August 5, 2016

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

Re: Healthy Ohio Program Section 1115 Demonstration

Dear Secretary Burwell:

We appreciate the opportunity to comment on Ohio's proposed Healthy Ohio Program (HOP) § 1115 Demonstration. The National Health Law Program (NHeLP) protects and advances the health rights of low income and underserved individuals. The oldest non-profit of its kind, NHeLP advocates, educates and litigates at the federal and state level.

NHeLP recommends that HHS not approve the HOP demonstration. The application includes numerous provisions unauthorized by any federal law and harmful to enrollees. Ohio's administration has been widely praised for its current Medicaid expansion that covers nearly 600,000 Ohioans. As a state that already expanded Medicaid, Ohio's new legislature-driven proposal to alter the administration's successful expansion should face a high "do no harm" standard for approval, especially given the strong and nearly universal opposition to the proposed demonstration expressed during the state comment period. Ohio's HOP application also raises serious procedural concerns regarding the § 1115 public process. We urge HHS to deny this application. We urge HHS to work with Ohio to preserve Medicaid expansion without harming current enrollees or jeopardizing enrollees in other states who may be affected by similar proposals. In its review, we urge HHS to zealously enforce its stated policies and the words of the Social Security Act's § 1115.

A. Transparency Requirements

Setting aside the substantive concerns addressed below, we believe HHS should deny Ohio's HOP application on procedural grounds. The Social Security Act requires the opportunity for a "meaningful level of public input" during the waiver application process, and in February 2012 HHS promulgated excellent

regulations at 42 C.F.R. § 431.400 et. seq. detailing that process.[1] Those regulations require, among other things, a state-level transparency process that includes public hearings and a public notice and comment period.[2] While Ohio did conduct the required processes, they explicitly submitted the Federal application without any consideration of the state level comments. Of 956 comments received, the state found that only 1% of them were "Supportive of Heathy Ohio," while large majorities found the proposals would be unaffordable (84%), decrease enrollment (72%), be too confusing (65%), cause individuals to forego care (63%), and disrupt continuity of care (57%), among other concerns.[3] Despite these serious concerns and the telling 1% support rate, Ohio's administration was "unable to modify" the proposal because it felt the terms of the legislation requiring the waiver request are fixed.[4] Effectively, therefore, this proposal was submitted for federal review without any possible modifications based on the state-level public process.

Regardless of a state's reasons, we believe that HHS cannot approve a demonstration that does not include a meaningful state comment process. Though in some cases it may be difficult to ascertain whether there was "meaningful" consideration of the state-level feedback, there can be no doubt that there was simply *no* consideration in this case. HHS must deny this proposal because of noncompliance with the legally mandated transparency process.

We also believe HHS should deny this request to set a clear precedent for future state legislatures. If state legislatures can define the required terms of a demonstration proposal so narrowly so as to foreclose any meaningful changes in the state-level hearing, notice, and comment process, it could eviscerate the transparency requirements. CMS must not allow state legislatures to make the state-level public process an exercise in futility.

B. Existing Enrollees

HHS has approved several Medicaid Expansion § 1115 demonstrations that include unprecedented waivers that in many cases negatively impact access to care for consumers and also conflict with the legal requirements for such demonstrations. HHS in some cases likely approved these waivers because, in exchange for the waivers, HHS could secure a Medicaid expansion that would cover thousands of individuals in an unexpanded stated.

Applications like Ohio's, which request modifying coverage for individuals *already* enrolled, create an entirely different cost-benefits analysis. HHS should set a higher standard for approving extensions or amendments to existing Medicaid expansion programs. Altering an existing demonstration risks worsening access to care for current enrollees. Moreover, approving such harmful provisions in the majority of states that have now expanded Medicaid could encourage widespread regression. HHS should not

[1] SSA § 1115(d)(2)(A).
[2] 42 C.F.R. § 431.408.
[3] Healthy Ohio Program 1115 Demonstration Waiver application, p. 41.
[4] Healthy Ohio Program 1115 Demonstration Waiver application, p. 41.

approve any waivers in Ohio that worsen care for current expansion enrollees, as our discussion below illustrates.

In addition, Ohio proposes to enroll "all non-disabled, Medicaid-eligible adults age 18 and older" into HOP."[5] The potential harm of the waivers Ohio requests will not be limited to Medicaid expansion enrollees. This would reduce access to care for a broader scope of current enrollees, and is a problematic precedent for all Medicaid enrollees nationwide. We recommend that CMS maintain a clear line that excludes non-expansion populations from potentially harmful waivers targeted at expansion populations. This is another reason that HHS should not approve Ohio's demonstration application.

C. Premiums and Cost Sharing Generally

Ohio's § 1115 application contains numerous premium and cost sharing features (each discussed below) which are not approvable under § 1115. Specifically, the proposal repeatedly violates three core requirements for § 1115 demonstrations:

- Section 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902.[6] Anything outside of § 1902 is not legally waivable through the §1115 demonstration process. Sections 1916 and 1916A are requirements independent of § 1902 and cannot be waived through § 1115. Even if this were not true, any waiver of cost sharing in § 1916 must comply with the waiver requirements of § 1916(f) – the only legal channel for such waivers. Ohio attempts to waive cost sharing requirements in § 1916 through § 1115 without meeting § 1916(f) requirements.
- A § 1115 demonstration is precisely that, a demonstration. Ohio's requests for § 1115 authority regarding premiums and cost sharing are not approvable because they will not test anything novel, given the well-known results of redundant studies on cost sharing and premiums. For example, a principal feature that Ohio seeks to waive, premiums for low-income enrollees, has been repeatedly tested and consistently shown to depress enrollment – including for the very populations of adults that is the focus of the Ohio proposals. *See* 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.
- Finally, § 1115 demonstrations must also be "likely to assist in promoting the objectives" of the Medicaid program. The objective of Medicaid is to furnish health care to low-income individuals. Many of the enhanced premium and cost sharing elements in Ohio's proposal cannot be approved because they would reduce access to care. The Social Security Act, particularly § 1916A, provides states with a great deal of flexibility to

[5] Healthy Ohio Program 1115 Demonstration Waiver application, p. 6.
[6] SSA § 1115(a)(1).

impose premiums, cost sharing, and similar charges. Yet, Ohio seeks to run past these options to implement proposals which research has established are harmful to low-income people, and which will clearly result in interrupted care, lost opportunities, and churning.

D. Premiums

Ohio's proposed plan is premised on monthly "contributions" that fund a quasi health savings account (HSA) model, the "Buckeye Account." But Ohio's proposed plan effectively requires premiums for populations legally exempt from Medicaid premiums, including those below 150% FPL. Ohio's extreme concern with consumer "skin in the game" 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. More importantly, reflecting decades of research into the subject, the Social Security Act specifically prohibits some of the essential HSA features that Ohio requests. Ohio's proposal, as designed, is not approvable by HHS.

Under current law, HHS should not approve monthly contributions for any individuals below 150% FPL.[7] "Any enrollment fee or similar charges" are illegal for this very-low-income population, whether they are called monthly fees, assessments, contributions, or premiums. [8] Ohio's "monthly contributions" meet the federal definition of a premium or similar charge. Given that monthly contributions are not permitted for this population below 150% FPL, *termination* for non-payment of contributions should also never be approved. Even if, contrary to law, HHS considered a waiver of the premium prohibition, it should still not be approvable because, given the well-established studies on the impact of premiums on low-income people, there is no experimental value to premiums nor do they promote the objectives of the Medicaid program, as required by § 1115(a).[9] **These studies may be confirmed by Ohio's *own* finding that over 125,000 individuals will lose coverage in 2018, the year HOP would start, relative to enrollment without HOP**.[10] Premiums for those living on incomes below 100% FPL are especially concerning, since they contradict the structure of the ACA, numerous Medicaid cost sharing protections set at 100% FPL, and no enforceable premiums have been approved to date for this population. We note, however, that, under the law, premiums are equally impermissible for individuals below 150% FPL whether they are mandatory or optional.

Ohio's proposed premiums should also be denied because they dramatically increase the population that might be subject to premiums. As mentioned earlier, the HOP

[7] *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).
[8] SSA § 1916A(a)(3)(A).
[9] 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).
[10] Healthy Ohio Section 1115 Demonstration Waiver: Summary, available at: http://medicaid.ohio.gov/Portals/0/Resources/PublicNotices/HealthyOhio-Summary.pdf.

proposal targets all non-disabled, Medicaid-eligible adults age 18 and older. HHS should not extend premium provisions, which have sometimes targeted expansion enrollees, to broader Medicaid populations. Some of the targeted groups are expressly exempted from cost sharing and premiums under the Medicaid statute. Ohio's proposal only exempts one group from its general premium requirement: pregnant women. The premiums will therefore be charged to numerous groups explicitly exempted in the statute, including women eligible for the breast and cervical cancer project, foster youth/ Title IV-E eligible children, and some services for Native Americans.[11] (We note, additionally, that some of the targeted groups, such as low-income 19 and 20 year olds, may not have been explicitly exempted in the statute because the statute *entirely* prohibits premiums on them as populations below 150% FPL, thus a prohibition in § 1916A(b)(3)(A) would have been nonsensical.)[12] In short, the proposed HOP premiums violate *both* the prohibition on premiums below 150% FPL *and* the prohibition on premiums for excluded populations that apply even when premiums can be charged to a small set of higher-income individuals. Such a policy would stand even more in conflict the objectives of Medicaid, a statutory prerequisite to approving the waiver. Instead of helping furnish care to low-income individuals, this provision will decrease participation in HOP, leaving more of these especially vulnerable populations in need.

E. Premium Waiting Period and Lockout

Ohio requests waiver authority to (1) delay enrollment of eligible individuals until a month in which they pay their premiums, and (2) bar individuals who have been terminated for failure to pay premiums from en-enrolling until they pay owed premiums. These waiting period and lockout provisions are a direct violation of the statutory requirement to enroll eligible individuals with "reasonable promptness."[13] In both cases, the requested waiver of this provision should not be approved because it clearly does not promote the objectives of Medicaid nor does it have any experimental value. As a matter of policy, waiting periods will do great harm to many individuals who will receive coverage *later* after applying, and we note that many individuals become eligible for Medicaid contemporaneous with serious and urgent medical needs. (See also the discussion of retroactive eligibility waiver below). Similarly, lockouts will severely harm individuals who need coverage but cannot afford to pay their past debts. Both policies grossly contradict the basic intent of the Affordable Care Act and well-established policy best practice of encouraging continuity of care in health coverage, as well as Ohio's stated goal of decreasing churning. We note they will also harm Ohio's provider infrastructure, as providers will continue to treat uninsured patients.

We note that Ohio places no limit whatsoever on the length of the waiting period or lockout, meaning the state could effectively *never* enroll an individual who doesn't pay the premium or *permanently* exclude one who cannot pay the debt. If HHS approved Ohio's request it would effectively set a precedent allowing states to implement unauthorized conditions of eligibility that totally block enrollment for some eligible individuals.

[11] SSA § 1916A(b)(3)(A)(i), (v), and (vii); 42 C.F.R. § 447.56(a)
[12] *See* SSA §§ 1916(c), 1916A(b)(1)(A).
[13] SSA § 1902(a)(8).

In addition to a waiver of § 1902(a)(8), Ohio also requests a waiver of § 1902(a)(3) to implement the waiting period and lock out. We are not aware of any previous waiver of this critical due process protection, and we strongly recommend that HHS never approve a waiver of this requirement. A waiver of this requirement in the context of Medicaid application, coupled with a waiver of reasonable promptness, would allow states to keep legal beneficiaries in limbo, without benefits or a path to benefits other than payment of premiums which themselves were charged contrary to the terms and objective of the Social Security Act.

Ohio *also* requests a waiver of "[e]ligibility" in § 1902(a)(10)(A) to implement the waiting period. We do not believe there is any reason for HHS to entertain this request since it is functionally equivalent to the requested waiver of § 1902(a)(8). At the same time, the potential problems with waivers allowing modifications of underlying eligibility categories, and the related precedents they set, are extremely grave. HHS should avoid approving such waivers at all costs.

Ultimately, we rank waivers of §§ 1902(a)(3), 1902(a)(8), and 1902(a)(10)(A) eligibility, among the most dangerous waivers HHS could possibly approve. These three provisions are cornerstones of the Medicaid entitlement for enrollees, as it is codified into the statute. They are the provisions that set out who is eligible, require states to enroll those eligible individuals, and allow such individuals to redress the failure of the state to do so. HHS should not waive these provisions under any circumstances.

F. Copayments

The Buckeye Account requires cost sharing from all participants, including groups that the Social Security Act specifically protects and exempts from cost sharing. (We note that, while there are no federally-recognized tribes in Ohio, many Native Americans living in Ohio are likely exempt from cost sharing.) As discussed above, these kinds of cost sharing policies cannot be approved through § 1115, and if they could, they would be required to comply with a waiver under § 1916(f). Subjecting these vulnerable populations to mandatory cost sharing has no demonstrative value and does not further the objectives of Medicaid; even the specter of cost sharing may reduce participation in the program.

In its waiver request, Ohio requests permission to charge copays for "all covered services." HHS should not approve any cost sharing for services excluded from cost sharing under the regulations.[14]

The HOP program implements arbitrary cost sharing standards that will confuse consumers without providing them any benefit. The two-tiered, segregated HSA is overly complex. It includes a "core portion" and a "non-core portion," each with distinct

[14] See 42 C.F.R. § 447.56(a)(2).

mechanisms for filling the account, different purposes the account can be used for during enrollment, and different policies for using or transferring the account after disenrollment. In addition, there are detailed rules around carrying forward value from year to year, preventive service incentives, rewards points, and other features.

Even sophisticated health policy analysts, well-versed in such designs, have difficulty understanding this design. Consumers and providers alike will suffer from this system; the complexity of the Buckeye Account will cause more problems than Ohio claims it will solve. The theoretical incentives Ohio wishes to create will fail to materialize due to the certain and inevitable confusion the system will create.

G. Annual and Lifetime Limits and Deductibles

The HOP proposal includes provisions to include mechanisms termed "Annual and Lifetime Limits" and "Deductibles." While these provisions do not implement such policies as they are commonly understood, we urge HHS to avoid approving any policy using such a name. We believe it would create confusion for other states that might pursue more problematic limits or deductibles. Regardless of the practical impact, we believe it would be harmful to approve an "amount, duration, and scope" waiver to allow "annual and lifetime limit." Furthermore, these policies may confuse consumers who may avoid care thinking they will be forced to pay a deductible or run into care limits.

With respect to the annual limits, we also believe it is problematic that consumers could hit their limit, be transitioned out of HOP, and then be transitioned back in the next year, and that this pattern could repeat year after year. We believe this policy is terrible for continuity, will confuse consumers, and contradicts Ohio's stated goal of reducing churning. We have similar concerns for the requested 90-day limit on long term services and supports (LTSS) enrollment, which will also create churn for vulnerable populations by moving them between managed care and fee for service plans.

H. Incentive Points and the Bridge Account

Adding to the complexity of Ohio's proposal is the Healthy Incentives Points system. These points (equivalent to dollars) may be credited to or deducted from the "core portion" of the Buckeye Account. Healthy Incentives Points may carry over to new policy periods if certain, as yet undefined preventive care goals are met. Rollover of "non-core" state contributions is contingent on the same goals.

The preventive services goals will unfairly benefit some consumers more than others. Consumers with more challenges – whether health conditions or social determinants of health – will be less likely to meet the requirement, and this will likely be discriminatory in practice and worsen health disparities. Additionally, consumers in poor health are likely to need treatment rather than preventive services, or they may be less able to complete preventive services goals. HHS should not approve what will likely be a discriminatory system, and should carefully monitor for discriminatory policies if any approval is issued.

Ohio also touts a "Bridge Account," which allows consumers to retain portions of the Buckeye Account when they obtain private or employer-sponsored insurance. The Bridge Account is presented as a mechanism to reduce churn. However, the majority of consumers will likely receive no benefit from the Bridge Account. The portion of the premiums they were charged that were not depleted via cost sharing may be small. State contributions in the Bridge account are likely to be minimal, because of the use of these funds as a "deductible." Additionally, state contributions are only included in the Bridge Account if the preventive services goals mentioned above are met, which is a remote possibility for many vulnerable enrollees. Experiences with previous 1115 demonstrations show that many consumers may not understand how these incentive systems work, or even be aware of the types of "benefits" that may be available.[15]

I. Retroactive Eligibility

Medicaid requires states to provide retroactive coverage for enrollees.[16] Ohio has requested § 1115 demonstration authority to waive this requirement. This waiver should not be allowed because there is no demonstrative value to the request. The entirely predictable result will be: (1) more low-income individuals experiencing medical debt collections and bankruptcy; (2) more providers – especially safety net hospitals – incurring losses; and (3) more individuals experiencing gaps in coverage when some providers refuse to treat them because the providers know they will not be paid retroactively by Medicaid. This policy has dubious hypothetical benefits and very concrete harms. For these same reasons, the § 1115 demonstration should not be approved because this does not promote the objectives the Medicaid.

J. Freedom of Choice for Family Planning Services and Supplies

The Healthy Ohio Plan application includes a broad request for waiver of freedom of choice. We recommend that any approval is clear that there is no waiver of freedom of choice for family planning services and supplies, and include language similar to the language in HHS's freedom of choice waiver in Indiana: "No waiver of freedom of choice is authorized for family planning providers." [17] The Social Security Act specifically requires freedom of choice for family planning services and supplies, even in managed care arrangements.[18] HHS and a number of district and federal circuit courts of appeal have consistently made clear that enrollees are entitled to obtain family planning services and supplies from any qualified Medicaid provider whether in or out of network.[19] Therefore, HHS should clarify that, regardless of any approval of freedom of choice waiver requests in the Healthy Ohio Plan, individuals remain entitled to obtain out-of-network coverage for family planning services and supplies, regardless of

[15] THE LEWIN GROUP, INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT 66-67 (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf (report commissioned by IN Family and Social Svcs. Admin.), stating that "survey data suggest that a large majority of HIP 2.0 members may not be aware of the HIP 2.0 policy that would allow them to get no-cost preventive care."

[16] SSA §§ 1902(a)(34); 42 C.F.R. § 435.915.

[17] Letter from Marilyn Tavenner approving Health Indiana Plan 2.0, 6 (Jan. 25., 2015).

[18] SSA § 1902(a)(23)(B).

[19] *See* CMS, State Medicaid Manual, § 2088.5.

whether there are available in-network family planning providers.

Conclusion

In summary, we have numerous concerns with the legality of Ohio's § 1115 demonstration application, as proposed. We fully support the use of § 1115 of the Social Security Act to implement true experiments. We strongly object, however, to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Social Security Act to protect Medicaid beneficiaries and ensure that the program operates in the best interests of the population groups described in the Act. We urge HHS to address our concerns prior to issuing any approval. If you have questions about these comments, please contact Leonardo Cuello (cuello@healthlaw.org). Thank you for consideration of our comments.

Sincerely,

Leonardo D. Cuello