New York's Proposed 1332 Waiver to Expand Essential Plan Eligibility
June 29, 2023

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to comment on the proposed 1332 waiver to expand Essential Plan eligibility. CHCANYS is the primary care association for New York's more than 70 federally qualified health centers (FQHCs), also known as community health centers (CHCs), serving 2.3 million patients at over 800 sites each year.

Community Health Centers are the standard bearers of primary and preventive care for medically underserved communities across the state. CHCs are non-profit, community run clinics that provide high-quality, cost-effective primary care as well as behavioral health, dental care, and social support services, to everyone, regardless of their insurance status or ability to pay. The majority of CHC patients are extremely low income; 89% live below 200% of the Federal poverty level. CHCs serve populations that the traditional healthcare system has historically failed: 68% are Black, Indigenous, or People of Color (BIPOC), 28% speak limited or no English, 13% are uninsured, and 4% are unhoused. Nearly 60% of our CHCs' patients are enrolled in public health insurance programs including Medicaid, Medicare, and CHIP. In short, CHCs are a crucial safety net for New York's residents of both rural and urban areas, working tirelessly to provide healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health, well-being, and ability to survive.

CHCANYS is generally supportive of the goals of the 1332 Waiver which strives to expand coverage of the Essential Plan to more low- and moderate-income New Yorkers. We appreciate New York's goal to reduce the uninsured population in New York by increasing access to high quality, affordable health insurance for low and moderate-income individuals; inclusion of residents with incomes up to 250% of the federal poverty level; and to continue to use the Essential Plan Trust Fund surplus to fund the program for consumer benefit. However, New York can do more to ensure all New Yorkers can access high-quality health care by expanding coverage to all immigrant New Yorkers and fully reimbursing CHCs for all Essential Plan enrollees. CHCANYS submits the following comments addressing these topics.

Expand Essential Plan Coverage to All Immigrant New Yorkers
CHCANYS supports providing healthcare coverage for all immigrant New Yorkers under the 1332 Waiver. CHCs serve populations that, historically, the traditional healthcare system has failed. Our communities are at the highest risk for negative health consequences resulting from income inequality, discrimination, racism, and a lack of access to healthcare and social services. Currently, 13% of CHC patients are uninsured – more than 2 times the statewide average. Because CHCs have robust outreach, enrollment, and navigation services, it is highly likely that most of those individuals are ineligible for health insurance due to their immigration status. Although CHCs treat everyone regardless of whether they are insured, uninsured individuals experience the most barriers in accessing care outside of CHCs. Everyone deserves meaningful ongoing access to affordable high quality healthcare services but there are currently hundreds of thousands of low-income New Yorkers who are excluded from accessing health insurance due to their immigration status. Even though immigrants make up 31% of workers in New York's essential businesses and 70% of New York's undocumented labor force work in essential

businesses, they are unable to access affordable healthcare.[1] People who are uninsured are more likely to receive an initial diagnosis in the advanced stages of a disease or live with unmanaged chronic conditions. According to Families USA,[2] more than 8,200 New Yorkers died from COVID-19 because they lacked health insurance coverage.

CHCANYS supports expanding healthcare coverage to all immigrants under the 1332 Waiver. Expanding coverage would not only avoid $500 million in annual Emergency Medicaid costs when uninsured immigrant patients seek emergency care at hospitals, it would also increase revenues for community health centers through Essential Plan reimbursements. Currently, health centers fund care for the uninsured through their uncompensated care programs, bolstered in part by sliding fee scales and other sources of funding cobbled together, but even those programs leave health centers incomplete for the full costs of providing services to the uninsured.

Reimburse the Community Health Center Bundled Rate for All Essential Plan Enrollees in Alignment with Medicaid and Medicare

The Governor's Fiscal Year 24 Enacted Budget directed DOH to contract with an independent actuary to study and recommend reimbursement methodologies for increasing rates in the Essential Plan. CHCANYS is supportive of these efforts and encourages the State to include CHCs in this initiative. In recognition of the comprehensive services health centers provide to patients – from primary care, behavioral health, and dental care, to enabling services such as transportation and case management services – health centers receive an all-inclusive, bundled rate under Medicaid and Medicare, the Prospective Payment System (PPS). This payment methodology is critical to health centers' ability to provide high-quality health care in low-income and underserved communities.

Currently, community health centers receive their all-inclusive, bundled rate only for "lawfully present" immigrants under the Essential Plan, previously covered under Medicaid, despite providing the same level of care and services to all Essential Plan patients. Reimbursement at the health center bundled rates for all Essential Plan enrollees is crucial to health centers' continued viability as they face unprecedented financial hardship due to COVID-19 recovery, workforce challenges, and the rising costs of operational expenses. CHCANYS encourages the State to align Essential Plan reimbursement with Medicaid and Medicare by reimbursing health centers at the community health center bundled rate (PPS) for all Essential Plan enrollees, based on today's costs.

Thank you for the opportunity to comment on the proposed 1332 Waiver to expand Essential Plan eligibility. We appreciate New York's goal of expanding Essential Plan coverage and hope to see that extend to all New Yorkers. For questions, please contact Marie Mongeon, Vice President of Policy, at mmongeon@chcanys.org.

[1] https://cmsny.org/publications/new-york-essential-workers/

[2] https://familiesusa.org/wp-content/uploads/2021/03/COV-2021-64_Loss-of-Lives-Report_Report_v2_4-20-21.pdf

July 3, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of the Coverage4All Coalition , I would like to thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services (CMS) for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

Coverage4All is a campaign to expand coverage to all New Yorkers, regardless of immigration status. It is a campaign of Health Care for All New York (HCFANY), and is co led by the Make the Road NY and New York Immigration. The campaign is a coalition of community members, community organizations, health care providers, unions, legal service providers, and labor, immigrant, and health care consumer advocates. With marginalized and uninured communities in mind, the Coverage4All coalition writes to: (1) welcome the proposed Waiver's expansion of Essential Plan coverage to consumers with incomes from 200 to 250 percent of the federal poverty level and urge HHS and CMS to require New York to eliminate the proposed $15 a month premium; and (2) urge CMS to review the Waiver carefully to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

(1) The proposed expansion of coverage will benefit New Yorkers, BUT the proposed $15 premium should be eliminated to maximize and maintain all eligible consumers in coverage.

New York's Basic Health Program (BHP) (branded as the "Essential Plan") has been a huge success for low-income New Yorkers, with over 1.1 million New Yorkers enrolled and an annual surplus of $2 billion. Immigrants and low-income community members rely on the Essential Plan for quality affordable coverage and would benefit from the expansion. Even with premium tax credits, individual market coverage remains too expensive for many consumers with incomes between 200 and 250 percent of FPL—as much as $1,200 a year for a Silver plan with a $1,700 deductible. This is a tough value proposition for many consumers. Accordingly, the Coverage4All coalition lauds the State for seeking to expand coverage to this population.

However, HHS and CMS should require the State to amend its proposal to charge these individuals a $15 per member per month premium. State law authorizes, but does not require, the State to charge the $15 premium. See N.Y. Soc. Servs. L. 369-ii(5) (a). Eliminating the premium can be accomplished administratively. It is well documented that even a small premium causes churning among low- and moderate-income enrollees. The State's assertion that it must charge a premium for adults at this income level because children at the same income levels pay a premium in the Child Health Plus (CHP) program is unfounded. This is a false "equity" claim. Children live with adults, and the whole family benefits from being charged less for health insurance coverage, freeing up additional income for food, school supplies, utilities and rent. Government officials should recognize the totality of a low-income family's budgetary needs.

Moreover, charging premiums would have a negligible effect on the 1332 Waiver program budget. Assuming 90,000 individuals will enroll in this eligibility group, their $15 premiums will generate just $16.2 million per year. This sum is particularly unimportant in light of the $5.8 billion in industry giveaways that the final Waiver proposal added after the public commented on an earlier proposal.

The Coverage4All coalition members were among the 30 organizations that commented on the draft proposal that the State shared for public comment. The publicly-shared draft Waiver proposal did not include the $5.8 billion in additional giveaways to providers and health plans, depriving the public of the opportunity to scrutinize and comment on them. The Final Waiver provides almost no concrete details about the nature of these new industry giveaways. CMS should carefully scrutinize these new spending allocations and require the State to provide the public an opportunity to review them in detail.

(2) CMS should review the Waiver closely to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage due to their immigration status.

The Coverage4All coalition strongly deplores the State's choice to omit coverage for immigrants who are otherwise ineligible for public coverage from the Waiver proposal. As a coalition striving to expand health insurance access for all New Yorkers, regardless of immigration status we know immigrants are a vital part of New York's communities and should be included in public coverage programs. Undocumented New Yorkers between the ages of 19-64 still remain one of the highest uninsured population throughout New York State. We believe the State should take advantage of the waiver, and include all New Yorkers regardless of immigration status, for the expansion of New York's BHP.

The State's final Waiver proposal ignores the vast majority of comments submitted from the public on the draft Waiver proposal. To gather the required public comments, New York State held two public hearings and accepted online comments. As noted in the final document, the 26 out of 30 organizational comments and over 1,600 individual comments sought to include immigrants. These comments stated that there was adequate surplus passthrough funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington states in their 1332 Waiver programs. The comments also noted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid

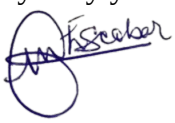
funding if it were to include immigrants in the 1332 Waiver program.

The State's final Waiver submission does not include immigrants, stating that "The State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status." No additional information about these alternative "federal solutions" are provided.

It is important for the federal and state governments to address immigrants and their need for coverage as part of the 1332 Waiver process.

Thank you for the opportunity to provide our testimony.

Very truly yours,



Arline Cruz Escobar
Director of Health Programs at Make the Road NY
On behalf of the Coverage for All Campaign
www.coverage4all.info

Community Service Society

Powering a more equitable New York

President and Chief Executive Officer
David R. Jones, Esq.

Executive Vice President and Chief Operating Officer
Steven L. Krause

June 28, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of the Community Service Society of New York (CSS), I would like to U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

CSS has worked with and for New Yorkers since 1843 to promote economic opportunity and champion an equitable state. CSS's Health Initiatives Department—along with its extraordinary network of community-based partners throughout New York State—has the great honor of helping over 100,000 consumers enroll in and use health insurance coverage, saving them over $40 million per year. These patients' experiences guide our health policy reports that seek to improve the health care system for all New Yorkers. In 2012, CSS issued: "***Bridging the Gap: Exploring the Basic Health Insurance Option for New York,***" the first report to model the benefit to New York in taking advantage of Section 1331 Basic Health Program (BHP) provision of the Affordable Care Act.[1] CSS and its partners successfully advocated for the launch of BHP (branded as the "Essential Plan") in 2015, and over 1.1 million New Yorkers have since enrolled, generating a surplus of $2 billion per annum.

CSS would like to raise three issues for your consideration as you review New York's submission: (1) the State's Waiver ignores the vast majority of 1000s of public comments, which sought to include immigrants: (2) the final Waiver submission is substantially different the one presented for public comment, spending over $5.8 billion on industry giveaways in lieu of

[1] https://www.cssny.org/publications/entry/bridging-the-gapJune2011RevisedJanuary2012

expanding coverage to immigrants; and (3) the Waiver's proposed $15 premium poses too great of a hardship for patients at this income level and would cost little to eliminate through the Waiver.

(1) <u>The State's Waiver ignores the vast majority of thousands of public comments, which sought to include immigrants.</u>

CMS should review the Waiver closely to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

To gather the required public comments, New York State held two public hearings and accepted online comments. As noted in the State's final Waiver submission, the 26 out of 30 organizational comments and over 1,500 individual comments sought to include immigrants. These comments noted that there was adequate surplus passthrough funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington states in their 1332 Waiver programs. The comments also indicted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid funding.

Despite this overwhelming support for immigrant inclusion, the State's final Waiver submission does not seek to expand coverage to immigrants, stating that "The State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status." No further detail has been provided.

CSS urges the federal and State governments to address immigrants and their need for coverage as part of the 1332 Waiver process.

(2) **<u>The final Waiver submission is substantially different the one presented for public comment, spending over $5.8 billion on industry giveaways in lieu of expanding coverage to immigrants</u>**.

The State's final Waiver submission is radically different than the draft submission that was provided to the public for comment. The State's draft (February) Waiver document indicated that over $10.2 billion surplus would be generated over the five years. By contrast, the State's final Waiver (May) submission – which was not provided to the public – projects just $2.86 billion in passthrough surplus (*see* Charts below).

CSS is concerned to identify the following previously undisclosed $5.8 billion in industry giveaway spending in the final Waiver proposal submitted in May:

- $800 million a year, $4 billion over 5 years on provider rate increases;
- $225 million a year, $1.125 billion on insurance companies ("quality incentive pool");
- $571 million over 5 years on Long Term Services and Supports (LTSS)
    - This is an especially strange request since only people ages 19-64 are eligible for the Essential Plan, so why would we spend on LTSS; and
- $125 million over 5 years for an unspecified behavioral health "grant program."

The Final Waiver provides almost no concrete details about the nature of these new industry giveaways.

CSS urges CMS to scrutinize carefully these new spending allocations and require the State to provide the public an opportunity to review them in detail.

(3) <u>The Waiver's proposed $15 premium poses too great of a hardship for patients at this income level and would cost little to eliminate through the Waiver.</u>

HHS and CMS should require the State to modify the Waiver's request to charge individuals between 200 and 250 percent of poverty a $15 per member per month premium. Assuming that the projected 90,000 individuals do in fact enroll in this eligibility group, their $15 premiums will generate just $16.2 million per year—a *de minimis* amount of revenue. It is well documented in the academic literature that even the smallest premiums for low-income people result in coverage gaps and medical debt. Outcomes that can be avoided here at very little government costs.

The State's Final Waiver document avers that it must require a $15 premium because the State charges a $15 premium for Child Health Plus for children at these same income bands. This response defies logic. The children live in families—reducing the premium for the parents means there is more disposable income for the entire family, benefiting children and parents (or caregivers) alike. Imposing premiums means that there is higher probability that enrollees will incur coverage gaps—which are important to avoid. To ensure affordability, and to avoid coverage gaps, the Waiver should be modified to eliminate the $15 premium.

In light of the $5.8 billion the State seeks to spend on industry giveaways, and the important benefit to physical and fiscal health of the enrollees, the federal government should require the State to eliminate this $15 premium during the course of its approval process.

Thank you for the opportunity to provide our testimony.

Very truly yours,

Elisabeth R. Benjamin, MSPH, JD
Vice President, Health Initiatives
Community Service Society of NY

Appendix

Surplus generated under the February 2023 1332 Draft Waiver document:

	2024	2025	2026	2027	2028	5-Year Total
Total program costs (Table 2.2.4, 1332 Actuarial Analysis, p. 13, in millions)	$7,403	$7,747	$8,189	$8,671	$9,180	$41,190
Total federal passthrough request (Summary Table p. 12, in millions)	$9,354	$10,050	$9,955	$10,646	$11,385	$51,390
Difference (SURPLUS)	**$1,951**	**$2,303**	**$1,766**	**$1,975**	**$2,205**	**$10,200**

Final Waiver Projected Surplus is cut to $2.86 billion, due to State spending on industry giveaways.

	2024	2025	2026	2027	2028	Total
Federal Funding	$9,833	$10,566	$10,417	$11,148	$11,921	$53,885
Program Costs,	$8,959	$9,724	$10,221	$10,771	$11,345	$51,020
Surplus (annual):	**$874**	**$843**	**$196**	**$377**	**$576**	**$2,866**

Surplus spent on $5.8 billion in industry giveaways in Final May 2023 1332 Wavier document.

Table C3. With-Waiver Summary of Enrollment, Premium, and Cost Estimates, PY 2024-2033

With Waiver - Scenario C	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	5-Year Total	10-Year Total
Unsubsidized On/Off-Exchange												
Enrollment[1]	63,102	61,122	120,753	120,002	119,255	118,513	117,776	117,043	116,315	115,592	96,847	106,947
Average Premium PMPM	$772	$809	$827	$866	$908	$951	$997	$1,045	$1,095	$1,147	$847	$956
Subsidized On-Exchange												
Enrollment[1]	168,922	170,243	87,405	87,979	88,556	89,138	89,724	90,313	90,906	91,503	120,621	105,469
Average Premium PMPM	$728	$763	$799	$838	$878	$920	$964	$1,010	$1,059	$1,110	$786	$883
Average APTC PMPM	$273	$299	$273	$301	$330	$361	$394	$429	$466	$505	$293	$352
Total Individual Market												
Enrollment[1]	232,024	231,365	208,157	207,980	207,812	207,651	207,500	207,356	207,222	207,095	217,468	212,416
Average Premium PMPM	$740	$775	$815	$854	$895	$938	$983	$1,030	$1,079	$1,131	$813	$920
Aggregate Premiums (millions)	$2,060	$2,151	$2,036	$2,132	$2,232	$2,337	$2,447	$2,562	$2,683	$2,810	$10,610	$23,449
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$361	$396	$434	$475	$518	$1,978	$4,162
Essential Plan												
Enrollment[1]	1,146,600	1,190,046	1,210,758	1,234,010	1,256,694	1,280,269	1,304,309	1,328,825	1,353,826	1,379,321	1,207,622	1,268,466
Average Premium PMPM	$569	$592	$615	$640	$665	$691	$719	$748	$777	$808	$617	$687
Aggregate Premiums (millions)	$7,825	$8,454	$8,935	$9,470	$10,028	$10,623	$11,253	$11,922	$12,630	$13,380	$44,712	$104,520
Quality Incentive Pool Costs (millions)	$225	$225	$225	$225	$225	$225	$225	$225	$225	$225	$1,125	$2,250
Provider Rate Adjustments (millions)	$800	$800	$800	$800	$800	$800	$800	$800	$800	$800	$4,000	$8,000
LTSS Coverage (millions)	$0	$131	$138	$147	$155	$165	$174	$185	$196	$207	$571	$1,498
SDoH/BH Grant Program (millions)	$25	$25	$25	$25	$25	$25	$25	$25	$25	$25	$125	$250
Reduction in Member Cost Sharing (millio	$100	$107	$114	$121	$128	$136	$145	$153	$163	$172	$571	$1,340
200-250% Member Premiums (millions)	($16)	($18)	($17)	($17)	($17)	($17)	($17)	($17)	($17)	($17)	($85)	($170)
Total Program Costs (millions)	$8,959	$9,724	$10,221	$10,771	$11,345	$11,957	$12,605	$13,293	$14,021	$14,793	$51,020	$117,688
Projected Federal Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Other Federal Spend/Revenue												
Pregnancy Medicaid Spend (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
ESRP Revenue (millions)	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Combined Totals												
Enrollment[1]	1,378,623	1,421,411	1,418,916	1,441,990	1,464,506	1,487,920	1,511,809	1,536,181	1,561,047	1,586,417	1,425,089	1,480,882
Projected Federal Spend (millions)	$517	$570	$267	$296	$328	$361	$396	$434	$475	$518	$1,978	$4,162

[1]5 and 10 year totals are straight averages

GREATER NEW YORK HOSPITAL ASSOCIATION
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July
Five
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Ellen Montz, PhD
Director, Center for Consumer Information & Insurance Oversight
Deputy Administrator, Centers for Medicare & Medicaid Services
200 Independence Avenue SW
Washington, DC 20201

Re: NY State of Health Section 1332 Innovation Waiver

Dear Dr. Montz:

Thank you for the opportunity to comment on the NY State of Health's Section 1332 State Innovation Waiver submitted to the Department of Treasury and Department of Health and Human Services on May 12, 2023 (the "Waiver"). Greater New York Hospital Association (GNYHA) has strongly supported New York's Essential Plan (EP) since its inception, and we applaud current efforts to further expand eligibility so even more New Yorkers can access affordable and comprehensive coverage.

We understand that given the limitations on coverage expansion available under Section 1331 of the Affordable Care Act, the New York State Department of Health (DOH) seeks Federal authority to expand EP coverage under Section 1332. We also understand that the existing EP population will not experience any changes to benefits, choice of plans, premium, cost-sharing or eligibility, and enrollment processes as a result of the Waiver[1].

The EP is an invaluable vehicle for providing access to comprehensive coverage for low-income New Yorkers not eligible for Medicaid. Expanded coverage has enormous individual and public health benefits, and also provides a mechanism for more adequately reimbursing health care providers for the cost of delivering care.

GNYHA therefore strongly supports the proposal to expand eligibility to residents with incomes up to 250% of the Federal Poverty Level (FPL). Based on information provided in the Waiver, we understand this population encompasses approximately 90,000 expected enrollees, the vast majority of whom will be able to seamlessly transition to EP plans offered by their existing Qualified Health Plan (QHP) insurers[2]. The EP plans newly available to this expansion population

[1] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, page 4.

[2] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, page 4.

will offer lower cost-sharing and premiums relative to the currently available QHP marketplace plans. Expanding coverage now, during the unwinding of the continuous coverage requirement in effect since the Families First Coronavirus Response Act, has the added and critical benefit of helping to smooth enrollment transitions and affordability for many Medicaid and EP enrollees. We further support DOH's commitment to investing in a range of EP benefits, including incentives for health plans to offer Social Determinants of Health and Behavioral Health benefit enhancements.

As New York prepares to transition the EP for currently eligible populations and expand eligibility to additional residents under a 1332 Waiver, adequate provider reimbursement rates will help ensure that beneficiaries have access to care and providers participating in the program are not destabilized. To that end, we are very pleased that, starting in Calendar Year 2023, New York State is investing up to $800 million in reimbursement to improve access to health care providers for all EP enrollees. For EP expansion to be an ultimately effective coverage strategy, EP premium rates —developed by DOH and used by health plans to inform network participation and rate negotiations with providers—must reflect provider costs of delivering high-quality services to EP enrollees.

We note that in addition to this newly eligible population of individuals with incomes up to 250% of the FPL, GNYHA has urged DOH to amend the Waiver request to include New York's immigrant population under age 65. As DOH itself explains, the Waiver is a key strategy for advancing health equity and "represents a significant opportunity to extend coverage to communities…that are disproportionately uninsured when measured by racial/ethnic identity…"[3]. Today, New York residents ineligible for subsidized QHP and/or Medicaid coverage due to their immigration status receive Emergency Medicaid coverage that, compared to the robust essential health benefits offered by EP plans, is limited in scope, providing only "emergency services" pursuant to Federal law.

We appreciate the need to move forward with the Waiver as submitted given the timing of the continuous coverage unwind, but we urge DOH to simultaneously continue exploring eligibility expansion for New York State's immigrant populations. We support DOH's stated intent to include the Deferred Action for Childhood Arrivals (DACA) population and to explore Federal solutions for coverage of individuals otherwise ineligible due to immigration status.

We look forward to continuing to work with DOH and the Centers for Medicare & Medicaid Services on EP expansion and operations. Please contact me at eleish@gnyha.org with any questions.

Sincerely,

Emily Leish
Senior Vice President, Health Finance and Managed Care

[3] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, page 19.

African Service Committee ☙ Children's Defense Fund-New York
Coalition for Asian American Children and Families ☙ Community Service Society of New York
Consumers Union ☙ Empire Justice Center ☙ Entertainment Community Fund
Hispanic Federation ☙ The Legal Aid Society ☙ Make the Road New York
Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York ☙ Raising Women's Voices-New York
Schuyler Center for Analysis and Advocacy ☙ South Asian Council for Social Services ☙ Young Invincibles

June 30, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of Health Care For All New York, I would like to thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services (CMS) for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers. HCFANY's Steering Committee members represent New York's diverse communities, including immigrants, seniors and people with disabilities, young people, and freelancers and other consumers purchasing coverage on the New York State of Health individual market. With these diverse communities in mind, HCFANY writes to: (1) welcome the proposed Waiver's expansion of Essential Plan coverage to consumers with incomes from 200 to 250 percent of the federal poverty level and urge HHS and CMS to require New York to eliminate the proposed $15 a month premium; and (2) urge CMS to review the Waiver carefully to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

(1) The proposed expansion of coverage will benefit New Yorkers, BUT the proposed $15 premium should be eliminated to maximize and maintain all eligible consumers in coverage.

HCFANY was an early proponent of New York adopting the Basic Health Program (BHP) provision of the Affordable Care Act. New York's BHP (branded as the "Essential Plan") has been

Health Care For All New York
c/o Amanda Dunker, Community Service Society of New York
633 Third Avenue, 10th Floor, New York, New York 10017
(212) 614-5312

a huge success for low-income New Yorkers, with over 1.1 million New Yorkers enrolled and an annual surplus of $2 billion.

Community members represented by HCFANY's Steering Committee rely on the Essential Plan for quality affordable coverage and would benefit from the expansion. Even with premium tax credits, individual market coverage remains too expensive for many consumers with incomes between 200 and 250 percent of FPL—as much as $1,200 a year for a Silver plan with a $1,700 deductible. This is a tough value proposition for many consumers. Accordingly, HCFANY lauds the State for seeking to expand coverage to this population.

However, HHS and CMS should require the State to amend its proposal to charge these individuals a $15 per member per month premium. State law authorizes, but does not require, the State to charge the $15 premium. See N.Y. Soc. Servs. L. 369-ii(5) (a). Eliminating the premium can be accomplished administratively. It is well documented that even a small premium causes churning among low- and moderate-income enrollees. The State's assertion that it must charge a premium for adults at this income level because children at the same income levels pay a premium in the Child Health Plus (CHP) program is unfounded. This is a false "equity" claim. Children live with adults, and the whole family benefits from being charged less for health insurance coverage, freeing up additional income for food, school supplies, utilities and rent. Government officials should recognize the totality of a low-income family's budgetary needs.

Moreover, charging premiums would have a negligible effect on the 1332 Waiver program budget. Assuming 90,000 individuals will enroll in this eligibility group, their $15 premiums will generate just $16.2 million per year. This sum is particularly unimportant in light of the $5.8 billion in industry giveaways that the final Waiver proposal added after the public commented on an earlier proposal.

HCFANY was among the 30 organizations that commented on the draft proposal that the State shared for public comment. The publicly-shared draft Waiver proposal did not include the $5.8 billion in additional giveaways to providers and health plans, depriving the public of the opportunity to scrutinize and comment on them. The Final Waiver provides almost no concrete details about the nature of these new industry giveaways. CMS should carefully scrutinize these new spending allocations and require the State to provide the public an opportunity to review them in detail.

(2) CMS should review the Waiver closely to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

HCFANY strongly deplores the State's choice to omit coverage for immigrants who are otherwise ineligible for public coverage from the Waiver proposal. HCFANY Steering Committee members lead the Coverage 4 All campaign for immigrant coverage. Immigrants are a vital part of New York's communities and should be included in public coverage programs.

The State's final Waiver proposal ignores the vast majority of comments submitted from the public on the draft Waiver proposal. To gather the required public comments, New York State held

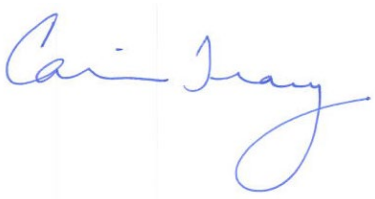
two public hearings and accepted online comments. As noted in the final document, 26 out of 30 organizational comments and over 1,500 individual comments sought to include immigrants. These comments stated that there was adequate surplus passthrough funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington in their 1332 Waiver programs. The comments also noted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid funding if it were to include immigrants in the 1332 Waiver program.

The State's final Waiver submission does not include immigrants, stating that "The State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status." No additional information about these alternative "federal solutions" are provided.

It is important for the federal and state governments to address immigrants and their need for coverage as part of the 1332 Waiver process.

Thank you for the opportunity to provide our testimony.

Very truly yours,



Carrie Tracy, JD
Senior Director, Health Initiatives
Community Service Society of NY

July 5, 2023

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Re: New York Section 1332 State Innovation Waiver

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide feedback on the New York 1332 State Innovation Waiver.

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. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Affordable Care Act, the Basic Health Program and the people that they serve. We urge the Department of the

Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that New York's healthcare programs provide quality and affordable healthcare coverage. We believe the state's proposal to use a Section 1332 waiver to expand its Essential Plan to more New Yorkers will advance these objectives. Once implemented, New York's waiver should reduce the number of people without insurance, substantially lower healthcare costs for at least 65,000 individuals each year, and improve health equity, while satisfying the federal guardrail protections governing waivers.

New York's proposal will lower healthcare costs for individuals between 200-250% of the federal poverty level. For example, compared to being enrolled in a standard silver plan with cost sharing reductions through the New York State of Health marketplace, an individual newly covered by the Essential Plan under this waiver would see their individual deductible decrease from $1,625 to $0 and their maximum out of pocket limit fall from $7,250 to $2,000.[1] Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[2] The state estimates that at least 65,000 individuals in the target group will save about $4,200 per year from the waiver's anticipated changes, a decrease in costs equal to an average of about 11% of household income for these New Yorkers.

At the same time, the state represents that the waiver will not affect eligibility requirements, benefits, or costs for existing categories of Essential Plan enrollees. We appreciate this commitment to preserving affordability and access to comprehensive coverage for the more than one million current enrollees of the program — a commitment we understand to be essential to the success of the proposed waiver. In a similar vein, we know the state expects the waiver proposal to have limited effects on coverage in the individual market. The Departments should work with the state to establish a plan to monitor these impacts, including effects on consumers who do not qualify for subsidized coverage.

We understand that, due to the affordability benefits of the waiver, New York's plan would also improve take-up of comprehensive coverage. The state projects that the waiver will increase combined enrollment in the Essential Plan and marketplace by 1.6% in 2024, and from 2.0%-2.1% (or about 28,000 people) in each year through 2028. In addition, we understand that the waiver would increase covered benefits for the target population — those who could have obtained coverage through the marketplace in the absence of the waiver but who instead will enroll through the Essential Plan — because their coverage will include the same essential health benefits covered by marketplace plans, plus vision and dental care. We are encouraged by and support all of these expected improvements.

Our organizations appreciate the state's efforts to minimize disruptions in coverage for individuals who will be shifting from individual market coverage to the Essential Plan, including reasonable approaches to mapping current Qualified Health Plan (QHP) enrollees into closely-matched Essential Plan alternatives. While the state notes that there is more than 95% overlap

between existing QHP and Essential Plan provider networks, even the most minimal disruption in providers or networks could lead to significant harm for patients with serious or chronic medical conditions. We urge the Departments to work with the state to ensure that enrollees, particularly those mapped from an existing plan into a different product, experience minimal disruption in their access to existing providers and provider networks through close cooperation with consumers, carriers, providers, and patient and consumer organizations through the transition process. The Departments should ensure that the state has considered whether there are ways to mitigate any impact, such as enhanced temporary flexibilities for certain enrollees to continue receiving care at formerly in-network providers who are now out-of-network.

Finally, our organizations support the positive effect that this waiver is expected to have on health equity in New York. Adult Black and Hispanic New Yorkers experience lower levels of health insurance coverage and higher incidences of preventable hospitalizations.[3] The state expects that the increase in affordability of coverage under the waiver will help to address these disparities.

Our organizations support this proposal as a method to improve affordability of healthcare for lower income individuals in New York, as well as equitable access to care, while complying with the 1332 waiver statutory guardrails. We urge the Departments to approve this proposal.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Cancer Support Community
Cancer*Care*
Crohn's & Colitis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
Susan G. Komen
The Leukemia & Lymphoma Society

[1] New York State of Health, "Standard Benefit Design Cost Sharing Description Chart." July 13, 2022. Available at: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%202023%20Standard%20Plans%20revised%207-13-22.pdf

[2] 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/.

[3] Department of Health, New York State. New York State Prevention Agenda Dashboard-State Level, 2023. Available at: https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
DEDUCTIBLE (single)	$0	$600	$1,750	$1,625	$250	$0	$4,700	$6,100	$9,100	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,750	$9,100	$7,250	$2,800	$1,000	$8,700	$6,900	$9,100	$0
COST SHARING – MEDICAL SERVICES										
Inpatient facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	$1,500 per admission	50% coinsurance	0% cost sharing	0% cost sharing
Outpatient facility – surgery, including freestanding am/surg centers	$100	$100	$150	$150	$75	$25	$150	50% coinsurance	0% cost sharing	0% cost sharing
Surgeon – inpatient facility, outpatient facility, including freestanding am/surg centers	$100	$100	$150	$150	$75	$25	$150	50% coinsurance	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or a hospital outpatient facility setting, including freestanding am/surg centers, not to office surgery. See also "Maternity delivery and post-natal care - physician/midwife" under "physician services".									
PCP	$15	$25	$30	$30	$15	$10	$50	50% coinsurance	0% cost sharing	0% cost sharing
Specialist	$35	$40	$65	$65	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
PT/OT/ST – rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	$50	50% coinsurance	0% cost sharing	0% cost sharing
ER	$100	$150	$500	$275	$75	$50	$500	50% coinsurance	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	$300	50% coinsurance	0% cost sharing	0% cost sharing
Urgent care	$55	$60	$70	$70	$50	$30	$75	50% coinsurance	0% cost sharing	0% cost sharing
DME/Medical supplies	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
Hearing aids	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
Eyewear	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – INPATIENT HOSPITAL SERVICES										
Observation stay/care unit	ER copay per case; copay is waived if direct transfer from outpatient surgery setting to an observation care unit.							50% coinsurance	0% cost sharing	0% cost sharing
Hospital services – non-maternity	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and newborn combined)	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility.							50% coinsurance	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – EMERGENCY MEDICAL SERVICES										
Facility charge – emergency room	ER copay per case; copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room.							50% coinsurance	0% cost sharing	0% cost sharing
Physician charge – emergency room visit	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Facility charge – freestanding urgent care center	Urgent care copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Physician charge – freestanding urgent care visit	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Pre-hospital emergency services, transportation, includes air ambulance	Ambulance copay per case							50% coinsurance	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – OUTPATIENT HOSPITAL/FACILITY SERVICES										
Outpatient facility surgery – facility charge, including freestanding am/surg centers	Outpatient facility - surgery copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Pre-admission/Pre-operative testing	$0 copay							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit		$50	$50	Specialist copay per visit		$50	50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	$35	$40	$75	$75	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	$35	$40	$175	$175	$35	$20	$175	50% coinsurance	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative & habilitative	PT/OT/ST copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Home care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PREVENTIVE AND PRIMARY CARE SERVICES	NOTE: For preventive care visits/services as defined in 42 USC § 300gg-13 or as required by state law, no cost-sharing (including deductible) applies. Such preventive care visits/services include, but are not limited to, those found in this section.									
Bone mineral density testing										
Gynecological exams / cervical cancer screening										
Immunizations										
Mammograms / breast cancer screening										
Prostate cancer screening										
Routine / annual exams										
Women's preventive health, including prenatal care										
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES										
Inpatient hospital surgery - surgeon	Surgeon copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding am/surg centers – surgeon	Surgeon copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing apply							50% coinsurance	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative and habilitative	PT/OT/ST copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Second medical opinion for cancer	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Maternity delivery and post natal care – physician or midwife	Surgeon copay per case for delivery and post-natal care services combined (only one copay per pregnancy)							50% coinsurance	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit (based on type of physician performing the service)		PCP copay if performed by PCP/ $50	PCP copay if performed by PCP/ $50	PCP/Specialist copay per visit (based on type of physician performing the service)		$50	50% coinsurance	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES (CONTINUED)										
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	$35	$40	$75	$75	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	$35	$40	$175	$175	$35	$20	$175	50% coinsurance	0% cost sharing	0% cost sharing
Allergy testing	PCP/Specialist copay per visit(based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Office/Outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – ADDITIONAL BENEFITS/SERVICES										
ABA treatment for Autism Spectrum Disorder	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Assistive communication devices for Autism Spectrum Disorder	PCP copay per device							50% coinsurance	0% coinsurance	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies							50% coinsurance	0% coinsurance	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit							50% coinsurance	0% coinsurance	0 cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies							50% coinsurance	0% coinsurance	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30-day supply but no more than $100 (including deductible) paid for a 30-day supply of insulin								0% coinsurance	0% cost sharing
Diabetic self-management education	PCP copay per visit							50% coinsurance	0% coinsurance	0% cost sharing
Home care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. Partial reimbursement for facility fees every six months if member attains at least 50 visits.									
COST SHARING – PEDIATRIC DENTAL SERVICES										
Dental office visit	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PEDIATRIC VISION SERVICES										
Eye exam visit	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames							50% coinsurance	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PRESCRIPTION DRUGS										
Generic or Tier 1	$10	$10	$15	$15	$9	$6	$10	$10	0% cost sharing	0% cost sharing
Formulary brand or Tier 2	$30	$35	$40	$40	$20	$15	$35	$35	0% cost sharing	0% cost sharing
Non-formulary brand or Tier 3	$60	$70	$75	$75	$40	$30	$70	$70	0% cost sharing	0% cost sharing

Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic plans) for a 90-day supply.

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.
Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).
The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

ADDITIONAL INSTRUCTIONS:

1. The following applies to the Platinum, Gold, Silver, Silver CSR, and non-HSA compliant Bronze plans:
   For an inpatient admission, the only copay that applies for an inpatient stay is the inpatient facility per admission copay; and if surgery is performed, a surgeon copay; and if a maternity delivery is performed, a maternity delivery copay (which is the same as the surgeon copay) if this copay has not already been collected as part of another maternity related claim.
   There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
   For a maternity stay, the inpatient per admission copay covers charges for the mother and newborn.
   # The inpatient facility copay per admission is waived for a readmission within 90 days of a previous discharge for the same or a related condition.

2. For the Gold and HSA-compliant Bronze plans, the deductible must be met first, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached.

3. For the non-HSA compliant standard Bronze plan, any combination of three visits indicated below are covered before the deductible, subject to the applicable copays. The copays paid for the three visits count towards the deductible. After the first three visits and for all other services, the deductible must be met, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached. These three visits are in addition to the ACA mandated preventive services for which no cost-sharing can apply. The following visits (or any combination), performed in person or using telehealth, are counted towards the three visits: primary care visits, specialist visits (including allergy visits and visits for second opinions), outpatient mental health visits, outpatient substance use disorder visits, ABA visits, and chiropractic care visits. Urgent care and office surgery do not count towards the three visits.

4. For the standard Silver plan and Silver 73 and 87 CSR plans, one visit indicated below is covered before the deductible, subject to the applicable copay. The copay paid for the one visit counts towards the deductible. After the first visit and for all other services, the deductible must be met, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached. This visit is in addition to the ACA mandated preventive services for which no cost-sharing can apply. Any of the following types of visits, performed in person or using telehealth, counts towards the one pre-deductible visit: a primary care visit, specialist visit (including allergy visit and a visit for second opinions), outpatient mental health visit, outpatient substance use disorder visit, ABA visit, or chiropractic care visit. Urgent care and office surgery do not count towards the one visit.

5. If the copay payable is more than the allowed amount, the copay is reduced to the allowed amount.

6. The maximum out-of-pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs) and includes the deductible.

7. The deductible is over a calendar year for individual products and over the calendar year or plan year (an option of the insurer) for small group products.
   For the Platinum, Gold, Silver and Silver CSR plans, the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames) and does not apply to prescription drugs. For the Bronze and Catastrophic plans, the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames) and prescription drugs).

8. No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA but additional services, like laboratory tests, which are delivered at the preventive care visit may be subject to the deductible or cost sharing.

9. Per ACA, the Catastrophic plan must include three primary care visits per calendar year to which the deductible does not apply. These three primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply. These three primary care visits are covered in full (i.e., no deductible and no cost sharing). For purposes of using these three primary care visits to which the deductible does not apply, a primary care visit is defined as a visit to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, or outpatient mental/behavior health services or substance use disorder services.

10. The family deductible is two times the single deductible; the family out-of-pocket limit is two times the single maximum out-of-pocket limit. For plan designs that are non-HSA plan designs, each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the family in aggregate meet the family deductible amount (or family out-of-pocket limit amount), then no family member needs to accumulate any more dollars toward the deductible (or out-of-pocket limit).

11. The pediatric dental cost-sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan may have its own deductible , cost-sharing, and associated premium.

* Bronze HSA Compliant plan satisfies the maximum out-of-pocket limit of $7,050 set by IRS for calendar year 2022.

The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

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Issue Brief

Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1]

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/)," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

Premiums and Cost Sharing in Medicaid and CHIP Today

Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1). Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4]

Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs			
Preferred	$4	$4	$4
Non-Preferred	$8	$8	20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Effects of Premiums (Table 1 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/))

A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5,6,7,8,9,10] Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39]

Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security. Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40,41,42,43,44,45,46,47,48,49] Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50,51,52] ,[53,54] Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55,56]

Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty. Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57,58,59,60,61,62,63,64,65] Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66,67,68,69] For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70,71,72] Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[73] Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families

without an offer of employer-sponsored coverage.[74] Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75,76,77]

Research finds varying implications of premiums for individuals with significant health needs. Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78,79,80,81] However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82,83] These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84,85]

Effects of Cost Sharing (Table 2 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/))

A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] including vaccinations,[88] prescription drugs,[89,90,91,92] mental health visits,[93] preventive and primary care,[94,95,96,97,98] and inpatient and outpatient care,[99,100] and decreased adherence to medications.[101,102,103] In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104,105] Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] Two studies have found that copayments do not negatively affect utilization.[107,108] In one case, the

authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109]

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110,111] Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112,113,114]

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.[115,116,117,118,119,120,121,122] For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia[123] and reduced treatment for children with asthma.[124] Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125,126]

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits.[127] Other studies find that these copayments do not affect use of the emergency room.[128,129]

Effects on State Budgets and Providers (Table 3 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/))

Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited. Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses.[130,131,132,133,134,135,136] One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137]

Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals. Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138,139,140] and increased emergency department use by uninsured individuals.[141,142] One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured individuals to help people who could not afford copayments and that copayments increased the rate of "no shows" for appointments at community health centers.[143]

Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

Study Tables

The three tables below support the Kaiser Family Foundation Issue Brief titled, "*The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*." The tables highlight findings from 65 studies published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. Each table corresponds to one of three sections in the brief: (1) effects of premiums; (2) effects of cost sharing; and (3) effects on state budgets and providers. The table lists studies in reverse chronological order, with the most recent studies first, and groups

the studies by nationwide and state-specific studies. Studies that apply to multiple sections are included in more than one table but list only the relevant findings for that section.

Table 1: Effects of Premiums

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
National Studies			
Gery P Guy, et. al., "The Role of Public and Private Insurance Expansions and Premiums for Low-Income Parents: Lessons from State Experiences," *Medical Care* 55, 3 (March 2017):236-243.	2000-2013 Current Population Survey (CPS) and Medical Expenditure Panel Survey (MEPS) data	Nonelderly parents with incomes at or below 300% FPL	• Estimates effects of different types of coverage expansions and premiums on parent coverage. • Higher public premiums were associated with a reduction in public insurance, and increased the likelihood of private insurance or being uninsured. A $500 increase in annual public premiums decreased the probability of public insurance by 1.9 percentage points, increased the probability of private insurance by 1.2 percentage points, and increased the probability of being uninsured by 0.6 percentage points. • Public premiums were a significant deterrent to coverage for parents in non-worker households and had effects on public coverage that were over 10 times as large as the effects among families with a worker. Among parents without a worker in the household, a $500

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			increase in annual public premiums decreased the probability of public insurance by 9.8 percentage points, increased the probability of private insurance by 2.9 percentage points, and increased the probability of being uninsured by 6.9 percentage points. Among parents with a worker in the household, both public and private premiums had a significant impact on insurance status.
Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, 8 (August 2014): 1353-1360.	1999-2010 Medical Expenditure Panel Surveys (MEPS) data	Children eligible for Medicaid or CHIP with incomes above 100% FPL	• Simulates the relationship between premiums and coverage by income level and by parental access to employer coverage. • Among eligible children in families with incomes between 101-150% of poverty, a $10 increase in monthly premiums is associated with a 6.7 percentage point reduction in having Medicaid or CHIP coverage and a 3.3 percentage point increase in being uninsured. The increase in likelihood of being

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			uninsured is larger among children whose parents lack offers of employer coverage. • Among eligible children in families with incomes above 150% of poverty, a $10 increase in monthly premiums is associated with a 1.6 percentage point reduction in Medicaid or CHIP coverage. In this income range, the increase in being uninsured may be higher among children whose parents lack an offer of employer sponsored coverage than among those whose parents have an offer.
Silviya Nikolova and Sally Stearns, "The Impact of CHIP Premium Increases on Insurance Outcomes among CHIP Eligible Children," *BMC Health Services Research* 14 (March 2014):101-107.	2003 Medical Expenditure Panel Surveys (MEPS) data in 19 states	Children assumed eligible for CHIP in the income range subject to premiums	• Simulates the effect of premium differences for children in states that have a tiered premium structure for CHIP, in which families at higher incomes pay higher premiums than families in a lower income group. • A $1 increase in premium for those in the higher income group was associated with a 1.7 to 2.2 percentage point

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			increase in the likelihood of being privately insured. • Premium increases were not associated with uninsurance rates.
Carole R Gresenz, Sarah E Edgington, Miriam J Laugesen and Jose J Escarce, "Income Eligibility Thresholds, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions," *Health Services Research* 48:2, Part II (April 2013):884-902.	2002-2009 Current Population Survey data	Children with family incomes 200%- 400% FPL	• Simulates effects of varying premium schedules (no, low, medium, and high premiums) for individuals with incomes between 200-400% FPL. • Across the examined income levels, premiums decrease enrollment in public coverage and increase enrollment in private coverage, with greater effects as premium contributions increase. Changes in uninsured rates are less sensitive to premiums at these income levels, particularly among those with incomes at 300% and 400% FPL, likely reflecting the greater availability of employer coverage at these income levels.
Gery P Guy, Jr., E. Kathleen Adams, and Adam Atherly, "Public and Private Health Insurance Premiums: How do they Affect Health Insurance Status of Low-Income	2000-2008 Current Population Survey data	Low-income childless adults (age 19-64) eligible for public coverage	• Estimates effects of public and private health insurance premiums on

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Childless Adults?," *Inquiry* 49 (Spring 2012):52-64.		expansions or premium assistance programs in 16 states and DC	insurance status of low-income childless adults eligible for public coverage or premium assistance programs. • Higher public premiums are associated with a decrease in the probability of having public insurance and an increase in the probability of being uninsured. A $1,000 increase in annual public premiums was associated with a 14.2 percentage-point reduction in the probability of public insurance and an 8.2 percentage point increase in the probability of being uninsured. • Increased private premiums decrease the probability of having private insurance. A $1,000 increase in annual private premiums was associated with a 3.3 percentage point reduction in the probability of private insurance. • Eligibility for premium assistance programs and increased subsidy levels are associated with lower uninsured rates. A $1,000 increase in

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the annual subsidy level for premium assistance was associated with a 3.4 percentage point reduction in the likelihood of being uninsured.
Jack Hadley, et. al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43, 4 (Winter 2006/2007).	1996-2003 Community Tracking Study Household Survey data	Children in families with incomes between 100%-300% FPL	• Estimates the effects of premiums on children's coverage. • Higher public premiums are significantly associated with a lower probability of public coverage and higher probabilities of private coverage and being uninsured. An increase in the public premium that leads to a 1% decrease in public coverage increases the probability of private coverage by .62%, while the probability of being uninsured increases by .38%. • Higher private premiums are significantly related to a lower probability of private coverage and higher probabilities of public coverage and being uninsured. If the probability of private coverage decreases by 1%,

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the probability of public coverage will increase by .55% and the probability of being uninsured will increase by .45%.
Genevieve Kenney, Jack Hadley, and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43 (Winter 2006/ 2007):345-361.	2000-2004 Current Population Survey data	Children with family incomes between 100% to 300% FPL and who meet the eligibility requirements for either Medicaid or CHIP coverage	• Simulates the effects of premiums on children's coverage. • Raising public premiums reduces enrollment in public programs, and increases the odds of having private coverage or being uninsured relative to having Medicaid or CHIP coverage. Public premiums have larger effects on lower income families. • For children with family incomes between 100%-300% FPL, increasing per-child public premiums by an average of $120 annually reduces public coverage by 1.4 percentage points, increases private coverage by 1.1 percentage points, and increases uninsured rates by .3 percentage points. • Larger reductions in public coverage were found among

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			lower income eligible children whose family incomes are between 100%-200% FPL. For these children, a $120 annual increase in public premiums would result in a 4.2 percentage point reduction in public coverage, a 3.2 percentage point increase in private coverage, and a 1.0 percentage point increase in the share uninsured. • Data also suggest that increases in public premiums may have more pronounced effects on uninsured rates when applied to Black or Hispanic children, whose families have lower levels of educational attainment. • A 10% increase in private coverage costs would lower private coverage by 1.4 percentage points, raise public coverage by .6 percentage points, and increase the share uninsured by .8 percentage points.
State Studies Back to top			

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
The Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, Prepared for Indiana Family and Social Services Administration (FSSA), (Washington, DC: Lewin Group, March 2017).	December 2016-January 2017 Surveys of enrolled, disenrolled, and not enrolled individuals, February 2015-December 2016 Indiana Family and Social Services Administration (FSSA) enrollment data and administrative data, and January-September 2016 data from 3 managed care entities (MCE)	**Indiana:** Medicaid expansion enrollees with incomes between 0-138% FPL	• Assesses the affordability of the Healthy Indiana Plan (HIP) 2.0's POWER Account Contribution (PAC) policy, which contains contributions that range from $1-$100 per month, depending on income. • Between February 1, 2015 and November 30, 2016, 55% of the 590,315 individuals eligible to pay PAC either never made a first payment or missed a payment during their enrollment. Individuals with incomes at or below poverty were more likely to not make a payment that those with incomes above poverty. • 15% of survey respondents reported that they are always or usually worried about having enough money to pay their PAC. • 44% of those who missed a payment cited not being able to afford to pay the contribution as the main reason for nonpayment and 17% indicated confusion regarding

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the payment process. Among those who never made a payment, 22% cited not being able to afford the contribution and 22% cited being confused about the payment process. • Individuals who disenrolled due to nonpayment or those who never enrolled because they did not make their first payment were less likely than those enrolled in HIP to report making appointments for both routine and specialty care. They were also less likely to report filling a prescription in the past six months or since leaving HIP. • 47% of those who disenrolled due to nonpayment and 41% of those who never enrollment because they did not make their first payment reported that they had insurance coverage, which was most commonly employer sponsored coverage.
MaryBeth Musumeci, et. al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, (Washington, DC: Kaiser Family	State administrative data	**Michigan and Indiana:** Adults enrolled in the Medicaid	• Examines early implementation experiences of

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Foundation, January 2017), https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/ (https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/).		expansion waiver programs	Michigan and Indiana Section 1115 Medicaid expansion waivers to low-income adults. • State data show that premium costs may deter eligible adults from enrolling in coverage. Particularly for very low-income adults, even very low premiums may be unaffordable. • In Michigan, from October 2014-July 2016, about 38% of beneficiaries who owed premiums had paid them. As of July 2016, over 112,000 Michigan beneficiaries owed past due premiums or copayments; about 44,200 (less than 40%) of these were in "consistent failure to pay" status, subjecting them to garnishment of their state income tax refunds. • 37% of Healthy Indiana Plan (HIP) 2.0 enrollees with incomes below poverty were not paying monthly premiums and, therefore, were enrolled in HIP Basic, the more limited benefit package with point-

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			of-service copayments, as of October 2016. To date, a limited number of Indiana beneficiaries with incomes above poverty have been locked out of coverage for failure to pay monthly premiums. Between August and October 2016, 4,621 HIP 2.0 beneficiaries were disenrolled and locked out of coverage for 6 months for failing to pay premiums.
James Marton et. al., "Estimating Premium Sensitivity for Children's Public Health Insurance Coverage: Selection but No Death Spiral," *Health Services Research* 50, 2 (April 2015): 579-598.	State administrative data, 2003-2006	**Georgia:** Children enrolled in PeachCare, Georgia's CHIP program	• Estimates the effects of premium increases on the probability that near-poor and moderate income children disenroll from public coverage. • A $1 increase in per child premium is associated with a 7.7-7.83% increase in the probability of a child disenrolling from CHIP. • The data suggest that families with children in poor health do not respond much differently than families with children in medium or good health to premium increases,

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			despite having a lower baseline probability of disenrolling from coverage.
Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (May 2014): 1-12.	State administrative data, 2008-2010	**Wisconsin:** Children and parents enrolled in BadgerPlus, Wisconsin's Medicaid and CHIP program	• Estimates the effects that premiums in Medicaid have on the length of enrollment. • A monthly premium increase from $0 to $10 results in 1.4 fewer months of continuous enrollment for both adults and children and increases the probability of disenrollment by 12-15 percentage points. • No or relatively small effects are found for other large discrete changes in premiums, suggesting that the premium requirement itself, more than the specific dollar amount, discourages enrollment.
Michael Hendryx, et al., "Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program," *Social Work in Public Health* 27, 7 (2012):671-686.	Survey of adults who stayed enrolled and disenrolled following premium changes.	**Washington State:** Low-income adults in Washington's Basic Health Plan	• Examines the effects of increased premiums and cost sharing in Washington's state-funded coverage program for adults

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			on enrollment and possible health care consequences of disenrollment. Effective January 2004, Washington made policy changes that increased average monthly premiums for adults from $27 to $35 and average monthly out-of-pocket costs from $29 to $52. • About 5% of enrollees disenrolled after the policy changes. Disenrollees were more likely to be younger adults, male, and have fewer children. Among all disenrollees, 39% indicated that they left because they obtained other coverage, 35% reported that they were no longer eligible, while 21% indicated that they left the program because they could not afford it. Middle-income enrollees were the most likely to have left because they had trouble paying for coverage. • 63% of disenrollees were aware of the changes in premiums and cost sharing. Among all disenrollees who

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			were aware of the changes, 26% cited the changes as a reason for disenrolling. Among disenrollees who were aware of the changes and left voluntarily, 34% cited the changes as a reason for disenrolling. Among those citing the changes as a disenrollment reason, the increase in the monthly premium was the most important change that affected their decision. • Overall, 37% of disenrollees had no health insurance when surveyed. Disenrollees reported less access to care, greater subsequent out-of-pocket costs, and more difficulty providing coverage for children than people who stayed enrolled.
Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.	State administrative data, 1999 and 2009	**Alabama:** Children enrolled in ALL Kids, Alabama's CHIP program	• Examines the effects of an annual premium increase as well as increases in copayments on enrollment and renewal in Alabama's CHIP program, ALL Kids. In October 2003, premiums for

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			individual coverage increased by $50 per year and copays by $1-$3 per visit. • The increases in premiums and copays are estimated to have reduced renewals that are completed within 12 months by 6.1% annually. This reduction is over one-third larger—up to 8.3%—if only immediate renewals are considered. • Families with a child who has a chronic condition were more likely to renew coverage overall. However, those with chronic conditions, African Americans, and those with lower family incomes were more sensitive to the premium increase.
Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs* 29, 12 (December 2010):2311-2316.	State administrative data and a mail survey, November 2003, 2004, and 2005	**Oregon:** Adults enrolled in Medicaid with income below 100% FPL	• Examines effects of premium and cost sharing increases for poor adults enrolled in Oregon's Medicaid program. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • During the study period between 2003 and2005, only 33% of OHP Standard plan enrollees remained continuously enrolled following the policy changes, compared to 69% of OHP Plus enrollees. Most disenrollment occurred in the first six months following the changes, when 44% of OHP Standard enrollees left the program. • Premium increases and rigid premium payment deadlines were a major reason why members reported disenrolled from the OHP Standard plan, accounting for nearly half of the disenrollment over the first six months. • At the end of the study, 32% of those who had left OHP Standard had become uninsured compared to 8% of those who had left OHP Plus.

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Citation	Data	Study Population(s)	Study Focus and Major Findings
Michael R Cousineau, Kai-Ya Tsai, and Howard A Kahn, "Two Responses to a Premium Hike in a Program for Uninsured Kids: 4 in 5 Families Stay In as Enrollment Shrinks by a Fifth," *Health Affairs* 31, 2 (February 2012):360-366.	L.A. Care Health Plan enrollment data, 2009-2011	**California:** Children enrolled a health insurance program for low-income immigrant children in Los Angeles County and those whose income exceeded 250% FPL	• Examines the effects of premium increases on disenrollment from a health insurance program for low-income immigrant children in Los Angeles County. In July 2010, L.A. Care Health Plan increased premiums for older children (age 6-18) to $15 per month for each child, with a maximum of $45 per family. Premium increases did not apply to younger children (ages 0-5). • After premiums increased, the retention rate among older children dropped by nearly five percentage points from an average of 98.1% to 93.8%. Much of the decline occurred in the first two months after the premium increase. As a result, monthly enrollment among older children declined by 39% after the premium increase. In contrast, the average retention rate for younger children did not change over the period.

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			• At the end of the study period, 59% of the older children subject to the premiums were still enrolled. Without the premium increase, it was expected that 80% of the children in this group would still be enrolled. As such, it is estimated that the increase resulted in an enrollment decline of 20%.
James Marton, Patricia G Ketsche, and Mei Zhou, "SCHIP Premiums, Enrollment, and Expenditures: A Two State, Competing Risk Analysis," *Health Economics* 19 (2010):772-791.	State administrative data for Kentucky, 2001-2004 and Georgia, 2003-2005	**Kentucky and Georgia**: Children enrolled in Medicaid and CHIP in Kentucky and Georgia	• Compares the effects of introducing new premiums and increasing premiums for children enrolled in CHIP in two states on enrollment in public coverage through CHIP or Medicaid. Kentucky introduced a $20 monthly premium for children in CHIP for the first time in 2003. In mid-2004, Georgia increased existing premiums in its CHIP program from $10 per family to sliding scale premiums ranging from $20-$40 for one child and $35-$70 for two or more children. • In both states, premium increases

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			lead to increases in children leaving CHIP and having no public health insurance in the two months immediately following the premium changes. In both states, data also show increases in the probability of children moving to lower income eligibility categories of CHIP that have lower premiums following the premium increase. In Kentucky, there also was an increase in the likelihood of children moving to Medicaid in the two months following the increase; however, this was not observed in Georgia. • Not all changes persisted over the longer term. However, in Kentucky, children continued to be more likely to exit to no public health insurance in the remaining seven months of the study period.
James Marton and Jeffery C Talbert, "CHIP Premiums, Health Status, and the Insurance Coverage of Children," *Inquiry* 47, 3 (Fall 2010):199-214.	State administrative data 2001-2005 and a survey of families that disenrolled from CHIP due to	**Kentucky:** Children enrolled in CHIP	• Examines whether the effects of new premiums in Kentucky's CHIP program on enrollment varied

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Citation	Data	Study Population(s)	Study Focus and Major Findings
	premium nonpayment		by children's health status and the extent to which children find alternative coverage after disenrolling due to premium nonpayment. In late 2003, Kentucky introduced a $20 per family per month premium for children in CHIP with family incomes between 151%-200% FPL. • Overall, the data show that children with a chronic condition are significantly less likely to disenroll from CHIP than children without a chronic condition. • The data suggest that introduction of the premium reduces the duration of CHIP coverage for the average child. However, the data suggest little differential impact of the premium increase by health status of children. • Survey results find 56% of families report alternative private or public health coverage for their children after losing CHIP coverage, while 44% had no insurance for their children

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			following disenrollment.
Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," *Health Affairs* 28, 2, (2009):w335-w345.	State administrative data; Current Population Survey (CPS) data, 2005-2007; provider utilization and financial reports; and structured interviews	**Missouri:** Nonelderly adults and children in Medicaid and CHIP	• Examines the effects of a broad range of policy changes in Missouri Medicaid and CHIP coverage, including new monthly premiums for CHIP. In 2005, Missouri adopted large policy changes to Medicaid and CHIP, including new monthly premiums of 1-5% of family income for children in CHIP with incomes above 150% FPL. • CHIP enrollment fell 30% between June 2004 and June 2006. In contrast, nationally, CHIP enrollment rose 3.4% over the same time period. • The share of low-income children in Missouri with Medicaid or CHIP coverage fell from 50.2% in 2004 to 40.5% in 2006, but increases in other types of insurance coverage prevented an increase in the share that were uninsured.
Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," *Health*	State administrative data, 2002-2004	**Florida**: Children enrolled in CHIP	• Examines the impact of premium changes in Florida's

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Citation	Data	Study Population(s)	Study Focus and Major Findings
Services Research 43, 2 (April 2008):458-477.			CHIP program on enrollment duration. Florida increased CHIP premiums for enrollees with incomes between 101-200% FPL by $5 per family per month in July 2002. These increases were reversed in October 2003 for those with incomes between 101-150% FPL, but maintained for those with incomes above 150% FPL. • Enrollment lengths decreased significantly immediately following the premiums increase, and the decrease was larger among lower income children (61%) than higher income children (55%). Enrollment lengths partially recovered in the longer term for both the temporary and permanent policy changes. • Children with significant acute or chronic health conditions had longer enrollment lengths and were less sensitive to premium changes than healthy children. Among

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			lower income children, healthy children experienced a 61% decline in enrollment within the first three months compared to a 39% decline for children with significant acute conditions.
James Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," *Journal of Policy Analysis and Management* 26 (2007):237-255.	State administrative data, 2001-2004	**Kentucky:** Children enrolled in CHIP	• Examines the impact of new premiums on enrollment duration for CHIP children in Kentucky. Kentucky introduced a $20 premium for children in CHIP with family incomes between 151-200% FPL in December 2003. • Results suggest that a premium reduces the length of enrollment, with the impact concentrated in the first three months after the introduction of the premium.
Genevieve Kenney, et. al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Part 2 (2007):2354-2372.	State administrative data, 2001 to 2004/2005	**Arizona and Kentucky:** Children enrolled in CHIP with family incomes between 101-150% FPL in Arizona and 151-200% FPL in Kentucky.	• Assesses whether new premiums in CHIP affect rates of disenrollment and reenrollment in CHIP and whether they have spillover enrollment effects on Medicaid. In July

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			2004, Arizona introduced CHIP premiums ranging from $10-$15 per month for families with incomes between 101-150% FPL. In December 2003, Kentucky introduced a premium of $20 per month per family for children in CHIP with family incomes between 151-200% FPL. • In both states, the premiums increased the rate of disenrollment among children subject to the premiums. The rate of disenrollment increased by 52% in Kentucky and by 38% in Arizona. All of the increases in disenrollment occurred during the first two or three months after introduction of the premium. Almost all the disenrollment is caused by children leaving public insurance rather than moving to Medicaid or other non-premium paying categories of CHIP. Findings also indicate a relatively small reduction in the rate of re-enrollment in both states.

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			• In both states, the premiums were associated with a decline in overall enrollment among children subject to the premiums. The premium reduced enrollment in the premium paying group by 18% in Kentucky and by 5% in Arizona, with some of the children leaving public coverage all together. Unlike the impacts on disenrollment, these effects are not limited to the first 2–3 months following the introduction of the premium, suggesting that the premium may have dampened new enrollment into the premium-paying category over a longer period of time.
Gina A Livermore, et. al., "Premium Increases in State Health Insurance Programs: Lessons from a Case Study of the Massachusetts Medicaid Buy-in Program," *Inquiry* 44 (Winter 2007):428-442.	2002-2003 Medicaid Management Information System (MMIS) and administrative data	**Massachusetts:** Enrollees in the Massachusetts CommonHealth-Working (CH-W) Medicaid buy-in program for people with disabilities	• Evaluates the impact of premium increases on disenrollment from a state-funded Medicaid buy-in program for people with disabilities in Massachusetts. In 2003, monthly premiums for the Massachusetts CommonHealth-Working (CH-W)

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			program increased from $37 to $51. • After a period of steady growth, CH-W enrollment decreased marginally (.5% decrease) in the months surrounding the premium change (February-August 2003) compared with 12.4% increase during the same period in the previous year. • The premium increase increased the likelihood of enrollees leaving Medicaid (MassHealth) altogether, but had no effect on the likelihood of moving to another Medicaid (MassHealth) eligibility category. Although statistically significant, the effect is rather modest. All else held constant, a $10 increase in the premium would increase the odds of leaving Medicaid (MassHealth) by 3%. • The analysis suggests that the premium changes had a relatively small impact on disenrollment and alone cannot explain the decline observed between

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			February and August 2003. Authors suggest that several aspects of the program may contribute to the limited impact on disenrollment, including it being a longstanding program, the changes increasing existing premiums rather than introducing new premiums, the exemption of enrollees with incomes under 150% FPL from premiums, the analysis accounting for the movement of enrollees to other categories of Medicaid coverage, and administrative procedures, including processes designed to minimize disenrollment due to nonpayment. Further, people with disabilities may be less price-sensitive to premiums given their significant health care needs.
Genevieve Kenney, et. al., "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States," *Inquiry* 43, 4 (Winter 2006-2007):378-92.	State administrative data, 2001-2004/2005.	**Kansas, Kentucky, and New Hampshire:** Children enrolled in CHIP with incomes between 150-200% FPL in Kansas and Kentucky and	• Examines the effects of new and higher premiums on CHIP enrollment in Kansas, Kentucky, and New Hampshire. In 2013, Kansas and

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Citation	Data	Study Population(s)	Study Focus and Major Findings
		with family incomes between 185-300% FPL in New Hampshire.	Kentucky increased premium levels, while Kentucky introduced new premiums. Kansas increased premiums from $10 to $30 per family per month for families with incomes between 151-175% FPL and from $15 to $45 per family per month for those with incomes between 176-200% FPL. New Hampshire increased premiums for families with incomes between 185% to 249% FPL from $20 to $25 per child per month and from $40 to $45 for families with incomes between 250-300% FPL. Kentucky introduced a $20 premium per family per month for 151-200% FPL. • In all three states, caseload growth rates in the six months prior to the premium increase were consistently higher than those in the six months after the increase. In Kentucky, the caseload of children subject to premiums decreased by 16.4% following the premium's introduction. The caseload stabilized

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			after several months but did not return to pre-premium levels nine months after the premium was introduced. In Kansas and New Hampshire, small declines in the caseload occurred immediately following the premium increase. The caseload resumed growing three to five months after the premium increase, though at lower rates than before the increase. In contrast, caseloads among other categories of public coverage without premiums grew over the period. • Premiums were found to reduce new enrollment by 10.1% and 17.7% in Kansas and New Hampshire, respectively. They also led to faster disenrollment in Kentucky and New Hampshire. • In Kentucky, larger disenrollment effects were found for nonwhite children relative to white children while in New Hampshire, disenrollment effects were

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			concentrated among children at the lower end of the income group subject to premiums.
Tricia J Johnson, Mary Rimsza, and William G Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* 96, 4 (April 2006):709-715.	Yuma HealthQuery (YHQ) community health data, 2001	**Arizona:** Children in Yuma County, Arizona who received non-traumatic care at an emergency room who were enrolled in CHIP or uninsured	• Simulates the effects of increasing CHIP premiums on health care use and public costs using data for children in Yuma, Arizona. • Estimates that a $10 increase in monthly premiums for CHIP would induce 10% of CHIP children to disenroll.
Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.	Survey of enrollees, 2003 and analysis of Medicaid eligibility files	**Oregon**: Adults enrolled in Medicaid	• Examines longitudinal effects on enrollees of a range of policy changes that were made in Oregon's Medicaid program. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			similar to the original OHP. • Nearly half (44%) of the OHP Standard members disenrolled in the six months after the program changes were implemented. • The increased premiums and cost sharing disproportionately affected the most economically vulnerable OHP members; for the vast majority of those who disenrolled, leaving OHP meant becoming uninsured. This was particularly true for those who left because of the increased costs. • Those who left OHP because of cost were more likely than those who left for other reasons not to have received needed care in the previous six months. Similarly, those who left because of cost were more likely to have skipped buying prescription medicines because of cost and were significantly less likely than those who left for other reasons to have a

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			usual source of care. • Those who left because of cost were significantly less likely than those who left for other reasons to have had a least one primary care visit in the past six months and significantly more likely to have had at least one emergency department visit in those same six months. • Those who left OHP because of cost were significantly more likely to owe $500 or more in medical debt than those who left for other reasons. The increased debt burden may have negatively affected their access to care.
Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).	Survey conducted between November 2003 and February 2004	**Oregon:** Adult Medicaid enrollees with incomes below 100% FPL	• Assesses the impact of policy changes made to Oregon's Medicaid program on enrollment, health care access, and use. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • 44% of individuals who disenrolled from OHP Standard following the changes reported that increased costs, including premiums, copays, and back-owed premiums, contributed to disenrollment; OHP Standard disenrollees with incomes between 0-10% FPL were significantly more likely to report difficulty paying premiums and copays than those with higher incomes. • Two-thirds of OHP Standard disenrollees became uninsured. • Disenrollees with very low incomes (43%) were more likely to have an emergency department visit than those still covered (35%); the difference was larger for those with chronic conditions.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.	Mail survey of OHP beneficiaries, October 2003	**Oregon:** Nonelderly adults enrolled in Medicaid	• Assess the impacts of policy changes in Oregon's Medicaid program on individuals living with chronic illness. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • Nearly half (46.3%) of OHP Standard beneficiaries disenrolled in the 10 months after the policy changes. Rates of disenrollment were lower among the chronically ill (42.8%) than those without chronic illness (49.6%). However, 68% of the chronically ill that did disenroll remained uninsured at the time of the survey.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• When asked why they disenrolled, 45% of the chronically ill and 43% of those without a chronic illness identified a reason related to the increase in cost sharing, such as inability to afford the new premiums or copays and/or owing premiums. • Increased costs disproportionately affected enrollment for those with lower incomes. Among those who lost coverage, 68.2% of those with zero income indicated cost sharing as the major reason for their loss, compared to 38.7% of those with incomes between 26%-100% FPL and 23.9% of those with income above 100% FPL. • Chronically ill persons who became uninsured after leaving OHP fared worse in terms of access to care, use of care, and financial burden than those who became uninsured but did not have a chronic illness.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).	Focus groups, 2004	**Oregon:** Medicaid adults with incomes under 100% FPL.	• Assesses the impact of policy changes made to Oregon's Medicaid program on poor adults who were subject to benefit reductions and premium and cost sharing increases. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • Increased premiums and stricter payment policies led many to face difficult decisions such as paying other bills late or skipping meals. For many, the new premiums and the stricter payment policies led to loss of coverage, and they had significant problems accessing care after losing coverage.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Utah Department of Health Center for Health Data, *Utah Primary Care Network Disenrollment Report*, (Salt Lake City, UT: Utah Department of Health Center for Health Data, Office of Health Care Statistics, August 2004).	State administrative and survey data, July and September 2003	**Utah:** Adults with incomes below 150% FPL who disenrolled from Medicaid	• Examines the effect of an enrollment fee and cost sharing on adults enrolled in a Medicaid limited benefit waiver program in Utah. In 2003, Utah implemented an annual enrollment fee and cost sharing in its Primary Care Network (PCN) waiver program for low-income adults. • During July-September 2003 (renewal period after first year), 27% were disenrolled. A survey of disenrollees found that 63% were uninsured at the time of the survey. Nearly half of surveyed disenrollees indicated that they were still eligible for the PCN program. • Nearly 30% of survey respondents indicated financial barriers to reenrollment. Most of those reporting financial barriers cited the $50 reenrollment fee as the barrier (63%) and 26% cited the copays. Over 75% of respondents who reported financial barriers to reenrollment

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			reported being uninsured after exiting the program. • Of those indicating they did not reenroll because the program did not meet their health needs, 20% reported copays were too high to use services. • About half of all respondents who disenrolled, regardless of reason for disenrollment, indicated not having seen a health care provider in the previous 12 months. Many disenrollees reported difficulty accessing needed care, particularly mental health care, alcohol/drug treatment, and dental services.
Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).	State administrative data, key informant interviews, a focus group, and interviews, September 2002-September 2003	**Washington State:** Immigrant families moved from Medicaid to Basic Health in Washington State	• Assesses the impact of changes in coverage options for low-income immigrants in Washington State. In 2002, Washington State eliminated three state-funded programs for individuals whose immigration status prevented them from qualifying for Medicaid. Instead, "slots" were set aside for them in

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the state's Basic Health program, which charges premiums and has more limited benefits than Medicaid. • 48% of families in the transition population did not make the transition and disenrolled during the first few months of the transition. • Premiums were a significant barrier to families obtaining and maintaining Basic Health coverage; 35.9% of those from the transition group who disenrolled from Basic Health in the first 11 months did so because they did not pay premiums. • Most (61%) of the group that successfully transitioned to Basic Health relied on assistance from third parties to pay premiums.
Maryland Department of Health and Mental Hygiene, *Maryland Children's Health Insurance Program: Assessment of the Impact of Premiums*, (Baltimore, MD: Department of Health and Mental Hygiene, April 2004).	State administrative and survey data, February 2004	**Maryland:** Children disenrolled from CHIP with incomes between 185-200% FPL	• Studies the effects of a new monthly premium in Maryland's CHIP program on program enrollment and health coverage. In 2003,

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			Maryland made several changes to its CHIP program, including requiring families with incomes between 185-200% FPL to pay a new monthly premium of $37 per family. • Enrollment data showed about one-quarter of families subject to the new premiums disenrolled. • In surveys conducted with parents, the most common reason given was gaining other coverage (41%), but 20% cited a premium related reason.
John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.	State administrative data, January 2002 – October 2003	**Oregon:** Adults with incomes below 100% FPL who disenrolled from Medicaid in Oregon	• Examines the effects of changes to Oregon's Medicaid program on enrollment and highlights the effects for enrollees at different income levels. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • OHP Standard experienced a nearly 50% drop in enrollment, with the largest declines experienced by those with no income (58% drop in October 2003 from 2002 levels). • Of those that left between May and October, 47% were disqualified for not paying premiums.
Norma I Gavin, et. al., *Evaluation of the BadgerCare Medicaid Demonstration*, Prepared by RTI International and MayaTech Corp. for the Centers for Medicare & Medicaid Services, (Research Triangle Park, NC: RTI International and MayaTech Corporation, December 2003).	Case study, including site visit interviews, focus groups, and document review; administrative enrollment data 1997-2002; and surveys of BadgerCare participating, eligible nonparticipating, and disenrolled families.	**Wisconsin:** Families enrolled in Medicaid/CHIP	• Evaluates Wisconsin's BadgerCare Medicaid/CHIP program for low-income families. BadgerCare, includes premiums for families with incomes over 150% FPL who must pay monthly premiums of approximately 3% of their income. • Premium paying families were less likely to remain enrolled over time, but the difference from families not subject to premiums was small.

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Citation	Data	Study Population(s)	Study Focus and Major Findings
			Premiums delayed reenrollment of families. • Of those disenrolled, 26% listed a problem with paying premiums as a reason for leaving BadgerCare. This was the most common reason for leaving the program.
Monette Goodrich, Joan Alker, and Judith Solomon, *Families at Risk: The Impact of Premiums on Children and Parents in Husky A, Policy Brief* (Washington, DC: Georgetown Center for Children and Families, November 2003), http://ccf.georgetown.edu/wp-content/uploads/2012/03/Far%20-%20impact%20of%20premiums.pdf (http://ccf.georgetown.edu/wp-content/uploads/2012/03/Far%20-%20impact%20of%20premiums.pdf).	State administrative data, August 2003	**Connecticut**: Children and adults enrolled in Medicaid	• Models potential effects of adding new premiums to Connecticut's Medicaid program. In 2003, Connecticut was planning to charge premiums for families with monthly incomes ranging from 50%-185% FPL for a family of three enrolled in Medicaid. • Estimates that premiums would contribute to an enrollment decline of by 86,744 adults and children. Of these persons who could be expected to lose coverage, 59,638 – approximately 69% – would be children; the remaining 27,106 would be parents or pregnant women.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• Of the adults that could be expected to lose coverage, 1,006 would be pregnant women. • Just under half of those who could be expected to lose coverage would be children and parents whose income falls below the poverty level – 26,212 children and 15,070 adults – with monthly incomes ranging from $604 to $1,196 a month. • The remaining 33,426 children and 12,036 adults who could be expected to lose coverage come from families whose incomes range from 100-184% of the poverty line.
Elizabeth Shenkman, et. al., "Disenrollment and Re-Enrollment Patterns in a SCHIP Program," *Health Care Financing Review* 23, 3 (Spring 2002:47-63.	Census of all children enrolled in CHIP program for at least 1 month from October 1, 1997-September 30, 1999.	**Florida**: Children enrolled in CHIP	• Examines the impact of four policy changes made to Florida's CHIP program on enrollment and re-enrollment, including a reduction in premiums. Prior to 1998, families paid $5-$27 per child per month (depending on the county where they lived) and family income while families above 186% FPL paid $55-$65

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			per child per month. In 1998, Florida changed its CHIP program, including extending subsidized premiums which reduced premiums to $15 per family per month for those 185%-200% FPL. Families above 200% FPL paid about $75 per child per month. • Larger decreases in monthly premiums had larger effects on reducing the likelihood of disenrollment. While an average of $5 per month decrease in premiums resulted in families being only 2% less likely to disenroll their children from the program, a $45 per month reduction in premiums meant that families were 17-20% less likely to disenroll their children from the program. • Families experiencing the mean premium change were slightly more likely to re-enroll their children following a disenrollment episode. For example, families experiencing the mean premium

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			change were 6-7% more likely to re-enroll post- versus pre-April 1998.
Leighton Ku and Teresa A Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36, 4 (Winter 1999/2000).	Interviews with state officials, review of state documents, and 1995 state data	**Washington**, **Tennessee**, **Hawaii**, and **Minnesota**: Medicaid/CHIP enrollees	• Examines the experiences in four states that implemented Medicaid expansion programs that include sliding-scale premiums for families. In the 1990s, Washington, Tennessee, Hawaii, and Minnesota initiated Medicaid expansion programs using sliding-scale premiums. • Participation in public health programs fell from 57% when premiums were equal to 1% of family income to 35% when premiums grew to 3% of family income. Participation continued to fall to 18% when premiums rose to 5% of family income.

Table 2: Effects of Cost Sharing

National Studies
State Studies

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
National Studies		
Charles Stoecker, Alexandra M Stewart, and Megan C Lindley, "The Cost of Cost-Sharing: The Impact of Medicaid Benefit Design on Influence Vaccination Uptake," *Vaccines* 5, 8, (March 2017).	Behavioral Risk Factor Surveillance System (BRFSS) data, 2003-2012	Nonelderly adult Medicaid enrollees receiving care on a fee-for-service basis
Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care* published ahead of print (February 2017).	National Health and Nutrition Examination Survey (NHANES) data, 1999-2012.	Adults age 20-64 enrolled in Medicaic in 18 states and those not enrolled i Medicaid with family incomes at or below 250% FPL who were identified to have hypertension or hypercholesterolem

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Lindsay M. Sabik and Sabina Ohri Gandhi, “Copayments and Emergency Department Use Among Adult Medicaid Enrollees,” *Health Economics* 25 (May 2016):529-542.	National Hospital Ambulatory Medical Care Survey (NHAMCS) and state-level data, 2001-2009	Nonelderly adult Medicaid enrollees

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Mona Siddiqui, Eric T Roberts, and Craig E Pollack, "The Effects of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005," *JAMA Internal Medicine* 175,3 (March 2015):393-398.	Medical Expenditure Panel Survey (MEPS) data, January 2001 to December 2010	Adult Medicaid enrollees

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Vicki Fung, et. al., "Financial Barriers to Care Among Low-Income Children with Asthma: Health Care Reform Implications," *JAMA Pediatrics* 168, 7 (July 2014):649-656.	2012 Telephone survey of 769 parents	Children between ages 4-11 with asthma

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Citation	Data	Study Population(
Jessica Greene, Rebecca M Sacks, and Sara B McMenamin, "The Impact of Tobacco Dependence Treatment Coverage and Copayments in Medicaid," *American Journal of Preventive Medicine* 46, 4 (April 2014):331-336.	Current Population Survey (CPS) Tobacco Use supplement data, 2001-2003, 2006-2007, and 2010-2011	Adults enrolled in Medicaid who reported smoking 1 months prior to the survey and lived in 2 states with consiste tobacco dependenc treatment coverage across Medicaid fee for-service and managed care.

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Gery P Guy Jr., "The Effects of Cost Sharing on Access to Care among Childless Adults." *Health Services Research* 45, 6 Pt. 1 (December 2010): 1720-1739.	Behavioral Risk Factor Surveillance System (BRFSS) data, 1997–2007	Nonelderly adults

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Karoline Mortensen, "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments," *Health Affairs* 29, 9 (September 2010): 1643-1650 .	Medical Expenditure Panel Surveys (MEPS) data, 2001-2006	Nonelderly adults enrolled in Medicaic
State Specific Studies Back to top		
Leah Zallman, et. al., "Affordability of Health Care Under Publicly Subsidized Insurance After Massachusetts Health Care Reform: A Qualitative Study of Safety Net Patients," *International Journal for Equity in Health* 14 (October 2015):112.	Face to face interviews with 12 individuals	**Massachusetts:** Individuals with Medicaid or subsidized coverage (Commonwealth Care) at a safety net hospital emergency department

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Leah Zallman, et.al., "Perceived Affordability of Health Insurance and Medical Financial Burdens Five Years in to Massachusetts Health Reform," *International Journal for Equity in Health* 14 (October 2015):113.	Face to face surveys	**Massachusetts:** A sample of 976 patients seeking car at three hospital emergency departments

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Daniel A Lieberman, et. al., "Unintended Consequences of a Medicaid Prescription Copayment Policy," *Medical Care* 52, 5 (May 2014):422-427.	State-level aggregate medication utilization data from the Center for Medicare and Medicaid Services (CMS), 2007-2011	**Massachusetts:** Prescription medication utilizatic in Massachusetts Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Bisakha Sen, et. al., "Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?," *Medicare & Medicaid Research Review* 4, 2 (May 2014).	State administrative and claims data, 1999-2007	**Alabama:** Children enrolled in CHIP

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Amitabh Chandra, Jonathan Gruber and Robin McKnight, "The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts," *Journal of Health Economics* 33 (2014): 57-66.	State enrollment and claims data, July 2007-June 2009	**Massachusetts:** Adults enrolled in Massachusetts Commonwealth Car a state-funded program that subsidizes insuranc for families with incomes <300% FPL

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
James Marton, et. al., "The Effects of Medicaid Policy Changes on Adults' Service Use Patterns in Kentucky and Idaho," *Medicare & Medicaid Research Review* 2, 4 (February 2013).	State administrative data, 2004-2008	**Kentucky:** Nonelderly, non-institutionalized adults enrolled in Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Bisakha Sen, et. al., "Did Copayment Changes Reduce Health Service Utilization among CHIP Enrollees? Evidence from Alabama," *Health Services Research* 47, 4 (September 2012):1303-1620.	State administrative data, 1999-2009	**Alabama:** Children enrolled in CHIP
Sujha Subramanian, "Impact of Medicaid Copayments on Patients with Cancer," *Medical Care* 49, 9 (September 2011): 842-847.	Medicaid administrative data linked with cancer registry data, 1999-2004	**Georgia:** Low-incom nonelderly adult Medicaid enrollees diagnosed with cancer

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Marisa Elena Domino, et. al., "Increasing Time Cost and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment," *Health Services Research* 46, 3 (June 2011):900-919.	Medicaid claims data from CMS, 2000- 2002	**North Carolina:** Nonelderly adults enrolled in Medicaic

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Citation	Data	Study Population(
Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs* 29, 12 (December 2010):2311-2316.	Survey, 2003, 2004, and 2005	**Oregon:** Low-incom adult Medicaid recipients with incomes under 100 FPL
Robert A Lowe, et. al., "Impact of Policy Changes on Emergency Department Use by Medicaid Enrollees in Oregon," *Medical Care* 48,7 (July 2010): 619-627.	State administrative	**Oregon**: Low-incom nonelderly adults enrolled in Medicaic

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
	data, 2001-2004.	

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Citation	Data	Study Population(
Joel F Farley, “Medicaid Prescription Cost Containment and Schizophrenia: A Retrospective Examination,” *Medical Care* 48, 5 (May 2010): 440-447.	CMS Medicaid Analytical Extract Data Files, 2001-2003	**Mississippi**: Medicaid patients with schizophrenia

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Citation	Data	Study Population(
Daniel M Hartung, et. al., "Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-service Medicaid Population," *Medical Care* 46, 6 (June 2008):565-572.	State claims data, 2002-2004	**Oregon:** Non-pregnant adults (parents receiving Temporary Assistance for Need Families, individuals with disabilities, and elderly individuals) enrolled in Medicaid receiving care on a fee-for-service basis

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).	Focus groups, 2004	**Oregon**: Adults enrolled in Medicaic with incomes under 100% FPL
Leighton Ku, et. al., *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*, (Washington, DC: Center on Budget and Policy Priorities, November 2004).	Utah Department of Health (UDOH) data, 2001-2002	**Utah:** Adults enrolle in Medicaid

Citation	Data	Study Population(
Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul db/db/pdflibrary/ DBfile 49007.pdf (http://www.hpm.umn.edu/ambul db/db/pdflibrary/DBfile 49007.pdf)	Medicaid Administrative Data 2001-2003 and Medicaid Benefits Survey 2003	**Utah**: Adults enrolle in Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

State Studies

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
State Specific Studies		
Bisakha Sen, et. al., "Health Expenditure Concentration and Characteristics of High-Cost Enrollees in CHIP," *Inquiry* 53 (May 2016):1-9.	Claims data, 1999 – 2011	**Alabama:** Children enrolled in CH

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Marisa Elena Domino, et. al., "Increasing Time Cost and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment," *Health Services Research* 46, 3 (June 2011):900-919.	Medicaid claims data from the Centers for Medicare & Medicaid Services (CMS), 2000-2002	**North Caroli** Nonelderly adults enrolle in Medicaid

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Maryland Department of Health and Mental Hygiene, *Estimated Medicaid Savings and Program Impacts of Service Limitations, Copayments, and Premiums,* (Baltimore, MD: Maryland Department of Health and Mental Hygiene, December 2010), https://mmcp.dhmh.maryland.gov/ (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf) Documents/ (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf) medicaidsavingsJCRfinal12-10.pdf (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf).	2009 state Medicaid data	**Maryland:** Medicaid and CHIP enrollee

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," *Health Affairs* 28, 2, (2009):w335-w345.	State administrative data; Current Population Survey (CPS) data, 2005-2007; provider utilization and financial reports; and structured interviews	**Missouri:** Nonelderly adults and children in Medicaid and CHIP

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Robert A Lowe, et. al. "Impact of Medicaid Cutbacks on Emergency Department Use: The Oregon Experience," *Annals of Emergency Medicine* 52, 6 (December 2008):626-534.	Hospital billing data from 26 Oregon emergency departments, 2002-2004	**Oregon:** Emergency department visits

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Health Management Associates, *Co-pays for Nonemergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis*, Prepared for the Texas Health and Human Services Commission, (Austin, TX: Health and Human Services Commission, May 2008).	N/A	**Texas:** Medic enrollees

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Neal T Wallace, et. al., "How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan," *Health Services Research* 43, 3 (April 2008):515-530.	Medicaid eligibility, claims and encounter data, November 2001-October 2002 and May 2003-April 2004	**Oregon:** Nonelderly adults enrolle in Medicaid

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Gina A Livermore, et. al., "Premium Increases in State Health Insurance Programs: Lessons from a Case Study of the Massachusetts Medicaid Buy-in Program," *Inquiry* 44 (Winter 2007):428-442.	2002-2003 Medicaid Management Information System (MMIS) and administrative data	**Massachuset** Enrollees in th Massachusett CommonHeal Working (CH- Medicaid buy program for people with disabilities

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Genevieve Kenney, et. al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Part 2 (2007):2354-2372.	State administrative data, 2001 to 2004/2005	**Arizona and Kentucky:** Children enrolled in CH with family incomes between 101-150% FPL in Arizona and 151-200% FPL Kentucky.

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Arizona Health Care Cost Containment System, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005,* (Phoenix, AZ: Arizona Health Care Cost Containment System, December 2006), http://citeseerx.ist.psu.edu/viewdoc/ (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf) download?doi=10.1.1.482.6057 (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf) &rep=rep1&type=pdf (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf).	N/A	**Arizona**: Medicaid program

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Tricia J Johnson, Mary Rimsza, and William G Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* 96, 4 (April 2006):709-715.	Yuma HealthQuery (YHQ) community health data, 2001	**Arizona:** Children in Yuma County Arizona who received non-traumatic car at an emergency room and we enrolled in CH or uninsured
Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).	State administrative data, key informant interviews, a focus group, and interviews, September 2002-	**Washington State:** Immigrant families move from Medicai to Basic Healt in Washingtor State

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
	September 2003	
John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.	State administrative data, January 2002 – October 2003	**Oregon:** Adul with incomes below 100% F who disenroll from Medicai

Table 3: Effects on State Budgets & Providers

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Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Steven Crawford and Garth L Splinter, *It's Health Care, Not Welfare: Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program,* Prepared for the Oklahoma Health Care Authority, (Oklahoma City, OK: Oklahoma Health Care Authority, January 2004).	Survey of physicians and other providers in Oklahoma	**Oklahoma:** Physicians an other health care provider
Pamela Hines, et. al., *Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties*, Prepared for Office for Oregon Health Policy & Research, (Salem, OR: Office for Oregon Health Policy & Research, December 2003).	Interviews with health center administrators and physicians in the Portland, Oregon metropolitan area.	**Oregon:** Heal center administrator and physician in the Portlan Oregon metropolitan area.

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Endnotes

Issue Brief

1. See Maine Department of Health and Human Services, 1115 Waiver Application, http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf (http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf); State of Wisconsin BadgerCare Reform Demonstration Project, Coverage of Adults Without Dependent Children with Income at or Below 100 Percent of the Federal Poverty Level, Draft 1115 Demonstration Waiver Amendment Application, https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-app.pdf (https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-app.pdf); Office of the Governor, Kentucky Health: Helping to Engage and Achieve Long Term Health, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf); and Indiana Family and Social Services Administration, Health Indiana Plan (HIP) Section 1115

Waiver Extension Application, https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf (https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf).

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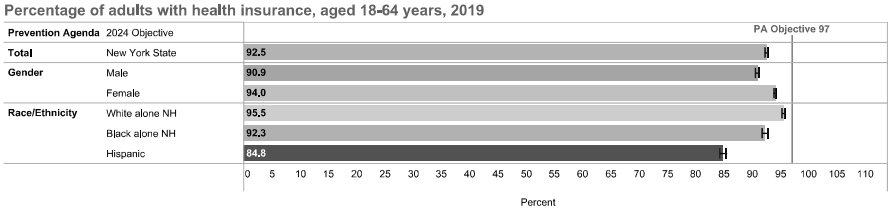
Select Year
2019

Select Group(s)
All

Percent
84.8 95.5

Percentage of adults with health insurance, aged 18-64 years, 2019



Percentage of adults with health insurance, aged 18-64 years, 2019

Group	Characteristics	Percent (90% CI)
Prevention Agenda	2024 Objective	97
Total	New York State	92.5 (92.3 - 92.7)
Gender	Male	90.9 (90.6 - 91.2)
	Female	94.0 (93.8 - 94.2)
Race/Ethnicity	White alone NH	95.5 (95.3 - 95.7)
	Black alone NH	92.3 (91.8 - 92.8)
	Hispanic	84.8 (84.2 - 85.4)

White Alone NH = White non-Hispanic. Black Alone NH = Black or African American non-Hispanic.

CI denotes confidence interval.

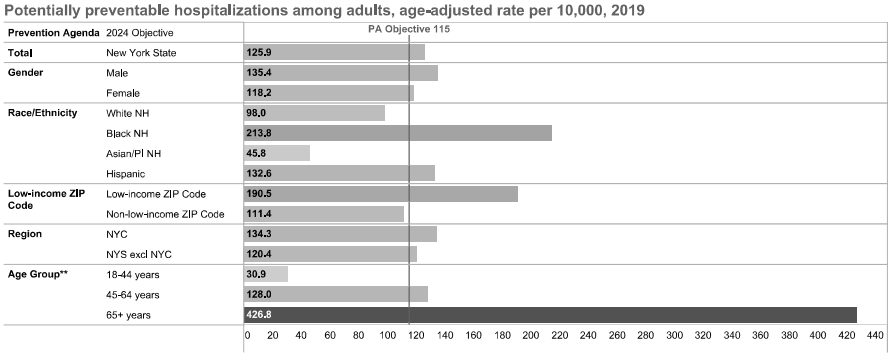
Data Source: U.S. Census Bureau, data as of July 2021

Select Year
2019

Select Group(s)
All

Age-adjusted rate
30.9 — 426.8

Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000, 2019



Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000, 2019

Group	Characteristics	Age-adjusted rate
Prevention Agenda	2024 Objective	115
Total	New York State	125.9
Gender	Male	135.4
	Female	118.2
Race/Ethnicity	White NH	98.0
	Black NH	213.8
	Asian/PI NH	45.8
	Hispanic	132.6
Low-income ZIP Code	Low-income ZIP Code	190.5
	Non-low-income ZIP Code	111.4
Region	NYC	134.3
	NYS excl NYC	120.4
Age Group**	18-44 years	30.9
	45-64 years	128.0
	65+ years	426.8

NYC = New York City. NYS excl NYC = New York State excluding New York City.

White NH = White non-Hispanic. Black NH = Black or African American non-Hispanic. Asian/PI NH = Asian, Pacific Islander non-Hispanic.

** Age group rates are crude rates

Data Source: SPARCS, data as of November 2021

healthcare education project

Healthcare • Education • Action!

July 3, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of the Healthcare Education Project, I would like to thank the U.S Department of Health and Human Services and the Center for Medicare and Medicaid Services for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

The Healthcare Education Project is a joint initiative of 1199SEIU United Healthcare Workers East and Greater New York Hospital Association (GNYHA). We have worked with Faith leaders, advocates, elected officials and stakeholders in protecting and expanding access to quality, affordable healthcare, a basic human right. With the understanding that health insurance coverage promotes economic and social stability while ensuring that our healthcare providers can continue to provide innovative equitable care, we have long advocated for coverage for the remaining uninsured populations in New York State which includes undocumented immigrants.

The Final 1332 Waiver submission should be revised to reflect its purpose of pursuing innovative strategies for providing access to high quality, affordable health insurance to the largest remaining uninsured (immigrant) population.

Moreover, the federal government should also closely examine the 1332 Waiver and encourage the State to include immigrants and uphold the overwhelming support for immigrant inclusion during the public hearing. The State Department of Health received 30 sets of labor, provider, academic, and consumer coalition comments and 1,643 individual comments—the vast majority asked it to use the then estimated $10 billion projected surplus to establish a state pass-through fund to cover undocumented immigrants.[1] Almost no comments were submitted opposing the inclusion of immigrants.

[1] NY State of Health, 'Essential Plan Expansion 1332 Waiver Submission and Review of Public Comments," https://info.nystateofhealth.ny.gov/1332. FROM SDOH's waiver application Table 2.2.4 is on page 13 of the actuarial analysis for costs and their summary chart on page 12 for the passthrough

At a time when our healthcare system is in grave need of a major investment, providing healthcare coverage to the largest uninsured population in NYS will begin to address the barriers to access in our healthcare system.

Thank you for the opportunity to provide our comments.

Sincerely,

Kirk Adams, Director

Healthcare Education Project 1199SEIU/GNYHA

revenue. February 9, 2023 draft waiver document is available here: https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf

HOUSING WORKS 57 Willoughby St, 2nd Floor, Brooklyn, NY 11201 WWW.HOUSINGWORKS.ORG

July 5, 2023

Federal Funds Should be Used to Pay for Healthcare Coverage For All

Dear Secretary Becerra and Administrator Brooks-LaSure,

I am the Chief Executive Officer of Housing Works, Inc., an organization committed both to ending HIV/AIDS as an epidemic and to serving New York's most marginalized residents. I thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services for the opportunity to provide comments on New York State's Section 1332 Innovation Waiver Essential Plan Expansion submission.

Housing Works must oppose the 1332 State Innovation Waiver application as drafted because it excludes immigrants.

Housing Works has been a leader in efforts to end HIV/AIDS as an epidemic in New York State. Persons without health insurance are unlikely to go for an HIV test even if they are at high risk for exposure. They are also unlikely to know about pre-exposure prophylaxis or that they can have access to it. Consequently, far too many people continue to receive their diagnosis of HIV at the same time as they learn that they have an AIDS diagnosis, and immigrants currently ineligible for health coverage for primary and preventive care are over-represented in this group. This could largely be prevented among immigrants if they are afforded health insurance coverage. This is one of many reasons we support health insurance coverage for every New York resident.

Of particular concern is the fact that the State's waiver application ignores the overwhelming majority of thousands of public comments submitted to the State calling for the application to include immigrants. New York State held two public hearings to gather public comments, as well as accepting virtual submissions. Comments from 26 out of 30 organizations and over 1,600 individuals requested the inclusion of immigrants without a documented status through the surplus passthrough funding in the draft submission, emphasizing that the federal and state governments would save over $1 billion per year in Emergency Medicaid funding. Despite this overwhelming support among providers, patients, and advocates, the State's final Waiver submission decided against expanding coverage to all immigrants.

Indeed, rather than heed the community's clear call for the urgently needed and cost-effective expansion of coverage for immigrants, the State has added new proposals not included in the draft offered for public review, to spend over $5.8 billion in industry giveaways for long term coverage and other funding for the hospitals that was not asked for by the public. The Final Waiver provides almost no concrete details about the nature of these new expenditures of public funds. We urge CMS to at least require the State to provide the public an opportunity to review these new spending allocations in detail.

Providing health insurance for immigrant communities – including hundreds of thousands of essential workers who kept our state functioning during a three-year pandemic – is both morally and fiscally responsible. Expanding coverage would avoid $500 million in annual Emergency Medicaid costs incurred when uninsured immigrant patients seek emergency care at hospitals. It would also increase revenues to health care providers at Federally Qualified Health Centers by

providing them essential plan rates and reducing the amount of sliding scale or uncompensated care provided.

Most importantly, however, we are all safer in the face of global public health threats when everyone has access to quality primary and preventive healthcare. Including immigrants in New York State's 1332 Wavier—just like Colorado and Washington states have done--is both economically sensible and the right thing to do. We hope that you can find a way to work with New York State toward a 1332 Waiver that extends essential plan health coverage to vulnerable immigrant New Yorkers.

Sincerely,

Charles King

CEO of Housing Works

THE LEGAL AID SOCIETY

199 Water Street
New York, NY 10038
(212) 577-3300
https://www.legalaidnyc.org

July 5, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

VIA ONLINE SUBMISSION: stateinnovationwaivers@cms.hhs.gov

Re: New York's Section 1332 Innovation Waiver Essential Plan Expansion submission

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of The Legal Aid Society, we would like to thank the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS") for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion ("Waiver") submission.

The Legal Aid Society is a private, not-for-profit legal services organization, the oldest and largest in the nation, dedicated since 1876 to providing quality legal representation to low-income New Yorkers. It is dedicated to one simple but powerful belief: that no New Yorker should be denied access to justice because of poverty. The Legal Aid Society's Health Law Unit ("HLU") provides direct legal services to low-income health care consumers from all five boroughs of New York City. The HLU operates a statewide helpline and assists clients and advocates with a broad range of health-related issues. We also participate in state and federal advocacy efforts on a variety of health law and policy matters.

With these diverse communities of New Yorkers with whom we work in mind, The Legal Aid Society writes to: (I) welcome the proposed Waiver's expansion of Essential Plan coverage to consumers with incomes from 200 to 250 percent of the federal poverty level ("FPL") and urge the Department of Health and Human Services ("HHS") and CMS to require New York to eliminate its proposed $15 per member, per month premium; and (II) urge CMS to review the Waiver carefully to determine if there is a way to expand Essential Plan eligibility to low-income, undocumented immigrants who are currently ineligible for public coverage for anything but emergencies.

I. The proposed Waiver's expansion of Essential Plan coverage from 200 to 250 percent FPL will benefit New Yorkers; however, the proposed $15 monthly

premium should be eliminated so that all eligible consumers can maintain coverage.

Many of The Legal Aid Society's clients benefit from New York's adoption of the Basic Health Program (BHP) provision of the Affordable Care Act. Our state's BHP, the Essential Plan, has been a demonstrable success: not only are over 1.1 million New Yorkers enrolled in the program, but the Essential Plan runs an annual surplus of $2 billion.

The Essential Plan provides quality, affordable health coverage to those who qualify. Expanding the income eligibility limit from 200 to 250 percent FPL would benefit those New Yorkers whom Legal Aid serves (i.e., those who are low-income and qualify for free legal services) by allowing them to access the same quality, affordable health coverage that their neighbors do. Right now, individual market coverage remains out-of-reach for New Yorkers whose incomes fall between 200 and 250 percent FPL. Individual market plans can cost $1,200/year for a Silver plan with a $1,700 deductible. The Legal Aid Society thus applauds New York for seeking to expand coverage to the population who may otherwise forego unaffordable coverage.

However, New York has proposed to charge this expansion group (individuals between 200 and 250 percent FPL) a $15 premium per member, per month. HHS and CMS should require New York to amend this proposal. New York State law authorizes, but does not require, the State to charge a $15 monthly premium.[1] Eliminating the premium can be accomplished administratively. It is well-documented that even a small premium causes coverage churn among low- and moderate-income enrollees. The State asserts that it must charge a premium for adults at this income level because children at the same income levels pay a premium in the Child Health Plus (CHP) program. This is unfounded and is a false "equity" claim. Children live with adults, and the whole family benefits from being charged less overall for health insurance coverage. Being charged less frees up additional money for families to spend on food, school supplies, utilities and rent. Government officials should recognize the totality of a low-income family's budgetary needs.

Moreover, charging a $15 per member, per month premium would have a negligible effect on the 1332 Waiver program budget. Assuming 90,000 individuals enroll in this 200 to 250 percent FPL eligibility group, their $15 premiums will generate just $16.2 million per year.[2]

[1] See N.Y. Soc. Servs. L. 369-ii(5)(a).

[2] This sum is a fraction of the $5.8 billion in industry giveaways that the State added in its final Waiver proposal after the public commented on an earlier Waiver proposal. The Legal Aid Society was among the 30 organizations that commented on the draft proposal that the State shared for public comment. The publicly-shared draft Waiver proposal did not include the $5.8 billion in payments to providers and health plans, depriving the public of the opportunity to scrutinize and comment on them. The Final Waiver provides almost no concrete details about the nature of this funding. CMS should carefully scrutinize these new spending allocations and require the State to provide the public an opportunity to review them in detail.

II. The Legal Aid Society urges CMS to review the Waiver carefully to determine if there is a way to expand Essential Plan eligibility to low-income, undocumented immigrants who are currently ineligible for public coverage for anything but emergencies.

The Legal Aid Society strongly opposes the exclusion of undocumented immigrants from the state's Waiver proposal. While we laud the expansion of Essential Plan eligibility to New Yorkers between 200 and 250 percent FPL, this expansion covers just 2% of our state's uninsured population. New York's 1332 Waiver proposal cruelly ignores a population who might otherwise be eligible for expanded Essential Plan coverage (25% of our state's uninsured immigrant population). This population is made up of 250,000 New Yorkers ages 19-64, who pay rent, pay taxes, and live and work in New York. New York has shown its commitment to providing coverage for otherwise-eligible undocumented New Yorkers up to age 18 through its Child Health Plus program, and plans to extend Medicaid coverage to individuals 65 and over, regardless of immigration status, as of January 2024.[3] Nonsensically, the exclusion of undocumented New Yorkers from the State's 1332 Waiver application requires those ages 19-64 to go without health coverage for a huge portion of their lives and subjects them to limited care and to potentially astronomical medical debt.

This coverage age-gap has real consequences. The Legal Aid Society recently worked with a client from Harlem who had a bad fall and became comatose. He has a wife and a young daughter. He was hospitalized in Manhattan and his hospital stay was covered by Emergency Medicaid. His health eventually improved and the hospital determined it was appropriate to discharge him with rehabilitation services, which Emergency Medicaid does not cover. His wife and daughter, too, wished for his discharge from the hospital with the goal of eventually getting him home with proper home care in place, something that Emergency Medicaid also does not cover. This left this client in limbo at the hospital, when he could have otherwise been safely discharged. Emergency Medicaid also does not cover organ transplants of any kind – whether solid organ, stem cell or bone marrow – including the immunosuppressants and other follow-up care needed for organ transplantation. This makes it nearly impossible for people without immigration status to receive organs because they cannot get onto organ waiting lists. In addition, The Legal Aid Society has worked with a client who needed an organ transplant and whose sister was an eager match. Unfortunately, our client's sister was unable to make a direct, living donation to our client because she was undocumented and therefore uninsured.

New York's final Waiver proposal ignores the vast majority of comments submitted from the public, including from The Legal Aid Society, on its draft Waiver proposal. To gather the required public comments, New York State held two public hearings and accepted online comments. As noted in the final Waiver proposal, 26 out of 30 organizational comments from labor interests, providers, academics, consumer coalitions and legal services providers, and over 1,500 individual comments, sought to include immigrants. These comments stated that there was adequate surplus pass-through

[3] NY SSL § 366(1)(g)(4).

funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington states in their 1332 Waiver programs. The comments also noted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid funding if New York State were to include immigrants in its 1332 Waiver program.

The State's final Waiver submission does not include immigrants, stating that, "[t]he State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status." New York provides no additional information about these alternative "federal solutions."

Federal and state governments should address immigrants and their need for coverage as part of the 1332 Waiver process. As we make our way out of the COVID-19 pandemic, The Legal Aid Society sees the devastating effects the pandemic has had and continues to have on our client communities, including immigrant New Yorkers. Undocumented New Yorkers are only eligible for Medicaid for the Treatment of an Emergency Condition (i.e., Emergency Medicaid). This means that those New Yorkers who qualify for Emergency Medicaid can seek covered care only once their condition becomes an emergency. This needlessly limits access to health care, which affects all New Yorkers, regardless of where they are born.

Thank you for the opportunity to comment and for your consideration of our perspective and input. If you need any additional information, please contact Lillian Ringel at (917) 581-2730 or lringel@legal-aid.org or Rebecca Antar Novick at (212) 577-7958 or ranovick@legal-aid.org.

Sincerely,

Lillian Ringel
Staff Attorney
Health Law Unit
The Legal Aid Society

Rebecca Antar Novick
Director
Health Law Unit
The Legal Aid Society

Medicaid Matters New York

July 3, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of Medicaid Matters New York, I would like to thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services (CMS) for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

Medicaid Matters New York is the statewide coalition representing the interests of people served by New York's Medicaid program. Our membership of over 100 individuals and organizational representatives come from a variety of perspectives, including community-based organizations, policy and advocacy groups, legal services agencies, community-based providers, and more. Medicaid Matters welcomes the proposed Waiver's expansion of Essential Plan coverage to people with incomes from 200 to 250 percent of the federal poverty level and urge HHS and CMS to require New York to eliminate the proposed $15 a month premium. In addition, we urge CMS to review the Waiver carefully to determine if there is a path forward to covering immigrants who are otherwise not eligible for public health insurance coverage.

Eliminate the $15 premium

New York's Basic Health Program (BHP; branded as the "Essential Plan") has been a huge success for low-income New Yorkers, with over 1.1 million New Yorkers enrolled and an annual surplus of $2 billion.

People across New York rely on the Essential Plan for quality affordable coverage and would benefit from the expansion. Even with premium tax credits, individual market coverage remains too expensive for many consumers with incomes between 200 and 250 percent of FPL—as much as $1,200 a year for a Silver plan with a $1,700 deductible. This is a tough value proposition for many consumers. Accordingly, Medicaid Matters lauds the State for seeking to expand coverage to this population.

However, HHS and CMS should require the State to amend its proposal to charge these individuals a $15 per member per month premium. State law authorizes, but does not require, the State to charge the $15 premium (see NY Soc. Servs. L. 369-ii(5)(a)). Eliminating the premium can be accomplished administratively. It is well documented that even a small premium causes churning among low- and moderate-income enrollees. The State's assertion that it must charge a premium for adults at this income level because children at the same income levels pay a premium in the Child Health Plus program is unfounded. This is a false "equity" claim. Children live with adults, and the whole family benefits from being charged less for health insurance coverage, freeing up additional income for food, school supplies, utilities and rent. Government officials should recognize the totality of a low-income family's budgetary needs.

Moreover, charging premiums would have a negligible effect on the 1332 Waiver program budget. Assuming 90,000 individuals will enroll in this eligibility group, their $15 premiums will generate just $16.2 million per year. This sum is particularly unimportant in light of the $5.8 billion in industry giveaways that the final Waiver proposal added after the public commented on an earlier proposal.

The publicly-shared draft Waiver proposal did not include the $5.8 billion in additional giveaways to providers and health plans, depriving the public of the opportunity to scrutinize and comment on them. The final Waiver provides almost no concrete details about the nature of these new industry giveaways. CMS should carefully scrutinize these new spending allocations and require the State to provide the public an opportunity to review them in detail.

Coverage for immigrants who are otherwise ineligible for public coverage

Medicaid Matters strongly opposes the State's choice to omit coverage for immigrants who are otherwise ineligible for public coverage from the Waiver proposal. Medicaid Matters supports and echoes the Coverage 4 All campaign calling for coverage for all New Yorkers, regardless of immigration status. Immigrants are a vital part of New York's communities and should be included in public coverage programs.

The State's final Waiver proposal ignores the vast majority of comments submitted from the public on the draft Waiver proposal. To gather the required public comments, New York State held two public hearings and accepted online comments. As noted in the final document, the 26 out of 30 organizational comments and over 1,500 individual comments sought to include immigrants. These comments stated that there was adequate surplus passthrough funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington in their 1332 Waiver programs. The comments also noted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid funding if it were to include immigrants in the 1332 Waiver program.

The State's final Waiver submission does not include immigrants, stating that "The State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status." No additional information about these alternatives is provided.

It is vital for the federal and state governments to address the need for immigrants coverage as part of the 1332 Waiver process.

Thank you for the opportunity to comment on the State's 1332 Waiver proposal.

Sincerely,

Lara Kassel
Coalition Coordinator

July 3, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of Make the Road NY, I would like to thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services (CMS) for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

Make the Road New York (MRNY) builds the power of immigrant and working-class communities to achieve dignity and justice. We are the largest member-led immigrant base-building community-based organizations in New York with over 25,000 members. MRNY operates welcoming storefront community centers in the heart of immigrant communities in Brooklyn, Queens, Staten Island, Long Island, and Westchester County. MRNY supports some of New York's most marginalized Latinx communities through the integration of high-quality services with community organizing, policy innovation, and transformative education. With these marginalized communities in mind, MRNY writes to: (1) welcome the proposed Waiver's expansion of Essential Plan coverage to consumers with incomes from 200 to 250 percent of the federal poverty level and urge HHS and CMS to require New York to eliminate the proposed $15 a month premium; and (2) urge CMS to review the Waiver carefully to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

(1) The proposed expansion of coverage will benefit New Yorkers, BUT the proposed $15 premium should be eliminated to maximize and maintain all eligible consumers in coverage.

MRNY was an early proponent of New York adopting the Basic Health Program (BHP) provision of the Affordable Care Act. New York's BHP (branded as the "Essential Plan") has been a huge success for low-income New Yorkers, with over 1.1 million New Yorkers enrolled and an annual surplus of $2 billion.

Immigrants and low-income community members rely on the Essential Plan for quality affordable coverage and would benefit from the expansion. Even with premium tax credits, individual market coverage remains too expensive for many consumers with incomes between 200 and 250 percent of FPL—as much as $1,200 a year for a Silver plan with a $1,700 deductible. This is a tough value proposition for many consumers. Accordingly, MRNY lauds the State for seeking to expand coverage to this population.

However, HHS and CMS should require the State to amend its proposal to charge these individuals a $15 per member per month premium. State law authorizes, but does not require, the State to charge the $15 premium. See N.Y. Soc. Servs. L. 369-ii(5) (a). Eliminating the premium can be accomplished administratively. It is well documented that even a small premium causes churning among low- and moderate-income enrollees. The State's assertion that it must charge a premium for adults at this income level because children at the same income levels pay a premium in the Child Health Plus (CHP) program is unfounded. This is a false "equity" claim. Children live with adults, and the whole family benefits from being charged less for health insurance coverage, freeing up additional income for food, school supplies, utilities and rent. Government officials should recognize the totality of a low-income family's budgetary needs.

Moreover, charging premiums would have a negligible effect on the 1332 Waiver program budget. Assuming 90,000 individuals will enroll in this eligibility group, their $15 premiums will generate just $16.2 million per year. This sum is particularly unimportant in light of the $5.8 billion in industry giveaways that the final Waiver proposal added after the public commented on an earlier proposal.

MRNY was among the 30 organizations that commented on the draft proposal that the State shared for public comment. The publicly-shared draft Waiver proposal did not include the $5.8 billion in additional giveaways to providers and health plans, depriving the public of the opportunity to scrutinize and comment on them. The Final Waiver provides almost no concrete details about the nature of these new industry giveaways. CMS should carefully scrutinize these new spending allocations and require the State to provide the public an opportunity to review them in detail.

(2) CMS should review the Waiver closely to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage due to their immigration status.

MRNY strongly deplores the State's choice to omit coverage for immigrants who are otherwise ineligible for public coverage from the Waiver proposal. MRNY is a co-lead of the Coverage 4 All campaign for immigrant coverage. Immigrants are a vital part of New York's communities and should be included in public coverage programs. We believe healthcare is a human right, and all new yorkers, regardless of immigration status, should have access to high quality healthcare. New York State should follow the examples of other states, such as Colorado and Washington, who have utilized the waiver to expand insurance access to its most vulnerable populations who are currently excluded from health insurance access, such as adults between the ages 19-64.

The State's final Waiver proposal ignores the vast majority of comments submitted from

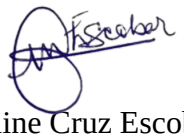
the public on the draft Waiver proposal. To gather the required public comments, New York State held two public hearings and accepted online comments. As noted in the final document, the 26 out of 30 organizational comments and over 1,600 individual comments sought to include immigrants. These comments stated that there was adequate surplus passthrough funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington states in their 1332 Waiver programs. The comments also noted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid funding if it were to include immigrants in the 1332 Waiver program.

The State's final Waiver submission does not include immigrants, stating that "The State is also seeking new federal solutions to support coverage of individuals otherwise ineligible for subsidized coverage due to their immigration status." No additional information about these alternative "federal solutions" are provided.

It is important for the federal and state governments to address immigrants and their need for coverage as part of the 1332 Waiver process.

Thank you for the opportunity to provide our testimony.

Very truly yours,



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NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Ashwin Vasan, MD, PhD
Commissioner

Gotham Center
42-09 28th St.
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July 5, 2023

via electronic submission: stateinnovationwaivers@cms.hhs.gov

Re: New York Section 1332 State Innovation Waiver

Dear CMS Administrators:

The City of New York ("NYC" or "the City") appreciates the opportunity to respond to New York State's (NYS) Section 1332 State Innovation Waiver application, which proposes to expand eligibility for the Basic Health Program (BHP) - called the Essential Plan (EP) in NYS - to individuals with incomes up to 250% of the Federal Poverty Level (FPL). The City supports the waiver's intent to broaden affordable insurance access for low- and moderate-income New Yorkers but objects to the State's unwillingness to use the waiver mechanism to expand EP eligibility to adults ages 19-64 whose immigration status prevents them from accessing insurance.

We appreciate CMS' recent clarification of options under Section 1332 concerning health insurance coverage for undocumented individuals[1] and feel strongly that the State is failing in its health equity commitments by not exercising such flexibilities. We outline our reasons here as well as in a comment previously submitted to the State that administrators failed to act on, but which we hope CMS will take under more careful consideration in evaluating this and future waiver applications.

Insurance coverage is limited for undocumented New Yorkers

Since passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and subsequent launch of the New York State of Health (NYSOH) Marketplace in 2012, both New York State (NYS) and New York City have seen a steady reduction in the number of people without health insurance.[2] Between 2013 and 2019, the number of uninsured residents of all ages living in NYC declined by 50%.[3,4]

[1] See: Department of Health and Human Services response to NYS Senate inquiry about 1332 options. 6 June 2023. Available at: rivera_response_and_1332_waiver.pdf (nysenate.gov)
[2] New York State of Health. "Bucking national trends, New York's uninsured rate continues to decline, reaching a historic low of 4.7 percent [Press release]." 15 March 2019. https://info.nystateofhealth.ny.gov/news/press-release-bucking-national-trends-new-yorks-uninsured-rate-continues-decline-reaching
[3] U.S. Census Bureau. American Community Survey 1-Year Estimate Public Use Microdata Sample for 2019, as analyzed by New York City Department of Health and Mental Hygiene, Health Access and Policy Unit.
[4] Note: We reference 2019 ACS data because 2021 estimates for uninsured rates were likely elevated by continuous Medicaid coverage under the COVID-19 Federal Public Health Emergency.

However, over 1 million New Yorkers (4.7% of state population), including nearly 570,000 NYC residents (6.9% of city population), remained uninsured in 2019. While continuous Medicaid coverage under the federal COVID-19 public health emergency dampened the impact of private coverage loss during the pandemic and contributed to a slight drop in city and state uninsured rates, a significant portion of New Yorkers remain ineligible for insurance in 2023 due to immigration status.[5]

New York State has the fourth largest undocumented population in the United States, the vast majority of whom live in New York City.[6] The NYC Mayor's Office of Immigrant Affairs estimates that nearly 476,000 immigrants living in NYC are undocumented, of which 46% are uninsured and largely ineligible for coverage.[7]

In New York State, insurance coverage for undocumented populations is limited to pregnant people and children under age 19 living in low- to moderate-income households. Beginning in 2024, state Medicaid eligibility will expand to include low-income undocumented New Yorkers ages 65 and older – a change the City strongly supports. However, without further action, undocumented adults ages 19-64 remain ineligible for affordable coverage options and must rely on Emergency Medicaid, safety net providers, and direct access programs to receive services and cover out-of-pocket costs.

Insurance coverage improves health outcomes and can decrease health care costs over time

Insurance coverage is a strong predictor of access to care and improved health outcomes. Numerous studies indicate that having a primary care provider (PCP) or usual source of care – both of which are strongly influenced by insurance status[8] – improves continuity of and access to preventive services.[9] Consequently, lack of insurance impedes a person's ability to access primary care and specialty services, including screenings and diagnostics linking patients to timely treatment and intervention.[10,11] For individuals with chronic conditions that require ongoing clinical management, living without health insurance can have critical consequences for both health outcomes and financial stability.[12] Indeed, barriers to primary care are associated with higher rates of preventable hospitalization and emergency department (ED) visits, which lead to greater costs for both patients and health care systems, especially when compared with regular primary care expenses.[13,14]

The Oregon Health Insurance Experiment provides an excellent example of how addressing barriers to care – in this case through the expansion of Medicaid coverage – can lead to measurable increases in primary care use. In surveying program participants, the study found that Medicaid coverage increased the probability that people reported themselves to be in "good to excellent" health by 25%.[15]

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[5] Conway D, Mykyta L. Decline in share of people without health insurance driven by increase in public coverage in 36 states. 15 September 2022. U.S. Census Bureau. https://www.census.gov/library/stories/2022/09/uninsured-rate-declined-in-28-states.html
[6] Pew Research Center. Unauthorized immigrant population trends for states, birth countries and regions. 12 June 2019. https://www.pewresearch.org/hispanic/interactives/unauthorized-trends/
[7] NYC Mayor's Office of Immigrant Affairs. State of Our Immigrant City: Mayor's Office of Immigrant Affairs (MOIA) Annual Report for Calendar Year 2020. 2021. https://www.nyc.gov/assets/immigrants/downloads/pdf/MOIA-Annual-Report-for-2020.pdf
[8] Glied S, Ma S, Borja A. Effect of the Affordable Care Act on health insurance access. 8 May 2017. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access
[9] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med*. 2008;23(9):1354–1360.
[10] Bovbjerg RR, Hadley J. Why Health Insurance Is Important. Urban Institute. November 2007. DC-SPG no.1. https://www.urban.org/sites/default/files/publication/46826/411569-Why-Health-Insurance-Is-Important.PDF
[11] Institute of Medicine Committee on the Consequences of Uninsurance. "Care without coverage: too little, too late." Effects of Health Insurance on Health. Washington, DC: National Academies Press. 2002.
[12] Hatch B, Marino M, Killerby M, et al. Medicaid's impact on chronic disease biomarkers: a cohort study of community health center patients. *J Gen Intern Med.* 2017;32(8):940–947.
[13] Rosano A, Loha CA, Falvo R, et al. The relationship between avoidable hospitalization and accessibility to primary care: a systematic review. *Eur J Public Health.* 2013;23(3):356–360.
[14] Parchman ML, Culler S. Primary care physicians and avoidable hospitalizations. *J Fam Pract.* 1994;39(2):123–128.
[15] Finkelstein A et al. The Oregon Health Insurance Experiment: Evidence from the First Year. *Quarterly Journal of Economics.* 2012;127(3):1057-1106.

The program also saw significant increases in critical preventive care services, including a 50% increase in cholesterol monitoring and a 100% increase in mammograms.[16]

The NYC Department of Health and Mental Hygiene's (NYC Health Department) ActionHealthNYC program also demonstrated how removing barriers to care can improve meaningful health care utilization while driving down unnecessary costs. Between 2016 and 2017, the NYC Health Department collaborated with the city's public hospital system, NYC Health + Hospitals (H+H), and several federally qualified health centers to provide direct access to primary care and coordination services for over 1,300 insurance-ineligible New Yorkers. The program was highly successful: After the program year, participants were more likely than their counterparts to report having utilized primary care,[17] having a PCP, or seeing a health care provider within the last 9 months. A more recent analysis found that the program was also successful in reducing ED visits for primary care-treatable conditions by 23%, driven by a 32% reduction in high-risk individuals.[18]

Many of the learnings of ActionHealthNYC were subsequently implemented in NYC Care, NYC Health + Hospitals' health care access program for New York City residents who are ineligible for health insurance or cannot afford the health insurance for which they are eligible. The program has maintained over 100,000 enrollees since fall 2021 while performing health insurance eligibility screenings annually. Preliminary analyses have shown that after six months in the program, 53% of enrollees with diabetes have seen an improvement in their hemoglobin A1C readings, and 40% of enrollees with hypertension have seen an improvement in their blood pressure. A preliminary analysis showed that patients enrolled in NYC Care utilized the emergency room 21% less than the non-NYC Care NYC Health + Hospitals patients.

Immigrants tend to be healthier than U.S.-born individuals

ActionHealthNYC and NYC Care's outcomes are even more compelling when applied to an almost entirely undocumented patient population. A wealth of literature supports the notion that immigrants tend to be healthier than most U.S.-born people. This is captured in a phenomenon called "the healthy immigrant effect," wherein recent immigrants assess their health status more favorably and utilize fewer or comparable health care resources than U.S.-born populations.[19,20] In one study, researchers in California found that undocumented Mexicans had 1.6 fewer physician visits compared to U.S.-born Mexicans; other undocumented Latinos had 2.1 fewer visits compared to U.S.-born counterparts.[21]

These data directly refute the misconception that immigrants tend to overuse health care resources and that expanding insurance coverage to previously ineligible populations yield a spike in unnecessary utilization. Indeed, we would anticipate welcome growth in primary care use as a result of expanded access and decreased rates of unnecessary and costly utilization. Moreover, noting that roughly three-quarters of undocumented people in NYS reside in NYC, we expect that a significant portion of individuals who would benefit from more inclusive EP eligibility will have already established a pattern of primary care use through the NYC Care initiative. This means that expanding coverage to this

[16] Baicker K, Finkelstein A. Oregon Health Insurance Experiment. National Bureau of Economic Research. July 2011.
[17] Sood RK, Bae JY, Sabety A, Chan PY, Heindrichs C., ActionHealthNYC: Effectiveness of a health care access program for the uninsured, 2016-2017. *AJPH.* 2021;111(7):1318-1327.
[18] Sabety A, Gruber J, Bae JY, Sood RK., Reducing Frictions in Healthcare Access: The ActionHealthNYC experiment for Undocumented Immigrants, 2023. Forthcoming. *American Economic Review: Insights.* https://www.aeaweb.org/articles?id=10.1257/aeri.20220126
[19] Hamilton TG. The healthy immigrant (migrant) effect: in search of a better native-born comparison group. *Social Science Research.* 2015;54:353-365.
[20] DeAnne K et al. The impact and implications of undocumented immigration on individual and collective health in the United States. *Nursing Outlook.* 2015;63(1):86-94.
[21] Ortega A et al. Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos. *JAMA Internal Medicine.* 2007;167(21):2354-2360.

population is unlikely to result in a sudden wave of acute health care needs or disproportionate utilization.

From a health economics perspective, expanding insurance access to a relatively healthy population is unlikely to incur disproportionate costs. On the contrary, it would ultimately yield savings through more meaningful health care use and better long-term health outcomes. A recent report from New York City Comptroller, Brad Lander, also found that expanding EP eligibility to undocumented people would provide an estimated $710 million in economic benefits.[22]

Essential Plan coverage shifts costs away from the City and State

In addition to lower hospitalization and ED utilization rates, the waiver application and our proposed amendment would shift costs away from state and local governments. Essential Plan coverage is federally funded through the Basic Health Plan Trust, which presently has an $8 billion surplus only to be used for coverage costs.[23] Should the waiver go into effect, CMS has clarified that future surplus may be used as passthrough funding to finance coverage for individuals who are not lawfully present.

New York City would also expect to see a financial benefit as Emergency Medicaid recipients and NYC Care enrollees transition to comprehensive Essential Plan coverage, allowing the City to recapture its local contributions to Emergency Medicaid (over $200 million annually) and lower NYC Care program costs.

Increasing access to insurance coverage for undocumented individuals would also bolster the state's safety net system. Providers would see a drop in uncompensated care costs ($1,174 per person covered each year), allowing more flexibility with resources,[24] and visits for EP-insured patients would afford higher reimbursement rates for the same services compared with Emergency Medicaid. The additional revenue would be helpful for essential safety net providers like NYC Health + Hospitals, which operate on the slimmest of financial margins.

Expanding coverage to undocumented people has public support and precedent in other jurisdictions

Finally, expanding insurance coverage to undocumented populations via the 1332 waiver pathway is not new. Other states, including Colorado and Washington, have already received permission from the Centers for Medicare and Medicaid Services to cover people regardless of immigration status.[25,26]

In addition to these historic precedents, public opinion also supports expansion of coverage for undocumented New Yorkers, with 8 out of 10 New Yorkers supporting quality health care for immigrants

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[22] New York City Comptroller Brad Lander. "Economic Benefits of Coverage For All." 15 March 2022. https://comptroller.nyc.gov/newsroom/nyc-comptrollers-office-estimates-710-million-in-annual-economic-benefits-from-expanding-health-coverage-for-immigrant-new-yorkers/

[23] Hammond B. "The Essential Plan's accumulated surplus balloons to $8 million, with no fix in sight." Empire Center. 8 September 2022. https://www.empirecenter.org/publications/the-essential-plan-surplus-balloons-to-8-billion/

[24] Blumberg L, Cuetthens M, Holahan J. How would state-based individual mandates affect health insurance coverage and premium costs? The Urban Institute. July 2018. https://www.urban.org/sites/default/files/publication/98805/2001925_state_based_individual_mandates.pdf

[25] Villeda K. "Washington's 1332 waiver presents opportunities for health equity." 23 January 2023. Community Catalyst. https://communitycatalyst.org/posts/washingtons-1332-waiver-presents-opportunities-for-health-equity/

[26] Monahan C, Giovanelli J, Lucia K. "HHS Approves Nation's First Section 1332 Waiver for a Public Option-Style Health Care Plan in Colorado." 12 July 2022. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2022/hhs-approves-nations-first-section-1332-waiver-public-option-plan-colorado

across all regions and political party affiliations, per a March 2022 poll conducted by non-partisan research firm PerryUndem.[27]

Conclusion

Despite previous and public indication that the State's proposal would extend EP eligibility to undocumented New Yorkers,[28,29] the submitted application backtracked on such promises.[30]

While the waiver as it currently stands will indeed improve coverage for some low- and middle-income New Yorkers, it will also deepen longstanding inequities based on immigration status and continue to relegate the health needs of undocumented people – the single largest population of remaining uninsured New Yorkers.

For these reasons, the City feels compelled to express its disappointment in the limited scope of the State's application. As one of the most densely populated and diverse localities in the country, we are deeply committed to expanding insurance access and eliminating barriers to care for all . An investment in the health of a neighbor is an investment in the health of the community. The public health of all New Yorkers is better when everyone has access to comprehensive coverage – it is a question of public health preparedness as well as a question of rights.

We thank CMS again for the opportunity to comment and look forward to working together to improve the health of all New Yorkers.

Sincerely,

Ashwin Vasan, MD, PhD
Commissioner
New York City Department of Health and Mental Hygiene

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[27] "Results from a Statewide Survey: How New Yorkers Feel About Affordability and Healthcare Reform." May 2022. Prepared by PerryUndem for the Robert Wood Johnson Foundation. https://nyhealthfoundation.org/wp-content/uploads/2022/05/PerryUndem-Presentation-Slides.pdf

[28] See: "Governor Hochul Announces Agreement on FY 2023 New York State Budget." 7 April 2022. Official YouTube Channel for Governor Kathy Hochul. https://www.youtube.com/watch?v=Ysb38zrpx6Q&t=2066s

[29] New York State Department of Health. 2022-23 Enacted Medicaid Budget Briefing and Questions & Answers. April 2022. Office of Health Insurance Programs. https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-23_enacted_budget_brief_qa.pdf

[30] New York State Department of Health. New York Section 1332 Innovation Waiver Essential Plan Expansion: Draft for Public Comment. 9 February 2023. https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf

July 5, 2023

The Honorable Xavier Becerra
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Chiquita Brooks-LaSure
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: New York Section 1332 Waiver Comments

Dear Secretary Becerra and Administrator Brooks-LaSure:

The New York Immigration Coalition (NYIC) appreciates the opportunity to comment on New York's Section 1332 waiver proposal. The New York Immigration Coalition is an umbrella policy and advocacy organization that works statewide with over 200 immigrant-serving member organizations. We also co-lead New York's Coverage4All campaign and are on the steering committee of Health Care for All New York.

Our coalition members serve immigrant New Yorkers that were the essential workers, hardest hit by the pandemic. Many of these New Yorkers need access to preventive and comprehensive healthcare, but they currently lack access to health insurance due to their immigration status. Thus, while NYIC commends New York State for their final 1332 waiver submission in taking steps to make the Essential Plan more affordable for people between 200-250% of the Federal Poverty Level, NYIC opposes New York State's 1332 waiver submission because it excludes coverage for these undocumented New Yorkers. NYIC supports the extension of the Essential Plan to provide health insurance for ALL income-eligible New Yorkers regardless of immigration status.[1]

[1] Some undocumented immigrants in New York State are eligible for Medicaid (pregnant women and women one year postpartum) or Child Health Plus (children under 19) and New York is also committed to increasing Medicaid coverage for undocumented immigrants over 65+. However, despite this progress, there still remains around 245,000 New Yorkers that remain uninsured because of their immigration status.

Expanding Coverage to Include All New Yorkers is The Right Thing to Do

The NYIC strongly believes that providing health insurance for income-eligible immigrant communities – including hundreds of thousands of essential workers who have kept New York State functioning during a three-year pandemic – is both morally and fiscally responsible. Providing coverage through the 1332 waiver to those who are currently unable to access coverage because of their immigration status will not only support these individuals but will strengthen health care for all New Yorkers.

Furthermore, there appears to be sufficient New York State surplus funding generated by the new 1332 Waiver to provide Essential Plan (EP) coverage to support the expansion of health coverage for all immigrants (240,000 New Yorkers) up to 250% of the Federal Poverty Level.

	2024	2025	2026	2027	2028	5-Year Total
Total Program Costs (Table 2.2.4, 1332 Actuarial Analysis, p.13, in billions)	7.4	7.7	8.2	8.7	9.2	41.2
Total Federal Passthrough Request (Summary Table p12, in billions)	9.4	10.1	10.0	10.6	11.4	51.4
Difference (SURPLUS)	2.0	2.3	1.8	2.0	2.2	10.2

Source: February 9, 2023 1332 Draft Waiver document (NY_1332_Waiver_Draft_Application_Actuarial.pdf)

There has also been demand in the state to do so. Between February 9, 2023, the New York State public filing, and May 12, 2023, the final official draft filing with the Federal Government, New York State Department of Health received 30 sets of labor, provider, academic, and consumer coalition comments and 1,643 individual comments – the vast majority asking the State to use the projected surplus to cover undocumented immigrants. Despite this overwhelming support for immigrant inclusion, and the Governors own commitment to use the 1332 waiver to expand health insurance coverage to all income-eligible New Yorkers in 2022, the State's final Waiver submission in May 12, 2023, did not seek to expand coverage to income-eligible immigrants.

Without the expansion of health insurance coverage to all New Yorkers, New York's proposed Final 1332 waiver submission will only provide coverage to two percent of New York's state uninsured population, when the expansion to include all income-eligible New Yorkers, regardless of immigration status, would have covered 25 percent of the state's uninsured population.

NYIC urges the Centers for Medicare and Medicaid Services (CMS) to encourage New York State to include health coverage for ALL income-eligible New Yorkers, regardless of immigration status.

Making Better Use of Federal Funds

The State's final Waiver submission on May 12, 2023, also differs from the draft submission that was provided to the public for comment on February 9, 2023. In the May 12, 2023 final official draft filing with

the Federal Government, the Department of Health chose to spend $5.8 billion on industry giveaways.[2] However, New York State failed to follow the public process to provide any of the information on these industry giveaways for public comment. The State also chose to include industry giveaways over listening to the majority of public comments calling for an expansion of health care coverage to undocumented immigrants.

NYIC encourages CMS to closely scrutinize New York's 1332 Waiver proposal to identify the undisclosed $5.8 billion in industry giveaway spending in the final Waiver proposal submitted. NYIC also urges CMS to encourage New York State to include health coverage for ALL income-eligible New Yorkers, regardless of immigration status in the 1332 Waiver.

New York has a broad goal of providing access to care to ALL income-eligible New Yorkers, regardless of immigration status, to keep New Yorkers healthy and out of the emergency rooms for their only access to care.

We truly look forward to supporting this policy goal on behalf of all immigrants in New York. We sincerely hope to work with CMS to ensure that the 1332 waiver that is approved for New York can be inclusive enough to provide health insurance that covers ALL income-eligible New Yorkers, regardless of immigration status.

Please contact Melinda Elias (melias@nyic.org) with any questions.

Sincerely,

Murad Awawdeh
Executive Director
New York Immigration Coalition

[2] $800 million a year. $4 billion over five years on provider rate increases. $225 million a year, $1.125 billion on insurance companies ("Quality Incentive Pool"). $571 million over five years on Long Term Services and Supports (LTSS). $125 million over 5 years for an unspecified behavioral health grant program. Source: NY 1332 Waiver Application_5.12.2023.pdf

New York Lawyers for the Public Interest
151 West 30th Street, 11th Floor
New York, NY 10001-4017

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of New York Lawyers for the Public Interest (NYLPI), I would like to thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion submission.

NYLPI's Health Justice program works to provide comprehensive screenings and legal representation to individuals, particularly those who are in health emergencies, including holistic support by providing our clients information on financial assistance, food banks and housing relief to meet their intersecting needs. The experiences of our clients inform our policy advocacy, and our commitment to seeking health care coverage for all New Yorkers.

NYLPI would like to raise three issues for your consideration as you review New York's submission: (1) the State's Waiver ignores the vast majority of thousands of public comments, which sought to include immigrants: (2) the final Waiver submission is substantially different than the one presented for public comment, spending over $5.8 billion on non-transparent industry giveaways in lieu of expanding coverage to immigrants; and (3) The barriers our clients face to accessing life saving organ transplants, largely due to their inability to qualify for adequate healthcare insurance, could be mitigated through inclusion in the Essential Plan.

(1) <u>The State's proposed waiver ignores the vast majority of thousands of public comments, which sought to include immigrants.</u>

New York State held two public hearings to gather public comments, as well as accepting virtual submissions. Comments from 26 out of 30 organizations and over 1,600 individuals requested the inclusion of undocumented immigrants through the surplus passthrough funding in the draft submission, and emphasized that the federal and state governments would save over $1 billion per year in Emergency Medicaid funding. Despite overwhelming support from the majority, the State's final Waiver submission decided against expanding coverage to all immigrants.

(2) <u>The State's final waiver submission was drastically different from the draft waiver, but not aligned with the proposed requests from the majority of public comments.</u>

The final Waiver did not reflect the changes that a large number of New Yorkers requested. Instead of expanding coverage for immigrants, the Waiver put forth proposals to spend over $5.8 billion in industry giveaways for long term coverage and other funding for the hospitals that was not asked for by the public. The Final Waiver provides almost no concrete details about the nature of these

new expenditures of public funds. NYLPI urges CMS to require the State to provide the public an opportunity to review these new spending allocations in detail.

(3) <u>The barriers our clients face to life-saving and economically sensible care due to their inability to access adequate healthcare insurance, could be mitigated through inclusion in the Essential Plan.</u>

For example, many of our clients that seek our legal services for assistance with accessing healthcare experience End-Stage Renal Disease (ESRD)and are in need of kidney transplants. Through the State's limited Emergency Medicaid program, they can only access dialysis treatment. However, dialysis is ineffective as a long-term solution, with an approximately 40 percent survival rate of five years after treatment begins. Once a patient is stabilized on dialysis treatment, the best practice is to try to find a transplant as soon as possible. Not only is dialysis an unsustainable long-term treatment, but it can also impose serious, cascading costs on patients and their families. While kidney transplants have a higher up-front cost, numerous studies have found that transplants are a more cost-effective solution in the long-term than ongoing dialysis.[1] Ultimately the most impactful and economically sensible solution would be by expanding eligibility for the state's Essential Plan or Medicaid programs to every New Yorker regardless of immigration status. This Waiver presents an opportunity to advance equitable access to kidney transplantation, and to allow New York State to save millions of dollars in doing so.

NYLPI has represented numerous clients whose ability to work, spend time with loved ones, and engage meaningfully in their communities is severely limited by ESRD and other serious health conditions. We believe that health is a human right, and that our clients' need for medical care can be met through access to comprehensive healthcare insurance and expansion of the Essential Plan. We hope the concerns we have identified above will help inform a close examination of New York's proposed Section 1332 Waiver to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

Thank you for the opportunity to provide public comment.

Noelle Peñas
Health Justice Community Organizer
New York Lawyers for the Public Interest

NYLPI has fought for more than 40 years to protect civil rights and achieve lived equality for communities in need. Led by community priorities, we pursue health, immigrant, disability, and

[1] For example, see David Axelrod, et al. An economic assessment of contemporary kidney transplant practice, 18 Am Journal Transplantation, 1168 (January, 2018), available at: https://pubmed.ncbi.nlm.nih.gov/29451350/. See also Robert A. Wolfe, et al., Comparison of Mortality in All Patients on Dialysis, Patients on Dialysis Awaiting Transplantation, and Recipients of a First Cadaveric Transplant, 341 N. Engl. J. Med. 1725 (Dec. 2, 1999), available at: http://www.nejm.org/doi/full/10.1056/NEJM199912023412303#t=article.

environmental justice. NYLPI combines the power of law, organizing, and the private bar to make lasting change where it's needed most.

NYLPI's Health Justice Program brings a racial equity and immigrant justice focus to health care advocacy, including ongoing work addressing the human rights crisis in immigration detention and advocating for healthcare for all New Yorkers.

We are writing to submit comments on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition" or "the Coalition") regarding New York State's proposed Section 1332 State Innovation Waiver.

The PHP Coalition represents eight health plans that serve more than 5.6 million New Yorkers enrolled in the State's government-sponsored healthcare programs: "Mainstream" Medicaid Managed Care (MMC), HIV Special Needs Plans (HIV SNPs), Health and Recovery Plans (HARPs), Child Health Plus (CHP), Essential Plan (EP), and subsidized Qualified Health Plan (QHP) coverage offered through the New York State of Health Marketplace. Three out of four New Yorkers enrolled in an EP or QHP are covered by a PHP Coalition plan.

The PHP Coalition is a committed partner to expanding health insurance coverage and access to health care services, while also improving healthcare quality, for the lowest-income New Yorkers. Coalition plans specialize in delivering high-quality services to populations that have traditionally faced barriers to care, with the goal of improving health and reducing health-related disparities.

In general, the Coalition strongly supports New York's many efforts in recent years to expand health care coverage – we share the State's goal to move toward universal, affordable, comprehensive coverage for all New Yorkers. The comments that follow on the 1332 State Innovation Waiver stem from the Coalition's extensive expertise managing care for people in EP and QHPs, and reflect our commitment to preserve, strengthen, and expand New York's public healthcare coverage programs.

Support for the Essential Plan Expansion

The PHP Coalition believes that the EP program is a fundamental, high quality, and popular component of New York's public healthcare coverage continuum, and we welcome the State's interest to expand it. The EP already provides low- to zero-cost coverage for comprehensive benefits (including dental and vision) to low-income New Yorkers through a robust and high quality network of providers. In addition, the flexibility and funding offered by the EP program has allowed health plans to make significant investments in advancing quality improvement and health equity and expanded health care access for people who traditionally face the most barriers to care.

Therefore, the PHP Coalition strongly supports the core goal of the 1332 State Innovation Waiver: expanding eligibility for EP beyond 200% of the federal poverty level (FPL), up to 250% FPL. Doing so will have a materially positive impact on consumers in that income range without impacting those who are already eligible for or enrolled in the EP now. As noted by the waiver application, the cost-sharing burden for this group may decrease by about $1,950 – improving overall affordability on average by $7,400 annually from 2024-2028, when coupled with the average $5,450 annual savings on premiums. The shift to EP for these consumers would also likely expand access to providers for a wider range of benefits, like vision and dental, access to which can be uniquely challenging for lower-income New

Yorkers. **We also support the proposed waiver's continuation of the EP Quality Incentive Program that has allowed plans to make numerous investments in providers and services to advance health equity.**

Before the release of the draft waiver application, the PHP Coalition understood that the State had considered expanding EP up to 250% FPL for all New York residents, regardless of their immigration status. However, the proposed waiver does not effectuate this change. There are approximately 245,000 New Yorkers between the ages of 19 and 64 who remain uninsured because of their immigration status. Expanding the EP to include these individuals would not only improve access to preventative care and more appropriate utilization of healthcare services, it could create a savings of over $500 million for New York State which is currently being spent on emergency Medicaid and uncompensated care for those who are uninsured due to their immigration status.[1,2] **The PHP Coalition strongly supports adding eligibility for <u>all</u> New York residents up to 250% FPL, regardless of immigration status, as another step toward more equitable and comprehensive coverage.**

The necessary shift in federal authority itself (from 1331 Basic Health Program to a 1332 State Innovation Waiver) to accomplish the expansion up to 250% FPL does not significantly impact our comments, except that the shift could impact the availability of the EP Trust Fund, a significant pool of largely untapped resources that could be used for a variety of purposes, such as reducing cost-sharing and improving quality in the EP program. **The PHP Coalition strongly supports New York State's request to maintain access to the EP Trust Fund for currently allowable uses and recommends that the State leverage these considerable dollars to improve consumer affordability for those already eligible for EP during the transition, where possible.**

Implications for Health Plans and Members in the QHP Market

While we support the proposed 1332 State Innovation Waiver, it raises important questions about the State's long-term vision for the QHP market. Namely, plans have existing concerns about the financial sustainability of the QHP product as membership shrinks statewide and adverse selection persists due to the program's monthly premium and high cost sharing expenses (despite premium tax credits and cost-sharing reductions). The proposed waiver would likely exacerbate these concerns without intervention. The application currently assumes carrier participation will not diminish as a result of the waiver but the long-term implications are a point of concern for plans that operate a QHP now. **The PHP Coalition recommends New York State proactively develop a plan to mitigate the QHP market impact, including structural changes to ensure that plans remain in the market over time.**

Concluding Remarks

The PHP Coalition strongly support the core goals of the proposed 1332 State Innovation Waiver, albeit with concerns about the impact on QHPs, and are eager to partner with New York State to implement the transition. In summary, the PHP Coalition offers the following recommendations:

- The Coalition strongly supports expanding eligibility for <u>all</u> New York residents up to 250% FPL *regardless of immigration status* under the 1332 waiver program, as another step toward more equitable and comprehensive coverage.

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[1] https://www.politico.com/newsletters/weekly-new-york-health-care/2023/02/13/lawmakers-continue-fight-to-extend-health-insurance-to-undocumented-new-yorkers-00082412

[2] https://www.nysenate.gov/sites/default/files/make_the_road_ny-_mrny_.pdf

- The Coalition supports the waiver application's continuation of the EP Quality Incentive Program that has allowed plans to make numerous investments in providers and services to advance health equity.
- The Coalition supports New York State's request to maintain access to the EP Trust Fund for currently allowable uses and recommends that the State leverage these dollars to improve consumer affordability for those already eligible for EP during the transition, where possible

The PHP Coalition appreciates the opportunity to comment on this important change in the structure of New York's public healthcare coverage programs. We look forward to working in partnership with New York State to effectuate this positive change for New Yorkers.

SENATOR
GUSTAVO RIVERA
33RD DISTRICT

NEW YORK
STATE
SENATE
ALBANY, NEW YORK 12247

CHAIRMAN, MAJORITY MEMBER
HEALTH
COMMITTEES:
ALCOHOLISM AND SUBSTANCE ABUSE
CRIME VICTIMS, CRIME AND CORRECTION
FINANCE
HIGHER EDUCATION
HOUSING, CONSTRUCTION AND
COMMUNITY DEVELOPMENT
MENTAL HEALTH

June 30th, 2023

The Honorable Xavier Becerra
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

The Honorable Janet Yellen
Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

Dear Secretary Becerra and Secretary Yellen,

I appreciate the ongoing dialogue we have been able to have about New York's Section 1332 Innovation Waiver as well as the opportunity to provide comments now that the waiver has been submitted. There remain outstanding issues I wish to bring to your attention with the hope that New York's continued dialogue with your offices can resolve these challenges.

During the public comment period on New York's 1332 waiver submission, the vast majority of the comments all focused on one particular issue: the expansion of coverage to New Yorkers that are otherwise ineligible due to their immigration status. Despite this significant support, which included public support from Governor Hochul and the New York State Department of Health, some concerns have been raised related to the costs associated with the expansion and New York's ability to finance the proposal without additional appropriations, which traditionally are not done outside of the state's budget process.

The letter that you provided on the issue in response to our outreach was very helpful. Unfortunately, due to the difficulty of estimating the population of immigrants that could be potentially eligible under an expansion of the 1332 waiver, fiscal concerns have persisted. This led to us updating our legislation related to this effort to authorize the New York State Department of Health to set limitations on the population covered to address these fiscal concerns. I would respectfully ask that during the review process of New York's 1332 waiver submission that your offices proactively engage the state's representatives on this issue and potential solutions to dispel any lingering fiscal concerns.

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DISTRICT OFFICE: 2432 GRAND CONCOURSE, SUITE 506, BRONX, NEW YORK 10458 (718) 933-2034 • FAX (718) 933-2825
grivera@nysenate.gov

One area where additional clarity would be helpful is if New York would be able to draw down additional pass through funding associated with reductions in Emergency Medicaid usage. While the programs are not explicitly linked, 42 USC 18052(a)(5) allows for coordinated waiver applications associated with Medicaid and other federal health initiatives. While I do not believe that provisions of Medicaid would need to be explicitly waived, the language seems indicative of an openness by the federal government to contemplate the impacts that an expansion of the basic health plan may have on other programs. Based on historical data my office has reviewed, the federal portion of Emergency Medicaid spending has exceeded approximately $400 million, on an annual basis, for the population of individuals that could be covered under a 1332 waiver expansion for individuals ages 19-64. It is also my understanding that the vast majority of emergency Medicaid spending in this space is related to providing services to individuals that cannot obtain comprehensive health care services based on their immigration status. Additional pass through resources, which you have indicated could be used to support this population, would be extremely helpful in addressing the fiscal concerns previously mentioned.

Additionally, an issue that would be helpful to clarify is if the surplus basic health plan funds that have already been accrued by the state can be utilized to provide services under the 1332 waiver for those individuals that would otherwise qualify for the basic health plan. While your letter was clear that such funds could not be used to support individuals that are not lawfully present, if funding could be drawn from this pool to support services provided to individuals that would traditionally qualify for the basic health plan, it would provide New York with additional fiscal support for the overall operation of the program.

Our ultimate goal is providing comprehensive services to all residents of the state, regardless of immigration status. I urge you to engage with New York to seek out creative solutions for expanding the 1332 waiver program to cover individuals that would be excluded solely on the basis of their immigration status. Such an approach will provide residents with access to critical health care services and will more effectively and efficiently deliver care while avoiding unnecessary and costly hospitalizations. I thank you for the opportunity to provide comments and look forward to our continued partnership working to provide every resident of the state much needed access to health care services.

Sincerely,

Gustavo Rivera
33rd District
New York State Senate

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New York Section 1332 Waiver Application

Individual public comment received during federal public comment period from June 6, 2023 through July 5, 2023.

7/5/23

I am [M.A.] an Arabic speaking New York State of Health Navigator , serving our immigrant communities in their own language for over 20 years and helping them with their health insurance coverage and access to health care.

Many of our communities are uninsured , under served low income families, Who can't afford to pay premiums, co pay or deductibles. Many has to decline to choose a plan to access health care because they can't afford it, they have to choose between paying for health insurance or paying for rent and putting food on their tables for their families.

With access to health care we can prevent our community members from getting sick with cancer , diabetes, blood prusser just to name few, it will help NYS to prevent and save lives' instead of Costley treatments. Approving NYS section 1332 Essential Plan Waiver and expanding to 250 percent of the FPL is very important and Essential to our Essential workers in the community.

Help us keep our communities healthy and safe , one family at the time, they have the right to access free and affordable health care with out the extra cost by expanding NYS Essential plan .