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February 6, 2020

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

Re: Georgia "Pathways to Coverage" Section 1115 Demonstration Waiver Application

Dear Secretary Azar,

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. CLASP submits the following comments in response to Georgia's Section 1115 Demonstration Waiver Application for Georgia Pathways to Coverage and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in the state.

These comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also 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.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. In fact, only 16 percent of poor adults receive health insurance through their jobs¹ and, according to recent a recent survey by the Bureau of Labor Statistics, low-wage workers pay more for employer-provided medical care benefits than higher-wage workers.² Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

This proposal's attempt to transform Medicaid and reverse its core function will keep individuals from gaining needed coverage, contribute to poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."³ This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be rejected.

Georgia is proposing to limit the increase of Medicaid eligibility to adults with incomes up to 100 percent of the Federal Poverty Line (FPL). This means that all adults between 101-138 percent of FPL who should be eligible for Medicaid under the Affordable Care Act will lose out on more affordable and comprehensive coverage. In addition, it will shift costs from the state to the federal government.

But even more egregious, Georgia is proposing to implement a work requirement as a *condition* of eligibility in its Georgia Pathways Medicaid program. Individuals below 100% of FPL will be required to meet work requirements—and individual between 50-100% FPL must also pay premiums—in order to be enrolled in and maintain Medicaid. CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Centers for Medicare and Medicaid Services (CMS) to immediately reject this request. Work requirements are inconsistent with the goals of Medicaid because they would act as a barrier to individuals being able to receive health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventive and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

CLASP opposes Georgia's proposal to limit its expansion of Medicaid, to require individuals with incomes as low as 51 percent of the FPL to pay premiums, and to limit health coverage only to individuals who meet new work requirements. Our comments that follow focus on the harmful impact the proposed work requirements will have on low-income Georgians and the state; we briefly address the other policies as well.

Proposals that Make Work Requirements A Condition of Eligibility for Georgia Pathways

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Do Not Promote Employment

Creating a work requirement for Medicaid eligibility is misguided and short-sighted. Lessons learned from other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.⁴ A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.⁵ Medicaid expansion enrollees from Ohio⁶ and Michigan⁷ reported that having Medicaid made it easier to look for employment and stay employed. Further, recent analysis by the New York Times finds that young single mothers' participation in the labor force increased four percentage points more in states that expanded Medicaid in 2014 compared to those that didn't, providing evidence that if people don't lose their health insurance when they go to work, they are more likely to work.⁸ Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Do Not Promote Employment Do Not Lead to Employer-Sponsored Insurance

The waiver request assumes that if participants become employed, they will be able to transition to affordable employer-sponsored insurance (ESI). Unfortunately, this is simply not the reality of many jobs in America. Only 49 percent of people in this country receive health insurance through their jobs—and only 16 percent of poor adults do so.⁹ The reality is that many low-wage jobs, particularly in industries like retail and restaurant work, do not

offer ESI, and when they do, it is not affordable.¹⁰ In fact, in 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under their employer offered insurance.¹¹ People working multiple part-time jobs or in the gig economy are particularly unlikely to have access to ESI. Even among low-income workers, Black and Hispanic workers are less likely to have access to ESI than their White counterparts.¹²

A recent study by the Urban Institute provides additional evidence in New Hampshire – a state that was recently approved to move forward with their work reporting requirement. The paper found that New Hampshire residents who could lose Medicaid under work reporting requirements will likely face limited and costly employer-sponsored insurance options. In particular, researchers found that less than one in ten part-time private-sector employees in New Hampshire were eligible for employer-sponsored coverage and just over half of full-time employees at firms with fewer than 50 employees were eligible for employer-sponsored coverage in 2017. Additionally, annual employee contributions for a single-coverage plan would represent 12.5 percent of annual income for a minimum-wage, full-time worker and 25.0 percent of annual income for a minimum-wage, part-time worker— more than ten times the percentage premium limit in the Marketplace for individuals earning 100 percent of the federal poverty level.¹³

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Grow Government Bureaucracy and Increase Red Tape

One of the key lessons of the Work Support Strategies initiative is that every time a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements.

As a result of Georgia's new administrative complexity and red tape, **eligible** people who are meeting the work requirements will have their health insurance suspended because the on-going processes to document work requirements coverage are too cumbersome—and they could become unenrolled. Recent evidence from Arkansas' implementation of work reporting requirements confirms that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 18,000 beneficiaries lost coverage before the program was suspended by a federal judge, likely becoming uninsured because they didn't report their work or work-related activities.¹⁴ As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.¹⁵ The recent study looking at the Arkansas program found that "work requirements have substantially exacerbated administrative hurdles to maintaining coverage". The study found a reduction in Medicaid of 12 percent, even though more than 95% of those who were subject to the policy already met the requirement or should have been exempt.¹⁶

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Do Not Reflect the Realities of Our Economy

This proposal requires that individuals demonstrate that they have 80 hours of work per month in order to be eligible for Medicaid; unfortunately, this does not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will have their health insurance suspended or churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum number of hours needed to become eligible for and retain Medicaid. Many low-wage jobs are

subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.¹⁷ This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Georgia's proposal to require 80 hours of work per month throughout the entire year for some families is incredibly blind to the reality of low-wage work. An analysis by the Urban Institute found that Kentucky's proposal to take away health care from individuals who do not work a set number of hours does not align with the reality of some working enrollees' lives. Urban found that an estimated 13 percent of nondisabled, nonelderly working Medicaid enrollees who do not appear to qualify for a student or caregiver exemption in Kentucky's Medicaid program could be at risk of losing Medicaid coverage at some point in the year under the work requirements because, despite working 960 hours a year, they may not work consistently enough throughout the year to comply with the waiver.¹⁸ Additional analysis from the Urban Institute shows that Medicaid enrollees who would potentially be subject to work reporting requirements are more likely to face barriers to employment, compared with privately insured adults. The analysis found that half of nonexempt Medicaid enrollees reported issues related to the labor market or nature of employment, such as difficulty finding work and restricted work schedules, as reasons for not working more, and over one-quarter reported health reasons.¹⁹

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness will be denied access to Medicaid coverage because they cannot meet the work requirement. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working. Additional research from the Kaiser Family Foundation shows that people with disabilities were particularly vulnerable to losing coverage under the Arkansas work reporting requirements, despite remaining eligible.²⁰

And, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,²¹ and nearly 20 percent had filed for Disability/SSI within the previous two years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement. The result is that many people with disabilities will, in fact, be subject to the work requirement and be at risk of losing health coverage.

People with chronic conditions and disabilities may have periods of time where they are unable to meet the necessary hours to meet their work requirement—and will have their Medicaid suspended and quickly terminated. Once terminated from Medicaid coverage, beneficiaries will likely become uninsured. Rather than supporting these individuals with appropriate health insurance so they can regain their health and go back to work, this proposal will put needed medical services and prescription drugs out of reach, including those needed to maintain positive health outcomes.

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Are Likely to Increase Churn

Georgia's proposal to impose work requirements as a condition of Medicaid eligibility is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid as their hours increase or the seasons change. People may be most likely to seek to re-enrollment once they need healthcare, and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

When the beneficiary enrolls in Medicaid, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.²²

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.²³ A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.²⁴

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.²⁵ Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of \$239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.²⁶

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Will Have a Disparate Impact on Communities of Color

We strongly oppose the proposal due to its disproportionate impact on communities of color. As discussed in more detail in the sections that follow, many people of color face employment challenges and, under the proposed policy, would be disadvantaged in being able to access and maintain Medicaid eligibility.

Racial income disparities persist in the United States: Due to persisting racial economic disparities and discrimination in hiring practices, average hourly wages for Black and Hispanic workers are substantially lower than their white counterparts.²⁷ In Georgia in 2017, for adults age 18-64, the poverty rate of the general population is approximately 14%. That percentage is significantly higher for both Black Americans and Latinos who have an estimated poverty rate of 18% in Georgia in 2017.²⁸ This makes it more likely that Black and Hispanic individuals will benefit from programs that support work by helping them access health coverage.

Employment discrimination limits access to the workforce for many people of color: Studies show that racial discrimination remains a key force in the labor market.²⁹ In a 2004 study, “Are Emily and Greg more employable than Lakisha and Jamal: A Field Experiment on Labor Market Discrimination,” researchers randomly assigned names and quality to resumes and sent them to over 1,300 employment advertisements. Their results revealed significant differences in the number of callbacks each resume received based on whether the name sounded white or African American. More recent research indicates that this bias persists. A study from 2013 submitted fake resumes of nonexistent recent college graduates through online job applications for positions based in Atlanta, Baltimore, Portland, Oregon, Los Angeles, Boston, and Minneapolis. African-Americans were 16% less likely to get called in for an interview.³⁰ Similarly, a 2017 meta-analysis of field experiments on employment discrimination since 1989 found that white Americans applying for jobs receive on average 36% more callbacks than African Americans and 24% more callbacks than Latinos.³¹

Hispanic and Black workers have been hardest hit by the structural shift toward involuntary part-time work: Despite wanting to work more, many low-wage workers struggle to receive enough hours from their employer to make ends meet. A report from the Economic Policy Institute found that 6.1 million workers were involuntary

part-time; they preferred to work full-time but were only offered part-time hours. According to the report, “involuntary part-time work is increasing almost five times faster than part-time work and about 18 times faster than all work.”³² Hispanic and Black workers are much more likely to be involuntarily part-time (6.8 percent and 6.3 percent, respectively) than their White counterparts, of whom 3.7 percent work part time involuntarily. And Black and Latino workers are a higher proportion of involuntary part-time workers, together representing 41.1 percent of all involuntary part-time workers. The greater amount of involuntary part-time employment among Black and Hispanic workers is primarily due to their having greater difficulty finding full-time work and more often facing work conditions in which hours are variable and can be reduced without notice.³³

People of color are more likely to live in neighborhoods with poor access to jobs: In recent years, majority-minority neighborhoods have experienced particularly pronounced declines in job proximity. Proximity to jobs can affect the employment outcomes of residents and studies show that people who live closer to jobs are more likely to work.³⁴ They also face shorter job searches and fewer spells of joblessness.³⁵ As residents from households with low-incomes and communities of color shifted toward suburbs in the 2000s, their proximity to jobs decreased. Between 2000 and 2012, the number of jobs near the typical Hispanic and Black resident in major metropolitan areas declined much more steeply than for white residents.³⁶

Due to overcriminalization of neighborhoods of color, people of color are more likely to have previous histories of incarceration, which in turn limit their opportunities: People of color, particularly African Americans and Latinos, are unfairly targeted by the police and face harsher prison sentences than their white counterparts.³⁷ After release, formerly incarcerated individuals fare poorly in the labor market, with most experiencing difficulty finding a job after release. Research shows that roughly half of people formerly incarcerated are still unemployed one year after release.³⁸ For those who do find work, it’s common to have annual earnings of less than \$500.³⁹ Further, during the time spent in prison, many lose work skills and are given little opportunity to gain useful work experience.⁴⁰ People who have been involved in the justice system struggle to obtain a driver’s license, own a reliable means of transportation, acquire relatively stable housing, and maintain proper identification documents. These obstacles often prevent them from successfully re-entering the job market and are compounded by criminal background checks, which further limit access to employment.⁴¹ A recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.⁴²

Further, work reporting requirements are part of a long history of racially-motivated critiques of programs supporting basic needs. False race-based narratives have long surrounded people experiencing poverty, with direct harms to people of color. For decades these narratives have played a role in discussions around public assistance benefits and have been employed to garner support from working-class whites.⁴³ Below are a few examples of the relationship between poverty, racial bias, and access to basic needs programs.

- When the “Mother’s Pension” program was first implemented in the early 1900s, it primarily served white women and allowed mothers to meet their basic needs without working outside of the home. Only when more African American women began to participate were work reporting requirements implemented.⁴⁴
- Between 1915 and 1970, over 6 million African Americans fled the south in the hope of a better life. As more African Americans flowed north, northern states began to adopt some of the work reporting requirements already prevalent in assistance programs in the South.⁴⁵
- As civil rights struggles intensified, the media’s portrayal of poverty became increasingly racialized. In 1964, only 27 percent of the photos accompanying stories about poverty in three of the country’s top weekly news magazines featured Black subjects; by 1967, 72 percent of photos accompanying stories about poverty featured Black Americans.⁴⁶
- Many of Ronald Reagan’s presidential campaign speech anecdotes centered around a Black woman from Chicago who had defrauded the government. These speeches further embedded the idea of the Black “welfare queen” as a staple of dog whistle politics, suggesting that people of color are unwilling to work.⁴⁷
- In 2018, prominent sociologists released a study looking at racial attitudes on welfare. They noted that white opposition to public assistance programs has increased since 2008 — the year that Barack Obama

was elected. The researchers also found that showing white Americans data suggesting that white privilege is diminishing led them to express more opposition to spending on basic needs programs. They concluded that the “relationship between racial resentment and welfare opposition remains robust.”⁴⁸

Proposals to Make Health Coverage Contingent On Meeting Work Requirements Will Harm Returning Citizens

Having a criminal record can make it extremely difficult to find a job and meet work requirements. Research shows that roughly half of returning citizens are still unemployed one year after release.⁴⁹ These individuals face many legal and social impediments to finding and retaining employment which can build stability and reduce the risk of recidivism. Taking away health coverage for not working a set number of hours per month only exacerbates this challenge. People with criminal records face many more legal barriers to employment such as occupational licensing bans that preclude them from obtaining even low skilled and entry level positions. Even an arrest record can be a long-term barrier to finding and keeping employment since many businesses conduct background checks; a recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.⁵⁰

Many people with criminal records need more time, training, and hands-on assistance to find adequate employment. Access to benefits, such as Medicaid can mean the difference between an individual successfully reintegrating into society, or recidivating.

Monthly Premiums Would Harm Low-income Households

CLASP strongly opposes this waiver proposal to require adults between 50-100% FPL to pay a monthly premium, going much further than HHS has previously permitted. What is more, Georgia proposes to make payment of premiums a condition of eligibility for Medicaid—and beneficiaries are not enrolled in the program until their first month’s premium is paid.

Medicaid has strong affordability protections to ensure that beneficiaries have access to a comprehensive service package and protects beneficiaries from out-of-pocket costs, particularly those due to an illness.⁵¹ Medicaid generally prohibits premiums for Medicaid beneficiaries with income below 150% FPL. Nonetheless, HHS has recently approved waivers allowing a few states to test the effects of imposing premiums. These states have been allowed to apply mandatory premiums for individuals with incomes between 100-150% FPL and only voluntary premiums for individuals with incomes below 100% FPL. Furthermore, no Section 1115 waivers have been approved to date for any Medicaid population that include premiums as a condition of eligibility or coverage or coverage lock-outs for non-payment for those under 100% FPL.⁵²

Studies of the Healthy Indiana waiver, which required Medicaid recipients with incomes between 100 and 138% of FPL to pay a premium⁵³ or face disenrollment or lockout,⁵⁴ have found that it deters enrollment. About one-third of individuals who applied and were found eligible were not enrolled because they did not pay the premium.⁵⁵

A large body of research shows that even modest premiums keep people from enrolling in coverage.⁵⁶ Individuals, particularly during period of unemployment or other financial hardship, may be unable to afford to make the payments. Low-income consumers have very little disposable income and often must make choices and stretch limited funds across many critical purchases. While Medicaid is designed to protect consumers against costs, this proposal adds another cost to their monthly budget.

Moreover, simply the burden of understanding the premium requirements and submitting payments on a regular basis may be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half

reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.⁵⁷ Finally, states or insurance companies may fail to process payments in a timely fashion, leading to benefit denials even for people who make the required payments.⁵⁸

Unlike private health insurance, the reality of this proposal is that individuals have to write checks on a monthly basis to purchase coverage. The vast majority of people with private insurance receive it through their employers, and have their share of the premiums automatically withheld from their paychecks, without having to take any positive action. Moreover, one-quarter of households with incomes under \$15,000 reported being “unbanked,”⁵⁹ which may create additional barriers to making regular payments.

We strongly encourage CMS to reject Georgia’s proposal to introduce premiums in Medicaid and to maintain Medicaid’s strong affordability protections.

Removing Conditions Around Existing Retroactive Coverage Does Not Further the Objectives of the Medicaid Program

Georgia’s proposal would remove conditions around its existing retroactive coverage waiver, which would allow the state to waive the statutory provision requiring that Medicaid reimburse medical costs incurred by Medicaid beneficiaries for up to three months before they apply if they were eligible during the retroactive period.

Retroactive coverage, which has been a feature of Medicaid since 1972, helps prevent medical bankruptcy and provides financial security to vulnerable beneficiaries by making Medicaid payments available for expenses incurred during the three-month period before application if the beneficiary was eligible for Medicaid during that period. Data from Indiana show how important retroactive coverage is for low-income parents in the state who incurred costs prior to enrollment. Medicaid paid \$1,561 on average on behalf of parents who incurred medical costs prior to enrolling in Medicaid.⁶⁰ Eliminating retroactive eligibility would instead lead to increased financial insecurity and instability for low-income families and higher uncompensated care costs for Medicaid providers.

As the court recognized in vacating approval of Kentucky’s first waiver, the primary objective of Medicaid is to provide affordable coverage, including when an individual moves in and out of the program, or is sick and otherwise eligible for Medicaid. Taking months of coverage away from people and exposing them to financial harm does not promote the objectives of Medicaid. Without retroactive coverage, parents may go without needed medical care and incur significant medical debt for care they receive prior to the effective date of enrollment. Research shows that children’s development can be negatively affected by issues resulting from poverty, such as toxic stress.⁶¹

In addition to helping individuals get the care they need, retroactive coverage ensures the financial stability of hospitals and other safety net providers as it allows them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care, helping them meet their daily operating costs and maintain quality of care. Under waivers that eliminate retroactive coverage, a hospital would no longer get paid for, say, providing an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident, increasing the hospital’s uncompensated care costs.

Proposal Leaves Many Georgians Without Access to Medicaid

Georgia is proposing to limit the increase of Medicaid eligibility to adults with incomes up to 100% FPL. This means that all adults between 101-138% FPL who should be eligible for Medicaid under the Affordable Care Act will lose out on more affordable and comprehensive coverage. Georgians in the expansion group defined by the Affordable Care Act (ACA) as up to 138 percent of poverty but not included in this expansion will face higher costs and potentially fewer benefits if purchasing health insurance through the Marketplace instead of being insured

through Medicaid.⁶² Moreover, persons with this level of income are less likely to enroll in Marketplace coverage due to out of pocket costs associated with Marketplace plans.⁶³ As a result, the partial expansion will leave thousands of Georgians without access to affordable health insurance.

Georgia's proposal shifts costs to the federal government (assuming that people become eligible for premium tax credits under the Affordable Care Act (ACA)). Further, this limitation on eligibility 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.³ 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 another⁴ because low-wage work is increasingly variable in hours and/or seasonal.⁵ The Affordable Care Act deliberately created an overlap between the eligibility levels for Medicaid and the premium subsidy tax credits in order to reduce the need for consumers to frequently switch between coverage under Medicaid and the Marketplace. Further, Medicaid provides continuous enrollment year-round, whereas enrollment in Marketplace coverage is limited to select weeks of the year and when people are eligible for a special enrollment period. For this population group, especially those with complex medical and life conditions, signing up for coverage during a time-limited period may not be realistic. Medicaid ensures that these individuals don't lose out on coverage by allowing them to enroll at any point during the year. As discussed below, the likelihood of people churning on and off coverage is increased by the burdensome work requirements included in this proposal. Even people who continue to be eligible will fall through the cracks as the paperwork burden increases.

Proposal to Expand HIPP Program Violates Federal Rules

Under its demonstration proposal, Georgia is seeking to expand the HIPP program through mandatory enrollment of demonstration participants if they have access to cost-effective ESI. Georgia's proposal seeks waiver authority to not provide the "wrap-around" benefits it's required to provide, but it also proposes to continue its current practice of not providing "wrap-around" cost-sharing – and no waiver authority is requested. Without the wrap-around benefits, individuals may lose access to the critical services they need but that aren't traditionally covered by ESI. Medicaid's robust benefit package is specifically designed to address the needs of low-income individuals. Without the wrap-around, individuals may lose those benefits. We urge CMS to review this matter and take action on a potential compliance issue with federal "wrap-around" cost-sharing protections under federal rules.

Conclusion

For all the reasons laid out above, CMS should reject Georgia's waiver application. If Georgia is serious about encouraging work and helping people move into jobs that allow for self-sufficiency (and affordable ESI) the state would be committed to expanding Medicaid to 138% of the Federal Poverty Level for all eligible adults.

Our comments include citations to supporting research and documents for the benefit of CMS in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposal.

Thank you for considering CLASP's comments. Contact Elizabeth Lower-Basch (elowerbasch@clasp.org) and Renato Rocha (rrocha@clasp.org) with any questions.

Citations accessed February 2020.

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