
Planned Parenthood Affiliates of Michigan

September 30, 2015

Andy Slavitt, Acting Administrator
Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Healthy Michigan 1115 Waiver Amendment

Dear Mr. Slavitt,

Planned Parenthood Affiliates of Michigan and Planned Parenthood Advocates of Michigan are pleased to submit comments on the amendment to Michigan's demonstration waiver, Healthy Michigan Plan (herein referred to as the "Healthy Michigan Plan Amendment"). We thank the Centers for Medicare and Medicaid Services (CMS) for seeking input from stakeholders on this important proposal.

We strongly support the state's continuation of the Healthy Michigan Plan. Healthy Michigan has enabled approximately 600,000 individuals to gain Medicaid coverage. Medicaid is vital to women's health and economic security; with Medicaid coverage, low-income women across the state are able to access critical health care services including prenatal care, family planning services, and life-saving cancer screenings. Continuing the Healthy Michigan Plan means that more hardworking, low-income women and their families will be able to access the care they need at no or low cost.

However, we are concerned about certain aspects of the Healthy Michigan Plan Amendment. Under the Amendment, individuals who have incomes between 100 and 133 percent of the federal poverty level (FPL) and remain enrolled in the Healthy Michigan Plan for 48 cumulative months (4 years) will be forced to choose between two options: 1) terminate their Healthy Michigan Plan coverage and receive coverage through a Qualified Health Plan (QHP); or 2) continue to receive Healthy Michigan Plan coverage but be subject to cost-sharing and monthly contributions that amount up to 7 percent of income. While we understand the State Department of Health and Human Services was required by law to submit this amendment, we encourage CMS to exercise its discretion and not approve measures that undermine critical consumer protections such as the imposition of high cost-sharing amounts.

I. CMS Should Clarify that Option 1 Implements Premium Assistance and that Enrollees will Remain Entitled to Medicaid Benefits and Cost-Sharing Protections.

Option 1 under the Healthy Michigan Plan Amendment would require an eligible individual to transition to QHP coverage. The proposal notes that "[c]onsistent with federal law, amounts comparable to the beneficiary's advanced premium tax credits and a cost-sharing subsidy in the form of premium assistance will be used to pay for their health coverage." This sentence is ambiguous. On one hand, "federal law" could refer to the provision of premium assistance under 42 C.F.R. § 435.1015, whereby a state uses Medicaid dollars to subsidize the cost of private insurance coverage for Medicaid enrollees. On the other hand, the state could intend for "federal law" to refer to the Affordable Care Act (ACA). Under this second interpretation, the state intends not to pay for any portion of the coverage and intends for an individual to gain access to tax credits and cost-sharing reductions provided under the ACA.

Notably, the second interpretation is legally impracticable. The ACA limits eligibility for premium tax credits and cost-sharing reductions to individuals who have incomes between 100 and 400 percent FPL and are not eligible for other minimum essential coverage such as Medicaid.¹ Yet the Healthy Michigan Plan Amendment does not automatically transition individuals to QHP coverage. Instead, individuals enrolled in the Plan continue to remain eligible for coverage under Option 2 (albeit with significantly increased cost-sharing requirements). Accordingly, individuals who choose Option 1 are still technically eligible for Medicaid coverage and would be disqualified from receiving any ACA subsidies for their health care coverage.

We assume the state does not intend for individuals enrolled in Option 1 to lose access to federal assistance for health coverage, nor require low-income individuals to bear the responsibility of paying the full cost of coverage. However, due to the ambiguity, we strongly urge CMS to clarify that Option 1 will provide premium assistance to eligible individuals who choose Option 1 and that coverage will comply with the premium assistance requirements set forth in 42 C.F.R. § 435.1015. This means that individuals enrolled in Option 1 will remain Medicaid enrollees and will remain entitled to all state-covered benefits and Medicaid cost-sharing protections. This clarification is critically important as it will ensure access to comprehensive care that is not cost-prohibitive.

II. CMS Should Not Approve the Cost-Sharing Requirements Under Option 2.

Option 2 under the Healthy Michigan Plan Amendment enables an eligible individual to remain enrolled in the Healthy Michigan Plan but imposes cost-sharing that amounts up to 7 percent of income. Included in the 7 percent of income are monthly contributions (premium payments) that amount up to 3.5 percent of income. This proposal goes far beyond what is currently permitted under federal law, which caps aggregate cost-sharing at 5 percent of a family's income.²

Increasing cost-sharing will not reduce the need for care. Higher cost-sharing will simply act as yet another obstacle to care for low-income individuals and families. Indeed, a 7 percent cost-sharing cap may make care cost-prohibitive and result in people postponing or delaying timely, critical treatment. Additionally, a 7 percent cost-sharing cap may result in Medicaid coverage being more expensive than cost-sharing required through QHP coverage. We strongly urge CMS to disapprove Option 2 as proposed and clarify that cost-sharing may not exceed 5 percent of family income, in line with federal law.

If, however, CMS approves the cost-sharing requirement in Option 2, we urge CMS to make clear that, consistent with federal law, pregnant women, pregnancy-related services, and family planning services and supplies will remain exempt from cost-sharing.³ In addition, if CMS approves Option 2 as proposed, we ask CMS to require the state to implement a healthy behavior standard that would reduce cost-sharing entirely. The state's proposal does not specify the healthy behavior standard, nor does the state explicitly stipulate that completion of a healthy behavior will eliminate all cost-sharing requirements. It is critical that CMS receive

¹ ACA § 1401(a) (adding 26 U.S.C. § 36B(c)(1)(A), (2)(B)).

² 78 Fed. Reg. 42160, 42310-42311 (Jul. 15, 2013) (adding 42 C.F.R. § 447.56(f)).

³ Family planning services provided through traditional Medicaid coverage and benchmark coverage for the new adult (expansion) population are exempt from cost-sharing. 42 U.S.C. § 1396o(a)(2)(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii); 42 C.F.R. § 447.53(b)(5). Pregnant women, regardless if they are enrolled in traditional Medicaid coverage or benchmark coverage provided to the new adult (expansion) population are exempt from cost-sharing. 42 U.S.C. §§ 1396o(a)(2)(B), 1396o(b)(2)(B) (added by ACA § 4107(c)(1)), 1396o-1(b)(3)(A)(ii), (b)(3)(B)(iii); 42 C.F.R. § 447.53(b)(2); 42 U.S.C. § 1396o(c).

absolute clarity on these points and ensure individuals enrolled in Option 2 have the ability to avoid high cost-sharing amounts.

Moreover, with respect to the healthy behavior incentive, CMS should ensure the incentive structure incorporates women's health services so that it is not inadvertently biased toward men. For example, if the state intends for the healthy behavior incentive to include a physical exam or wellness screening (as other states have), CMS could ensure that well-woman exams satisfy the incentive so that a woman only needs to complete one exam per year to maintain her incentive – similar to man – instead of having to complete two separate exams that accomplish the same purpose.

III. CMS Should Ensure the State has Sufficient Mechanisms in Place to Provide Pregnant Enrollees Timely Access to All Covered Pregnancy-Related Care.

The Healthy Michigan Plan Amendment fails to address what will happen to women who become pregnant while enrolled in the Healthy Michigan Plan and are at the cusp of the two options. While we assume this omission was an oversight, we urge CMS to confirm that, consistent with federal guidance, women who become pregnant after enrolling in the Healthy Michigan Plan will be able to choose to proceed with her options under the Healthy Michigan Plan or transfer to the pregnant woman eligibility group and receive traditional Medicaid coverage.⁴ Moreover, it is imperative that the state have mechanisms in place that are precise and efficient to ensure that pregnant women receive care in a timely manner and are not inadvertently charged for care. We ask CMS to seek confirmation from the state that a revised Healthy Michigan Plan will be able to quickly identify pregnant enrollees, notify them of their rights to choose their coverage, and ensure exemption from cost-sharing.

IV. Approval of the Healthy Michigan Plan Amendment Should be Contingent on the State Having Sufficient Eligibility and Enrollment Systems and Robust Provider Networks.

CMS must ensure the state has sufficient eligibility and enrollment processes in place to guarantee smooth transitions between coverage. This is particularly important if CMS approves Option 1 and individuals can transition to a QHP. Specifically, with respect to Option 1, we ask CMS to require the state to continue Healthy Michigan Plan coverage until QHP coverage begins so that individuals do not experience a gap in care.

Likewise, we also ask CMS to make certain that QHP provider networks and Healthy Michigan Plan provider networks are sufficient to implement the revised Healthy Michigan Plan. The state estimates that the Healthy Michigan Plan has resulted in an enrollment increase of approximately 600,000 individuals. It is critical that CMS make sure existing provider networks are sufficient to continue serving this increased patient population and can continue to meet patient demand. Alternatively, and at a minimum, CMS should clarify in the approved waiver that enrollees may go out-of-network if in-network providers are unable or unwilling to provide a covered service in a reasonable time.

⁴ CMS, *Medicaid/CHIP Affordable Care Act Implementation Frequently Asked Questions*, Q2 (May 22, 2012), available at <http://www.medicaid.gov/state-resource-center/FAQ-medicaid-and-chip-affordable-care-act-implementation/downloads/Eligibility-Policy-FAQs.pdf>.

In particular, it is critical that enrollees have access to women's health services without delay. Family planning services, pregnancy-related care, and other women's preventive health care are not only mandatory covered services, they are also time-sensitive. A few days without contraception can result in an unintended pregnancy, and delays in prenatal care can result in poorer birth and maternal health outcomes. Moreover, women (in particular, low-income women) rely on women's health providers as their main source of care, meaning that OB/GYN providers are often gateways to the broader health care system for their patients.⁵ Safeguarding access to women's health providers will, therefore, both ensure women receive the care they need and also build a program that reflects the unique ways women access health care.

We thank CMS for the opportunity to submit these comments. If you have any questions, please feel free to contact me at Lori.Carpentier@ppmchoice.org

Sincerely,

A handwritten signature in cursive script that reads "Lori Carpentier".

Lori Carpentier, President and CEO
Planned Parenthood Affiliates of Michigan

⁵ PerryUndem Research & Communication, *Women & OB/GYN Providers* (Nov. 2013) (research conducted for Planned Parenthood Federation of America). http://www.plannedparenthood.org/files/4914/0656/5723/PPFA_OBGYN_Report.FINAL.pdf.