December 15, 2017

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Matt Wimmer
Administrator
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Idaho Department of Health and Welfare
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Re: Idaho Combined 1332 and 1115 Waiver Proposals

Dear Commissioner Cameron and Administrator Wimmer:

The American Cancer Society Cancer Action Network (ACS CAN) Idaho appreciates the opportunity to comment on Idaho's proposed joint Section 1332 and 1115 waiver applications. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Access to health care is paramount for persons with cancer and survivors. An estimated 7,310 Idahoans are expected to be diagnosed with cancer this year and an estimated 70,970 Idahoans are cancer survivors.[1] For these Idahoans, access to affordable health insurance can be a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[2]

ACS CAN supports a robust marketplace from which consumers can choose a health plan that best meets their needs. We also support state flexibility and efforts to improve eligibility, quality, efficiency, and effectiveness in Medicaid through innovative approaches. States that expanded their Medicaid program have seen significantly greater gains in coverage compared to those that have not expanded their programs.[3,4] Additionally, states that have expanded Medicaid coverage have seen a trend towards early-stage diagnosis for select cancers[5] as well as increased smoking cessation among low-income

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[1] American Cancer Society. *Cancer Facts & Figures 2017*. Atlanta, GA: American Cancer Society; 2017.
[2] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-with-cancer-care.
[3] Soni A, Sabik LM, Simon K, Sommers BD. Changes in insurance coverage among cancer patients under the Affordable Care Act. *JAMA Oncol.* Published online October 19, 2017. doi: 10.1001/jamaoncol.2017.3176.
[4] Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among nonelderly patients with cancer after the Affordable Care Act. *J Clin Oncol.* Published online September 8, 2017. doi: 10.1200/JCO.2017.73.7817.
[5] Jemal A, Lin CC, Davidoff AJ, Han X. Changes in insurance coverage and stage at diagnosis among nonelderly patients with cancer after the Affordable Care Act. *J Clin Oncol.* Published online September 8, 2017. doi: 10.1200/JCO.2017.73.7817.

expansion adults[6] due to improved access to preventive health care services and evidence-based smoking cessation services. We share your concern that thousands of Idahoans currently lack access to comprehensive coverage, in part because the state has not expanded the Medicaid program. We believe that the proposed joint waivers seek to address this issue, but unfortunately fall short of expanding coverage to all low-income Idahoans.

As discussed in more detail below, we have a number of questions and concerns with the proposed waivers – both as individual waivers as well as the policy issues that may arise with simultaneous implementation of the waivers. **We strongly urge the State to work with Idaho stakeholders to address these issues before proceeding with federal approval of the waivers.** As a precursor to potential future discussions, we offer the following detailed comments:

Comments on the Joint Waiver Proposals

Under the proposed 1332 and 1115 waivers, individuals whose income is between 138 percent to 400 percent of the federal poverty level (FPL) who otherwise would qualify for advanced premium tax credits (APTCs)[7] and have one of the identified hierarchical condition categories (HCC) categories listed in the 1115 waiver application would move from the marketplace to the Medicaid program. This proposal raises a number of questions:

Required vs. optional policy: **It is not clear whether individuals who meets the HCC would be "strongly encouraged" to move to the Medicaid program (either through financial or other incentives) or whether they would be required to move to the Medicaid program from the Marketplace.** It is also unclear whether individuals could choose to remain in the Marketplace and forego access to APTCs or whether they would be denied that option outright. We urge the State to clarify its intent.

Moving Between Coverage: **The proposed waivers are not clear on what happens if an individual is diagnosed with one or more HCCs during the middle of the plan year.** For example, would the individual be permitted to remain in the marketplace plan (and continue to be entitled to receive the APTCs) or would the individual be immediately moved into the Medicaid program upon diagnosis of one of the HCCs?

If the diagnosis of one or more of the HCCs becomes a triggering event that requires the individual to move to the Medicaid program, such policy raises a number of questions. It is not clear how the State will be alerted to the fact that the individual has received a diagnosis of one or more of the HCCs. Will the marketplace plan be required to conduct routine chart reviews to determine whether a diagnosis has been made? Will participating providers be required to notify the state if an enrollee is diagnosed with one or more HCCs? If so, how will the provider know whether the individual qualifies for an APTC or whether they are enrolled in a marketplace plan without qualifying for any tax credits. This requirement seems overly burdensome on the marketplace plan, and indeed, is not a requirement imposed on any marketplace plan offered in any other state.

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[6] Koma JW, Donohue JM, Barry CL, Huskamp HA, Jarlenski M. Medicaid coverage expansions and cigarette smoking cessation among low-income adults. *Med Care.* 2017; 55: 1023-29.

[7] For purposes of this comment letter, unless otherwise stated references to "APTCs" are presumed to include individuals who also meet the eligibility requirements to obtain CSRs, which are available to individuals whose income is between 100 percent and 250 percent of FPL.

Continuity of Care Issues: Cancer patients undergoing an active course of treatment for a life-threatening health condition, such as cancer, need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes.

It is unclear from the waivers, how the State intends to ensure that individuals transitioning from one type of insurance coverage to another can continue to see their health care provider if medically necessary. Failure to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic condition like cancer, could have devastating effects on patients, their families, and providers.

We strongly urge the State to add additional continuity of care provisions that would minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses, such as cancer. We urge the State to establish a clearly defined process through which enrollees being transitioned to either the marketplace or Medicaid can inform the Department that they are in active treatment, allowing them to maintain their cancer care treatment regimen and continue to see their providers through the same health care systems through the end of their treatment. This will ensure that the Department's goal of establishing "consistent and reliable coverage" is met.

New Enrollees: **It is unclear from the waivers whether a new enrollee (one who previously had private insurance and did not receive coverage under a marketplace plan) and who has one or more HCCs – but who is no longer in active treatment for the condition – would be required to enroll in coverage in the Medicaid program (and be denied access to coverage in the marketplace).** For example, if an individual lived in another state and received successful treatment for lung cancer, it is not clear whether the previous diagnosis of lung cancer would preclude the individual from enrolling in the Marketplace or whether the pre-existing condition would require the individual to enroll in Medicaid.

We note that due to advancements in lung and brain cancers, the long-term survival of these diseases has increased.[8] In addition, advancements in pediatric oncology treatments have resulted in improvements in long-term mortality rates for childhood cancer.[9] If a child successfully completes treatment for cancer, it is unclear whether the diagnosis will permanently exclude the individual from receiving APTCs in the marketplace.

Enrollee notification: **Assuming that a diagnosis of one or more HCCs constitutes a triggering event that causes the individual to leave the marketplace plan and obtain coverage under the Medicaid program, it is unclear how the individual will be notified of the change in coverage.** Neither waiver makes any mention of whether there is an affirmative requirement that the individual cease enrollment in the marketplace and subsequently affirmatively applies for coverage under the Medicaid program. It is hard to imagine how an individual would be made aware of these requirements, unless notified by the State. We would caution that if such policy were to be implemented (e.g., the individual was required to switch coverage) such notification should not be made to the individual in the form of notice of termination of APTCs. Such a policy would be overly burdensome because it remains unclear under the waivers where (and if) the individual would receive coverage during the adjudication of an appeal. A

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[8] American Cancer Society. *Cancer Treatment & Survivorship Facts & Figures 2016-2017.* Atlanta, GA: American Cancer Society; 2016.

[9] Alliance for Childhood Cancer and American Cancer Society. *Translating Discovery into Cures for Children with Cancer.* Atlanta, GA: 2016.

denial of coverage during the adjudication of an appeal could raise a number of federal due process requirements.

Family coverage: **Both waivers are silent on what happens in cases where one or more of the members of a family who have obtained family coverage in the marketplace and receive APTCs are diagnosed with one or more of the HCCs during the plan year.** Conceivably the individual(s) who have one or more of the HCCs would be required to obtain coverage under the Medicaid program. However, were this policy to be implemented, it changes the coverage for the other family members who could remain in marketplace and receive APTCs. For example, if a family is enrolled in coverage that counts all enrollee's costs towards the family deductible, then removing a high-cost family member will have financial ramifications for the family members who remain covered under the marketplace plan (i.e., they may have a harder time meeting their combined deductible).

Remaining uninsured: It is not clear from the combined waivers whether the waivers intend to provide universal coverage for all Idahoans or whether specific populations may still remain uninsured under this waiver. Table 4 (below) clearly indicates that if the state simply expanded its Medicaid program 186,000 individuals under 400 percent FPL would receive coverage through the expansion or Marketplace APTCs/CSRs, whereas under the proposed joint waivers, only 109,000 individuals under 400 percent FPL would receive coverage:

Table 4

Insured Lives			
Income Level	**Status Quo**	**Medicaid Expansion**	**1332/1115 Waiver**
<100% FPL	0	79,000	22,000
100% to 138% FPL	21,000	40,000	21,000
139% to 400% FPL	67,000	67,000	66,000
Total	**88,000**	**186,000**	**109,000**

From this table, 77,000 Idahoans would still be without coverage under the combined waivers (relative to a traditional Medicaid expansion).

We strongly urge Idaho to provide additional information on the populations of individuals who may remain without health insurance coverage under these waivers. For example, it appears from the information provided in the 1332 waiver, that 78,000 Idahoans[10] currently lack health coverage due to the fact that the State did not expand its Medicaid program. At the same time, Table 3 estimates that 22,000 Idahoans would receive APTCs and CSRs under the 1332 waiver proposals.

[10] Page 2 of the 1332 waiver application states that "Idaho estimates that 78,000 Idaho residents have incomes under 100% FPL and are without health coverage." Page 5 of the same document states that "Another 79,000 Idahoans with incomes under 100% FPL would also gain eligibility through the Medicaid expansion."

Comments Specific to the Section 1332 Waiver

Amount of CSR Subsidy: Under federal law, individuals between 100 percent and 250 percent of FPL qualify for cost-sharing reduction subsidies, depending on the person's income. Idaho seeks to waive this requirement to extend CSRs to individuals below 100 percent of the FPL. **While we applaud the State for seeking a creative solution to provide coverage to individuals below 100 percent FPL, it is not clear from the waiver how much subsidy will be provided to individuals below 100 percent FPL.**

The CSRs were designed by Congress for individuals whose income is between 100 to 250 percent FPL. Extending CSRs to some individuals below 100 percent FPL will help some qualifying individuals afford coverage. However, it is not clear whether under the waiver the state intends to provide a greater subsidy for individuals under 100 percent FPL. For example, a childless adult at 50 percent FPL would pay a greater share of his/her income for coverage under the waiver than an individual at 100 percent FPL. We are concerned that lower-income individuals – the very people to whom this waiver is intending to extend coverage – may still not be able to afford coverage even under the waiver. We do not believe this is the State's intent and ask for further clarification on how to ensure that low-income individuals can afford coverage under the waivers.

Work Requirements Unclear: Throughout the 1332 waiver, references are made to "working Idaho households." **It is unclear whether this is a term of art intended to refer to Idahoans who do not meet eligibility for other coverage (e.g., coverage under the Children's Health Insurance Program (CHIP)) or whether Idaho is intending to impose a work requirement, as other states have sought to do under their 1115 waiver demonstration authority.**

We would be concerned that proposing any type of work requirement as a condition of eligibility for Idahoans to maintain their health care could adversely impact the most vulnerable Idaho residents, particularly low-income cancer patients and survivors. A work requirement as a condition of eligibility could severely limit eligibility and access to care for low-income Idaho residents managing complex chronic conditions, including cancer patients and recent survivors. While we understand the intent of a work requirement is to further encourage employment, many cancer patients in active treatment are often unable to work for periods of time or require significant work modifications due to their treatment.[11,12,13] Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.[14] If this requirement is included as a condition of eligibility for coverage, many cancer patients could find they are ineligible for the lifesaving cancer treatment services provided through their Marketplace insurance plan or the Medicaid program.

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[11] Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

[12] de Boer AG, Taskila T, Tamminga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

[13] Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv*. 2016; 10:480. doi: 10.1007/s11764-015-0492-5.

[14] Ramsey SD, Blough DK, Kirchhoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy then People Without a Cancer Diagnosis. *Health Affairs*. 2013; 32(6): 1143-1152.

If it is the Departments' intent to include a work requirement as a condition of eligibility, we urge the Departments to utilize the federal medically frail designation (42 CFR §440.315(f)) that would exempt individuals with serious, complex medical conditions from the proposed work requirement – particularly those with cancer and recent survivors. With respect to cancer, the definition of medically frail should explicitly include individuals who are currently undergoing active cancer treatment – including chemotherapy, radiation, immunotherapy, and/or related surgical procedures – as well as new cancer survivors who may need additional time following treatment to transition back into the workplace.

High-Risk Pool: **The 1332 waiver makes several references to the Idaho Individual High Risk Pool (IIHRP), however the application provides little information regarding how this program will be utilized. We urge the State to provide further clarification.** One can assume from the application that the IIHRP will be utilized as an "invisible" high-risk pool, which is more akin to a reinsurance program rather than a high-risk pool that requires individuals with certain conditions to obtain coverage only through the high-risk pool. We strongly urge the State to utilize an IIHRP more akin to a reinsurance program. Similar programs adopted in other states have been shown to prove successful in reducing premiums and adding some stability to the market.

Federal Budget Neutrality: The 1332 waiver states that proposed policies will be budget neutral to the federal government. The application also notes that the State is currently working on actuarial certifications, which it intends to submit to CMS as part of its final application in January 2018. While we are pleased the proposed waiver is anticipated to meet the budget neutrality requirement, we are disappointed that such actuarial analysis was not included as part of the proposal that was made available for stakeholder input.

We strongly urge the State to make the actuarial analysis available for public review and comment before a federal application is sought. Not only will this ensure compliance with the federal requirements – which require a public notice and comment period for the complete application – but it will also allow stakeholders the opportunity to review the actuarial analysis to determine its impact. Without this analysis stakeholders are not made aware of whether the federal requirement has been met. If the federal budget neutrality requirement is not met, it is not clear whether the State intends to make other changes – such as reducing eligibility or benefits and/or increasing premiums and cost-sharing – to ensure compliance with the budget neutrality requirement. Were such changes proposed, given that they would significantly impact that overall scope of the waiver, we would strongly urge the State to resubmit the application for public review and comment at the state level before submitting an application for federal approval.

Comments Specific to the Section 1115 Demonstration

Hierarchical Condition Categories: Under the 1115 waiver, individuals who meet certain eligibility criteria[15] and who have one of the hierarchical condition categories (HCC) laid out in the waiver application will be eligible for a new category of Medicaid eligibility, referred to as "Medically Complex Individuals." We note that some, but not all cancer types are included in the HCC categories. Neither the 1332 waiver nor the 1115 waiver offers any evidence or justification for how they chose the 24 HCC categories. **We ask for clarification on how and why the Idaho Department of Health & Welfare chose these categories.**

We note that earlier versions of the 1115 waiver contained fewer HCCs than the application dated November 22nd. We ask that the state provide additional information on why new HCCs were included and whether the State intends to make any additional HCCs should it choose to file a federal application. We also ask that the Department provide information on the process they would utilize to add any future changes to the list of HCCs.

Network Adequacy: Idaho's 1115 waiver states that the managed care provider networks currently in place will be utilized. However, according to the Health Resources & Services Administration (HRSA),[16] the *2016 Idaho Primary Care Needs Assessment*,[17] and *Get Healthy Idaho* publication from the Idaho Department of Health & Welfare,[18] Idaho appears to have provider shortages throughout the state. **We request clarification from the Department on how they will ensure the greatest possible provider participation in the Medicaid program to ensure that the additional 5,000 Medically Complex Individual enrollees they expect to add to the program will have adequate network coverage of their complex medical needs.**

We note that qualified health plans (QHPs) in the marketplace are required to adhere to certain network adequacy requirements. We fear that moving individuals from marketplace coverage into the Medicaid program may limit an individual's ability to access a medically necessary provider. To the extent that plan networks may be limited in the Medicaid program, particularly if due to the provider shortages in the State, we urge the State to consider allowing individuals to remain in the marketplace (with access to APTCs) in order to ensure they can continue to have access to the providers needed for their care.

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[15] Under the waiver, individuals would be deemed eligible for the new Medicaid eligibility category if they (1) are under the age of 64 years of age; (2) are not otherwise eligible for Medicaid; (3) do not have access to an affordable employer-sponsored plan; and (4) make up to 400 percent FPL.

[16] Health Resources & Services Administration. *Map Tool: Health Professional Shortage Areas.* Updated November 30, 2017. Accessed at https://datawarehouse.hrsa.gov/Tools/MapTool.aspx?tl=HPSA&gt=State&cd=16&dp=PC .

[17] Idaho Department of Health and Welfare. *2016 Idaho Primary Care Needs Assessment*. Published January 2016. Accessed at http://healthandwelfare.idaho.gov/Portals/0/Health/Rural%20Health/2016%20IDAHO%20PRIMARY%20CARE%20NEEDS%20ASSESSMENT.pdf.

[18] Idaho Department of Health and Welfare. Division of Public Health. *Get Healthy Idaho: Measuring and Improving Population Health*. Updated January 2017. Accessed at http://healthandwelfare.idaho.gov/Portals/0/Health/Get_Healthy_Idaho.vers2017.online.pdf.

Conclusion

We appreciate the opportunity to provide comments on Idaho's proposed joint 1332 and 1115 demonstration waivers. In light of the comments raised above, we believe the current waiver should undergo a significant redraft before the proposal is submitted to HHS. We stand ready to work with you and other stakeholders to ensure that the proposed waivers are designed in a manner that ensures that consumers have access to the comprehensive coverage that meets their needs, both in the individual market and Medicaid program. If you have any questions, please feel free to contact me at Luke.Cavener@cancer.org or 208-695-4536.

Sincerely,

Luke Cavener
Government Relations Director
Idaho American Cancer Society Cancer Action Network