



Our Mission: To drive efforts to cure psoriatic disease and improve the lives of those affected.

December 3, 2019

On behalf of the more than eight million Americans living with psoriasis and psoriatic arthritis, the National Psoriasis Foundation (NPF) appreciates the opportunity to submit comments on Georgia's 1115 Demonstration Waiver Application for its Georgia Pathways to Coverage initiative. As the patient advocacy organization for the psoriatic disease community for more than 50 years, the NPF is keenly aware of the improvements in health outcomes that have resulted from advances in treatment innovation. Therefore, the NPF remains committed to ensuring beneficiaries with psoriasis and psoriatic arthritis have access to the full range of treatments and therapies necessary to successfully manage their disease. In its current form, NPF urges Georgia to withdraw its application for the Georgia Pathways program. In order to address these complex and serious issues, we request that the state convene a group of stakeholders to discuss solutions how to adequately provide affordable and comprehensive health care coverage for our patients in Georgia.

Eligibility

Under the Georgia Pathways plan, only individuals with incomes below 100 percent of the federal poverty level (\$1,778 per month for a family of three) who can prove that they work at least 80 hours per month would be eligible for Medicaid. This could drastically limit the number of patients with serious and chronic conditions like psoriasis and psoriatic arthritis who receive access to the quality and affordable healthcare coverage that they need.

While no exemption criteria can prevent the potential coverage losses associated with work reporting requirements, Georgia has not proposed any exemption criteria that would allow individuals who are unable to meet the work reporting requirements to apply for coverage. This means that patients who have serious health conditions that prevent them from working 80 hours per month would have **no pathway to coverage** that could help them to treat these conditions. Patients living with psoriasis or psoriatic arthritis dedicate a significant amount of time and effort to maintaining their disease, and comorbid conditions, while managing work and family life. Data shows 79% of Medicaid enrollees are in families with at least one worker, with nearly two-thirds (64%) with a full-time worker and another 14% with a part-time worker; one of the adults in such families may not work, often due to caregiving or other responsibilities.¹ However, employed Medicaid enrollees facing work requirements have trouble with reporting requirements. While exceptions to work requirements may apply, as many psoriatic disease patients know, exceptions processes can also be overly burdensome. This discrimination against patients with health conditions that prevent them from working is unacceptable.

Once enrolled, individuals may be able to qualify for short-term exemptions in certain situations. Still, the NPF is concerned that these exemption criteria may not capture all individuals with serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees may have to report their exemption, creating opportunities for administrative error that could jeopardize their coverage.

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For the first six months, members will have to report their hours and work activities monthly. This will put a significant administrative burden on enrollees, which will likely decrease the number of individuals with Medicaid coverage. For example, Arkansas also implemented a work reporting requirement where Medicaid enrollees had to report their hours worked or their exemption. During the first six months of implementation, the state terminated coverage for over 18,000 individuals.² Georgia has not provided an estimate of the coverage losses associated with this proposal in its waiver application.

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with psoriatic disease. If the state finds that individuals have failed to comply for one month, their coverage will be suspended, and if the state finds that individuals have failed to comply for three months, they will be disenrolled. Due to the heterogeneous characteristics of this chronic immune-mediated disease, psoriatic disease requires sophisticated medical care. Treatments that work for one person may not work for others, and many patients cycle through numerous accepted treatment options.³ Without the tools to control their symptoms, people with psoriatic disease cycle through periods of intense pain; fatigue; unbearable itch; whole-body inflammation; flaking and bleeding of large swaths of the skin; and joint degradation. Recent research also suggests that the risk for comorbidities such as cardiovascular disease may increase with the severity of psoriatic disease, thereby magnifying the critical need for continuous access to effective treatment options.⁴

If individuals are able to meet the reporting requirements for six consecutive months, they will be exempt from further reporting and re-evaluated for eligibility during their annual redetermination. However, if individuals do not report a change in their employment status, they will be responsible for any capitation and cost-sharing expenses. This exposes already low-income individuals to enormous financial risk. Unfortunately, patients with psoriatic disease are all too familiar with the burden that comes with the high cost of therapies, which can result in reduced access, outcomes and overall well-being. A 2018 NPF Advocacy survey of NPF members found that nearly 50 percent of psoriasis and psoriatic arthritis patients, many of who live on a fixed income, experienced financial strain due to the cost of their therapies. Even more alarming, almost one in four patients with psoriatic disease spend more than \$150 per month in out-of-pocket costs to access treatment needed to manage their chronic conditions. Due to these burdensome work requirements and the threat of our patients losing continuous coverage, the NPF is opposed to this policy.

Financial Barriers

For the few individuals who are able to meet this limited eligibility criteria, the proposal still creates numerous financial barriers that will jeopardize their coverage. Individuals with incomes above 50 percent of the federal poverty level will have to pay monthly premiums and will lose coverage if they fail to pay premiums for three months. This policy would likely both increase the number of enrollees who lose Medicaid coverage and also discourage eligible people from enrolling in the program. Research has shown that even relatively low levels of cost-sharing for low-income populations limit the use of necessary healthcare services.⁵ For example, when Oregon implemented a premium in its Medicaid program, with a maximum premium of \$20 per month, almost half of enrollees lost coverage.⁶

This policy will not only apply to – and jeopardize coverage for – new enrollees, but for individuals who are currently enrolled in Medicaid through the Transitional Medical Assistance (TMA) program. Additionally, it is unclear how the state may try to recoup capitation and other payments for any months that individuals do not pay their premiums and if, as with the work reporting requirement policy above,

patients may be put at significant financial risk. NPF is concerned that these premiums will create significant financial barriers for patients that jeopardize their access to needed care and therefore opposes this policy.

Georgia's proposal also includes a number of copayments for individuals with incomes above 50 percent of the federal poverty level that could be a significant financial burden for patients. The most egregious of these is a \$30 copay for non-emergency use of the emergency department (ED). This policy could deter people from seeking necessary care during an emergency.

People should not be financially penalized for seeking lifesaving care or any other critical health problem that requires immediate care. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they cannot afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED.

Evidence suggests this type of cost sharing may not result in the intended cost savings.⁷ Research demonstrates that low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes. 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.⁸ This provides further evidence that copays may lead to inappropriate delays in needed care. NPF opposes this punitive proposal for a \$30 copayment for non-emergent use of the ED.

Reduced Benefits

Individuals would be required to enroll in employer sponsored insurance (ESI) if it is available and determined to be cost effective for the state. However, the state would not provide any wraparound services for individuals regardless of the benefit package in their ESI. Combined, these factors would be very problematic for patients like those in the psoriatic disease community who rely on health insurance to provide meaningful coverage for medically necessary services. Additionally, the state would not help individuals with the costs of coinsurance or deductibles required in their ESI. A 2019 survey of NPF patient members showed that over half of our community takes a prescribed biologic and nearly 50 percent utilize more than treatment to manage their disease. NPF opposes the requirement to enroll in ESI without wraparound services and full financial protection for patients.

Additional Costs

Administering any number of these requirements will be expensive for the state of Georgia. States such as Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and work activities alone will cost tens of millions of dollars.⁹ This would divert federal resources from Medicaid's core goal – providing health coverage to those without access to care – and compromise the fiscal health of Georgia's Medicaid program.

In its current form, NPF opposes this waiver proposal. Instead, we urge Georgia to focus on solutions that promote adequate, affordable and accessible coverage. We request that the state convene a group of stakeholders to discuss solutions how to adequately provide affordable and comprehensive health care coverage for our patients in Georgia.

We appreciate your consideration of our comments. If you or your colleagues have any questions, please feel free to contact the NPF by reaching out to Matthew Moran, Federal Government Relations & Health Policy Manager at mmoran@psoriasis.org.

Sincerely,



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¹Robin Rudowitz, MaryBeth Musumeci, and Cornelia Hall, “A Look at November State Data for Medicaid Work Requirements in Arkansas,” Kaiser Family Foundation, December 18, 2018. Available at: <https://www.kff.org/medicaid/issue-brief/a-look-at-november-state-data-for-medicaid-work-requirements-in-arkansas/>; Arkansas Department of Health and Human Services, Arkansas Works Program, December 2018. Available at: http://d31hzhk6di2h5.cloudfront.net/20190115/88/f6/04/2d/3480592f7fbd6c891d9bacb6/011519_AWReport.pdf

³ Stern RS, Nijsten T, Feldman SR, Margolis DJ, Rolstad T. Psoriasis is common, carries a substantial burden even when not extensive, and is associated with widespread treatment dissatisfaction. *Journal of Investigative Dermatology Symposium Proceedings*. 2004 Mar; 9(2):136-9

⁴ <https://www.aad.org/member/clinical-quality/guidelines/psoriasis>

⁵ 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/>.

⁶ Id.

⁷ See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. *J Gen Intern Med*. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. “The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings.” Center on Budget and Policy Priorities (July 2005), available at <http://www.cbpp.org/5-31-05health2.htm>.

⁸ 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.

⁹ Misty Williams, “Medicaid Changes Require Tens of Millions in Upfront Costs,” Roll Call, February 26, 2018. Available at <https://www.rollcall.com/news/politics/medicaid-kentucky>.