

October 17, 2014

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

Dear Secretary Burwell:

The undersigned organizations appreciate the opportunity to comment on the proposed amendment to the Arkansas Health Care Independence Program demonstration project, which was submitted to the Centers for Medicare & Medicaid Services (CMS) on September 15, 2014. We have concerns with specific aspects of the amendment request that should be addressed during the approval process. Our specific concerns focus on several areas where the proposed amendment request will present barriers for people seeking to enroll in coverage or receive care.

We also have a more general concern that the proposed amendment adds an additional and unnecessary level of complexity to the existing demonstration. The added complexity will not only increase the administrative burden for state workers, but it will also cause confusion for beneficiaries, which could limit enrollment of eligible people.

Premiums

Allowing Arkansas to impose premiums in the form of Independence Account contributions will limit enrollment of eligible people. Arkansas proposes that enrollees with incomes above 50 percent of the poverty line 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.

Premiums have been shown to limit enrollment of eligible people in other Medicaid demonstrations. Evaluations in Oregon and Wisconsin have shown that charging premiums to Medicaid beneficiaries results in steep declines in coverage. In 2003, Oregon increased premiums imposed on its waiver population whose incomes were below the poverty line from \$6 to \$20. Within a year, enrollment in the waiver had dropped by half and nearly a third of those who lost coverage cited the increased premium cost as a primary reason. Data from the Wisconsin Department of Health Services’ preliminary evaluation on the effect of premiums imposed in 2012 on parents and caretaker relatives with incomes between 133 and 150 percent of poverty show that about two-fifths of affected enrollees lost coverage due to non-payment of a premium. States such as Washington, which expanded coverage to low-income adults outside of Medicaid, also saw the harmful effect premiums have

on enrollment. Over a third of those enrolled in Washington's state-funded Basic Health program were disenrolled because they failed to pay their premiums.

"Choice" of Monthly Independence Account Contributions or Cost-Sharing

Individuals are not provided an appropriate "choice" of monthly contributions or cost-sharing. Beneficiaries who do not make timely IA contributions would be subject to cost-sharing, including co-pays and coinsurance, for services they receive. Beneficiaries with incomes *above* the poverty line would pay the QHP-level cost-sharing amount at the point-of-service while beneficiaries *below* the poverty line would swipe their IA debit cards at the point-of-service but would then receive a bill. Anyone failing to pay their co-pays would accrue a debt to the state.

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 beneficiaries. As described above, premiums deter enrollment and decrease participation in coverage. Cost sharing deters individuals from seeking care, including necessary care.

We urge CMS to consider, an alternative approach to monthly IA contributions before a beneficiary is subject to cost-sharing particularly for people with incomes below the poverty line. One idea would be to exempt beneficiaries who utilize age-appropriate recommended preventative services within a specified period from cost-sharing if they cannot afford the proposed monthly IA contributions, which range from \$5 to \$25 depending on the beneficiary's income. An alternative such as this is consistent with the recent demonstration approvals in Iowa and Pennsylvania.

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. NEMT is a critical benefit that ensures that individuals with significant health care needs have access to needed medical care. 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 your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu), Judy Solomon (Solomon@cbpp.org), or Jessica Schubel (jschubel@cbpp.org).

CC: Cynthia Mann, Vikki Wachino, Eliot Fishman

American Association on Health and Disability
American Cancer Society Cancer Action Network
Center on Budget and Policy Priorities
Community Access National Network
Community Catalyst
Disability Rights Arkansas
Families USA
Georgetown University Center for Children and Families
HIV Medicine Association
March of Dimes
National Alliance on Mental Illness
National Alliance on Mental Illness Arkansas
National Association of Community Health Centers
National Disability Rights Network
National Health Care for the Homeless Council
National Health Law Program
National Women's Law Center