April 26, 2024

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

Re: Florida Children' Health Insurance Program Section 1115 Demonstration Waiver

Dear Secretary Becerra,

The undersigned organizations appreciate the opportunity to comment on Florida's request to implement a section 1115 waiver to increase eligibility for the Children's Health Insurance Program (CHIP) up to 300 percent of the federal poverty level (FPL). As part of the request, the state seeks to implement new monthly premium tiers for its new eligibility group of children living in families with incomes from 200 percent to 300 percent FPL, and with these tiers, increase premiums for its existing Healthy Kids program for enrollees above 133 percent up to 200 percent FPL. The demonstration application indicates that enrollment would be subject to monthly premiums and Florida requests authority to make enrollment contingent on continued payment of these monthly premiums.

We urge you to approve the state's request to extend coverage to 300 percent FPL, subject to the recommendations below. This increase in the upper income threshold for the Healthy Kids program will be incredibly beneficial to Florida's children and families and fits squarely within the purpose of the CHIP statute.[1]

However, we urge you not to approve the state's requests to continue and broaden its punitive monthly premium structure and to terminate coverage for non-payment of monthly premiums. We also ask you to clarify explicitly that the approval does not include authority to terminate coverage for nonpayment of premiums because doing so would be contrary to federal law requiring 12-month continuous eligibility for children[2] and CMS guidance implementing the law.[3]

It appears that **Florida is currently violating federal continuous eligibility protections and seeks to continue to do so.** We are extremely concerned by recent data that indicates that Florida has been disenrolling children for nonpayment of premiums since January 1, 2024, when a federal continuous eligibility requirement for children went into effect. **According to data from the state, 22,576 children have been disenrolled already in 2024 for nonpayment of premiums,[4] in violation of the Social Security Act (as amended by the Consolidated Appropriations Act,**

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[1] As we have noted previously, expanding coverage to children through the CHIP program is not something that should require demonstration authority as coverage is indeed the express purpose of CHIP and its value is well established; however, we recognize that most states are unable to simply amend their CHIP state plan until Congress takes action to amend Section 2110 (b)(1)(B)(ii) of the Social Security Act, which limits CHIP income eligibility expansions. This limitation inadvertently became more restrictive after the adoption of the Modified Adjusted Gross Income (MAGI) standard.

[2] Consolidated Appropriations Act, 2023 P.L. 117-328. https://www.congress.gov/117/plaws/publ328/PLAW-117publ328.pdf

[3] Frequently Asked Questions, "Mandatory Continuous Eligibility for Children in Medicaid and CHIP" Centers for Medicare & Medicaid Services, October 27, 2023, https://www.medicaid.gov/sites/default/files/2023-10/faq102723.pdf.

[4] "Recent Data regarding KidCare Disenrollments – Florida is currently disenrolling children from KidCare for non-payment of premiums," Florida Health Justice Project, https://www.floridahealthjustice.org/publications--media/recent-data-regarding-kidcare-disenrollments-florida-is-currently-disenrolling-children-from-kidcare-for-non-payment-of-premiums

2023 (CAA), P.L. 117-328) and CMS guidance.[5] It appears from the trends in the data that the state has not changed its premium disenrollment policy since January 1, 2024.

CMS should deny the state's punitive premium structure and should not approve any waiver or expenditure authority allowing the state to terminate coverage for non-payment of premiums. As described in more detail below, terminations for failure to pay premiums lead to reduced access to health care, including disruptions to on-going treatment for common conditions such as asthma and life-threatening conditions such as cancer and are not permissible since the passage of the CAA.

Florida's proposed premium structure imposes significant barriers to accessing health care for children and would be financially burdensome for their families.

Florida's proposal includes a new tiered premium structure that will increase premiums for its existing Healthy Kids program up to 200 percent FPL *and* impose premiums for the new eligibility group up to 300 percent FPL. Florida's proposal to impose high monthly premiums will deter enrollment and pose a significant barrier to access to health care for children. Children without insurance are less likely to have a regular source of care, to seek and receive preventive care and treatment when ill, and more likely to experience poor health outcomes. In addition, families often suffer economic harm, including high medical debt and even bankruptcy as a result of their uninsurance.[6]

In light of these facts, various federal programs limit premiums for the lowest income enrollees. As CMS noted in its December 22, 2023 letter regarding the Healthy Indiana Plan, evidence suggests that premiums beyond those authorized under the Medicaid statute may reduce access to coverage and care.[7] The Medicaid statute generally prohibits premiums below 150 percent FPL. Currently, for Marketplace place enrollees with income at 150 percent FPL and below, silver level plans are available with no premiums (this temporary measure was proposed to be made permanent in the Administration's budget).[8] Yet, *in Florida's Healthy Kids program, the state imposes premiums to families starting at 133 percent FPL, meaning many children in the Healthy Kids program have higher premiums than similarly situated individuals in Medicaid or Marketplace plans.* The state also proposes in the demonstration application to raise these premiums by three percent each year (p. 7).[9]

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[5] Op. cit. (2).; Op. cit. (3).

[6] Aubrianna Osorio and Joan Alker, "Kids with Gaps in Coverage Have Less Access to Care," Georgetown University Center for Children and Families, October 15, 2021, https://ccf.georgetown.edu/2021/10/15/kids-with-gaps-in-coverage-have-less-access-to-care/; Lunna Lopes et al., "Health Care Debt In The U.S.: The Broad Consequences of Medical and Dental Bills," KFF, June 16, 2022, https://www.kff.org/report-section/kff-health-care-debt-survey-main-findings/; Glenn Flores et al., "The Health and Healthcare Impact of Providing Insurance Coverage to Uninsured Children: A Prospective Observational Study," *BMC Public Health* 17 (May 2017), https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-017-4363-z; Jennifer E. DeVoe et al., "'Mind the Gap' in Children's Health Insurance Coverage: Does the Length of a Child's Coverage Gap Matter?" *Ambulatory Pediatrics* 17 (March 2008), https://www.sciencedirect.com/science/article/pii/S153015670700216X

[7] December 22, 2023 letter from the Centers for Medicare and Medicaid Services to the state of Indiana, available at https://www.medicaid.gov/sites/default/files/2023-12/in-cms-ltr-to-the-state-12222023_1.pdf

[8] "Fact Sheet: The President's Budget for Fiscal Year 2025," The White House, March 11, 2024, https://www.whitehouse.gov/briefing-room/statements-releases/2024/03/11/fact-sheet-the-presidents-budget-for-fiscal-year-2025/

[9] Florida Agency for Health Care Administration, Children's Health Insurance Program Eligibility Extension, Section 1115 Title XXI Research Demonstration New 5-Year Demonstration Request, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chip-elig-03202024-pa.pdf

Research specific to separate CHIP programs indicates similar effects of premiums as found in Medicaid.[10] (Note that all of these studies were conducted before the CAA's 12-month continuous eligibility provision, which prohibits states from disenrolling children for non-payment of premiums after the first month of enrollment, went into effect.) A study of premiums in separate CHIP programs in Kansas, Kentucky, and New Hampshire found premium increases were associated with lower caseloads in all three states. In New Hampshire, where the upper income threshold for separate CHIP was 300 percent FPL, raising premiums by $5 led to reductions in new enrollment and faster disenrollment. On average, the increased premium reduced new enrollment each month by 17.7 percent. These effects were even greater among the 185 percent to 250 percent FPL eligibility group. In New Hampshire, only 3.1 percent of children who were disenrolled in a given month were later re-enrolled following a one-month gap in coverage.[11] Studies in Georgia on separate CHIP premiums for children in families between 101 and 235 percent FPL found that increases in premiums increased the likelihood of children exiting public coverage; in one study, an increase in monthly premiums between $5 to $15 led to an estimated 3 to 9 percent enrollment loss.[12]

A study using a decade of national data to estimate the impact of increased premiums in Medicaid or CHIP on children in families above 150 percent FPL found that a $10 increase in monthly premiums is associated with 1.6 percentage point reduction in Medicaid or CHIP coverage, and this increase in uninsurance is likely higher among those children whose parents do not have access to employer-sponsored insurance.[13] Two studies looking at the impact of a premium increase in CHIP of $120 annually for children in families between 100 and 300 percent FPL found decreases in public coverage rates by 1.4 percentage points and 3.1 percentage points, as well as a 1.09 percentage point increase in the uninsured rate.[14]

These harmful effects of premiums in CHIP programs have also been seen in Florida specifically. In July 2003, Florida increased Healthy Kids premiums for all enrollees from $15 to $20 (however, CMS later determined that the $20 premium exceeded federal cost sharing limits for families with incomes below 150 percent FPL, and premiums for this group subsequently were reduced to $15 and remained at $20 for families between 151 and 200 percent FPL). A study looking at the impact of the temporary increase found that children across all health status categories experienced a decrease in enrollment in the months immediately following the premium increase (by 61 percent for children in families with incomes between 101-150 percent FPL, and 55 percent for the 151-200 percent FPL eligibility category). Despite some recovery following the reduction back to

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[10] Separate CHIP programs are governed by Title XXI of the Social Security Act, which has less stringent rules on premiums than govern Title XIX CHIP plans where states use CHIP funding to expand their child Medicaid programs.

[11] Genevieve Kenney et al., "Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States," *INQUIRY: The Journal of Health Care Organization, Provision and Financing* 43 (November 2006), https://journals.sagepub.com/doi/abs/10.5034/inquiryjrnl_43.4.378

[12] James Marton et al., "Estimating Premium Sensitivity for Children's Public Health Insurance: Selection but No Death Spiral," *Health Services Research* 50 (April 2015), https://onlinelibrary.wiley.com/doi/full/10.1111/1475-6773.12221; James Marton et al., "SCHIP Premiums, Enrollment, and Expenditures: A Two State, Competing Risk Analysis," *Health Economics* 19 (July 2010) https://onlinelibrary.wiley.com/doi/abs/10.1002/hec.1514

[13] Salam Adbus et al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33 (August 2014), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.0182

[14] Genevieve Kenney et al., "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence of 1999 to 2003," *INQUIRY: The Journal of Health Care Organization, Provision and Financing* 43 (November 2006), https://journals.sagepub.com/doi/epdf/10.5034/inquiryjrnl_43.4.345; Jack Hadley et al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," *INQUIRY: The Journal of Health Care Organization, Provision and Financing* 43 (November 2006), https://journals.sagepub.com/doi/epdf/10.5034/inquiryjrnl_43.4.362

$15 for the lower income group, decreased enrollment lengths remained below pre-premium increase levels throughout the year following the increase.[15]

Evidence makes clear the harmful impact of premium increases in separate CHIP programs across eligibility groups. Simply put, premiums create a barrier to enrolling and retaining health coverage for children in low and moderate wage working families and increase the likelihood that these children will be uninsured. Significant impacts of premium imposition and increases are seen even at seemingly small dollar amounts. CMS should ensure that any premiums imposed by the state are not disruptive to coverage and the objectives of Title XXI and its overall limit on premiums and cost-sharing of five percent.

The proposed demonstration does not comply with federal continuous eligibility requirements.

The application before you does not explicitly ask for a waiver of any provisions of federal law; but the state requests the equivalent expenditure authority to impose its premium structure, specifically including continued disenrollment for nonpayment of monthly premiums.[16] In addition, the enrollment projections in the demonstration make clear that the state plans to continue to disenroll children for nonpayment of premiums, in contravention of federal law. This request should be denied.

As noted above, CMS's October 27th FAQ prohibits states from disenrolling children for non-payment of premiums after the first month of enrollment because this would violate the statutory guarantee of 12 months continuous eligibility for children enrolled in Medicaid or CHIP, which was afforded by the CAA.[17] This is an important protection that ensures that children do not become uninsured for some period of time. Therefore, CMS should not allow Florida to terminate coverage for a child (at any income level) if their family fails to make a premium payment, in accordance with federal law. The state has not provided a compelling demonstration hypothesis to justify this loss of coverage.

Florida did not comply fully with federal transparency requirements in its submission of the Section 1115 request.

As you know, the department initially determined that the state's Section 1115 was not complete and it was sent back to the state for revision.[18] The resubmitted current version of the state's application attached all public comments received during the state public comment period but it did not, in our view, comply with §431.412(a)(viii) which requires states to report on "how the State considered those comments when developing the demonstration application." The state did not for example respond to the public comments it received that premiums are likely to create a barrier to enrollment for some families.

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[15] Jill Boylston Herndon et al., "The Effects of Premium Changes on SCHIP Enrollment Duration," *Health Services Research* 43 (April 2008), https://onlinelibrary.wiley.com/doi/abs/10.1111/j.1475-6773.2007.00777.x

[16] Op. cit. (9) (page 10).

[17] Op. cit. (2).; Op. cit. (3).

[18] See https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/fl-chldrn-hlth-insure-prgrm-elgblty-extnsn-cms-incmptns-lter.pdf

Our comments include citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for the purposes of the Administrative Procedure Act.

Thank you for your willingness to consider our comments. If you need additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

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