October 26, 2018

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

Re: Healthy Michigan Plan Section 1115 Demonstration Extension Application

Dear Secretary Azar:

Thank you for the opportunity to submit comments on Michigan's Section 1115 Demonstration Extension Application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage chronic health conditions. The diversity of our groups and the patients and consumers we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible healthcare coverage. Our organizations strongly support the Healthy Michigan Program, which has extended coverage to 655,000 low-income individuals and families in the state. This coverage helps patients access medications to manage chronic conditions, preventive services like cancer screenings, and many other treatments needed to stay healthy.

Several 1115 waiver proposals submitted to and approved by the Centers for Medicare and Medicaid Services (CMS) in recent months have jeopardized patients' access to quality and affordable healthcare coverage.[i] Michigan's proposed waiver similarly threatens access to healthcare by creating new financial and administrative barriers that could lead patients with serious, acute and chronic conditions to lose their healthcare coverage. Our organizations therefore offer the following comments on Michigan's proposal.

Premiums and Healthy Behavior Requirements

Under the waiver, individuals with incomes between 100 and 138 percent of the federal poverty level (approximately $1,372/month to $1,893/month for a family of two) would face new barriers to coverage after receiving 48 cumulative months of coverage through the Healthy Michigan program. These individuals would be required to pay monthly premiums equal to five percent of their income and complete or commit to an annual healthy behavior, unless they can demonstrate that they qualify for an exemption. Individuals who cannot meet this requirement will lose their coverage. A premium of five percent of monthly income will range from approximately $50 to $67 for an individual, a sizable cost for this low-income population. Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.[ii] This means that patients may cut back on the healthcare that they need to manage their condition and stay healthy. Additionally, our organizations are concerned that, instead of incentivizing healthy behaviors, the requirement to complete an annual healthy behavior will reduce coverage for individuals in need of care. Ensuring that Medicaid enrollees have access to comprehensive health coverage that includes all of the treatments and services that they need to live healthy lives would likely be a more effective approach to improving health of Medicaid enrollees in Michigan.

Work and Community Engagement Requirements

The Healthy Michigan Plan would also create a work and community engagement requirement. Individuals between the ages of 19 and 62 would be required to either demonstrate that they work at least 80 hours per month or meet exemptions. One major consequence of this proposal will be to increase the administrative burden on all patients. Individuals will need to attest that they meet certain exemptions or have worked the required number of hours on a monthly basis. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. Arkansas is currently implementing a similar policy requiring Medicaid enrollees to report their hours worked or their exemption. As of October, four months into implementation of the state's work and community engagement requirement, Arkansas has terminated coverage for 8,462 individuals and locked them out of coverage until January 2019.[iii] An additional 12,589 individuals who have either not met or not reported meeting the requirements for one or two months are at risk for losing coverage in the coming months.[iv] In another case, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[v] These experiences suggest that the new requirements will result in significant coverage losses and red tape for patients. Our organizations ask HHS to reject the work and community engagement requirements outlined in the proposal.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases, including lung diseases. If the state finds that individuals have failed to comply with the new requirements for three months, they will

be locked out of coverage for *at least* one month. Additionally, if the state finds that individuals have misrepresented their compliance, these individuals will be locked out of coverage for one year. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

Our organizations are also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from meeting these requirements. While we are pleased that patients will have the option to demonstrate that they qualify for an exemption through self-attestation, the reporting process still creates opportunities for administrative error that could jeopardize coverage. No exemption criteria can circumvent this problem and the serious risk to the coverage and health of the people we represent.

Administering these requirements will be expensive for Michigan. The Michigan House Fiscal Agency estimates that the state's administrative costs will be approximately $20 million, in addition to one-time information technology costs of up to $10 million.[vi] States such as Kentucky, Tennessee and Virginia have also estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.[vii] These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Most people on Medicaid who can work already do so.[viii] A study published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.[ix] The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. In another report looking at the impact of Medicaid expansion in Ohio, the majority of enrollees reported that that being enrolled in Medicaid made it easier to work or look for work (83.5 percent and 60 percent, respectively).[x] Terminating individuals' Medicaid coverage for non-compliance with these requirements will therefore hurt rather than help people search for and obtain employment.

The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. During the state comment period, Michigan stated that "MDHHS expects annual HMP enrollment to decrease but the total number of beneficiaries who will be impacted is unknown at this time." In the application submitted to CMS, the state stated that approximately 400,000 enrolled beneficiaries could be impacted by the waiver changes but did not provide a specific estimate of the number of enrollees who would lose coverage. According to one estimate by the Michigan House Fiscal Agency, up to 54,000 Michiganders will lose their coverage as a result of the work and community engagement requirements in the waiver.[xi] Based on the experiences in other states, the coverage losses are likely to be substantial. A recent analysis of Arkansas's experience implementing its section 1115 waiver revealed that informing enrollees about new requirements, expecting enrollees to understand complex rules, and having enrollees navigate complicated systems to track compliance or report exemptions has created confusion and resulted in thousands of enrollees losing coverage.[xii]

Our organizations are deeply concerned about the coverage losses associated with all of the proposals in this waiver. Collectively, we believe that healthcare should affordable, accessible and adequate. Michigan's Section 1115 Demonstration Extension Application does not meet that standard. Thank you for the opportunity to provide comments.

Sincerely,

American Heart Association
American Lung Association
Arthritis Foundation
Crohn's and Colitis Foundation
Epilepsy Foundation
Family Voices
Global Healthy Living Foundation
Hemophilia Federation of America
Leukemia and Lymphoma Society
Lutheran Services in America
NAMI, National Alliance on Mental Illness
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
National Psoriasis Foundation
Susan G. Komen
United Way Worldwide

CC: The Honorable Seema Verma, Administrator
Centers for Medicare and Medicaid Services

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[i] American Lung Association, A Coordinated Attack: Reducing Access to Care in State Medicaid Programs, July 2018. Accessed at http://www.lung.org/assets/documents/become-an-advocate/a-coordinated-attack.pdf.

[ii] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[iii] Arkansas Department of Health and Human Services, Arkansas Works Program, August 2018. Accessed at: https://ccf.georgetown.edu/wp-content/uploads/2018/09/091218_AWReport_Final.pdf; Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[iv] Arkansas Department of Health and Human Services, Arkansas Works Program, September 2018. Accessed at: https://m.arktimes.com/media/pdf/9.18_-_aw_work_requirements_report.pdf.

[v] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

[vi] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[vii] Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, https://www.rollcall.com/news/politics/medicaid-kentucky.

[viii] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 2018. Accessed at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[ix] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

[x] Ohio Department of Medicaid, 2018 Ohio Medicaid Group VII Assessment: Follow-Up to the 2016 Ohio Medicaid Group VIII Assessment, August 2018. Accessed at: http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf

[xi] Michigan House Fiscal Agency, Legislative Analysis of Healthy Michigan Plan Work Requirements and Premium Payment Requirements, June 6, 2018. Available at: http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf.

[xii] MaryBeth Musumeci, Robin Rudowitz and Cornelia Hall, "An Early Look at Implementation of Medicaid AWork Requirments in Arkansas," Kaiser Family Foundation, October 8, 2018, https://www.kff.org/medicaid/issue-brief/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas/?utm_campaign=KFF-2018-October-Medicaid-Arkansas-Work-Requirements.