

JUSTICE IN AGING

FIGHTING SENIOR POVERTY THROUGH LAW

December 7, 2019

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

[Submitted via Medicaid.gov](#)

Re: Utah Primary Care Network—Fallback Plan

Justice in Aging appreciates the opportunity to comment on Utah’s proposed “Fallback Plan” amendment to its Primary Care Network demonstration waiver under section 1115 of the Social Security Act. Justice in Aging is an advocacy organization with the mission of improving the lives of low-income older adults. We use the power of law to fight senior poverty by securing access to affordable health care, economic security and the courts for older adults with limited resources. We have decades of experience with Medicare and Medicaid, with a focus on the needs of low-income beneficiaries and populations that have traditionally lacked legal protection such as women, people of color, LGBTQ individuals, and people with limited English proficiency. Justice in Aging conducts trainings and engages in advocacy regarding Medicare and Medicaid, provides technical assistance to attorneys and others from across the country on how to address problems that arise under these programs, and advocates for strong consumer protections at both the state and federal level.

While we support the proposed expansion of Medicaid to adults with incomes up to 138% of federal poverty level, we disagree with the restrictions and barriers to coverage the state is imposing or is seeking approval to impose on the expansion population. Specifically, we urge the Department of Health and Human Services (HHS) to reject Utah’s requests to cap enrollment; to take coverage away from enrollees when the state decides the enrollee has committed an “intentional program violation”; to charge premiums to enrollees with incomes over the poverty line; to impose a premium surcharge on enrollees who use the emergency department for non-emergency care; and for authority to make significant changes to benefits without amending its waiver.

We also remain opposed to Utah’s intention to continue conditioning Medicaid eligibility on meeting “community engagement” requirements for the reasons cited in our previous comments.¹ As explained

¹ We request that our previous comments be included in the administrative record for this proposal. The comments are available at

https://public.medicaid.gov/connect.ti/public.comments/showUserAnswers?qid=1896899&voteid=320465&nextURL=/connect.ti/public.comments/questionnaireVotes?qid=1896899&sort=respondent__commonName&dir=asc&startrow=51&search= and <https://ccf.georgetown.edu/wp-content/uploads/2012/03/PCN-Amendment-Commentsfinal.pdf>

WASHINGTON

1444 Eye Street, NW, Suite 1100
Washington, DC 20005
202-289-6976

LOS ANGELES

3660 Wilshire Boulevard, Suite 718
Los Angeles, CA 90010
213-639-0930

OAKLAND

1330 Broadway, Suite 525
Oakland, CA 94612
510-663-1055

in Justice in Aging’s issue brief attached², this policy will directly harm older adults under age 60 and family caregivers and cause thousands of low-income Utah residents to lose Medicaid coverage and impose barriers to accessing Medicaid for those who are newly eligible under the state’s voter-approved expansion. This will also have a negative effect on adults age 60 and older whose caregivers and family are denied access to health care.

The remainder of our comments focus on our opposition to the proposed premium and copayment provisions and request to eliminate the three-month retroactive eligibility protection.

Imposing Premiums and Charges for Emergency Department Visits Will Decrease Coverage and Impede Access to Necessary Care

Utah is proposing to charge premiums of \$20 per month (\$30 for married couples) to an estimated 40,000 enrollees with monthly income between \$1,040 and \$1,436. After the month of application, these premiums would have to be paid in advance to avoid disenrollment. We disagree with the state’s estimate that only 3% of enrollees would lose coverage for non-payment of premiums. Research shows that premiums and cost-sharing, even when nominal, are a barrier both to enrollment and continuation of coverage.³ For example, in Indiana, 7% of enrollees who had to pay premiums were disenrolled for non-payment and many more never paid the premium necessary to start coverage. The impact of these premiums would be compounded by Utah’s lack of a grace period and its proposed “surcharge” for non-emergency use of the emergency department (ED). If an individual had difficulties paying a \$20/month premium, it is unlikely that they will be able to catch up on multiple months.

On top of premiums, Utah is proposing to add a \$10 surcharge for each enrollee’s use of the ED for non-emergency care. First, the application fails to explain how this provision meets the Medicaid statute’s narrow exceptions for cost-sharing to exceed established limits or overcomes the prohibition of imposing cost-sharing on “emergency services.” Moreover, the Medicaid Act’s copayment provisions are non-waivable.⁴

Second, the application does not define what is a “non-emergent” or “inappropriate” visit or how the state would identify a “non-emergent use of the emergency department” that would incur the surcharge. Under statute, “emergency services” include services necessary to evaluate or stabilize any condition for which a “prudent layperson” would understand the need for immediate medical attention.⁵ However, under Utah’s proposal, an older adult who is having difficulty breathing, who prudently reports to the ED, could be charged the cost-sharing if the state decides it was “inappropriate” based on the ultimate, post hoc “non-emergent” diagnosis.

² Justice in Aging, Medicaid Work Requirements: The Impact on Family Caregivers and Older Adults (Nov. 2018), available at <http://www.justiceinaging.org/wp-content/uploads/2018/11/JusticeInAging-Medicaid-IssueBrief-November19-11am-2018.pdf>;

³ Kaiser Family Foundation, “The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings,” (June 2017), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

⁴ Section 1115 allows for waiver of provisions within 42 U.S.C. § 1396a, but copayment-related provisions are found outside of § 1396a. These provide limited authorization for copayments, along with beneficiary protections. See 42 U.S.C. §§ 1396o, 1396o-1.

⁵ 42 CFR § 447.51.

Such cost-sharing would be especially punitive towards older adults ages 50 to 64, since they are more likely to experience such health issues and may face greater barriers to accessing care. It would be entirely unfair to penalize a layperson for choosing emergency room care when they are experiencing breathing difficulty, weakness, or pain; this is particularly true in the case of an older adult who may have a cognitive impairment.

Finally, the proposed use of ED cost-sharing and premiums, which have been extensively studied, are neither experimental nor likely to promote the objectives of Medicaid. Premiums and cost sharing have been heavily studied both prior to and after implementation of the Affordable Care Act and these studies have produced redundant, consistent findings: premiums significantly reduce low-income individuals' participation in Medicaid and other health coverage and copayments harm low-income people by causing them to forego medically necessary care.⁶ Moreover, studies of Medicaid and CHIP nonemergency ED copayments specifically, including peer-reviewed evaluations of nonemergency ED copayments, consistently show that: (1) Medicaid enrollees use the ED at comparable rates to private pay patients if you factor in their health status, and are no more likely to use the ED for non-urgent visits; and (2) copayments are ineffective at reducing nonemergency ED use.⁷

Eliminating Retroactive Coverage Would Expose People to Crushing Debt

We urge HHS to deny Utah's request for permission to eliminate the federal protection that provides up to three months of retroactive Medicaid coverage for enrollees with incomes between 100 and 138% of the federal poverty level. First, the application does not consider the combined effect of eliminating hospital presumptive eligibility and retroactive coverage for this population. Second, the only apparent hypothesis the state appears to be testing is saving money. However, saving the state money is neither an objective of the Medicaid program, nor is this policy likely to achieve this goal. In fact, eliminating retroactive coverage may very well cost the state more money by ballooning uncompensated care costs and increasing emergency room use.⁸

Third, the retroactive coverage protection enables people who, by definition, cannot afford and are not eligible for other health coverage access to necessary care and treatment by giving providers assurance that Medicaid will reimburse them and can be the difference between financial ruin and being able to recover from an unexpected health emergency. In many instances, a person who needs health care cannot be expected to apply for Medicaid coverage at the exact moment they become

⁶ See David Machledt & Jane Perkins, National Health Law Program, Medicaid Premiums and Cost Sharing (March 2014) available at <http://www.healthlaw.org/publications/search-publications/Medicaid-Premiums-Cost-Sharing#.U5cW-ij3Ijw>; Kaiser Family Foundation, The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings (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/>

⁷ *Id.*; Mona Siddiqui et al., The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005, 175 JAMA INTERNAL MED. 393 (2015); Karoline Mortensen, Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments, 29 HEALTH AFFAIRS 1643 (2010); David J. Becker et al., Co-payments and the Use of Emergency Department Services in the Children's Health Insurance Program, 70 MED. CARE RES. REV. 514 (2013).

⁸ Justice in Aging, Medicaid Retroactive Coverage: What's at Stake for Older Adults When States Eliminate this Protection? (Sept. 2019), <https://www.justiceinaging.org/wp-content/uploads/2019/09/Medicaid-Retroactive-Coverage-Issue-Brief.pdf?eType=EmailBlastContent&eld=a7bb9cdd-1ce1-4012-b154-7981533a4875>.

eligible: they may be hospitalized after an accident or unforeseen medical emergency; they may be struggling to cope with the shock of a diagnosis or sudden decline in functional ability; they may also be unfamiliar with Medicaid, or unsure about when their declining financial resources might fall within the Medicaid eligibility threshold. Medicaid's three-month retroactivity window is a rational and humane response to these concerns. We emphasize that retroactive eligibility is only available to persons who would have met the Medicaid eligibility standards for the month[s] in question had they applied sooner.⁹ Under Utah's proposal, however, a person who has barely \$1,000 per month in income could be hit by an uninsured driver on the evening of December 31st and be liable for thousands of dollars of hospital expenses due to the "failure" to file a Medicaid application within 36 hours, when December becomes January.

Finally, by increasing uncompensated care, eliminating retroactive coverage jeopardizes the ability of providers, especially rural hospitals, to continue to serve their communities. In turn, this decreases access to care for all Medicaid enrollees and, in the case of medically underserved areas, all Utah residents.

Conclusion

Thank you for consideration of our comments. We have cited research demonstrating the harms of these proposals and we respectfully request that HHS review each of the sources cited and made available to the agency through active hyperlinks. We further request that the full text of each of the sources cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

If any questions arise concerning this submission, please contact Natalie Kean, Senior Staff Attorney, at nkean@justiceinaging.org.

Sincerely,



Jennifer Goldberg

Deputy Director

⁹ 42 U.S.C. § 1396a(a)(34).