CLASP
policy solutions that work for low-income people

October 20, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Administrator Verma,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. These comments draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that additional steps and transitions both increase burden on caseworkers and make it harder for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the 1115 Demonstration Waiver Amendment Application and raises concerns about the effects of the waiver amendment, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Massachusetts. This waiver amendment takes a step backwards—negatively impacting coverage stability for adults. Our specific comments follow.

Reduction in Eligibility

This proposal reduces Medicaid eligibility for adults. The limit for eligibility is dropped from 133 percent of the federal poverty level (FPL) to 100 percent of the FPL for all non-disabled adults. This means that all adults, with some limited exceptions, between 101-133 percent FPL will lose their access to Medicaid. Instead, these adults will be shifted to ConnectorCare, the Marketplace. If implemented, it is estimated that this provision will transition more than 140,000 non-disabled adults off of Medicaid and to ConnectorCare.

CLASP strongly opposes this provision and any reduction in eligibility because it will result in more people becoming uninsured or having interruptions in their continuity of care. What is more, no explanation is offered for how this will promote the goals of Medicaid; rather, this is simply a shift of costs to the federal government (assuming that people become eligible for premium tax credits under the

Affordable Care Act (ACA)). The state acknowledges that this budget gimmick saves the state a net $88 million.

In addition, the state wants to continue receiving the enhanced Medicaid expansion federal match for eligible adults with income below the poverty line — a policy that CMS has said isn't permissible and has never been approved. In 2012, CMS issued guidance stating that while it would consider partial expansion proposals, the enhanced Medicaid expansion match rate wouldn't be available for a partial expansion.[1] This means that a state's regular Medicaid match rate would apply, as is the case in Wisconsin's partial expansion waiver.

Regardless of the federal match rate that would be available, we urge you to reject this request, which would not promote the objectives of the Medicaid program because it would likely lead to loss of coverage. Experience from other states that have lowered Medicaid eligibility, such as Wisconsin, Connecticut and Rhode Island, shows that even when efforts are made to assure a smooth transition to marketplace coverage, people get lost in the transition. In Rhode Island, despite considerable efforts, 1,271 parents of the 6,574 (or 19 percent) who lost Medicaid when the state rolled back eligibility never applied to enroll in a qualified health plan (QHP), and likely became uninsured.[2] During the first round of a similar parent eligibility rollback in Connecticut, only one in four parents losing Medicaid coverage enrolled in a QHP.[3] In Wisconsin, only one-third of those losing Medicaid coverage purchased QHPs although the state had predicted that 90 percent would.[4]

This eligibility reduction will result in an increase in the number of low-income individuals who churn between Medicaid, the marketplace and being uninsured. This will have negative health consequences, as changes in coverage often require changes in health care providers, and can lead to interruptions in treatment. In one recent study, even among those who churned with no gap in coverage, 29 percent reported a decrease in their overall quality of care as a result of the transition.[5] This is particularly harmful for those with significant health conditions.

Changes in employment, income and family structure all impact churn. Low-income individuals are more at risk of churning from one type of coverage to another[6] because low-wage work is increasingly variable in hours and/or seasonal.[7] A more consumer-friendly way to reduce churn is to implement 12-month continuous eligibility.

Impacts on Enrollment

A cornerstone of the Medicaid program is that consumers may enroll as soon as they are eligible without having to wait for an arbitrary "open enrollment" period. Consistent with the intent of Medicaid, MassHealth allows continuous enrollment throughout the year, with retroactive coverage.

Conversely, ConnectorCare does not allow for continuous enrollment. Being determined newly eligible for ConnectorCare *is* considered a qualifying event and triggers a special enrollment period (SEP), but this does not mitigate the enrollment barriers for those who have been previously determined eligible or who are churning from one program to another or churning on and off ConnectorCare. Workers who have previously been on Medicaid may not understand the urgency of applying for ConnectorCare within the

SEP window, and may not prioritize applying given the other stressors involved in starting a new job, arranging child care, and so forth. Moving consumers onto ConnectorCare creates an on-going barrier to enrollment that does not exist in MassHealth.

In addition, ConnectorCare does not automatically enroll consumers into a health plan. It requires consumers to proactively enroll in a plan. Annual renewals too require consumer action. Consumers who are facing multiple stressors and a high cognitive load may not complete the initial enrollment process, or may lack the necessary information to choose the plan that best fits their health needs.

This policy will also cause more parents and children to be covered under different systems. Currently, parents and children between 100-133 percent FPL are insured through MassHealth, and are subject to the same enrollment processes and requirements. These parents will now be moved into a different health insurance system from their children, who will remain MassHealth-eligible. With the different timelines and requirements, it is increasingly likely that either parents or children will experience gaps in coverage, with effects on their ability to access health care. Continuous coverage for low-income parents is more likely to result in continuous coverage for their children.[8] As discussed above, ConnectorCare does not offer continuous coverage, and many parents may not take the steps needed to enroll in a health plan. These parents would likely become uninsured, and children in low-income families are more likely to be uninsured if their parents are uninsured.[9] Furthermore, navigating two separate insurance policies in families is burdensome and time consuming, particularly if the parents and children have different provider networks.[10]

Waiver of Massachusetts' Obligations to Provide Payment of Emergency Services to Lawfully Present Immigrants Is Not Waivable and Would Result in Uncompensated Care

Massachusetts is seeking to "eliminate redundant MassHealth Limited coverage for adults who are also eligible for comprehensive, affordable coverage through the Health Connector" by waiving the requirement to provide Medicaid payment of emergency services for lawfully present immigrants who do not meet the Medicaid immigration standard. Section 1903(v) requires states to provide payment of emergency services to individuals who meet all Medicaid requirements except for the immigration status requirement. This is not a waivable provision under 1115, which only allows waivers of provisions in section 1902.

The state's claim that providing emergency services is redundant coverage is not accurate. Medicaid eligibility is not restricted to people who are ineligible for other coverage. When people have other coverage Medicaid acts as the "payor of last resort" filling in by ensuring that beneficiaries aren't saddled with deductibles or copayments or payments for services not covered by the other plan. For example, a person can enroll in employer sponsored coverage and still qualify for Medicaid eligibility to wrap around the employer coverage. Massachusetts' proposal would treat immigrants differently than other people who qualify for both Medicaid and other forms of coverage.

Massachusetts' plan to encourage enrollment in Health Connector plans by increasing outreach and engaging community partners should be pursued. Getting more people enrolled in comprehensive coverage may even help avoid preventable emergency-related costs. However, no outreach campaign

reaches everyone. This is particularly likely for immigrants who often experience additional barriers to enrollment, such as language access barriers and distrust of government institutions. The state should not penalize those who do not enroll by denying them coverage for emergencies. Some consumers would likely miss out initially from extra outreach and still others would become eligible after the initial transition period the state proposes. The target audience is always changing, as people move or have changes in their income or households. It's unrealistic to assume all eligible people will sign up especially under limited enrollment periods in the Health Connector. Given that many consumers would not enroll in Health Connector plans, waiver of this provision would ultimately result in increased uncompensated care for hospitals and may lead consumers to delay or not seek needed emergency services.

Thank you for consideration of these comments. Please contact Suzanne Wikle (swikle@clasp.org) with any questions.

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[1] Centers for Medicare & Medicaid Services, "Frequently Asked Questions on Exchanges, Market Reforms and Medicaid," December 10, 2012, https://www.medicaid.gov/federal-policy-guidance/downloads/FAQ-12-10-2012-Exchanges.pdf.

[2] Kate Lewandowski, "Parent Eligibility Roll-Back in Rhode Island: Causes, Effects and Lessons Learned," September 2015, https://www.communitycatalyst.org/resources/publications/document/RI-parent-rollback-081215-KL.pdf?1439834245.

[3] Langer, S. et al. "Husky Program Coverage for Parents: Most Families Will Feel the Full Impact of Income Eligibility Cut Later ln 2016," http://www.ctvoices.org/sites/default/files/h16HUSKYIncomeEligibilityCut.pdf.

[4] Guy Boulton, "One-third who lost BadgerCare coverage bought plans on federal marketplace," Journal Sentinel, July 2014, http://archive.jsonline.com/business/almost-19000-badgercare-plus-recipients-enrolled-in-obamacare-b99312352z1-267339331.html.

[5] Sommers BD, Gourevitch R, Maylone B, Blendon RJ, and Epstein AM, "Insurance Churning Rates For Low-Income Adults Under Health Reform: Lower Than Expected But Still Harmful For Many," Health Affairs, October 2016, https://www.ncbi.nlm.nih.gov/pubmed/27702954.

[6] Community Catalyst, "Health Insurance Churn: The Basics," November 2016, https://www.communitycatalyst.org/resources/publications/document/Health-Insurance-Churn-November-2016_FINAL.pdf.

[7] Jessica Gehr, "Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers," CLASP, June 2017, http://www.clasp.org/resources-and-publications/publication-1/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf.

[8] Leighton Ku and Matt Broaddus, "Coverage of Parents Helps Children, Too," Center on Budget and Policy Priorities, October 2006, https://www.cbpp.org/research/coverage-of-parents-helps-children-too.

[9] Sylvia Guendelman, Megan Wier, Veronica Angulo, and Doug Oma, "The Effects of Child-Only Insurance Coverage and Family Coverage on Health Care Access and Use: Recent Findings among Low-Income Children in California," Health Services Research, February 2006, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1681533/.

[10] Ibid.