsylvania to clearly define their request. Unlike Arkansas, Pennsylvania, already has a very mature Medicaid managed care market, and there is significant overlap between issuers in the marketplace and the Medicaid program (perhaps as high as 75 percent according to an analysis by the Association of Community-Affiliated Plans). Given this overlap, the value of using a "private coverage" approach raises questions as to how purchasing coverage in the private health insurance market through a procurement process differs from how the state is already doing business in its Medicaid and Children's Health Insurance Programs. We are concerned that the proposal is intended to avoid federal requirements that protect beneficiaries such as Medicaid managed care rules. Moreover, Pennsylvania already has in place a relatively robust and successful Medicaid Section 1906 Health Insurance Premium Payment program that subsidizes employer-sponsored coverage when it is cost-effective, so we do not understand why this new approach to employer coverage is needed.

We urge CMS to reject the state's request for benefit and cost-sharing waivers for the newly eligible. The state seeks to waive all wraparound services with the exception of FQHC/RHC services for adults 21 and older in the newly eligible population. The application also includes explicit requests to waive family planning and non-emergency medical transportation – in addition to a general request to deny "wraparound services". Finally we note that the state seeks to waive cost-sharing requirements in order to impose a $10 copay on non-emergency use of the emergency room.

Medicaid beneficiaries have unique needs because of their low-incomes. They are unlikely to be able to obtain necessary health care services that are not covered by Medicaid. We urge CMS to reject the state's requests to waive benefits and cost-sharing provisions in accordance with CMS guidance issued on March 2013 which stated: "*Under all these arrangements, beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections. States must have mechanisms*

in place to "wrap-around" private coverage to the extent that benefits are less and cost sharing requirements are greater than those in Medicaid."

Freedom of Choice for Family Planning Services

The Pennsylvania proposal would allow the state to limit Medicaid enrollees' freedom to seek care from the provider of their choice for all services, including family planning services and supplies. This limitation would also mean that the state would not need to pay for services provided out-of-network. The Medicaid statute recognizes states' heightened obligations with regard to access to family planning services and this obligation has been recognized by CMS in addressing proposals to waive freedom of choice by other states. Section 1902(a)(23)(B) of the Social Security Act guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if the provider is outside of their Medicaid managed care network, while in Iowa's recent 1115 waiver approval, CMS required the state to "ensure payment of state plan rates of family planning services that the QHP considers to be out-of-network." We urge CMS to require Pennsylvania to meet the same standard for Healthy Pennsylvania enrollees and other Pennsylvania Medicaid beneficiaries.

The state's request to reduce benefits for current Medicaid eligibles through the establishment of two categories -- "high risk" and "low risk" – should not be considered by CMS. It appears that the state is seeking a very broad waiver of "amount, duration and scope" requirements in part to allow reductions in benefits for those currently eligible and deemed low risk. Again we object to the overly broad nature of this request. CMS should remove this aspect of the proposal from consideration, as it is irrelevant to the purpose of the demonstration – which is to explore new ways of providing Medicaid coverage to the newly eligible population.

We commend the state for not requesting a waiver of EPSDT services for the newly eligible 19 and 20 year olds.

Yours sincerely

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[i] Based on Kaiser Family Foundation subsidy calculator for a household with 1 adult age 30, in Pennsylvania, zip code 19104 (West Philadelphia).

[ii] States can charge premiums on children eligible under the Family Opportunity Act and medically needy individuals below 150% FPL without a waiver, but Pennsylvania has proposed premiums to a broader group of low-income adults.