The Honorable Tom Price, Secretary

United States Department of Health and Human Services

200 Independence Ave., SW

Washington, DC 20201

Submitted electronically via *Medicaid.gov*

Re: Comments on Iowa's IHWP request to waive three month retroactive coverage

Dear Secretary Price:

Families USA is grateful for the opportunity to comment on the state of Iowa's waiver amendment request to modify its existing waiver, Iowa Health and Wellness Plan (IHWP).

Families USA a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans.

We are strongly in support of Iowa's decision to accept federal funding to extend Medicaid to more low income parents and adults. However, the amendment to waive retroactive coverage runs contrary to the objectives of the Medicaid program and that would diminish Medicaid enrollees' ability to access health care.

Our concerns and suggestions are discussed in greater detail below. Many of these concerns can, and should, be addressed during the waiver amendment approval process.

CMS should reject Iowa's request to waive mandatory three-month retroactive eligibility.

Iowa's request to waive Section 1902(a)(34) of the Social Security Act, which requires three months retroactive coverage for newly eligible individuals, does not promote the objectives of the Medicaid program and the state does not adequately justify its request. Iowa's rationale for the amendment is based on the commercial market practice not to begin coverage retroactively; the state seeks to align Medicaid coverage with private coverage while encouraging continuous enrollment. Unlike the commercial market, however, Medicaid beneficiaries must re-establish eligibility annually, leading to significant annual disenrollment at renewal even for people who are otherwise eligibility. This leads to gaps in Medicaid coverage, and retroactive payment can help to preserve access to care despite these gaps.

The state provides no data support the assertion that the absence of retroactive eligibility will encourage continuous coverage or better prepare individuals for private coverage. Instead, the research bears out that repeal of retroactive coverage will lead to greater consumer debt and hospital uncompensated care, in opposition to the objectives of the Medicaid program.

Without retroactive coverage, many individuals who are admitted to the hospital for emergencies and other catastrophic illnesses may incur substantial medical bills while they wait for Medicaid coverage to kick in. Indiana state data shows that individuals racked up an average of $1,561 in Medicaid bills prior to Medicaid coverage becoming active under that state's waiver of retroactive coverage.[1] With retroactive coverage, Medicaid keeps these bills from becoming medical debt. Medical debt makes it harder for low income people to get ahead; it contributes to half of all bankruptcies in the United States.[2] High debt and bankruptcies make it harder for low-income people to obtain credit and do things that will help them get ahead, such as buying a car, which can expand job opportunities. By increasing enrollees' medical debt and the associated financial burdens and strain, this program changes would make it harder for enrollees to move off Medicaid and onto the private coverage the state encourages.

While operating a presumptive eligibility program and providing coverage the first day of the month of application may in some ways mitigate the risk of incurring medical

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[1] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf.

[2] David U. Himmelstein, MD et al. *Medical Bankruptcy in the United States, 2007: Results of a National Study,* The American Journal of Medicine (2009) available online at http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf

debt, in many cases application filings are delayed until the following month, particularly if someone is admitted towards the end of a month.

Without retroactive coverage, providers may face huge uncompensated care costs and may be dis-incentivized to treat low-income Medicaid eligible patients. Retroactive coverage allows physicians and clinics to treat patients who are eligible for Medicaid when they are sick and need care and be assured they can get paid after the patient enrolls.

Actuarial analyses of Medicaid payments have shown that about 5 percent of Medicaid payments occur during the retrospective eligibility period.[3] According to several officials at a safety net hospital, eliminating retroactive eligibility would result in about a 5 percent loss of Medicaid revenue.[4] The Congressional Budget Office found a repeal of Medicaid retroactive coverage would result in a loss of $5 billion in federal funding for states and hospitals from 2017 to 2026.[5]

Granting this request would result in more uncompensated care. Hospitals absorb sixty percent of the cost of uncompensated care in the medical community. [6] That would predictably reduce provider program participation. Policies that have the predictable effect of reducing provider participation make it harder for enrollees to receive care: this proposed waiver would hinder rather than further the objections of the Medicaid program. The proposal is thus contrary to the purpose of 1115 waivers and should be denied.

Suggestions to minimize the harm of a waiver of retroactive eligibility

We strongly oppose any waiver of three month retroactive eligibility. However, if the state and CMS are determined to go this route, we suggest only a provisional approval contingent on the results of an evaluation. The waiver of retroactive coverage should only be approved for six months to one year during which time the state should evaluate the waiver's effect on consumer medical debt and gaps in coverage as well as provider uncompensated care burden. Only after the results of this evaluation should CMS consider any approval much less one with no specified end date.

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[3] Lewin Group, *Assessment of Medicaid Managed Care Expansion Options in Illinois*, prepared for the Commission on Government Forecasting and Accountability (Lewin Group, May 3, 2005).

[4] The Commonwealth Fund, *The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals* (June, 2017) available online at http://www.commonwealthfund.org/publications/fund-reports/2017/jun/financial-impact-ahca-on-safety-net-hospitals#/#8

[5] Congressional Budget Office Cost Estimate, The Better Care Reconciliation Act (June 26, 2017) https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf

Any waiver in retroactive coverage must also be coupled with a robust outreach and enrollment program, not simply presumptive eligibility. In an effort to meet the states' goal of promoting continuous coverage, Iowa should likewise revisit its policy of charging IHWP enrollees above fifty percent of poverty premiums. Premiums have been shown by a voluminous body of research to make it harder for individuals to get covered. Ensuring all eligible individuals are continuity enrolled in the program will help guard against the adverse effects of provider and beneficiary debt in the event of a temporary waiver of retroactive coverage.

Thank you for the opportunity to comment. Please don't hesitate to contact Dee Mahan at dmahan@familiesusa.org or Andrea Callow at acallow@familiesusa.org with any questions.

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