FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

October 17, 2014

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

By E-Mail to: Sylvia.Burwell@hhs.gov

Re: Comments on Arkansas Health Care Independence Program Section 1115 Waiver Amendment

Dear Secretary Burwell:

Families USA is grateful for the opportunity to comment on the state of Arkansas's Health Care Independence Program Section 1115 waiver amendment to modify its existing Medicaid expansion program.

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 seeing a strong Medicaid program for all enrollees in Arkansas and across the United States.

However, we believe that the program changes in the Arkansas waiver amendment include components that set extremely troubling precedents for the Medicaid program, and for future Medicaid expansions, including components that are contrary to the program's objectives and that would greatly diminish Medicaid enrollees' ability to access health care.

Our concerns are discussed in greater detail below. We believe that these concerns can, and should, be addressed during the waiver amendment approval process.

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The Use of Health Savings Accounts (Independence Accounts) Generally

We support the state's goal of encouraging accountability and rewarding responsible health care choices. However, the proposed structure of the Independence Accounts could have a negative impact on enrollees' access to care, especially for those below the poverty line and those in poor health who must use a lot of health care services. In particular, the "choice" set up between the payment of premiums or the payment of cost-sharing for very low income individuals does not present a real choice at all, and instead establishes a punitive cost-sharing structure that will inhibit access to care.

Premiums

Arkansas proposes that enrollees with incomes above 50% of poverty make monthly contributions to their Independence Accounts (IA), which could be used to pay cost-sharing charges, including co-pays and coinsurance. These monthly contributions are similar in purpose to premiums – they require that beneficiaries make monthly payments for health care services – and should be treated as a "similar charge" to premiums under section 1916(a)(1) of the Social Security Act.

We oppose the imposition of monthly premiums on very low-income people as it (1) presents a real and substantial coverage barrier which is contrary to the objectives of the Medicaid program and (2) has no demonstration value.

As a rule, we oppose the imposition of premiums on Medicaid beneficiaries below 150% of poverty. Monthly premiums can make it difficult for individuals to retain coverage. In particular, we have serious concerns with the imposition of premiums on individuals with incomes below 100% of poverty. It is long-standing Medicaid policy that premiums not be imposed on individuals below poverty.

- **Arkansas' proposed contributions will pose a hardship to beneficiaries and will limit their ability to retain coverage.**
  Medicaid demonstrations have shown that even premiums as low as 1% of income—essentially the premium level proposed for the lowest income enrollees—can limit enrollment of eligible people.[1]

[1] The proposed $5 monthly premium for individuals with incomes 50-100% of poverty is essentially one percent of income for an individual at 50% of poverty.

- **Premiums reduce enrollment.** A study of multiple Medicaid programs in which premiums were imposed found that for low-income families, premiums as low as one percent of income are associated with decreased enrollment.[2]

- **<u>Allowing Arkansas to impose premiums in the form of Independence Account contributions will limit enrollment of eligible people.</u>**
  Experience from Medicaid programs that have imposed premiums shows that recurring monthly payment obligations can make it difficult for individuals to keep coverage.

  - **Premiums negatively affect coverage retention even among higher income Medicaid enrollees.** 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. While Wisconsin's premium payment was a higher percent of income than that proposed in the Arkansas amendment, Arkansas is proposing to impose premiums on a much lower income population (51 to 138 percent of poverty). Even though a lower percent of income, Arkansas's proposed premiums would impose a greater financial burden relative to income, inevitably resulting in program drop-out.[3]

  - **Premium payments have been shown to be a hardship for very low-income individuals.** A decade ago, Oregon imposed premiums on adults with incomes below the poverty level. Premiums ranged from $6 per month for people with no income to $20 per month for people at the poverty line. In the nine months that followed the increase, nearly half of those that had been on the program were

[2] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 2005, available online at http://www.cbpp.org/files/5-31-05health2.pdf.

[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.

no longer enrolled and the majority of them were left without coverage.[4]

The purpose of an 1115 demonstration project is to give the Secretary authority to approve pilot, experimental or demonstration projects that promote the objectives of the Medicaid program.

In light of the robust body of evidence surrounding premiums, we believe the amounts proposed by Arkansas will adversely affect eligible individuals' ability to obtain and maintain health care coverage. That is an outcome that is contrary to the objectives of the Medicaid program.

Furthermore, given that past demonstrations have clearly shown that premium payments negatively affect enrollment rates and coverage retention, and that this effect is well known, imposition of premiums in the Arkansas program will not serve any demonstration purpose.

The Choice between Monthly Account Contributions or Cost sharing

Enrollees who do not make their monthly account contributions would be subject to cost-sharing for services they receive. Enrollees with incomes below poverty would swipe their IA debit card and receive a bill. An individual failing to pay that bill would initially have amounts taken from any amounts accrued in his or her IA account and, once that account is exhausted, would incur a debt to the state. Enrollees with incomes above poverty would pay the QHP-level cost sharing at the point of service and may be denied care if they fail to make that payment.

The "choice" between cost sharing and monthly contributions is not a true "choice."

Given the longstanding and robust body of evidence showing the negative effects premiums and cost sharing have on low-income beneficiaries, we do not believe making monthly IA contributions or being subject to cost-sharing offers a real "choice" to enrollees. Cost-sharing has been shown to deter individuals from seeking care, including necessary care. The structure proposed penalizes those individuals who are unable to pay monthly premium obligations but are sickest and need the most care.

[4] Leighton Ku and Victoria Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities, July 2005, available online at http://www.cbpp.org/files/5-31-05health2.pdf

The penalty regarding a "debt to the state" is vague and could impose additionally financial hardship on individuals already facing significant financial pressures.

We strongly urge that this penalty be removed. However, if it is retained, before approval we urge CMS to obtain clarification as to what exactly this "debt to the state" represents. CMS should ensure that penalties do not place extremely low-income individuals at further financial disadvantage, which would clearly be the case if the state were allowed to seize tax refunds. Additionally, the penalty should not be structured in any way that might create a record that could make it more difficult for individuals to obtain or retain employment, get credit, execute a lease for housing, or otherwise take steps that might improve their personal financial situation.

We urge CMS to consider an alternative approach to monthly IA contributions before a beneficiary is subject to cost-sharing.

One approach would be to exempt beneficiaries from cost sharing if they utilize age-appropriate recommended preventative services within a specified period. An alternative such as this is consistent with the recent demonstration approvals in Iowa and Pennsylvania.

Hardship Exemption

The waiver amendment does not mention a hardship exemption for individuals who are unable to make IA account contributions. This is a serious omission. We urge that a hardship exemption be included in the program. This should include a clearly defined, non-onerous process for obtaining an exemptions and an easy to access application process. This would be consistent with what has been approved in Iowa.

Non-Emergency Medical Transportation

CMS should deny the state's request to waive non-emergency medical transportation (NEMT). The state's request to waive NEMT for beneficiaries enrolled in the demonstration does not further objectives of the Medicaid program, and only serves to limit access to care. In fact, the preliminary NEMT evaluation from Iowa's demonstration shows that this benefit is relatively inexpensive to provide and is not widely used. However, those who utilize the benefit are primarily those with serious health care conditions, including severe mental illness and end stage renal disease. NEMT is a critical benefit that ensures that individuals with significant health care needs have

access to needed medical care in a timely manner, thus keeping them out of more expensive institution settings.

We urge you to deny this request, or at the very least, only provide a one-year waiver and evaluate the waiver's effect on beneficiaries' access to care, which is consistent with the recent approvals in Iowa and Pennsylvania.

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

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