

KEEPING ARKANSANS COVERED

HOW CHANGES TO THE PRIVATE OPTION COULD IMPACT FAMILIES



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HOW CHANGES TO THE PRIVATE OPTION COULD HURT FAMILIES



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5 THINGS YOU SHOULD KNOW ABOUT HEALTH COVERAGE AND THE PRIVATE OPTION

1. The Private Option has allowed more than 211,000 adults in Arkansas access to health coverage. Also, 25,000 children have coverage as a result of their parents enrolling.
2. Currently, Private Option enrollees are not required to make any premium payments or pay deductibles. This program uses Medicaid funds to pay for private insurance plans.
3. An amendment has been proposed to require all Private Option enrollees to make monthly contributions to health savings accounts, called "Independence Accounts." Imposing cost-sharing requirements, including premiums, are known to reduce enrollment and create barriers to care for people with low incomes.
4. Many Private Option enrollees were previously uninsured and unfamiliar with concepts included in the proposed amendments, such as non-emergency transportation, extension of benefits, and health savings accounts. Also, low health literacy rates in Arkansas add an additional challenge to helping consumers understand proposed changes to their coverage.
5. Although enrolled in private plans, people with coverage through the Private Option have the same federal rights and consumer protections as traditional Medicaid beneficiaries.

PROPOSED CHANGES TO THE PRIVATE OPTION

The Arkansas Department of Human Services (DHS) recently submitted waiver amendments to the U.S. Department of Health and Human Services (HHS) to make several changes to the Private Option beginning February 1, 2015. As required by Act 257 of 2014, DHS must submit and seek approval from HHS to make the following changes:

- Creation of a health savings account model, or Independence Accounts, that require monthly contributions;
- Requirement for people with incomes below 50 percent of the federal poverty level to make monthly payments;
- Implementation of new limits on non-emergency transportation, such as rides to a doctor's appointment.

While Arkansas Advocates for Children and Families (AACF) supports the continued implementation of the Private Option, the proposed amendments to Arkansas's waiver should not be approved. They place undue financial burdens on low-income families, and they seek to waive several important consumer protections. The financial impact of these changes is also a potential threat to long-term sustainability of the Private Option. This report outlines AACF's concerns about the proposed amendments.

OVERVIEW OF THE PRIVATE OPTION

In 2013, Arkansas made history in passing a bipartisan measure to extend health care coverage to low-income families by using federal dollars to purchase private insurance plans. The Health Care Independence Program, also known as the Private Option, allows individuals that are 19-64 years old with incomes up to 138 percent of the federal poverty level to enroll in private marketplace plans and uses Medicaid funds to make the monthly premium payments.

INCOME ELIGIBILITY LIMITS FOR THE PRIVATE OPTION (138% FPL)

Family Size	1 person	2 people	3 people	4 people	Each add'l person
Yearly Income	\$16,105	\$21,707	\$27,310	\$32,913	\$5,603

Source: Centers for Medicare & Medicaid Services 2014 Poverty Guidelines; Includes 5 percent income disregard

AACF is very supportive of the effort to extend health coverage to low-income adults in Arkansas. The Private Option has allowed 211,000 underinsured adults in Arkansas access to health coverage.¹ Because of the "welcome mat" effect, an additional 25,000 children have also enrolled in ARKids First as their parents signed up for their own coverage. **Arkansas leads the nation in reducing the number of uninsured adults by cutting the rate in half, from 22.5 percent in 2013 to 12.4 percent midway through 2014.**²

COST-SHARING REQUIREMENTS

CMS should not approve the proposed amendment to impose new cost-sharing requirements on individuals enrolled in the Private Option. Monthly contributions would be required for all individuals earning over 50 percent of the federal poverty level. These monthly contributions would be \$5 for adults earning 50-99 percent FPL and \$10-25 for individuals with incomes from 100-138 percent FPL.

The proposed monthly contributions should be considered to be premiums and thus prohibited for Medicaid beneficiaries below the poverty line. The monthly contributions should be treated as a "similar charge" to premiums under section 1916(a)(1) of the Social Security Act since it applies whether or not enrollees utilize care. To date, no state Medicaid demonstration projects have been approved that require adults in the mandatory group of low-income individuals, in Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, to pay premiums below the poverty line as proposed in the Arkansas plan. If approved, this would set a new, dangerous precedent that conflicts with the Medicaid statute.³ Premiums have been shown to limit enrollment of eligible people in numerous studies.⁴ AACF supports the current Private Option standards that do not require any premiums or deductibles.

The amendment to impose cost-sharing requirements on a broader population does not promote the goals of the Medicaid statute because it would reduce access to health

coverage for individuals with low incomes. A Medicaid demonstration project like this one is required to be “likely to assist in promoting the objectives” of the Medicaid Act. Charging low-income individuals a premium or other cost-sharing requirement is not an appropriate use of demonstration authority. Existing evidence tells us that premiums reduce enrollment and reduce access to care.⁵ Cost-sharing has been shown to lead to significant reductions in the use of services, including effective and essential services.

INDEPENDENCE ACCOUNT CONTRIBUTIONS

Arkansas’s waiver amendments propose the monthly contributions be collected through Independence Accounts. They are structured like health savings accounts and require that beneficiaries pay contributions. The state will also make contributions to ensure funds are sufficient to cover deductibles, co-payments, and coinsurance obligations.

Failure to make monthly contributions will result in financial burdens for enrollees and create barriers to care. The proposed amendments are financially burdensome because they include a requirement that says an individual who fails to make monthly contributions will end up in debt to the state. Even more financially burdensome requirements are proposed for beneficiaries above the poverty line. If they fail to make payments, then co-payments and coinsurance will be due at the point of service. A large body of research has demonstrated that cost-sharing requirements in Medicaid reduce access to care and can lead to poor health outcomes. In Oregon, a similar experiment with cost-sharing resulted in increased medical debts and unaffordable care among Medicaid enrollees.⁶

Independence Account requirements are complicated and will create confusion for beneficiaries. Many of the adults enrolled in Private Option coverage were previously uninsured, and the concepts related to health savings accounts will be unfamiliar. It is estimated that over 37 percent of adults in Arkansas have low health literacy, which far exceeds the national rate of 12 percent.⁷ Additionally, people who are uninsured or enrolled in Medicare and Medicaid are more likely to have low health literacy. This may result in increased access barriers for beneficiaries who are unaware of required contributions and face financial penalties for failing to make payments.

The startup and administration costs for Independence Accounts could exceed total contributions collected from beneficiaries. DHS has not released estimates of

the cost of operating Independence Accounts or the total monthly contributions to be collected from Private Option enrollees. However, the state recently approved a \$9.3 million contract for a third-party vendor to administer health savings accounts for Private Option enrollees.

Indiana implemented a similar program through the Healthy Indiana Plan (HIP) in 2008 and recently submitted a demonstration waiver proposal for HIP 2.0. Indiana’s plan features health savings accounts called POWER accounts. Enrollees make monthly payments, along with state and federal contributions, to cover their deductibles.⁸ The HIP 2.0 proposal cites research demonstrating some savings to the state.⁹ Yet, studies show mixed results regarding costs and savings, particularly from health reimbursement arrangements and health savings accounts.¹⁰ Even without administering individual accounts, collection costs and monitoring out-of-pocket caps may exceed the value of premiums collected, calling into question the reason for charging small monthly amounts. For example, Virginia imposed a \$15 per-child, per-month premium on families with incomes between 150–200 percent of the federal poverty level. Virginia then permanently eliminated premiums when a study indicated that the state was spending \$1.39 in administrative cost to collect every \$1 in premiums.¹¹ So, it is unclear if implementing health savings accounts would negatively impact Arkansas’s ability to promote cost-effective use of the health care system, as required in the approved waiver. This may also threaten the sustainability of the Private Option and put beneficiaries at risk of losing affordable coverage.

NON-EMERGENCY TRANSPORTATION

Access to non-emergency transportation is an important benefit for beneficiaries enrolled in the Private Option. Lack of transportation has been shown to reduce use of health care services among low-income people.¹² The Private Option must ensure access to care for enrollees, including those who need assistance with transportation. Arkansas’s obligation to provide non-emergency transportation should not be waived unless the state’s proposal clearly states how enrollees would obtain the transportation services they need. While the proposal promises that an extension of the limited transportation benefit will be available, it does not provide sufficient details on how beneficiaries will qualify for or access this extension. Also, the process of informing beneficiaries of the change in benefits, the availability of extended benefits, and how to access them should be described in detail.

CONCLUSION

AACF is proud of the progress in Arkansas to extend coverage to uninsured adults. We think it is vitally important to prevent future changes to the program that place these gains in coverage and health care access at risk. As the program evolves, it is critical that it continues to be a pathway to coverage for low-income adults in Arkansas.

For more information on this report, please contact Marquita Little (mlittle@aradvocates.org) at Arkansas Advocates for Children and Families.

NOTES

- ¹ Arkansas Department of Human Services. Email from Amy Webb on 10/15/2014.
- ² Witters, D. (2014) Gallup. Arkansas, Kentucky Report Sharpest Drops in Uninsured Rate. Retrieved from: <http://www.gallup.com/poll/174290/arkansas-kentucky-report-sharpest-drops-uninsured-rate.aspx?sf29424162=1>.
- ³ Similar comments were submitted by the Center on Budget and Policy Priorities and Georgetown University Center for Children and Families on the Healthy Indiana Plan 2.0 1115 Waiver submission. Indiana's waiver application proposed imposing premiums on people with income below 50% FPL. Comments are available here: <http://ccf.georgetown.edu/wp-content/uploads/2014/09/CBPP-and-CCF-HIP-2-0-Comments.pdf>.
- ⁴ Kaiser Commission on Medicaid and the Uninsured (2013). Premiums and Cost-Sharing in Medicaid. Retrieved from <http://www.kff.org/medicaid/8417.cfm>.
- ⁵ Strong. (2013). The Facts on Medicaid Copayments: Considerations for Arkansas. Arkansas Advocates for Children and Families.
- ⁶ Ibid. Also see O'Malley and Artiga. (2005) Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences. Kaiser Commission on Medicaid and the Uninsured.
- ⁷ Arkansas Department of Health (2013). Arkansas's Big Health Problems and How We Plan to Solve Them. Retrieved from <http://www.healthy.arkansas.gov/aboutADH/Documents/Accred/ARHealthReportHealthProblems.pdf>.
- ⁸ Kaiser Family Foundation (2008). Summary of Healthy Indiana Plan: key facts and issues. Retrieved from <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/7786.pdf>.
- ⁹ Medicaid.gov. Healthy Indiana Plan 2.0 1115 Waiver Application. Retrieved from <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2.0/in-healthy-indiana-plan-support-20-pa.pdf>.
- ¹⁰ Bundorf, K. Robert Wood Johnson Foundation (2012). Consumer-Directed Health Plans: Do They Deliver? Retrieved from <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf402405>. See also National Health Law Program. NHLP Comments on Healthy Indiana Plan 2.0 ad Healthy Indiana Plan Retrieved from <http://www.healthlaw.org/component/jsfsubmit/showAttachment?tmpl=raw&id=00Pd000000E5pcMEAR>.
- ¹¹ Tricia Brooks (2013). Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters. Retrieved from <http://ccf.georgetown.edu/ccf-resources/handle-with-care-how-premiums-are-administered-in-medicaid-chip-and-the-marketplace-matters/>
- ¹² Shoup. (2011). The Leadership Conference Education Fund. The Road to Health Care Parity: Transportation Policy and Access to Health Care. Retrieved from <http://civilrightsdocs.info/pdf/docs/transportation/The-Road-to-Health-Care-Parity.pdf>.

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