October 15, 2015

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

Dear Secretary Burwell,

The undersigned organizations write in response to your request for public comments on Montana's proposal to expand Medicaid through a Section 1115 Medicaid demonstration, known as the Health and Economic Livelihood Partnership (HELP) Program. We commend Montana for moving forward to expand Medicaid for as many as 70,000 low-income residents, and for proposing a waiver to implement 12-month continuous eligibility for adults as a way to reduce churn. We believe, however, that the proposal includes provisions that would place an undue financial burden on expansion beneficiaries (particularly those with incomes below the poverty line) that would make it less likely that they enroll in coverage. Moreover, those who do enroll may not get all the health care services they need due to the added burden of cost-sharing charges that would apply to many health care services.

We hope that CMS and Montana can successfully negotiate a waiver agreement that allows the HELP Program to be implemented in a way that does not impose an undue financial burden on beneficiaries – especially those with incomes below the poverty line – and which is compatible with the goals and objectives of the Medicaid program.

Montana proposes to charge a monthly premium equal to 2 percent of income *and* maximum allowable Medicaid cost-sharing to all eligible beneficiaries, even those with little or no income. This combination of premiums and maximum co-pays for people below poverty goes well beyond what has been approved in any other state. Indiana is the only state which is allowed to charge premiums to people with incomes below 50 percent of poverty. But there, beneficiaries with incomes below poverty are *either* charged premiums with a co-pay on non-emergency use of the emergency room, or are given a different benefit package with maximum allowable co-pays but *no* premiums.

Montana has proposed a demonstration hypothesis – that "premiums will not pose a barrier to eligible participants enrolling in Medicaid" – which has already been tested many times, with the results showing quite the opposite, that premiums and cost-sharing deter people with low incomes from accessing needed medical care. A recent ASPE report detailed this research and also showed that people living in poverty tend to be less healthy and need more medical care than people with higher incomes.[1]

The combination of premiums and co-pays in Montana's proposal would set a dangerous precedent not just for the next round of states considering whether to expand Medicaid, but

[1] 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

also for states that have already done so. Arizona has submitted an amendment to its Medicaid expansion that would impose a similar premium and co-pay structure as Montana on 570,000 adult beneficiaries. Ohio, which has enrolled 600,000 people in its Medicaid expansion, plans to seek a waiver to impose 2 percent monthly premiums on all non-disabled adults, regardless of income. If Arizona, Ohio, or other states are allowed to implement a premium and co-sharing structure similar to what Montana has proposed it would likely lead to significant coverage losses in those states.

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

Premiums and maximum co-pays for all expansion enrollees. Montana proposes that newly eligible adults pay a premium equal to 2 percent of their income, while also being subject to cost-sharing at maximum levels allowed under Medicaid. The proposal states that "individuals" will be charged premiums at this amount, so we assume that spouses living together would each pay premiums equal to 2 percent of household income. No state has been allowed to charge premiums *and* maximum allowable co-pays to people below the poverty line. In principle, we are always concerned that premiums and cost-sharing for low-income individuals and families will depress enrollment and use of important health care services. Nevertheless, HHS has allowed three states to charge ostensible premiums to people with incomes below the poverty line – and Montana's proposal goes well beyond the waivers approved in Arkansas, Indiana and Iowa.

- In Indiana, people with incomes below poverty have a choice of premiums at 2 percent of income without co-pays other than a co-pay for non-emergency use of the emergency room (HIP Plus), or co-pays but no premiums (HIP Basic). No beneficiaries with incomes below poverty have to pay both.

- Iowa has permission to charge premiums to beneficiaries with incomes between 50 and 100 percent of the poverty line, but people in this income range are not charged copays except for an $8 co-pay for non-emergency use of the emergency room. In addition, and of particular importance: 1) the Iowa premiums are far below those in the Montana proposal, at $5 per *household*; 2) Iowa beneficiaries are not charged any premiums in their first year of enrollment; 3) as long as beneficiaries complete a health risk assessment and a check-up each year, no premiums are charged for the following year; and 4) the monthly invoices sent to beneficiaries who are subject to premiums make it clear that beneficiaries can attest to hardship, in which case premiums are waived entirely.

- Arkansas received permission to charge a $5 monthly fee to beneficiaries with incomes between 50 and 100 percent of the poverty line, with the fee going into an "Independence Account" that beneficiaries would draw upon for co-pays. Importantly, providers are paid regardless of whether there are funds in a beneficiary's account and while unpaid charges are a collectible debt, the debt is waived if the beneficiary attests to financial hardship. (Arkansas did not implement the fee, as it found that setting up and administering the accounts would be too costly and burdensome administratively.)

Even without the cost-sharing obligations Montana intends to impose, the proposed premiums are dramatically higher than the Arkansas and Iowa premiums, and beneficiaries in Montana would not be able to waive the charges based on financial hardship (on page 23 of its proposal, Montana indicates that it will not include a hardship exemption) or avoid them through a reasonably constructed healthy behavior program:

- An eligible couple with income at $15,000 a year in Montana would pay $600 a year ($300 each), as compared to ostensible premium charges of $60 a year in Iowa and $120 a year in Arkansas. Even if Montana is proposing to charge premiums for the couple based on its household income, the premiums would be $300, still significantly more than both Iowa and Arkansas.

- A single individual with income at $10,000 a year would pay $200 a year ($16.66 a month) in Montana, as compared to an ostensible premium charge of $60 a year in Iowa and Arkansas.

- A single parent with two children with income of $20,000 a year would pay $400 a year ($33.33 a month) in Montana, as compared to ostensible charges of $60 a year in Iowa and Arkansas.

Penalties for failure to pay premiums and co-pays. Montana's proposal says enrollees with incomes above the poverty line who fail to pay their premiums "will be disenrolled from coverage until they pay overdue premiums or until the Department of Revenue assesses the premium debt against their income taxes" (page 2). In response to public comments the state says the disenrollment will happen after three months of missed payments (page 23). The state also indicates that there will be no hardship exemption for people unable to make premium payments. We urge CMS to include a broad hardship exemption, like that approved in Iowa, under which each monthly invoice sent to a beneficiary includes the opportunity to attest to financial hardship. If disenrollment is approved for people with incomes above poverty, we urge CMS to structure it like approved lock-outs in Iowa and Pennsylvania, in which beneficiaries can promptly re-enroll in coverage. However, if a three-month lock-out is approved, the special terms and conditions should be clear as to how and when individuals can re-enroll in coverage.

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. The state's authorizing legislation says people will be exempt from disenrollment if they meet 2 of 4 criteria. Two of these four (recent military service and enrollment in a Montana college) are narrow and unachievable for most people, and a third (involvement in a work force development program) serves no purpose for people who are employed. It is likely that a very small number of people would be able to meet the criteria as laid out in state law.

Montana's proposal contains virtually no information on what happens to people with incomes below the poverty line who miss premium payments, other than in the public comment section where it says these individuals will remain enrolled in coverage (page 23). A robust body of research shows that merely charging premiums to people with incomes below poverty can be a deterrent to signing up for coverage, whether or not they are ultimately penalized for missing payments.[2] We urge CMS to include a broad hardship exemption, like that in Iowa, in the final terms and conditions approving the waiver.

Lack of specifics on who is an individual with "exceptional health care needs." 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 should more clearly define what qualifies as an "exceptional" need and the process for determining when someone meets the standard.

"Taxpayer Integrity Fee." The state's authorizing legislation includes a provision that requires the state to assess a $100 per month fee on expansion beneficiaries who have more than one residence, one light vehicle, and more than $50,000 in "cash and cash equivalent." An additional $4 per month would be assessed for each $1,000 a person has above this amount. In its response to public comments the state indicates that it intends to implement this fee, and believes it can do so without obtaining a waiver from HHS (page 26).

The MAGI methodology established in the ACA for determining the eligibility of newly eligible adults explicitly prohibits the use of an asset test and does not permit that prohibition to be waived. The ACA eliminated asset tests to align the methodology used in Medicaid with that used in the Marketplace to determine eligibility for premium tax credits and cost-sharing reductions. Montana's legislation, however, effectively imposes an asset test on people with assets over certain levels.

The argument may be made that the fee is not an asset test because people with assets requiring payment of the fee would not be ineligible for Medicaid, as is usually the case with asset tests. But if the fee is not an asset test then it is essentially a premium and as such would require a waiver. Moreover, inquiry into a household's assets itself, which would be necessary to administer the fee, is prohibited under the ACA.[3]

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[2] For more information of the effect premiums have on people with low incomes, see the ASPE report mentioned above, and Jessica Schubel and Judith Solomon, "States Can Improve Health Outcomes and Lower Costs in Medicaid Using Existing Flexibility," Center on Budget and Policy Priorities, April 9, 2015, http://www.cbpp.org/research/health/states-can-improve-health-outcomes-and-lower-costs-in-medicaid-using-existing.

[3] Medicaid regulations prohibit state Medicaid agencies from requiring applicants to provide information that is not "necessary to make an eligibility determination or for a purpose directly connected to the administration of the State plan." 42 CFR §435.907(e). States cannot impose asset tests on newly eligible beneficiaries, so asking them about their assets or requiring that they consent to disclosure by third parties such as banks would be unlawful.

Continuous eligibility. We commend Montana for including a waiver to implement 12-month continuous eligibility for all MAGI adults in the state. Continuous eligibility is an important tool that can be used to reduce churn, promotes improved assessment of health care quality, and reduces administrative burdens on both the state and individual. We urge CMS to grant this waiver.

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We urge CMS to work with Montana to arrive at a waiver agreement that allows the state to implement the Medicaid expansion, but in a way that does not place an undue financial burden on beneficiaries, especially those with incomes below the poverty line, and does not set a dangerous precedent that other states may seek to replicate.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judy Solomon (solomon@cbpp.org).

American Association on Health and Disability
American Congress of Obstetricians and Gynecologists
Center on Budget and Policy Priorities
Children's Defense Fund
Epilepsy Foundation
Georgetown University Center for Children and Families
HIV Medicine Association
March of Dimes
National Association of Pediatric Nurse Practitioners
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