August 11, 2024

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

**Re: Iowa Health and Wellness Plan Extension Request**

Dear Secretary Becerra:

Thank you for the opportunity to submit comments on Iowa's Health and Wellness Plan Extension Request.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness, and manage chronic health conditions. Our organizations and the populations we serve are diverse and offer aa wealth of knowledge and expertise that should be a valuable resource for decisions affecting the Medicaid program and the people that it serves. We urge the Centers for Medicare and Medicaid Services (CMS) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that Iowa's Medicaid program provides quality and affordable healthcare coverage. Our organizations oppose numerous harmful policies in this proposal, including the continued imposition of premiums and healthy behavior requirements, copayments for non-emergency use of the emergency room, elimination of non-emergency medical transportation (NEMT), and elimination of retroactive coverage for most Medicaid beneficiaries. These policies do not promote the objectives of Medicaid and we urge CMS to reject these requests. Our organizations offer the following comments on Iowa's Health and Wellness Plan Extension Request:

**Premiums and Healthy Behaviors**
Iowa proposes to continue imposing monthly premiums on adults with incomes at or above 50% of the federal poverty level ($1,076 per month for a family of three) if they do not complete certain healthy behavior requirements after the first year of coverage, as well as terminating coverage for individuals with incomes above 100 percent of the federal poverty level who do not pay these premiums. Our

organizations oppose these policies, which will create confusion and jeopardize access to care instead of incentivizing healthy behaviors.

The evidence is clear that premiums make it harder for individuals to obtain or keep healthcare coverage through the Medicaid program.[1] An analysis of Michigan's Medicaid demonstration found that premiums made it more likely that healthy enrollees would leave the program, leaving those with greater medical needs in the risk pool.[2] The inclusion of premiums can also exacerbate existing disparities in access to healthcare, as they have been shown to lead to lower enrollments for Black enrollees and lower-income enrollees, compared to their white and higher-income counterparts, respectively.[3] For patients with chronic conditions, gaps in healthcare coverage can disrupt access to regular care, leading to worse health outcomes and costly hospital visits. CMS has previously indicated that premiums do not promote the objectives of the Medicaid program, as seen in recent decisions regarding waivers for Montana[4] and Arkansas[5].

Our organizations remain concerned that, instead of incentivizing healthy behaviors, requirements to complete an annual health risk assessment and exam will create confusion and reduce coverage for individuals in need of care. Penalizing individuals for not completing healthy behaviors has not been found to improve health outcomes and in fact has resulted in less access to care.[6] It is likely that these requirements will deter eligible enrollees and serve as an unnecessary barrier to coverage. Our organizations urge CMS to keep Medicaid accessible and equitable by rejecting monthly premiums and healthy behavior requirements.

**Copayments for Non-Emergency Use of the Emergency Department**

Our organizations oppose the continued copay for non-emergent use of the Emergency Department. The state does not indicate how or when an emergency room visit will be determined to be non-emergent, leaving it unclear how individuals will be charged for seeking emergency care. Emergency Department copays have been shown to deter patients from seeking care, which can result in negative health outcomes for patients with acute and chronic diseases. For example, a study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[7] People should not be financially penalized for seeking lifesaving care for complications from a cancer treatment or any other critical health problem that requires immediate care. Our organizations urge CMS to reject Iowa's request to continue assessing copays for non-emergent use of Emergency Department.

**Waiver of Non-Emergency Medical Transportation**

Our organizations oppose Iowa's continuing waiver of non-emergency medical transportation (NEMT) benefits. Without NEMT benefits, individuals may go without needed care due to the lack of available transportation to medical appointments, especially those in rural areas who may live further away from providers or specialists. Iowa has one of the highest shares of population living in rural areas in the country, at 36.9%,[8] making it clear that NEMT benefits will be crucial for this population to access care. Research shows that patients with chronic conditions, including asthma and heart disease, who have access to NEMT are significantly more likely to meet the recommended number of healthcare visits each year.[9] Within the context of the healthy behavior requirements, the NEMT waiver renders it more challenging for individuals to complete their required health risk assessment and wellness exams without adequate transportation and will be subsequently penalized by having to pay a monthly premium. Our organizations urge CMS to reject this policy in order to ensure access to necessary care for Iowans.

**Waiver of Retroactive Coverage**
Our organizations oppose the ongoing waiver of 90-day retroactive eligibility for most individuals in Iowa's Medicaid program. Retroactive eligibility in Medicaid prevents gaps in coverage by covering individuals for up to 90 days prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness to begin treatment without being burdened by medical debt prior to their official eligibility determination, providing crucial financial protections to newly enrolled beneficiaries.

Medicaid paperwork can be burdensome and often confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. In Indiana, Medicaid recipients were responsible for an average of $1,561 in medical costs with the elimination of retroactive eligibility.[10] Medicaid enrollees who face substantial costs at their doctor's office or pharmacy could end up delaying their treatment because of these costs. For patients with chronic disease, this can increase their health risks and exacerbate their conditions.

Patients with underlying health conditions who are unable to access regular care are often forced to go to emergency rooms and hospitals if their conditions worsen, leading health systems to provide more uncompensated care. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as $2.5 billion more in uncompensated care as a result of the waiver.[11]

Our organizations urge CMS to work with Iowa to reinstate retroactive eligibility for the general Medicaid population. This is in line with the goals of Medicaid and would relieve the burden of medical debt faced by many Medicaid beneficiaries.

**Conclusion**
Our organizations strongly oppose the above proposals in Iowa's application that create barriers to care. These harmful policies do not promote the objectives of Medicaid and will likely worsen access to care in the state. Our organizations urge CMS to reject this extension request and to work with the state to move the existing dental benefits to state plan authority.

Thank you for the opportunity to provide comments.

Sincerely,

American Lung Association
Cancer*Care*
Child Neurology Foundation
Cystic Fibrosis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Leukemia and Lymphoma Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The AIDS Institute

[1] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[2] Cliff, Betsy Q et al, "Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules." National Bureau of Economic Research, May 2021. Available at: w28762.pdf (nber.org)

[3] University of Wisconsin-Madison Institute for Research on Poverty. (2019). Evaluation of Wisconsin's BadgerCare Plus Health Coverage for Parents & Caretaker Adults and for Childless Adults 2014 Waiver Provisions. Available at https://www.irp.wisc.edu/wp/wp-content/uploads/2019/11/BC-2014-Waiver-Provisions-Final-Report-08302019.pdf

[4] Letter from Centers for Medicare and Medicaid Services to Marie Matthews, Medicaid Director, Montana Department of Public Health and Human Services, December 21, 2021. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf

[5] Letter from Centers for Medicare and Medicaid Services to Dawn Stehle, Deputy Director for Health & Medicaid, Arkansas Department of Human Services, December 21, 2021. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ca.pdf

[6] Katch, Hannah and Solomon, Judith, "Restriction 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/restrictions-on-access-to-care-dont-improve-medicaid-beneficiaries-health

[7] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.

[8] https://data.census.gov/table/DECENNIALCD1182020.H2?q=rural

[9] Thomas, L. V., & Wedel, K. R. (2014). Nonemergency Medical Transportation and Health Care Visits among Chronically Ill Urban and Rural Medicaid Beneficiaries. *Social Work in Public Health*, *29*(6), 629–639. https://doi.org/10.1080/19371918.2013.865292

[10] Healthy Indiana Plan 2.0 CMS Redetermination Letter. July 29, 2016. 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

[11] Virgil Dickson, "Ohio Medicaid waiver could cost hospitals $2.5 billion", Modern Healthcare, April 22, 2016. Available at: http://www.modernhealthcare.com/article/20160422/NEWS/160429965