December 11, 2014

The Honorable Cynthia Burwell
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

By E-Mail to: Cynthia.Burwell@hhs.gov and submitted to www.medicaid.gov

Re: Comments on Arizona's proposed amendment to the Health Care Cost Containment System demonstration project submitted to the Centers for Medicare & Medicaid Services (Cost-Sharing for Arizona's Expansion Population)

Dear Secretary Burwell:

Families USA is grateful for the opportunity to comment on the 1115 waiver amendment request submitted by the state of Arizona.

We are a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans. We are committed to Arizona's continued acceptance of federal funds to cover the Medicaid expansion population.

However, we have serious concerns with the amount of cost sharing Arizona seeks to impose on beneficiaries. Both premiums and high non-emergency ER co-pays set dangerous precedents for the Medicaid program and for future Medicaid expansions. Notably, Arizona's request to charge a $200 co-pay for non-emergency use of the ER should be denied.

Co-payment for non-emergency use of an emergency room

CMS should reject Arizona's request to charge a $200 co-payment for non-emergency use of the ER. This substantially exceeds the amount allowed in regulations, is exorbitant when viewed in light of Medicaid enrollees' income, does not further the purposes of the Medicaid program and does not comply with requirements for cost-sharing waivers specified in 1916(f).

The amount is excessive and does not serve a demonstration purpose.

We support strategies to discourage inappropriate use of emergency room services, provided there are adequate consumer protections in place. Those include providing a complete medical assessment to confirm no emergency exists and making arrangements for individuals to receive needed medical care quickly. We do not have issue with the state's request to apply higher cost sharing for non-emergency use of emergency room services than cost-sharing imposed on

other services, provided those consumer protections are in place. However, regulations set cost sharing for non-emergency use of the ER at $8 for individuals with incomes below 150 percent of poverty.[1]

Arizona seeks to charge a $200 co-pay, exceeding the amount allowed in regulation 25 fold. To put this in perspective, a $200 copay represents 20 percent of a person living at the poverty line's monthly income. Regulation limits all cost sharing to 5 percent of income calculated monthly or quarterly for all Medicaid beneficiaries below 150 percent of poverty.[2] One non-emergency visit to the ER in a quarter would alone represent almost 7 percent of a person with income at 100 percent of poverty's income. The state offers no justification for its request to charge such an exorbitant co-pay in contravention of two separate regulatory limits.

To date, CMS has refused requests from both Iowa and Pennsylvania to charge $2 more cost-sharing above what is allowed in regulations for non-emergency use of the ER. CMS should likewise deny Arizona's request to charge $192 more than what is allowed. Such extreme cost-sharing will represent a significant hardship on Medicaid enrollees and are not in keeping with the spirit of the Medicaid program.

<u>The requirements of 1916(f) are not met</u>

Arizona's request to impose a $200 mandatory co-pay on people who use the emergency room (ER) in non-emergency situations does not represent an appropriate use of section 1115 waiver authority, because section 1115 does not provide authority to waive the cost-sharing provisions in section 1916 of the Social Security Act. Waivers of cost-sharing provisions can only be approved under the separate waiver authority in section 1916(f). Arizona's proposal does not meet any of the requirements of 1916(f) including (1) that beneficiary participation be voluntary or (2) that the waiver period last for only two years. This request should therefore be denied.

Premiums for enrollees above 100% FPL

We oppose the imposition of monthly premiums on very low-income people as it represents a real and substantial coverage barrier which is contrary to the objectives of the Medicaid program and has no demonstration value.

As a rule, we oppose the imposition of premiums on Medicaid beneficiaries below 150 percent of poverty. A large body of literature has shown that even nominal premiums can make it difficult for individuals to retain coverage. As such, the imposition of premiums serves no demonstration purpose.

For example, In July 2012, Wisconsin added or increased premiums for some adults enrolled in its Medicaid program, BadgerCare. Enrollees with incomes between 133 and 150 of poverty who had previously had no premium costs were required to pay three percent of their income in premiums. Preliminary analysis showed that premium payments had a negative effect on the ability of these low-income enrollees to maintain coverage. From July through September 2012, there was a 24 percent enrollment reduction due to non-payment of premiums for those in the 133 to 150 percent of poverty income group.[3] Imposition of premiums on lower income Medicaid enrollees will predictably result in some dropping coverage, an outcome that does not further the objectives of the Medicaid statute.

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[1] 42 C.F.R § 447.54.

[2] 42 C.F.R. § 438.108

[3] See Wisconsin Department of Health Services Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings," available online at: http://www.dhs.wisconsin.gov/MAreform/report12.11.12.pdf; Wisconsin Council on Children and Families, "Evaluation of Last Year's BadgerCare Changes Makes Strong Case Against New Waiver," September 4, 2013, available online at: http://wccf.org/pdf/BadgerCare_changes_evaluation.pdf

Thank you for the opportunity to submit these comments. If you have any questions, please do not hesitate to contact us.

Sincerely,

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Andrea Callow
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Cc:
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