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October 17, 2014

Cindy Mann, Director
Center for Medicaid and CHIP Services
Centers for Medicare and Medicaid
Department of Health and Human Services

Re: The Proposed Amendment to the Arkansas Health Care Independence Program Demonstration

Submitted via email

Dear Ms. Mann:

AARP is pleased to submit comments on the Proposed Amendment to the Arkansas Health Care Independence Program Section 1115 Medicaid Demonstration. AARP is a nonprofit, nonpartisan organization, with a membership of more than 37 million, that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

AARP continues to support the efforts of the Arkansas Department of Human Services to implement a unique strategy to address the serious lack of access to health care among the uninsured in Arkansas. We have been a strong supporter of the demonstration initiative through our advocacy in Arkansas and support the implementation of the Private Option, which to date has extended health care coverage to approximately 200,000 low-income Arkansans. However, AARP is concerned with some of the changes to the demonstration in the proposed amendment, specifically, the premium requirements on individuals with incomes above 50% of the FPL, aspects of the health savings accounts or "Independence Accounts," and limitations on non-emergency medical transportation services as a wrap-around benefit.

Premium Requirement

AARP opposes amending the demonstration to require monthly contributions by beneficiaries with incomes between 50-100% of the FPL. AARP has consistently opposed premiums requirements on these low-income individuals. Allowing Arkansas to impose this type of cost-sharing is contrary to federal law that protects all Medicaid

beneficiaries earning up to 150% of the FPL. AARP strongly believes that the current statutory limits on premiums and cost-sharing should set the ceiling for beneficiary exposure to out-of-pocket costs. If this change is approved, we are concerned that it would likely result in reduced access to needed care or create undue service barriers. Indeed, current federal Medicaid law limits cost-sharing for this income cohort to nominal levels because research has shown that cost-sharing reduces access to services and causes low-income individuals to forego necessary care.¹ AARP urges CMS to uphold the intent of Congress and protect this group from exposure to the increased cost-sharing under this proposal.

The Independence Accounts

AARP is concerned with the Independence Accounts for several reasons. First, as discussed above, we believe that imposing financial contributions on very low-income individuals – even as little as \$5-\$25 per month – could discourage them from enrolling in Private Option and would be counter to the purpose of the coverage expansion. Even for those who do enroll, there would be onerous consequences for non-payment, as noted below. We believe that such consequences will lead to poorer health outcomes for enrollees, higher costs for health plans, and increased emergency room use and uncompensated care costs.

Second, enrollees above 100% of FPL, who are unable to make their monthly contributions would be responsible for the qualified health plan (QHP)-level copayments and would be denied services if the copayment is not paid. Not only could this be confusing to newly enrolled individuals, but higher copayments under the QHP could be another barrier to access. We believe that denying needed services to individuals with very low-incomes because they are not financially able to make co-payments will result in poorer health outcomes for the individual and potentially subject the health plans in which they are enrolled to higher costs. Those unable to make point-of-service cost-sharing obligations will see their health conditions deteriorate to the point where they will need to use more costly emergency room services, thus exposing health plans to more financial risk. While enrollees with incomes below 100% of FPL who do not make their contributions would not be subject to this same penalty of being denied services, they would be billed for any Medicaid copayments incurred and all enrollees who fail to pay copayments would accrue a debt to the state.

We strongly urge the state to provide enrollees the added protection of the option to request a hardship waiver if they cannot afford their monthly payments. We urge CMS and Arkansas to develop a framework for a monthly contribution hardship waiver as part of any amended terms and conditions – to ensure individuals at risk of losing their health coverage due to financial insecurity or because they will face the risk of deprivation of food, shelter or other necessities will not go without needed care or have to seek care in the emergency room. Additionally, we urge you to work with the state to

¹ Dague, L. (2014). The effect of Medicaid premiums on enrollment: A regression discontinuity approach. *Journal of Health Economics*, 37, 1-12.

provide the option of cost-sharing relief to individuals who take part in healthy behaviors or preventative services.

Third, AARP is concerned the Independence Accounts could be administratively burdensome and difficult for consumers to understand. Since a significant number of low-income enrollees will lack a relationship with a banking institution, it will be important that the state establish consumer-friendly alternatives for enrollees to pay by cash if they cannot pay their monthly contributions by check. Moreover, for those individuals who do not have regular access to the Internet, it will be important to develop alternative means of payment beyond online accounts. The overall complexity of these accounts may be confusing to the beneficiaries participating in the program. If CMS approves this model, we urge the inclusion of an intensive and sustained education effort, that is linguistically and culturally appropriate, so that consumers receive clear, straight forward information on the accounts, how they work, as well as their rights and responsibilities. This education effort should be accompanied by consumer-tested educational materials explaining the many different features of the accounts, such as how to make the payments and when amounts are withdrawn, when enrollees will have to pay out-of-pocket for services, and how the roll-over process works.

Finally, we are concerned that the proposed amendment does not include an evaluation of these accounts. Any well-designed evaluation must assess the effect of the accounts on take-up rate and enrollee participation in the Private Option, whether the accounts have caused enrollees to forego needed services, and the administrative costs associated with managing the Independence Accounts as part of its overall cost-effectiveness. If CMS approves the proposed accounts, we ask that you require Arkansas to consider all these questions in its evaluation process.

Non-Emergency Medical Transportation

As AARP noted in its comments on the original waiver application, we strongly support the provision of wrap-around benefits required for the alternative benefit plan (ABP) but not covered by QHPs, such as non-emergency medical transportation. We believe CMS should deny the state's request to limit non-emergency medical transportation to eight trip legs per year, with the exception of medically frail individuals. Placing arbitrary limits on non-emergency medical transportation would be contrary to CMS' guidance issued on March 19, 2013,² which noted that even in alternative, "premium assistance" Medicaid expansion arrangements, like the demonstration in Arkansas, "beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections. States must have mechanisms in place to 'wrap-around' private coverage to the extent that benefits are less ... than those in Medicaid."

Recent analysis also illustrates the vital role Medicaid non-emergency transportation plays for low-income individuals in accessing health care services, especially those with

² Centers for Medicare & Medicaid Services. "Medicaid and the Affordable Care Act: Premium Assistance." March 2013.

chronic illnesses who require recurring medical appointments.³ Limiting this benefit could be especially harmful in Arkansas because of its' significant rural population. We strongly believe this lack of coverage is counterproductive to the goal of improving the health status of low-income Arkansans' because it will likely lead to more missed appointments and health complications. If CMS decides to approve this part of the amendment, we encourage CMS to grant only a one year approval to the state, so that the impact on beneficiaries' access to care can be evaluated in a more timely fashion. This approach would be consistent with recent approvals in Iowa and Pennsylvania. We also ask that a consumer-friendly process for requesting additional units of non-emergency medical transportation services be detailed as part of any approval, and the state commit to developing a communications plan to make enrollees aware of this process and the steps to obtain an extension of benefits.

Thank you for the opportunity to provide comments. If you have any questions, please do not hesitate to contact KJ Hertz on our Government Affairs staff at (202) 434-3732 or khertz@aarp.org.

Sincerely,



David Certner
Legislative Counsel and Legislative Policy Director
Government Affairs

³ A recent study, "Medicaid Expansion and Premium Assistance: The Importance of Non-Emergency Medical Transportation (NEMT) To Coordinated Care for Chronically Ill Patients," (MJS & Company, March 2014) published by the *Journal of Health Economics* found that the "premium requirement itself, more so than the specific dollar amount, discourages enrollment." <http://web1.ctaa.org/webmodules/webarticles/articlefiles/NEMTreportfinal.pdf>.