October 16, 2025

Secretary Robert F. Kennedy, Jr.
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Montana "Health and Economic Livelihood Partnership (HELP)" Section 1115 Demonstration Request

Dear Secretary Kennedy,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Montana's proposed "Health and Economic Livelihood Partnership (HELP)" section 1115 demonstration.[1] The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax, and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Montana is seeking authority to implement a work reporting requirement demonstration targeting Medicaid expansion adults ages 19-64. Non-exempt enrollees would be required to participate in at least 80 hours per month of qualifying activities including work, community service, education, or workforce training programs. Non-exempt enrollees would also be subject to graduated premiums, in addition to the H.R. 1 cost-sharing requirements (beginning in October 2028). If approved, the state is seeking to implement these work reporting requirements "as soon as practicable," prior to the H.R. 1 mandate that all Medicaid expansion states impose work reporting requirements, subject to the requirements of H.R. 1, starting January 1, 2027.

Work reporting requirements create a demonstrable threat to health care access and wellbeing for low-income adults. While Montana will be required under federal law to impose this problematic policy by January 1, 2027, the new federal law does not require the state to begin implementing work reporting requirements under the "as soon as practicable" timeline the state is proposing. The January 2027 timeline does not give states adequate time to develop necessary systems, engage stakeholders, and educate affected enrollees. Starting the work reporting requirements prior to January 1, 2027 will harm coverage and should not be approved. Furthermore, the state is not permitted to impose premiums under current law, and pursuant to additional restrictions in H.R. 1 (starting October 2028). **Montana should not be allowed to impose premiums on its Medicaid expansion population, and we urge you to reject this and the rest of the state's proposal.**

[1] "Montana Health and Economic Livelihood Partnership (HELP) Demonstration," September 2025, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/mt-he-lvhd-prtnrsp-pndg-help-aplctn-pa.pdf.

Work reporting requirements create unnecessary obstacles to accessing coverage, and implementing sooner than required will risk greater coverage losses.

Work reporting requirements create red tape barriers to accessing and maintaining coverage, resulting in coverage loss. When Arkansas implemented work reporting requirements in 2018, twenty-five percent of the individuals subject to the work requirement (over 18,000 people) lost coverage in five months, including many individuals who were working or eligible for an exemption.[2] Research has consistently shown that work requirements fail to promote employment.[3] In fact, access to Medicaid coverage is supportive of finding and maintaining work.[4]

While the state does not offer a clear timeline in its proposal, it is seeking to implement work requirements "as soon as practicable" if approved. The implementation process for any state's work requirement will require developing policy, updating systems, and training workers; this is a substantial undertaking for state agencies and necessitates ample time to properly put all operational pieces in place. Although the state has made an effort to align its proposal with requirements set forth in H.R. 1, the state admits in its proposal that differences exist between its statutorily mandated work requirement proposal and H.R. 1.[5] There are still significant details of the federally mandated work requirements that are yet to be determined or clarified pending CMS issuing regulations to guide implementation, which are not required until June 2026. Considering that all work reporting requirements must comply with H.R. 1 standards, and that the law specifically prohibits waivers of those standards, it makes little sense, and will waste resources, for the state to rush to build new systems and processes ahead of these regulations (and other guidance CMS may issue).

Montana's proposal acknowledges inevitable coverage losses. If implemented in 2026, the state estimates an enrollment decline of 5,797 individuals in the first year.[6] Implementing work requirements quickly and before full agency guidance is available also risks greater enrollee confusion about the policy and resulting coverage losses. For example, if the state begins imposing the policy as currently proposed, but regulations later change the state's processes for exemption verification or the length of time exemptions are viable for, people would be in danger of not being aware of the changes. The state trying to implement work requirements even more rapidly and without full guidance could result in even larger coverage losses than would already occur from the

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[2] Elizabeth Hinton and Robin Rudowitz, "5 Key Facts About Medicaid Work Requirements," KFF, February 2025, https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/#:~:text=3.,in%20care%2C%20and%20medical%20debt.

[3] Congressional Budget Office, "Work Requirements and Work Supports for Recipients of Mean-Tested Benefits," June 9, 2022, https://www.cbo.gov/publication/57702; LaDonna Pavetti, "TANF Studies Show Work Requirements Proposals for Other Programs Would Harm Millions, Do Little to Increase Work," Center on Budget and Policy Priorities, November 2018, https://www.cbpp.org/sites/default/files/atoms/files/11-13-18tanf.pdf; Benjamin Sommers, et al., "Medicaid Work Requirements In Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care," https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538.

[4] Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020," KFF, May 17, 2020, https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/; Larisa Antonisse and Rachel Garfield, "The Relationship Between Work and Health: Findings from a Literature Review," KFF, August 7, 2018, https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[5] "Montana Health and Economic Livelihood Partnership (HELP) Demonstration," pg. 8.

[6] Ibid, pg. 25.

problematic policy, either from system errors or difficultly that enrollees will have in navigating new forms of red tape.

Montana is also extremely unprepared to implement work requirements. The state ranks at the very bottom of the Georgetown University Center for Children and Families analysis of state readiness to implement work reporting requirements, falling in the bottom quartile on 7 of 8 metrics evaluated (and in the bottom 5 states on half of the metrics), including Ex Parte Renewal Rate, Overall Renewal Rate, Application Processing Time, Call Center Wait Times, and Call Center Abandonment Rate.[7] Montana is unlikely to have the systems capacity to effectively implement work requirements in 2027, much less implement them early. As such, Montana's demonstration will not promote coverage, and should not be approved under section 1115. Montana's proposal also has little experimental value, as required by section 1115, considering that Congress has *already* acted to create the statutory option for work requirements, specifically barred experimentation using section 1115 (at section 1902(xx)(10)), and any "lessons learned" would come long after national implementation is completed. Finally, since Montana is already *required* to implement state plan work requirements in just over a year, the waiver can hardly be considered "necessary to enable [Montana] to carry out" such a project, as required by section 1115(a)(1).

If it approves the demonstration, CMS should approve the state's proposal to allow long-lasting exemptions to work requirements.

Montana proposes to have some exemptions to the work reporting requirement be permanent, such as an exemption for blindness. This is a commonsense policy that CMS should allow broadly for states implementing work reporting requirements and will hopefully specify in its forthcoming guidance and regulations. Other exemptions, such as physical, intellectual, or developmental disability, disabling mental disorder, or substance use disorder, should also receive long-lasting or permanent exemption status, as would be clinically appropriate for these conditions. It would be a waste of state resources to regularly reevaluate exemption status for individuals with long-lasting or permanent conditions that impact their ability to comply with the work reporting requirements. Allowing these exemptions to be long-lasting or permanent reduces state administrative burden and red tape barriers to coverage, and promotes continuity of coverage. Evidence shows that even short gaps in health insurance coverage can be highly consequential, contributing to disruptions in physician care and medication adherence and increased emergency department use.[8] These gaps can be particularly consequential for individuals with serious conditions that require regular access to care, prescription medications, or medical equipment.

Montana's request to charge premiums creates barriers to coverage and should not be approved.

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[7] Tricia Brooks, et al., "Are States Ready to Implement HR 1 and Medicaid Work Reporting Requirements?", Georgetown University Center for Children and Families, September 4, 2025, https://ccf.georgetown.edu/2025/09/04/are-states-ready-to-implement-hr-1-and-medicaid-work-reporting-requirements.

[8] Benjamin Sommers et al., "Insurance Churning Rates for Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many," Health Affairs, Vol. 35(10), October 2016, https://pubmed.ncbi.nlm.nih.gov/27702954/.

Montana's demonstration requests authority to charge expansion adults (with some exceptions) monthly premiums. In addition, the state requests authority to raise premiums over time. Premiums would start at 2% of household income for the first two years and then subsequently increase by 0.5% annually up to a maximum of 4% of household income. Enrollees exempt from the work reporting requirement would also be exempt from premium increases, but would be subject to on-going 2% premiums. For individuals with income at or below 100% of the federal poverty level (FPL), the state would not disenroll them for failure to pay, but the state would provide notice to the Department of Revenue, which would in turn collect the amount due for nonpayment by assessing the amount against the enrollee's annual income tax. For individuals above 100% FPL, the state would, after a 90-day notice period, terminate their coverage and similarly pass their file to Department of Revenue for collections.

In its demonstration application, Montana estimates that thousands of individuals (up to 2.5% of *total* enrollment) will disenroll due the premium assessment.[9] This is consistent with voluminous evidence showing Medicaid premiums result in large coverage losses. However, analysis of Montana's prior premiums (implemented 2017-2019) show the termination rates were far above 2.5% when evaluated as a proportion of the enrollees who could actually be subject to termination (i.e., in this case, the subset from 100-138% FPL not otherwise exempt). In 2019, nearly one in four of the individuals subject to termination for nonpayment was terminated.[10]

Premiums are a significant barrier to obtaining and maintaining Medicaid coverage, particularly impacting those with incomes below the poverty level who are more likely to become uninsured if premiums are charged.[11] Research consistently shows that premiums lead to disruptions in coverage and cause financial hardship. Your agency's recent letter to the state of Indiana outlines the many harms that arise from charging premiums to very low-income people citing multiple studies that provide evidence for this conclusion.[12] In Montana, 80% of those terminated in the 2017-2019 premiums reported they could not afford the premiums.[13] Finally, we note that Montana has already demonstrated inability to provide adequate outreach and assistance for premiums in the past, with focus groups reporting multi-hour wait times for consumer assistance and low knowledge of the consequences for nonpayment of premiums.[14]

In Indiana, which requires adults to pay monthly premiums between $1 and $20, over 35,000 individuals either didn't make their initial payment or missed payments in a single year, leading to non-enrollment, downgraded coverage, or disenrollment.[15] A recent federal court decision vacated Indiana's continuation of premiums, ruling there was no reasonable basis to conclude they promote

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[9] "Montana Health and Economic Livelihood Partnership (HELP) Demonstration," pg. 26.
[10] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," KFF, September 2021, https://www.kff.org/medicaid/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers.
[11] Ibid.
[12] Centers for Medicare & Medicaid Services. (2023, December 22). *Letter to the State of Indiana* [PDF file]. https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-cms-ltr-to-the-state-12222023.pdf.
[13] Guth et al., "Understanding the Impact of Medicaid Premiums & Cost-Sharing."
[14] Ibid.
[15] Lewin Group, "Healthy Indiana Plan Interim Evaluation Report," pg. 150, December 18, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf#page=250.

coverage.[16] The Indiana decision underscores that disenrollment for non-payment of premiums is not permitted.

A recent study from Michigan's evaluation of its "Healthy Michigan Plan" found that premiums imposed on beneficiaries with incomes above 100 percent of the federal poverty level led to a higher likelihood of individuals voluntarily disenrolling from coverage and adverse selection. The study indicated that healthier expansion enrollees were more likely to disenroll, leaving those with greater medical needs and costs in the risk pool.[17] Montana's application does not provide estimates on the effects of premiums or disenrollment on the risk pool.

Montana's premiums are also problematic because of recent changes to Medicaid law made by H.R. 1. Even under *current* law, CMS appears to lack the authority to approve the requested premiums. Congress generally prohibited premiums on such lower income individuals when it enacted section 1916 of the Social Security Act, and this provision is not waivable under section 1115, which is restricted to waiver of provisions in section 1902. The mere existence of a cross-reference in section 1902(a)(14) does not negate the independent constraint imposed by section 1916. However, beginning in October 2028, H.R. 1 adds an additional and specific prohibition on premiums for Medicaid expansion enrollees above 100% FPL. Therefore, even *if* section 1916 premium prohibitions could be construed as reachable through a waiver of 1902(a)(14), it would clearly not promote Congress's objectives for Medicaid to allow premiums for a group where Congress has placed such a recent and explicit prohibition alongside a requirement to charge cost-sharing. Allowing termination of coverage for nonpayment of premiums would be even more contrary to Congress's design. CMS already lacks current authority to allow premium waivers, and this will become doubly true in 2028, when Montana indicates it plans to renew its waiver request. As such, CMS should not approve a temporary waiver for premiums that would require complicated systems changes for the state to implement only to be dismantled a short time later. Not only is this wasteful, but it would lead to incredible confusion for enrollees.

We also urge CMS to reject two additional features of Montana's requested premiums. First, CMS should not allow the state to increase premiums based on length of time enrolled. Low-income workers do not control the fact that their wages are low and they have no other coverage source available. Increasing premiums merely punish them for the conditions of their employment and will dimmish coverage. Second, CMS should not allow the state to pass "debt" to the Department of Revenue for collection. This policy creates significant and on-going administrative burden for the state and enrollees. In addition, many individuals will not be knowingly consenting to such an arrangement; in the similar Montana premium demonstration in 2017-2019, only 40% of people disenrolled knew about tax collection.[18] Many others will be scared away from coverage out of fear, again harming coverage. Threatening to pass the files of individuals who live in poverty, many of whom are below tax filing thresholds, to tax authorities is cruel and futile.

We urge CMS to reject Montana's request to charge premiums. There is ample evidence that premiums result in harmful consequences and there is no reason to test this approach any longer in Montana or elsewhere. Charging premiums is inconsistent with coverage as the objective

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[16] Rose v. Becerra, *Civil Action 19-2848 (JEB)*, (D.D.C. Jun. 27, 2024). https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv2848-68.

[17] Betsy Q. Cliff et al., "Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules," *American Journal of Health Economics*, *8*(1), December 2021, https://doi.org/10.1086/716464.

[18] Guth et al., "Understanding the Impact of Medicaid Premiums & Cost-Sharing," Footnote 45.

of the Medicaid program; the evidence is clear and there is no longer a valid experimental purpose in testing related hypotheses. CMS already phased out similar premiums in Montana from 2021 to 2022, "based on CMS's determination that premiums can present a barrier to coverage, and therefore, charging premiums beyond those specifically permitted in the Medicaid statute are not likely to promote the objectives of Medicaid," and citing detailed data about the coverage losses in Montana.[19] CMS went on to explain that this finding was based on research across different state 1115 demonstrations showing that premiums harm coverage. **Given CMS's specific findings on premium demonstrations in Montana and other states, which are confirmed by numerous independent studies, there is no reasonable or evidence-based justification for CMS reversing its policy in Montana's new application.** The only material change in the circumstances since CMS's prior Montana decision is an *additional* Congressional prohibition against premiums.

Conclusion

Our comments include citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for the purposes of the Administrative Procedure Act.

Thank you for your willingness to consider our comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

[19] "Montana Health and Economic Livelihood Partnership (HELP) Demonstration."