

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 Section 1115 Demonstration Project

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the proposed Healthy Pennsylvania demonstration project.

While we support the state's decision to accept federal Medicaid funding to provide coverage to newly eligible low-income parents and adults, we believe the proposal has serious flaws. In general, the demonstration request is unacceptably vague and includes many features that are outside the scope of what can and should be approved by your department. Our comments below highlight our most significant concerns.

Pennsylvania's proposal to tie work-related activities to the conditions of 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 appears to be 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 underlying concerns about the state's request to charge premiums to low-income Medicaid beneficiaries, so using lower premiums as an incentive to work is problematic. The state should not be permitted to charge premiums at all for people with incomes below the poverty line and if allowed for those with incomes above the poverty line, they should be no more than the amounts charged in the Marketplace.

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 extremely unfair and an inappropriate use of demonstration authority. The premise that a reduction in premiums would serve as a work incentive is also highly questionable. It is just as likely and probably more likely that providing unfettered access to health care services to newly eligible poor and low-income beneficiaries would enable them to obtain and maintain employment. Moreover, many potentially eligible beneficiaries are already working, but their employers do not provide health coverage. A CBPP analysis of census data showed that 81 percent of workers earning less than 138 percent of poverty do not have health coverage through their employer.¹

The state's request to purchase private coverage is vague, lacks clear objectives, and outside the scope of the Secretary's discretion to approve demonstration projects.

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 significant respects.

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.

Pennsylvania should be required to define its request more clearly. 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 a relatively robust and successful Medicaid Section 1906 Health Insurance Premium Payment program in place that subsidizes

¹ Center on Budget and Policy Priorities, "If Low-Income Adults are to Gain Coverage, States Must Expand Medicaid", March 13, 2013.

employer-sponsored coverage when it is cost-effective, so we do not understand why this new approach to employer coverage is needed.

The fact that Pennsylvania already operates a robust Medicaid managed care program and HIPP program also raises questions about its demonstration purpose of reducing churn. Building on the overlap that exists between its managed care plans and the Marketplace, Pennsylvania could take steps to limit churn without opening up the market to all plans in the individual market. In fact such a move would seem to be likely to increase churn beyond what would be expected with a straight Medicaid expansion.

We are also concerned about the lack of accountability between the private plans and the state's Medicaid agency. While premium assistance allows for federal matching funds to be used for premiums paid to private health plans, it does not abrogate the rights of beneficiaries to applicable protections afforded by the Medicaid statute. CMS should ensure that the state is able to effectively monitor and oversee the provision of services to "private coverage" participants by the QHPs. In our view, at minimum, carrying out the responsibility of the Medicaid single state agency requires a contractual relationship between Pennsylvania and any health plans participating in the demonstration.

The March 2013 CMS guidance on premium assistance is clear that beneficiaries who enroll in QHPs through a premium assistance demonstration remain Medicaid beneficiaries. Regardless of the demonstration, the Pennsylvania Department of Public Welfare is the single state agency and it remains responsible for oversight, monitoring, and ensuring that all beneficiaries receive the benefits and protections afforded by the Medicaid statute.

It is difficult to see how the Pennsylvania Medicaid agency can carry out its responsibility as the single state agency without a relationship to the health plans delivering services. This is especially the case if the intent is to allow beneficiaries to enroll in health plans not only offered through the Marketplace but in the individual market outside the Marketplace. With beneficiaries spread throughout the state's insurance market, it will be impossible for the Medicaid agency to ensure that health care services are being delivered in a manner that does not discriminate against Medicaid beneficiaries or that the services meet quality and adequacy standards. If, for example, a health plan fails to provide a covered benefit at all, how will the Pennsylvania Medicaid agency intervene to ensure that the benefit is provided?

CMS should not approve 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 \$25 per month (\$300 per year) premiums for adults with incomes above 100 percent of the poverty line for households with one adult and \$35

per month (\$420 per year) for households with more than one adult. These premiums would apply across the board to existing adult beneficiaries in both the Low and High Risk Benefit Plan and the expansion population in the Healthy Pennsylvania Private Coverage Option. These amounts would at a minimum be adjusted annually by the inflationary increase in the medical care component of the Consumer Price index.

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 percent of the poverty line is \$232 per year.² 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. Wisconsin has been charging premiums at three percent of income to parents and caretaker relatives with incomes between 133 and 150 percent of the poverty level, and recent data from the Wisconsin Department of Health Services' preliminary evaluation show that two-fifths of relevant enrollees lost coverage due to non-payment of premium. We suggest, at a minimum, that CMS require that the premium in Medicaid for people above poverty not 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 to 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 has requested 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. 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

² Based on Kaiser Family Foundation subsidy calculator for a household with 1 adult age 30, in Pennsylvania, zip code 19104 (West Philadelphia).

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 two, 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.

Final federal regulations issued on July 5, 2013 clearly state that no further consequences can be applied for non-payment of Medicaid premiums, other than terminating eligibility if an individual fails to pay for 60 days [42 C.F.R. S 447.551(b)(5)]. These final regulations also prohibit states from instituting a premium lockout period in CHIP that exceeds 90 days. 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. Pennsylvania’s proposed lock-out periods are inconsistent with recent federal regulations and 1115 waiver approvals. CMS should reject the lockout periods.

CMS should reject Pennsylvania’s proposal to restructure benefits.

Pennsylvania proposes to make significant changes in its current Medicaid benefit package. Beneficiaries not enrolled in the premium assistance component of the demonstration would receive either a “low risk” or “high risk” benefit package based on the results of a health screening. The hypothesis is that the health screening will “help identify the benefit plan that best serves [beneficiaries’] needs.” Regardless of whether this is an appropriate hypothesis for a demonstration project—and we would argue that it is not—the design of the proposal shows that the real purpose of the proposal is to make cuts in benefits. In effect, this aspect of the proposal is an attempt to cloak significant benefit cuts in the guise of a demonstration project:

- First, targeting benefits based on risk is not necessary in a well-run Medicaid program. Benefits should be provided based on a beneficiary’s need for the benefit, which can change over time. For example, someone who is “low risk” could experience a temporary condition requiring more than 2 hospitalizations in the course of a year but still not fit in the high-risk category. In a state like Pennsylvania with a mature managed care program, targeting benefits in this

way seems especially unnecessary given that the health plans already manage utilization of the benefits based on medical necessity.

- Second, some benefits are eliminated for both groups. The state could eliminate optional benefits such as optometrist, podiatrist and chiropractor services, as it proposes to do, but this should be done through a state plan amendment not hidden in a lengthy and complex proposal for a demonstration project. Elimination of these benefits has nothing to do with ensuring people are in the right benefit category.
- Third, there are cuts in a number of benefits for both the low- and high-risk group, again making it clear that the real purpose is cutting benefits. Services such as radiology, inpatient drug and alcohol treatment, inpatient acute hospital, and peer support are now provided without limit. The proposal would limit these services for both groups with lower limits for the low-risk category. Again, there is no relationship of the change in benefits to the claimed hypothesis or to the purpose of the demonstration project.

CMS should reject the state’s request to waive retroactive eligibility.

The state’s request to waive retroactive eligibility for the newly eligible serves no clear purpose and will only put newly eligible beneficiaries at risk of medical debt and providers at risk for bad debt. The Arkansas demonstration upon which this is allegedly modeled does not include such a provision, and we urge you to reject Pennsylvania’s request.

If approved, the duration of Pennsylvania’s demonstration project should be no more than three years.

Pennsylvania proposes a demonstration that would last for five years, from January 1, 2015 through 2019. The March 2013 guidance on premium assistance demonstrations states that CMS would consider premium assistance demonstrations for a length that aligns with the 2017 start date for State Innovation Waivers. In approving waivers in Arkansas and Iowa, CMS adhered to this principle and should continue to do so if Pennsylvania’s request is approved.

Pennsylvania should clarify how and where individuals will apply for coverage and which entity will make eligibility determinations.

Pennsylvania proposes that individuals will apply for coverage through “the web portal, via phone, by mail, or in-person.” “Web portal” is too vague of a term; CMS should require that online applications be submitted through the Marketplace or the state Medicaid agency, as it has done in Arkansas and Iowa.

Pennsylvania proposes that its application process will only determine eligibility for coverage through Medicaid and the Healthy Pennsylvania program. The process should screen for eligibility for *all* coverage options, which would include CHIP and advance premium tax credits and cost-sharing reductions.

Pennsylvania also proposes that individuals who are determined eligible for coverage but do not select a plan will be auto-assigned to a plan in their geographic area. CMS should require greater clarity on how this process will work. For example, in Arkansas' private option demonstration the state Medicaid agency is required to notify beneficiaries who do not select a QHP that they have been auto-assigned into a plan along with information about the effective date of their coverage. Beneficiaries who are auto-enrolled are given a 30-day period from the date of their enrollment to switch to another QHP.

Conclusion

Thank you for the opportunity to share our views. Please contact Judith Solomon at the Center on Budget and Policy Priorities or Joan Alker at the Georgetown University Center for Children and Families if you would like additional information.

Yours truly,

A handwritten signature in black ink that reads "Judith Solomon". The signature is written in a cursive, flowing style.

Judith Solomon
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