August 9, 2024

The Honorable Xavier Becerra
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Iowa Health and Wellness Plan Section 1115 Demonstration Extension

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Iowa's request to extend its "Iowa Health and Wellness Plan (IHAWP)" section 1115 demonstration (Project # 11-W-00289/8) for five years. The state is seeking to continue all of its existing authorities, including imposing monthly premiums on expansion adults if a healthy behavior requirement is not met, disenrollment for non-payment of premiums for those with incomes above 100 percent FPL, eliminating non-emergency medical transportation for the expansion population, and removing 90-day retroactive coverage for most adult Medicaid enrollees.

The majority of the provisions the state is requesting to continue do not further the objectives of the Medicaid program. To the contrary, premiums, disenrollment for nonpayment of premiums, and eliminating NEMT benefits create barriers to coverage and care while waiving retroactive coverage exposes beneficiaries to medical debt. *We urge CMS to deny the state's request to extend these features of the demonstration that establish barriers to coverage, for the reasons detailed below.* (We are not commenting on the dental services provided through the demonstration but support the continuation of these benefits either through the demonstration or another authority).

Iowa's request to continue charging premiums creates barriers to coverage and should not be approved.

Iowa's demonstration request seeks to maintain authority to require expansion adults (with some exceptions) with incomes at or above 50 percent of the Federal Poverty Level (FPL) ($1,076 per month for a family of three) to pay monthly premiums and complete "healthy behaviors" requirements – a health risk assessment and annual exam – as conditions of eligibility. The state does not propose any changes to its current premium obligations or disenrollment structure; nor does it provide projections of disenrollment as a consequence of premiums.

Premiums and their consequences for non-payment vary based on income level. Individuals with incomes between 50 percent and 100 percent FPL ($2,152 per month) are subject to premiums up to $5 per month but cannot be disenrolled for non-payment. Those with incomes between 100 and 138 percent FPL ($2,969 per month) face $10 monthly premiums and are disenrolled from coverage after a 90-day grace period if premiums are not paid. Unpaid premiums may be considered collectible debt after 90 days.

Premiums are a significant barrier to obtaining Medicaid and CHIP coverage, particularly impacting those with incomes below the poverty line who are more likely to become uninsured if

premiums are charged.[1] Research consistently shows that premiums lead to disruptions in coverage and cause financial hardship. Your agency's recent letter to the state of Indiana outlines the many harms that arise from charging premiums to very low-income people citing multiple studies that provide evidence for this conclusion.[2]

In Indiana, which requires adults to pay monthly premiums between $1 and $20, over 35,000 individuals either didn't make their initial payment or missed payments in a single year, leading to non-enrollment, downgraded coverage, or disenrollment.[3] A recent federal court decision vacated Indiana's continuation of premiums, ruling there was no reasonable basis to conclude they promote coverage.[4] The Indiana decision underscores that disenrollment for non-payment of premiums is not permitted.

A recent study from Michigan's evaluation of its "Healthy Michigan Plan" found that premiums imposed on beneficiaries with incomes above 100 percent of the federal poverty line led to a higher likelihood of individuals voluntarily disenrolling from coverage and adverse selection. The study indicated that healthier expansion enrollees were more likely to disenroll, leaving those with greater medical needs and costs in the risk pool.[5] Iowa's application does not provide estimates on the effects of premiums or disenrollment on the risk pool.

Iowa's approach requiring a health risk assessment to avoid premiums unfairly penalizes those unable to complete it, especially individuals with cognitive or physical disabilities, limited English proficiency, or other barriers. This requirement creates additional obstacles for maintaining coverage, leading to decreased participation and increased hardship. While the state does not disenroll individuals for not completing healthy behaviors, imposing premiums effectively penalizes them by creating a tax obligation or reducing benefits. Research shows that such penalties do not improve health outcomes but instead reduce access to care.[6]

We urge CMS to reject Iowa's request to charge premiums. There is ample evidence that premiums result in harmful consequences and there is no reason to test this approach any longer in Iowa or elsewhere. Charging premiums is inconsistent with coverage as the objective of the Medicaid program; the evidence is clear and there is no longer a valid experimental purpose in testing related hypotheses.

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[1] Madeline Guth, Meghana Ammula, and Elizabeth Hinton, "Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers," Kaiser Family Foundation, September 9, 2021, available at: https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

[2] Letter to Indiana FSSA Director Cora Steinmetz from CMCS Director Daniel Tsai, December 22, 2023, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/in-cms-ltr-to-the-state-12222023.pdf.

[3] Lewin Group, "Healthy Indiana Plan Interim Evaluation Report," pg. 150, December 18, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf#page=250.

[4] Rose v. Becerra, *Civil Action 19-2848 (JEB)*, (D.D.C. Jun. 27, 2024). https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2019cv2848-68

[5] Betsy Q. Cliff, *et. al,* "Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules," *American Journal of Health Economics*, *8*(1), pg. 127–150, available at: https://doi.org/10.1086/716464.

[6] Hannah Katch and Judith Solomon, "Restrictions on Access to Care Don't Improve Medicaid Beneficiaries" Health," Center on Budget and Policy Priorities, December 11, 2018, available at: https://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes.

Waiving retroactive eligibility does not promote the objectives of Medicaid, and Iowa has produced no evidence that it is meeting its demonstration objectives.

Iowa has requested a continuation of its waiver of the three-month period of retroactive eligibility that applies to all non-pregnant adults, with the exception of those who are residing in a nursing facility at the time of application. Under federal law, Medicaid payments are available for medical expenses for a full three-months prior to the month of application. The purpose of this protection remains the same today as it was 50 years ago when it was established – to support prompt access to medical care and protect low-income people from incurring medical debt and the providers who serve them from providing uncompensated care. **We urge you to deny the request to waive retroactive eligibility**.

We have previously commented on our disagreement with CMS' decisions to waive retroactive coverage as it does not promote the objective of Medicaid – which is to provide coverage for low-income people – not to take it away. Data from Indiana show how important retroactive coverage was for parents in that state; in a one-year pilot to assess whether retroactive coverage was an important protection for these relatively low-cost enrollees Medicaid paid $1,561 on average for costs incurred prior to enrolling.[7]

In its letter to the state of Tennessee regarding its Section 1115 waiver, CMS recently expressed its concerns about waivers of retroactive eligibility noting that "*we are not currently inclined to support waivers of retroactive eligibility and have no plans to approve new requests for waivers of retroactive eligibility."* [8] CMS also cites the paucity of evidence around the impacts of waivers of retroactive eligibility; Iowa has to date produced no evidence that this waiver which has been in place since 2017 has achieved its stated goal – which according to the state (P. 6) is to "*Encourage members to obtain and maintain health insurance coverage, even when healthy."* [9]

Iowa asserts that its evaluation of this provision has been delayed due to the COVID-19 public health emergency and that results of a survey of enrollees will become available in July 2024 (P. 12).[10] To truly assess whether the state's hypothesis that eliminating retroactive coverage will encourage enrollment while healthy is borne out, the state would need to dedicate resources to educate one group of Iowa residents who were not enrolled in Medicaid but were potentially eligible on the rules of retroactive coverage and compare their decisions on when to enroll with a control group who were not aware of the rules. This has not happened nor is it likely to.

Moreover, the recent Medicaid unwinding process in Iowa did not go well with 72 percent of terminations resulting from procedural denials or process failures rather than determinations of

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[7] 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.
[8] Letter to TennCare Director Stephen Smith from CMCS Director Daniel Tsai, June 21, 2024, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/tn-tenncare-iii-cms-ltr-to-state.pdf
[9] Iowa Health and Wellness Plan Section 1115 Demonstration Extension Application, July 9, 2024, available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ia-wllns-pln-pa.pdf.
[10] Ibid.

ineligibility.[11] This is above the national average of 69 percent procedural denials. This large-scale failure by the state to complete the process successfully for the majority of enrollees suggests that members' ability to maintain Medicaid coverage is considerably impacted by the state's enrollment and renewal processes and *not* a member's desire to maintain coverage. Furthermore, the high number of procedural disenrollments and increasing delays in application processing[12] makes retroactive coverage even more important, as many individuals likely experience gaps in coverage following loss of Medicaid before reenrollment.

Eliminating non-emergency medical transportation benefits affects Iowans' ability to access needed care and is not a valid experiment.

Iowa has requested to extend its waiver of non-emergency medical transportation (NEMT), first granted in 2014, which impacts expansion eligible adults in the demonstration, except for those who are medically frail or younger than age 21. **We recommend that CMS deny Iowa's request to continue its waiver of NEMT**, consistent with CMS's current policy sunsetting NEMT waivers.[13] Iowa's request does not promote the objectives of Medicaid and is not a legitimate experiment, as is required for section 1115 demonstrations.

The primary objective of Medicaid, laid out in the statute[14] and confirmed by courts, is to help furnish medical assistance and other services. An NEMT waiver, which explicitly *eliminates* a service, cannot possibly be construed as helping to *furnish* services, and instead leads to harm. In addition, elimination of the transportation services logically and inexorably leads to reduced access to all of the other medical services for which transportation may be used, including preventive care services. Nearly 4 million people nationally miss or delay medical care each year because they lack access to affordable transportation, according to one study.[15] Failure to provide NEMT likely leads to a host of costs related to delayed or forgone access to preventive and/or necessary care. NEMT may be especially important for the large proportion of rural Iowans that may not have access to public transit or medical providers close by. The policy also leads to additional harm because it impedes compliance with healthy behaviors requirements in the Iowa demonstration (such as wellness exams), which then leads to increased costs in the form of premiums that have been allowed under the waiver. Finally, CMS should note that as recently as June 2024, a federal court yet again struck down an NEMT waiver concluding that it was harmful to coverage, including specifically citing to evidence from states *including Iowa*.[16]

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[11] Georgetown University McCourt School of Public Policy Center for Children and Families analysis of state Medicaid unwinding renewal data, available at: https://ccf.georgetown.edu/2023/07/14/whats-happening-with-medicaid-renewals/.

[12] Georgetown University Center for Children and Families analysis of state Medicaid and CHIP MAGI application processing times, available at: https://ccf.georgetown.edu/2024/01/26/medicaid-application-data/.

[13] CMS Letter to Traylor Rains, Oklahoma Health Care Authority, Temporary Extension Approval, November 1, 2023, https://www.medicaid.gov/sites/default/files/2023-11/ok-soonercare-cms-tmpry-extnsn-aprvl.pdf.

[14] Social Security Act § 1901.

[15] P. Hughes-Cromwick and R. Wallace, *et al.*, "Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation", Transit Cooperative Research Program (Oct. 2005), available at: https://nap.nationalacademies.org/read/22055/chapter/2.

[16] Rose v. Becerra, Memorandum Opinion, D.C. District Court, June 27, 2024, Appendix A, https://ccf.georgetown.edu/wp-content/uploads/2024/07/Dist-Ct-Opinion-HIP-2.0-premiums-etc-vacated-06.27.2024.pdf.

In addition, the NEMT waiver is not a valid experiment. CMS should consider three important points. First, to the extent the state attempts to put forth evidence there is no harm—that (even if true) does not amount to a legitimate experiment. Withholding NEMT to see how much it *hurts* people is no more a legitimate experiment than withholding antibiotics to see how many people develop uncontrolled infections.

Second, while the state offers some data points purporting to show people without NEMT in the demonstration are "no worse off" than other people in Medicaid with NEMT, the comparison groups are not really comparable. The state's member survey itself says as much: "it is understood that the members of these two programs differ significantly based on their Medicaid eligibility categories and, thus, their demographic characteristics."[17] For example, the adult expansion group, with medically frail individuals exempted, has less mental health needs ("less likely … to report fair or poor mental or behavioral health;" 24% to 32%) and is more likely to be single and male than the Medicaid populations (more likely "mothers and women associated with families") to which it is being compared. In addition, numerous responses from individuals in the survey indicate state's NEMT benefit is inadequate ("missed 4 appointments and I had to report one of the drivers," "never showed up," "cannot get help with transportation," "hot mess," "really sucky," etc.) and people don't know about it or understand how to use it. Given that the benefit of having the services is negligible for those that have it, it is meaningless to use that failure as a benchmark by which to conclude that waiving the service does not have a negative impact on enrollees. CMS should reject the waiver and work with the state to ensure a robust NEMT benefit for all enrollees.

Third, even assuming there is no harm to enrollees, after a full decade operating the waiver, the state has not provided meaningful evidence that it does much to *promote* coverage. The lack of evidence on this point should not be a justification to give the state more time to develop evidence. The state has had a full decade to operate the policy, and at this point should be accountable for not having an affirmative basis to continue it.

We recommend that CMS deny the NEMT waiver because the policy does not promote coverage and at this point includes no experiment.

Guidelines for charging copayments for non-emergent use of the emergency department should be more clearly defined and monitored.

Iowa's extension application proposes to continue charging an $8 copay to individuals in the expansion group for "non-emergency" use of the emergency department (ED). CMS should ensure that the state's copayment system is fully compliant with CMS regulations on ED copays, including those at 42 CFR §§ 447.51 and 54. This includes, first, defining "emergency" based on the expectations of a "prudent layperson" with "average knowledge" *at the time of admission*. We note that the regulations should prohibit charging a copayment if the individual could have reasonably believed they had an emergency or for *required* emergency screening services, even if the condition does not end up being an emergency.

Second, in order for Iowa to allow the ED copay charge, the state must require the hospital to: (1) inform the individual of cost-sharing obligations for non-emergency services, (2) provide the

[17] Iowa Health and Wellness Plan 2022 Member Survey Report, 2022, https://iro.uiowa.edu/view/pdfCoverPage?instCode=01IOWA_INST&filePid=13892765130002771&download=true.

name and location of an *available* and *accessible* alternative non-emergency services provider, (3) confirm such provider can provide the services in a timely manner (and with less cost-sharing, if applicable), and (4) provide a referral to coordinate scheduling for treatment by the alternative provider. Finally, given that Iowa has one of the highest shares of population living in rural areas (36.9 percent),[18] the state should require that individuals should not have to travel too far for an alternative to be deemed "accessible."

The state's application is not forthcoming about the policies being requested to continue.

As described above, Iowa's current demonstration contains policies that have significant implications on the ability for individuals enrolled in the adult expansion group to maintain Medicaid coverage and access necessary services. Given this context, it is particularly important for the public to understand the waiver authorities the state is seeking to continue to be able to effectively comment on the state's extension request. Yet, the state does not provide any discussion of the policies nor the waiver authorities currently in place that would be continued if the state's request is approved as proposed until more than halfway through its application.

The details of the premium and healthy behavior requirements are not included until page 43 of the application. The list of waiver authorities – one of the requirements for the federal comment period of an extension application – is even further down (page 58) as part of the documents for the second state comment period public notice. This comes after the state had to conduct a second state comment period to provide additional information to its initial proposal to meet the federal requirements for a complete application for a section 1115 demonstration extension.

The state's failure to provide a free-standing section or upfront discussion of the proposed policies to continue results in a less-than-transparent application that may hinder the public's ability to offer comprehensive comments on the extension request.

Conclusion

Our comments include citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for the purposes of the Administrative Procedure Act.

Thank you for your willingness to consider our comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

American Association on Health and Disability
Center for Health Law and Policy Innovation
Center for Law and Social Policy
Center on Budget and Policy Priorities
Cystic Fibrosis Foundation
Epilepsy Foundation
Georgetown University Center for Children and Families

[18] U.S. Census Bureau, Urban and Rural data, https://data.census.gov/table/DECENNIALCD1182020.H2?q=rural.

Justice in Aging
Lakeshore Foundation
March of Dimes
Medicare Rights Center
Mental Heath America
National Association of Pediatric Nurse Practitioners
National Multiple Sclerosis Society