

September 26, 2013

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Proposals for Iowa Marketplace Choice Plan and Iowa Wellness Plan

Dear Secretary Sebelius:

We appreciate the opportunity to comment on Iowa's two proposals for Section 1115 Medicaid demonstration projects—the Iowa Marketplace Choice Plan and the Iowa Wellness Plan—which were submitted to CMS on August 23, 2013.

We support your department's efforts to move forward with approval of Iowa's demonstration projects that will expand Medicaid to low-income adults. However, we are particularly concerned that in the Iowa Wellness Plan the state proposes to impose monthly premiums on beneficiaries with incomes as low as 50 percent of the poverty line after they have been enrolled for a year. Because no premiums will actually be imposed in 2014, we suggest that you consider conditionally approving the waiver so that low-income Iowans get coverage on January 1, 2014, while withholding final approval to charge premiums to people with incomes below the poverty line. Proceeding in this way would give you ample time to work out a modified approach to premiums and/or cost-sharing that would allow Iowa to test its wellness plan without imposing premiums on people with incomes below the poverty line.

We have a number of other concerns related to the proposals, which are detailed below, including the request to waive family planning and non-emergency transportation benefits; increased cost-sharing for non-emergency use of the emergency room; the lack of detail in the budget neutrality analysis; and the request to waive retroactive benefits.

Premiums

Iowa Wellness Plan Section 4.1: Participant Financial Contribution Amounts

Allowing Iowa to impose premiums on people with incomes below 100 percent of the poverty line would set a new and dangerous precedent in the Medicaid program and does not comport with the purposes of the Medicaid Statute. If approved, Iowa's plan would be the first Medicaid demonstration project approved since the creation of a mandatory group of low-income individuals (described in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act) that would require adults with incomes below 100 percent of the poverty line to pay premiums. Demonstration projects must be "likely to assist in promoting the objectives" of the Medicaid statute. Charging premiums to people with very low incomes is not an

appropriate use of demonstration authority because experience already clearly shows that premiums decrease enrollment of very low-income beneficiaries.

CMS should instead conditionally approve the waiver so that low-income Iowans can get coverage in January, while working out a way other than by imposing premiums for Iowa to pursue the goals of the demonstration projects. The proposed demonstration would waive financial contributions for a member during the initial year of membership, so premiums would not kick-in for any enrollee until January 1, 2015. CMS and Iowa have more than a year to work on a modified approach that complies with the Medicaid statute.

Premiums have already been shown to limit enrollment of eligible people.

Monthly premiums for people with incomes below the poverty line will likely to lead current lowacare enrollees to lose coverage, and will cause newly eligible adults to drop coverage or not enroll at all.

Charging premiums to Medicaid beneficiaries has consistently been shown to result in steep declines in coverage. A recent experiment in Wisconsin charged premiums set at three percent of income. The premiums were imposed on 18,544 parents and caretaker relatives who in July 2012 had *incomes between 133 and 150 percent of the poverty line*. Data from a preliminary evaluation conducted by the Wisconsin Department of Health Services showed the following after the first six months:

- Only 31 percent of the adults in that income range who were participating in BadgerCare in July 2012 were still in the premium-paying category six months later.
- Failure to pay a premium caused 21 percent of the original 18,544 to lose their coverage within six months.
- Slightly more than two-fifths of enrollees lost coverage due to non-payment of a premium.

In a more analogous situation a decade ago, Oregon raised premiums for adults with incomes below the poverty line. Premiums ranged from \$6 per month for people with no income to \$20 per month for people with incomes at the poverty line. Nine months after the increase, *nearly half of the people who had been enrolled were no longer receiving coverage*. About three-quarters of those who lost coverage became uninsured.

The proposed demonstrations are administratively complex and likely to be unnecessarily costly. Taken together, the two demonstration projects would create four different Medicaid programs for adults. Administrative costs are not included in the budget neutrality estimates, although one of the stated purposes of Iowa's enabling legislation is "health care cost containment and minimization of administrative costs." (Iowa Senate File 446, Sec. 168(d)).

The four programs within Medicaid would include: 1) the standard Medicaid program for medically frail people; 2) the Health Insurance Premium Payment (HIPP) program that currently provides premium assistance program for people with cost-effective employer coverage; 3) the marketplace choice program for people with incomes from 100 to 133 percent of the poverty line; and 4) the wellness program.

Iowa already operates a well-run HIPP program, but operating three additional programs with eligibility dependent on income, health status, and the availability of cost-effective employer sponsored coverage—all factors subject to frequent changes—will be a significant administrative challenge and very costly for the state. Moreover, because of the complexity, it is likely that beneficiaries will often be in the wrong program for periods of time. This could lead to periods of uninsurance when premiums are too high or when employer coverage is no longer available and could also lead to a lack of access to appropriate benefits for people who should be classified as medically frail.

The waiver needs to include a more detailed plan for required wellness activities and hardship exemptions. The current waiver proposal does not contain adequate detail about the targeted preventive health behaviors or other services that will be required to have premiums waived. The waiver proposal says that Iowa “*might* include a health risk assessment or an annual physical in the preceding 12-month enrollment period”, and that “Iowa *may* develop other criteria related to health promotion and preventive services over time.” (emphasis added). Under the waiver’s proposed approach, an enrollee who makes the best effort to see a primary care provider but is unable to see one, or who takes steps toward wellness goals but does not achieve them in the time allotted, would be charged a monthly premium and lose coverage if s/he is unable to pay the premium. We suggest a modified approach that would allow enrollees to stay enrolled and encourage them to meet wellness goals in other ways.

One possible approach would be to combine the imposition of modest copayments for certain types of care; waivers of copays for enrollees working to meet wellness goals; and hardship exemptions that waive copays if the enrollee is facing a particular financial hardship.

EPSDT

Iowa Wellness Plan Section 3.3: Covered Benefits
Iowa Marketplace Plan, P. 18

Waiving EPSDT for 19 and 20 year-olds violates recent CMS guidance, 19 and 20 year olds should not be included in the demonstration. Iowa is requesting a waiver so that 19 and 20 year- olds who are entitled to receive Early Periodic Screening Diagnosis and Treatment (EPSDT) benefits can be enrolled in the wellness program or a qualified health plan in the health insurance marketplace where EPSDT services are not included in the benefit package. As a result, 19 and

20 year olds would not receive vision or hearing services, including hearing aids, or other EPSDT services they might need. Guidance issued by CMS on March 29, 2013, states that only “individuals whose benefits are closely aligned with the benefits available on the Marketplace” should be included in premium assistance demonstrations. The lack of alignment between EPSDT and the wellness and marketplace plans suggests 19 and 20-year olds should not be included in the demonstration at this time. Moreover, CMS should not allow waiver of EPSDT in the Wellness Plan. The Medicaid statute and regulations allow children under 21 to be enrolled in Alternative Benefit Plans. However, EPSDT benefits must be included in those plans. This requirement should not be waived.

Non-Emergency Transportation

Iowa Wellness Plan Section 3.3: Covered Benefits
Iowa Marketplace Plan, P. 18

Alternative Benefit Plans, including those provided to newly eligible beneficiaries, must include non-emergency transportation. Iowa’s proposal to waive non-emergency transportation is not an appropriate use of demonstration authority. Without any support for its hypothesis, Iowa proposes to test whether waiving non-emergency transportation presents a barrier to receiving care. This is not an appropriate use of demonstration authority. Regardless of whether a beneficiary is in regular Medicaid or an alternative benefit plan, non-emergency transportation is required. The regulations for alternative benefit plans, state that “if a benchmark or benchmark-equivalent plan does not include transportation to and from medically necessary covered Medicaid services, the State must nevertheless assure that emergency and non-emergency transportation is covered for beneficiaries” (42 CFR §440.390).

Leaving out non-emergency transportation services will make it harder for adults in the wellness plan to access services that will either keep them healthy or put them on the road to good health and creates a risk of higher Medicaid costs when enrollees delay treatment. Failing to provide non-emergency transportation will make meeting the wellness goals harder and may also increase costs if beneficiaries delay getting care because they cannot get to a doctor’s office. Research has shown that lack of transportation reduces health care utilization among low-income people. (Lily Shoup, Transportation for America, *Improving access to health care by improving transportation options*, July 17, 2009 cited in The Leadership Conference Education Fund, *The Road to Health Care Parity: Transportation Policy And Access to Health Care* (April 2011)). This can be a particular problem for people living in rural areas in Iowa where appropriate medical care might be quite far away. The lack of transportation will also create obstacles in getting to the required primary care visit and in building a relationship with a provider.

Family Planning

Iowa Marketplace Choice Plan, p. 14-18: Benefits and p. 23: Waiver of Free Choice of Family Planning Providers

Leaving out family planning in the Marketplace plan and limiting free choice in both plans violates Medicaid law and regulations and also creates a risk of higher Medicaid costs.

While enrollees in the Iowa Wellness plan would receive family planning services, the proposed Iowa Marketplace Choice Plan does not list family planning services on its list of covered benefits. Further, the proposed Marketplace Choice Plan requests a waiver of the beneficiary free choice of family planning provider at Social Security Act §1902(a)(10)(A). This suggests that enrollees in the Marketplace choice plan with incomes above 100% FPL are not guaranteed access to family planning services nor will they have a free choice of provider. This violates recent regulations that require Medicaid Alternative Benefit Plans to include family planning services and supplies (42 CFR §440.335). Leaving out family planning services and access to a choice of providers may result in additional costs to Medicaid given that any births resulting from unintended pregnancies will likely be paid for by Medicaid.

Co-Pay for Non-Emergency Use of ER

Iowa Wellness Plan Section 4.1: Participant Financial Contribution Amounts
Iowa Marketplace Choice Plan, p. 24: Waiver of Cost Sharing Requirements

The proposed \$10 co-pay for non-emergency use of the emergency department exceeds what is allowed under Medicaid rules.

Both waivers propose to charge a \$10 copayment for non-emergency use of the emergency department. Current Medicaid cost-sharing rules set different limits based on income of the enrollee. Co-pays for non-emergency use of the emergency room by individuals with incomes at or below 150% FPL cannot exceed \$8.00. While seemingly a small amount, every dollar counts for low-income populations. Further, the July 15, 2013 Final Rules establish that states can't impose cost-sharing at the emergency room unless the beneficiary has been provided with an appropriate referral to an alternative provider (42 CFR 447.54).

Retroactive Benefits

Iowa Wellness Plan Section 10: List of Proposed Waivers and Expenditure Authorities and Iowa Marketplace Choice Plan, p. 25

Both the Wellness Plan and Marketplace Choice plan should continue to provide retroactive benefits.

Both proposed plans request a waiver of retroactive coverage, but they provide no meaningful justification for waiving retroactivity other than the state legislation, alignment with the Marketplace and "promoting consumer accountability." The wellness plan is a system of care developed by the state of Iowa, so it could be designed to include retroactive eligibility as part of the contracts with the proposed ACO's or retroactive coverage could be provided through the fee-for-service program. In the marketplace, the state could also provide retroactive eligibility for Marketplace Choice Plan participants through a fee-for-service

program. Both programs could potentially be designed to honor Medicaid's longstanding retroactivity provisions that both prevent low-income enrollees from medical bills they cannot pay, and also support hospital and safety net providers that serve these beneficiaries.

Budget Neutrality

Iowa Wellness Plan Section 7: Demonstration Financing and Budget Neutrality
Iowa Marketplace Choice Plan p. 39: Budget Neutrality

The proposals do not provide sufficient detail to show that the demonstration will meet the budget neutrality requirement. Iowa has not provided sufficient information to evaluate whether its proposal will be budget neutral. The budget neutrality documents prepared for the Marketplace Choice plan do not include projected costs without a waiver, nor the long term costs to Medicaid of unintended births due to the lack of family planning services. The budget neutrality documents prepared for the Wellness Plan do not include the administrative costs of running so many Medicaid plans and collecting income-based premiums, or the costs in addition to the savings of not providing non-emergency transportation. The Government Accountability Office (GAO) recently criticized HHS for a lack of transparency in determining budget neutrality. The GAO also raised concerns regarding the use of unproven hypotheses as to the costs of providing coverage without the waiver. CMS should request more information—including an honest projected cost without a waiver, the administrative costs of running so many different plans, costs of not providing family planning in the marketplace choice plan, and not providing non-emergency transportation— in addition to the costs it saves so that the budget neutrality of the proposal can be fully evaluated.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu), Sonya Schwartz (ss3361@georgetown.edu), or Judy Solomon (Solomon@cbpp.org).

Center on Budget and Policy Priorities
Georgetown University Center for Children and Families