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,

Community Catalyst greatly appreciates the opportunity to comment on the proposed Healthy Pennsylvania demonstration project.

Community Catalyst is a national non-profit advocacy organization dedicated to quality affordable health care for all. Since 1997, Community Catalyst has been working to build the consumer and community leadership required to transform the American health system. With the belief that this transformation will happen when consumers are fully engaged and have an organized voice, Community Catalyst works in partnership with national, state and local consumer organizations, policymakers, and foundations – including in Pennsylvania. We provide leadership and support to change the health care system so it serves everyone - especially vulnerable members of society.

We enthusiastically support Pennsylvania's decision to accept federal Medicaid funding to extend coverage to low-income parents and adults. Taking up the ACA's Medicaid expansion would bring health coverage to 500,000 to 700,000 Pennsylvanians, lowering the state's uninsured rate by over 50% and improving Pennsylvanians' health and financial well-being. The value of providing coverage to these low-income uninsured families cannot be overstated.

However, we have significant concerns with the design of the proposed Healthy Pennsylvania demonstration project. These concerns can and should be addressed before HHS approves this waiver. Some elements of the proposal as it currently stands would undermine beneficiaries' access to coverage and care, undercutting the purpose of expanding coverage to this population.

Before approving this waiver proposal, we urge HHS to:

**Reject the provisions that charge premiums or that leave the door open to premiums on beneficiaries, especially on those below 100% FPL.** The current proposal would require premiums for people with income above 100% FPL, would leave the door open to premiums on those below 100%, and would deny coverage for up to 9 months for those who don't pay. This would devastate the very families this program is meant to help. Families in this income range are already trying hard - and often failing – to make ends meet. Premiums will force these families into worse economic hardship than they are already facing. They could end up forgoing food or safe childcare to make

their premium payments, which could seriously undermine the health of these families and defeat the underlying goal of providing health care coverage.

Additionally, a substantial body of literature demonstrates that even nominal premiums deter enrollment into the program. Family budgets at this income level are very susceptible to unexpected monthly changes in income or unexpected expenses such as a car repair. As a result, many families who are able to initially enroll will at some point find themselves unable to pay these premiums. Under the program design outlined in this proposal, these families will then be locked out of coverage for months, leaving them uninsured and with no recourse for accessing needed health services. This is unnecessarily punitive and exactly the situation that the Medicaid program is designed to avoid.

We urge CMS to work with Pennsylvania to eliminate premiums on all Medicaid beneficiaries. This is the only way to ensure that this coverage expansion truly reaches the population who needs it most.

**At the bare minimum, CMS should explicitly deny Pennsylvania the authority to charge premiums on those below 100% FPL, and allow nominal premiums for those above 100% FPL only with important consumer protections in place:**

- *Ensure that the premiums charged on those above 100% FPL are lower than the premiums these enrollees would have faced in the Marketplace.* The premiums proposed for adults earning above 100% FPL in Pennsylvania's waiver application are, in some cases, over $100 per year *more* than what those beneficiaries would pay for second-lowest cost silver tier plan (which isn't even their lowest-cost option) in the marketplace with tax credits. For example, under this proposal single adults at 101% FPL would pay $300 per year for Medicaid, compared to $232 for the second-lowest cost silver-tier plan in the marketplace.[1] A family of two adults would be charged $420 per year under this waiver, compared to $313 in the marketplace for the second-lowest cost silver plan[2]. In many cases, people could pay even lower premiums in the Marketplace by choosing a less expensive plan. Under no circumstances should beneficiaries be charged more in Medicaid than they would in the Marketplace.

- *Require Pennsylvania to seek a waiver amendment with public comment at both the state and federal levels if it wants to raise the premiums at a later date.* The current proposal seeks open-ended authority to raise premiums at a later date. Given that premiums on those earning less than 150% FPL are explicitly

[1] http://kff.org/interactive/subsidy-calculator/#state=pa&zip=19102&income-type=percent&income=101&employer-coverage=0&people=1&alternate-plan-family=individual&adult-count=1&adults%5B0%5D%5Bage%5D=27&adults%5B0%5D%5Btobacco%5D=0&child-count=0&child-tobacco=0

[2] http://kff.org/interactive/subsidy-calculator/#state=pa&zip=19102&income-type=percent&income=101&employer-coverage=0&people=&alternate-plan-family=individual&adult-count=2&adults%5B0%5D%5Bage%5D=27&adults%5B0%5D%5Btobacco%5D=0&adults%5B1%5D%5Bage%5D=21&adults%5B1%5D%5Btobacco%5D=0&child-count=0&child-tobacco=0

prohibited by Medicaid statute, this open-ended authority to increase premiums on this population would undermine the waiver process. Pennsylvania should have to specify a premium schedule for the length of the waiver; if it later wants to increase premiums, Pennsylvania should be required to submit those changes to public input process as well as federal approval.

- *Reject any lockout periods for non-payment of premiums.* Pennsylvania's waiver would lock beneficiaries out of coverage for up to 9 months if they fail to pay premiums, even once they pay their back-due premiums. Any proposal that could leave eligible populations locked out of Medicaid coverage is unacceptable. This element of the Pennsylvania demonstration proposal clearly runs counter to the objectives of the Medicaid program, as it would explicitly deny access to coverage for the very people the program is supposed to help. We urge CMS to work with Pennsylvania to develop another enforcement or incentive system for payment of premiums, if it does allow premiums in the program.

- *Ensure beneficiaries have access to a simple process by which premiums can be waived due to financial hardship or other good cause.* For example, in the recently-approved Iowa 1115 demonstration project, the state will grant premium waivers to beneficiaries who self-attest to a financial hardship, and the opportunity to self-attest will be on each premium invoice. This is an essential consumer protection that HHS should require with any waiver to charge premiums to those below 150% FPL in Medicaid.

**Reject any proposal that ties an individual's employment status or participation in work-related activities to their Medicaid eligibility, premiums or cost-sharing.** The proposed amendment to the Healthy Pennsylvania demonstration application would charge different premiums to beneficiaries based on their employment status and their participation in job training or employment-related activities. While this is less punitive than the original proposal to tie Medicaid *eligibility* to employment status and participation in employment-related activities, it is still unacceptable.

Any proposal to link employment status or participation in employment-related activities with Medicaid participation, premiums or cost-sharing should be rejected as being outside the scope of the Secretary's authority to approve demonstration projects. Demonstration projects must assist in promoting the objective of the Medicaid program, which is to provide health care services to low-income and vulnerable people. While encouraging employment is a laudable goal, it is unrelated to the objectives of the Medicaid program.

Moreover, this is a punitive and counterproductive measure. We know from decades of research that charging premiums on low-income beneficiaries reduces take-up and increases churn in the program. We also know that Medicaid improves both mental and physical health; this no doubt puts its beneficiaries in a better position to gain employment. By charging higher premiums to those without full-time employment, this proposal creates barriers to coverage that will prevent low-income families from

accessing the care they need to get better, thereby reducing their chances at obtaining full-time employment. This proposal would also likely discriminate against the sickest Medicaid beneficiaries, since it is more difficult for sick people to find and keep jobs or to participate in job-training programs.

**Disallow Pennsylvania to slash its current Medicaid benefit package for existing Medicaid beneficiaries through this waiver.** Although Pennsylvania describes this proposal as an effort to move away from "one size fits all" coverage, the new plan is plainly an attempt to gut the state Medicaid plan. This is clear from the fact that both the low-risk and high-risk plans include benefit packages that are significantly less comprehensive than the existing state plan benefit. These changes should not be approved because they are incidental to the underlying purpose of this waiver (to expand Medicaid through premium assistance), they would undermine the care of existing beneficiaries, and they do not meet section 1115's requirements of an experimental purpose or of promoting the objectives of the Medicaid Act. In addition to blocking the intent of Pennsylvania to scale back its current Medicaid program through an expansion waiver, CMS should also specifically deny the "amount, duration, and scope" waiver request based on the vagueness of the request. Granting the state such an open-ended authority would undermine not only the care that existing vulnerable adults are currently receiving, it would also undermine the waiver process.

**Preserve important Medicaid rights and protections for the newly eligible Medicaid expansion population.** As required in guidance from CMS, premium assistance enrollees do not forgo their rights as Medicaid beneficiaries. However, as currently drafted the Pennsylvania waiver would deny newly eligible who enroll through premium assistance access to to Medicaid benefits and other Medicaid-guaranteed consumer protections. Before approving Pennsylvania's premium assistance waiver, CMS should require that Pennsylvania guarantee:

- *"Wrap-around" coverage for all Medicaid-guaranteed benefits that are not provided by plans participating in the private option.* We urge HHS to uphold its requirement that beneficiaries served by a premium assistance program do not lose the benefits they are entitled to in Medicaid. This is an essential protection for these enrollees, because Medicaid benefits are carefully tailored to the needs of the vulnerable population the program serves.

  Pennsylvania should be required to provide wrap-around coverage to beneficiaries enrolled in premium assistance for all Medicaid benefits not covered in the exchange package. This includes non-emergency transportation, family planning services and supplies, freedom of choice for family planning services, and drugs not on the exchange plans' formularies.

  We strongly support the state's decision not to waive FQHC services and payment, and request that CMS not allow the state to alter that decision.

- *Retroactive and point-in-time coverage.* Medicaid law guarantees beneficiaries retroactive coverage for three months prior to the application. In contrast, the proposed waiver would not only deny retroactive coverage for those eligible for the private option (except in the cases where someone is determined presumptively eligible by a hospital), it would also create a delay of up to six weeks after the date of application before an applicant's coverage begins. It is not acceptable for private option beneficiaries to lose their rights to both retroactive and point-in-time coverage. Further, this waiver request fails the test for 1115 waiver-approval, since it tests no hypothesis about how to better serve the underlying objectives of the Medicaid program. Indeed, it will ultimately lead to more people uninsured and unable to access care at any given point-in-time as well as higher uncompensated care costs – exactly the opposite of the intent of Medicaid. We urge HHS to require that the state extend to all private option applicants the same Fee-for-Service retroactive coverage it plans to provide for beneficiaries who were determined presumptively eligible by hospitals, and to provide point-in-time coverage for all Medicaid beneficiaries.

- *Medicaid appeals rights*. The Pennsylvania application would require premium assistance enrollees to use the QHP appeals process for denials of QHP-covered benefits and provider access issues. Regardless of the fact that Pennsylvania may enroll some Medicaid-eligible individuals into private market coverage via premium assistance, these individuals remain Medicaid enrollees and subject to Medicaid due process protections. Both Arkansas and Iowa's waivers protect premium assistance enrollees' rights to use the state fair hearing process for all appeals. We urge CMS not to allow Pennsylvania to waive this requirement; it would ill-serve beneficiaries and set a new low-standard that other states will doubtlessly pursue.

- *Cost-sharing protections*. The Healthy Pennsylvania proposal seeks to waive cost-sharing requirements in order to impose a $10 copay on non-emergency use of the emergency room. It also alludes to future changes to the cost-sharing structure for those under 100% FPL in year 2 of the demonstration and beyond, without specifying exactly what those changes are. CMS should ensure that beneficiaries under the premium assistance waiver are guaranteed the same cost-sharing protections as are guaranteed under Medicaid law, and deny Pennsylvania's request for increased cost-sharing. This request fails the requirements of 1115 waivers, because it does not test a new hypothesis (indeed, decades of research confirm that increasing cost-sharing reduces access to needed care), and it does not promote the underlying objectives of the Medicaid program.

**Require further detail about the healthy behaviors they intend to incent among beneficiaries, and place strict parameters on the program.** The Healthy Pennsylvania waiver amendment would reduce beneficiaries' monthly contribution amounts if they meet certain "healthy behavior" standards. While we support some programs to incentivize healthy choices in Medicaid, we are concerned by the lack of details in Pennsylvania's proposed framework. We urge CMS to obtain more information about

how Pennsylvania plans on implementing this proposal, and to place certain parameters on this incentive program:

- *Allow rewards, not punitive measures, as incentives for healthy behaviors*. Consistent with the design of the Medicaid Incentives for the Prevention of Chronic Diseases, we believe incentives for beneficiaries to participate in preventive measures should be *rewards*, not punishments.

- *Disallow outcome measures of "healthy behaviors"*. Many factors that contribute to measurable health outcomes, like healthy weights and smoking status, are outside of enrollees' control. For example, no one can control whether healthy foods or safe places to exercise at night are available in their neighborhoods. In general, and especially when the incentive is a punishment on enrollees who fail to meet the healthy behavior standards, we urge CMS to restrict healthy behavior metrics to process or participation measures. For example, a state may incentivize enrollees to complete a risk assessment with a health care provider, or to complete a smoking cessation program. It should *not* create rewards or punishments based on whether they successfully quit smoking or whether their underlying health improves. This is consistent with the types of measures included in the recently-approved Iowa Wellness Plan.

  It should be noted that in order to fairly incentivize participation in these programs, CMS should ensure that the state makes them truly available to the range of people enrolled in Medicaid, such as by making them accessible to people living with various disabilities, with restricted time availability, and with language barriers.

Thank you for considering our comments. If you would like any additional information, please contact Katherine Howitt, Senior Policy Analyst, at khowitt@communitycatalyst.org or 617-275-2849.

Respectfully submitted,

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