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October 14, 2015

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

**Re: Montana Section 1115 HELP Program
Demonstration**

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to Montana's proposed Social Security Act § 1115 demonstration application, the Montana Health and Economic Livelihood Partnership Program (HELP).

NHeLP is supportive of Medicaid expansion in Montana, and we encourage HHS and the State to develop an approvable demonstration. However, HHS should not approve a few components of the current demonstration proposal as these features are not authorized by Medicaid law and are harmful to enrollees. Most importantly, HHS should not approve a waiver of § 1902(a)(8) reasonable promptness because this would be inconsistent with the objectives of the Medicaid statute, the legal requirements of § 1115, and broadly threaten the future of Medicaid enrollment. In its final review, we urge HHS to zealously enforce its stated policies and the words of § 1115. Finally, we encourage HHS to fully support some of the positive features of Montana's proposal that are innovative and that will improve Medicaid for Montana recipients.

A. Premiums

Montana's § 1115 application includes a request to impose premiums that is not approvable under § 1115. Specifically, the proposal violates three core requirements for § 1115 demonstrations:

- Section 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.¹ Anything outside of § 1902 is not waivable through the §1115 demonstration process. Montana attempts to impose premiums by requesting waiver of § 1902(a)(14). However, §§ 1916 and 1916A prohibit any premiums under 150% of the Federal Poverty Level (FPL).² These are substantive requirements that rest outside of § 1902 and independently require state compliance. Any reference to the (a)(14) provision in § 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of §§ 1916 and 1916A.
- A § 1115 demonstration is precisely that, a *demonstration*. Montana’s requests for § 1115 authority regarding premiums is not approvable because, as proposed, and given the well-known results of redundant studies on premiums, it will not test anything. Premiums for low-income enrollees have already been tested repeatedly and consistently shown to depress enrollment – including for the very population of adults that is the focus of the Montana proposal.³
- Section 1115 demonstrations must also be “likely to assist in promoting the objectives” of the Medicaid Act.⁴ The objective of Medicaid is to *furnish* health care to low-income individuals.⁵ The proposed premiums in Montana’s proposal cannot be approved because they *reduce* access to care.⁶ The Medicaid Act, particularly § 1916A, already provides states like Montana with a great deal of flexibility to impose premiums (for higher income individuals), cost sharing, and similar charges. Yet, Montana seeks to bypass these options to implement proposals that the research has already established are harmful to low-income people – policies that will clearly result in interrupted care, lost opportunities, and churning.

Montana seeks premiums to help Medicaid enrollees “become responsible consumers.”⁷ However, this ignores the fact that Medicaid’s legal cost-sharing system *already* provides generous flexibility for states to create strong incentives for enrollees to avoid unnecessary care. We note that the impact of Montana’s requested premiums will be extremely harsh since Montana is the first state proposing to charge premiums at

¹ Social Security Act (SSA) § 1115(a)(1).

² See SSA §§ 1916(c), 1916A(b)(1)(A). There are very limited exceptions to this rule, for certain populations, that are not broadly applicable to the Medicaid expansion population. See, e.g., § 1916(d).

³ David Machledt and Jane Perkins, *Medicaid Cost-Sharing and Premiums* (March 2014), available at <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.UzneLoX3IX5>.

⁴ SSA § 1115(a).

⁵ See SSA § 1901.

⁶ For example, in 2003, Oregon experimented with charging sliding scale premiums (\$6-\$20) and higher copays on some groups in an already existing § 1115 demonstration for families and childless adults below poverty. Nearly *half* the affected demonstration enrollees dropped out within the first nine months after the changes. Bill J. Wright et al., *The Impact of Increased Cost Sharing on Medicaid Enrollees*, 24 Health Affairs 1106, 1110 (2005).

⁷ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 23.

the highest rate HHS has allowed and to impose this burden on individuals all the way down to 0% FPL, *in addition* to the maximum legal cost-sharing. Even if this were posed as an experiment, we already know how the hypothetical would be answered. Redundant, multiple research has already consistently established that these premiums will dissuade applicants from even applying and cause others to lose coverage when they are enrolled.

Since monthly contributions are not permitted for this population below 150% FPL, *termination* for non-payment of contributions should also never be approved for anyone in this population. Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict the structure of the ACA and numerous Medicaid cost-sharing protections set at 100% FPL. We note that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are enforceable or not.

B. Lockout until Debt Repayment or Assessment

Under Montana's requested waiver of the § 1902(a)(8) "reasonable promptness" requirement, an individual above 100% FPL who is terminated for failure to pay premiums would be barred from coverage until she (1) repays her outstanding premium debt or (2) has the debt "assessed" against her state tax return. As a result of this provision, individuals who are determined eligible for Medicaid would not be enrolled as the statute requires. Such a waiver is not approvable under § 1115.

All § 1115 demonstrations must promote the "objectives of Medicaid," namely to furnish care for enrollees, and there is no plausible argument that delaying enrollment into Medicaid for numerous months helps furnish medical assistance. Furthermore, § 1115 demonstrations must actually *demonstrate* something, and Montana provides no hypothesis about what this lockout provision might test, nor is any such viable hypothesis imaginable. Montana's waiver request fails to satisfy multiple legal requirements of § 1115 authority, and this waiver should not be approved.

In addition, this waiver would be a bad policy for Montana Medicaid enrollees. This provision would unnecessarily increase the number of uninsured in Montana by preventing low-income individuals from re-enrolling in Medicaid due to their debt. We note that many consumers will attempt to re-enroll precisely at critical moments when they need medical care and delays could dramatically worsen health outcomes. Such a policy not only harms consumers, but also the entire state health care system that absorbs the costs of paying for uncompensated care.

Montana's proposed lockout provision is also dangerously ambiguous about the options for re-enrollment. The first option, paying premium debt, appears to have no associated time limit. As proposed, this option could lock an individual out of care for years. The second option, "assessment" on state tax revenue, is not defined. It is our understanding that Montana *might* pursue a regular (quarterly is suggested in the application) assessment process by which individuals are sent a bill for their debt (the "assessment") and allowed to reenroll once the bill is sent independent of whether they

pay the bill. Such a quarterly assessment policy would effectively act as a 3-month lockout. However, based on the language of the application, it is also possible the State might simply make assessments pursuant to annual tax filings. This would mean an individual disenrolled in January (ex. January 2017) might have to wait until April of the *following* year (ex. April 2018) to reenroll. This would effectively amount to a 16-month lockout. And this is *assuming* that “assessment” is defined as being billed for the debt; if assessment is defined to mean Montana actually collecting payment, this option too could have no end date. Therefore, while Montana’s proposed policy *might* be implemented in a way that effectively makes it less harmful than Indiana’s (i.e., quarterly assessment, defined as being sent a bill), nothing in the proposal assures this is the case. Most importantly, even *if* Montana implements the quarterly assessment mitigation policy, a 3-month lock out would harm consumers and the mitigation would not cure the underlying illegality of the policy.

We believe that HHS should be particularly cautious in approving such an (a)(8) waiver. Allowing states flexibility not to enroll individuals who are known to be eligible threatens the most basic guarantee of Medicaid. As states face budgetary pressure over the coming decades they will invoke this flexibility as a budgetary control tool and it has the potential to eviscerate the meaning of the Medicaid entitlement. HHS should not approve this or any other similar waivers of § 1902(a)(8).

C. Taxpayer Integrity Fee

Montana’s waiver application suggests that the State will pursue a “taxpayer integrity fee.” Although the fee is not described, Montana may intend to use its state tax authority to levy an extra charge on Medicaid expansion enrollees who have higher assets. If such a fee is a condition of eligibility, it is an explicit premium and could not be implemented because such premiums are not legal *and* in any event no waiver was requested for the premium. Montana may believe that if it makes the fee independent of Medicaid eligibility (*i.e.*, the fee and consequences for non-payment involve other state processes), then the fee could be legally imposed without a federal waiver. However, the fee is illegal in either case.

First, the clear intent of the ACA was to eliminate asset tests for all MAGI populations, including Medicaid expansion individuals, and such asset tests are expressly prohibited by Medicaid law at § 1902(e)(14). Furthermore, federal 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.”⁸ Waiving asset test prohibitions would not help furnish medical assistance for enrollees or achieve any useful demonstration. As a practical matter, we note that even *if* the asset fee would only be assessed on a small percentage of applicants, the requirement to provide asset information and related verification (in addition to being illegal) would be a major deterrent and barrier to enrollment.

⁸ 42 C.F.R. § 435.907(e).

Second, regardless of the penalty for not paying the fee or how it is assessed by the State, any such fee associated with Medicaid coverage is a premium. The Medicaid Act specific states that “[t]he term ‘premium’ includes any enrollment fee or similar charge.”⁹ There is no distinction made for a “fee” that is charged through some independent state process, whether it impacts enrollment or not. By any construction, the fee is a premium.

Third, as a premium it would be illegal under Medicaid law for populations below 150% FPL. Montana itself recognizes this fact in its attempt to request a waiver for the other premium charge the State proposes. While we do not believe that premiums should be approved, the State has failed to even *request* waiver authority for the taxpayer integrity fee, meaning there is not even a hypothetical legal authority for it to impose such a fee.

Ultimately, the taxpayer integrity fee cannot be implemented because it is absolutely intertwined with Medicaid eligibility to the point where it is, in practice, a condition on eligibility in excess of the Medicaid eligibility criteria clearly enumerated in Federal law.¹⁰ Medicaid is a medical assistance program, period. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide assistance to all individuals who qualify under federal law,¹¹ and courts have held additional eligibility requirements to be illegal.¹² Section 1115 cannot be used to short circuit the Medicaid protections, because the taxpayer assessment can in no way promote the objectives of the Medicaid Act or demonstrate anything.

D. Workforce Development

We appreciate that Montana is concerned about the employment opportunities available to low income individuals. Most of our low income clients are employed, but those who are not employed repeatedly report difficulties finding employment despite their exhaustive efforts to find work. We therefore fully support states’ efforts to create *independent* (from Medicaid) and *voluntary* employment supports for lower income individuals, as accessible employment supports are services that our clients, particularly those with disabilities, have sought and been denied for decades. However, Montana’s demonstration application mentions workforce development in the context of Medicaid, and we are concerned that the State may attempt to condition Medicaid eligibility on participation in some kind of work program (e.g., the State may offer an exception to termination for failure to pay premiums for individuals who participate in a workforce program).

⁹ SSA § 1916A(a)(3)(A).

¹⁰ See generally SSA § 1902.

¹¹ *Id.* §§ 1902(a)(10)(A), (B).

¹² *Camacho v. Texas Workforce Comm’n*, 408 F.3d 229, 235 (5th Cir. 2005), *aff’g*, 326 F. Supp. 2d 803 (W.D. Tex. 2004) (finding that Texas could not “add additional requirements for Medicaid eligibility”). See generally *Carleson v. Remillard*, 406 U.S. 598 (1972) (invalidating state law that denied AFDC benefits to children whose fathers were serving in the military where no such bar existed in federal law governing eligibility).

Under the law, HHS cannot allow Montana to implement any kind of work search requirement that is in any way related to Medicaid. This means that HHS cannot approve a waiver allowing a work search requirement *and* that HHS cannot allow Montana to independently (*i.e.*, without a waiver) implement a work search requirement by altering Medicaid status based on participation, otherwise targeting Medicaid enrollees for state benefits or penalties contingent on participation, or even creating the appearance of Medicaid impacts based on participation.

Like the taxpayer integrity fee, a work search requirement is an illegal condition of eligibility. (See analysis above in Part C). From a practical standpoint, work requirements applied to health coverage get it exactly backwards. An individual needs to be healthy to be able to work, and a work requirement can prevent an individual from getting the health care they need to be able to work. We note finally that in almost any system in which eligibility is conditioned or attached to work search, there are likely to be serious violations of nondiscrimination laws, as persons with disabilities may end up with fewer benefits or higher costs due to their condition or the lack of adequate systemic supports to foster their employment.

E. Medicaid Family Planning Services and Supplies (FPSS) Requirements

In its application, Montana indicates that “[f]ederal law requires the ABP to cover the ten essential EHBs, which include family planning services.” We appreciate Montana’s confirmation that it will fully comply with the EHB standard, which requires the state to cover all FDA-approved methods of contraception. However, independent of the EHB the ABP also directly requires coverage of “medical assistance for family planning services and supplies” (*i.e.*, traditional Medicaid FPSS).¹³ Therefore, we urge HHS to clarify for Montana that its benefit package must comply with both the EHB requirement *and* the Medicaid FPSS requirement.

F. Coverage for Pregnant Women

In its proposal, Montana states that “[i]f a woman becomes pregnant during her coverage year and notifies either the TPA or the Department of her pregnancy she will be given the choice to maintain her coverage in the ABP or enroll in Standard Medicaid.”¹⁴ We appreciate Montana’s recognition of federal guidance, which requires states to inform women “of the benefits afforded to pregnant women under the State’s program.”¹⁵ In addition to permitting a pregnant woman to change coverage, the state must also provide all women with a notice of their coverage options and the benefits available to pregnant women under the state’s standard Medicaid program, at the time of enrollment and then subsequently at each redetermination. Due to confidentiality and safety concerns, any such notice must not contain confidential medical information about a woman’s specific pregnancy status. Lastly, women who do choose to change

¹³ SSA § 1937(b)(7).

¹⁴ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 25.

¹⁵ 77 Fed. Reg. 17149 (March 23, 2012).

their coverage must be given complete information about the implications of that change, such as potential changes in plans, providers, and available benefits.

G. Harm Mitigation

While we do not believe that HHS has the authority to approve the waivers discussed above, we do appreciate that following the advice of Montana advocates, the State has taken steps to mitigate some of the harm for enrollees. However, as a matter of law, mitigating the harm does not cure the illegality nor eliminate the harm, even though it would reduce the negative consequences for consumers. If, against our recommendation, HHS approves any of the unlawful waivers, HHS should implement all of the harm mitigation strategies that the Montana advocates have suggested, including:

- (1) No termination for failure to pay premiums for individuals below 100% FPL;¹⁶
- (2) No denial of services for failure to pay co-payments for individuals below 100% FPL;¹⁷
- (3) Full compliance with 5% aggregate cap for all costs, including premiums;¹⁸
- (4) Exemptions from the premiums, termination, and lockout for individuals who: (a) are identified as medically frail or have “exceptional health care needs”;¹⁹ (b) are American Indians/Alaskan Natives;²⁰ (c) live in underserved areas;²¹ (d) have special care continuity needs;²² or (e) participate in wellness programs if such programs are available and active in the individuals geographic areas (protection from termination and lockout only).²³

If HHS grants any waivers, it should retain all of these mitigating provisions and define them broadly and clearly in Special Terms and Conditions. HHS should also require Montana to implement a broad hardship exemption against disenrollment as was request by Montana state advocates. HHS should also ensure that any wellness requirements or incentives do not discriminate against enrollees based on illness, disabilities, or health status. And, HHS should require the State to be clear about the hypotheses it is testing and how it will test them.

¹⁶ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 23.

¹⁷ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 23.

¹⁸ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 2.

¹⁹ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 2.

²⁰ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 6.

²¹ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 6.

²² Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 6.

²³ Montana Section 1115 Health and Economic Livelihood Partnership (HELP) Program Waiver application at 2.

H. 12-month Continuous Eligibility

Montana has requested a waiver of § 1902(e)(12) to implement 12-month continuous eligibility. We strongly support this waiver request. This waiver will clearly help furnish medical assistance for low-income individuals and has demonstrative value. Of course, the State should be clear about what this waiver is testing, and the results of this demonstration should be reported (We also commend the State and HHS for working to implement Express Lane eligibility with SNAP data, and agree the State does not need waiver authority to make this improvement).

Conclusion

In summary, we strongly support Medicaid expansion in Montana and encourage HHS to work with the State to achieve it, but we recommend that HHS not approve certain waiver components that are not legal under Medicaid law and will harm consumers. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org) or Jane Perkins (perkins@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

A handwritten signature in black ink that reads "Elizabeth G. Taylor". The signature is written in a cursive, flowing style.

Elizabeth G. Taylor,
Executive Director