

February 7, 2020

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

Re: Georgia “Pathways to Coverage” Proposed Section 1115 Demonstration Project

Dear Secretary Azar,

The undersigned organizations appreciate the opportunity to comment on Georgia’s proposed section 1115 demonstration project, called “Pathways to Coverage.” Georgia’s proposal would provide coverage to adults with incomes at or below the poverty line who meet an 80-hour per month work requirement. Georgia is also asking to impose significant restrictions and requirements on eligibility for demonstration enrollees who manage to meet the monthly work requirement and also limit their benefits.

We urge you to disapprove this proposal, because it fails to promote Medicaid’s central objective of providing affordable coverage to vulnerable, low-income Georgians who are currently uninsured.

Georgia’s Proposal Falls Short on Coverage

At best, Georgia’s partial Medicaid expansion proposal would provide short periods of coverage to a small number of low-income adults who manage to meet a work requirement and pay unaffordable premiums. The proposal falls far short of full Medicaid expansion, which would provide affordable coverage to hundreds of thousands of Georgians.

By Georgia’s own estimates there are more than 660,000 uninsured Georgians with incomes below 138 percent of the poverty line.¹ Georgia estimates that between 487,000 and 598,000 Georgians would gain Medicaid coverage if the state implemented full expansion.² Yet the demonstration would only extend coverage to about 25,000 in the demonstration’s first year, according to the proposal-- an enrollment projection that’s likely too optimistic in light of its restrictive policies. Even by the fifth year of the demonstration, projected enrollment (52,000) is only about 10 percent of enrollment under full expansion.

The limited scope of Georgia’s proposal means that Georgia will continue to miss out on the benefits of Medicaid expansion, including a significant reduction in the state’s uninsured rate. Following implementation of Medicaid expansion, the uninsured rate among adults with incomes below 200 percent of the poverty line fell to 10.9 percent in expansion states compared to 20.6 percent in non-expansion states.³ Moreover, Medicaid expansion was associated with 19,200 fewer

¹ Georgia Department of Community Health Waiver Project, “Georgia Environmental Scan Report,” July 8, 2019, <https://medicaid.georgia.gov/document/publication/georgia-environmental-scan-report-posted-71819/download>

² Department of Audits and Accounts, “Fiscal Note (LC 46 0015),” January 18, 2019, https://opb.georgia.gov/sites/opb.georgia.gov/files/related_files/site_page/LC%2046%200015.pdf

³ Center on Budget and Policy Priorities. “Chart Book: The Far-Reaching Benefits of the Affordable Care Act’s Medicaid Expansion,” Updated November 6, 2019, <https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid>

premature deaths among adults aged 55-64 between 2014 and 2017, according to landmark research.⁴ State-by-state estimates based on this research suggest that 1,336 Georgians died prematurely because of the state's decision to reject Medicaid expansion.⁵

Studies show Medicaid expansion improves access to care. For example, Medicaid expansion in Arkansas and Kentucky resulted in larger gains in access to care for low-income adults than in Texas, a non-expansion state.⁶ In Louisiana, more than 355,000 people have visited a doctor since Medicaid was expanded, and tens of thousands of people have received screenings for breast or colon cancer.⁷ Hospital uncompensated care costs fell by an average of 55 percent in states that expanded Medicaid, compared to an 18 percent decline in states that did not expand.⁸

Georgia's Waiver Fails to Meet the Requirements of Section 1115

Section 1115 of the Social Security Act (the Act) provides the Secretary of Health and Human Services with authority to approve demonstration projects that promote Medicaid's objectives. To the extent needed to carry out such demonstrations, the Secretary can allow states to waive certain provisions of the Medicaid statute and provide federal matching funds for expenditures that aren't usually allowed under Medicaid, often called "expenditure authority."

Before the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) approved demonstration projects that expanded coverage to low-income adults without children who couldn't be covered under the Medicaid statute. These demonstration projects often included limits on coverage that weren't generally permissible under Medicaid law, such as enrollment caps, limited benefit packages, and higher than nominal cost-sharing, in large part to keep spending on the demonstration projects budget neutral to the federal government. Most states covering adults without children, for example, put limits on the number of adults they would cover, because open-ended coverage would have likely increased federal spending above their budget neutrality limits. These adults, who didn't have a pathway to Medicaid coverage in the statute prior to the ACA, were covered through expenditure authority. In other words, state expenditures on the services they received were matched even though they were not eligible for Medicaid. These demonstration projects promoted the objectives of Medicaid, because they provided coverage to low income people who couldn't otherwise have it.

With the ACA's expansion of coverage to adults with incomes at or below 138 percent of the poverty line, expenditure authority is no longer needed to match state expenditures on coverage for adults without children. There is now a direct pathway to coverage for all adults, unlike in the pre-

⁴ Sarah Miller *et al.*, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," National Bureau of Economic Research working paper, August 2019, <https://www.nber.org/papers/w26081>

⁵ Matt Broaddus and Aviva Aron-Dine, "Medicaid Expansion Has Saved at Least 19,000 Lives, New Research Finds," Center on Budget and Policy Priorities, November 6, 2019, <https://www.cbpp.org/research/health/medicaid-expansion-has-saved-at-least-19000-lives-new-research-finds>

⁶ Benjamin D. Sommers, Robert J. Blendon, E. John Orav, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *Journal of the American Medical Association*, October 2016, <https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420>

⁷ "Healthy Louisiana Medicaid Expansion Dashboard," Louisiana Department of Health, December 16, 2019, <http://www.ldh.la.gov/HealthyLaDashboard/>

⁸ Matt Broaddus, "ACA Medicaid Expansion Drove Large Drop in Uncompensated Care," Center on Budget and Policy Priorities, November 6, 2019, <https://www.cbpp.org/blog/aca-medicaid-expansion-drove-large-drop-in-uncompensated-care>

ACA days when expenditure authority was used to provide federal match for expenditures on a group not specifically mentioned in the Medicaid statute.

Yet CMS continues to undermine the ACA’s Medicaid expansion by approving restrictions on coverage for such adults that undermine the coverage Congress intended in the ACA. Georgia’s proposal goes even farther by conditioning eligibility on work and paying premiums for adults with incomes below the poverty line, covering just a sliver of those who would be eligible under a regular Medicaid expansion.

The Supreme Court’s NFIB decision held that states could choose whether to take up the ACA’s Medicaid expansion. However, once the state takes up expansion, it can’t pick and choose how to cover adults who would be eligible. As the district court said in *Stewart v. Azar*, nothing in the court’s analysis in NFIB “allows for ‘additional discretion’ in how the states comply with Medicaid requirements for the expansion population as compared to the traditional one.” Georgia’s totally inadequate proposal fails to promote the objectives of Medicaid, by applying unlawful restrictions on people who should be eligible under Medicaid expansion.

Georgia’s Proposal Further Undermines Coverage by Imposing a Work Requirement

In order to gain coverage under Georgia’s proposal, applicants must demonstrate that they’re working or participating in work-related activities for 80 hours per month. There are no exemptions from the work requirement, meaning people who cannot work due to a disability, serious illness, or caregiving responsibilities could not get coverage. By its very nature, the proposal would exclude a significant number of people who would be entitled to coverage under Medicaid expansion. While nearly 60 percent of Medicaid beneficiaries are working, 35 percent of those not working reported that illness or a disability was the primary reason and 28 percent reported that they were taking care of home or family.⁹

Georgia’s proposal includes complex reporting requirements. Such requirements themselves have caused loss of coverage in Arkansas.¹⁰ Enrollees must report their hours monthly by attesting to meeting the requirements and submitting a paystub or other supporting documentation in-person or through an online portal. Those who don’t meet the requirement would face suspension of their benefits. If they don’t meet the requirements for three consecutive months following the suspension, they will lose their coverage altogether. Those who manage to show that they have met the requirement for six months would be exempt from some of the reporting requirements, but they would still have to inform the state if their employment status changes, such as increases and decreases in hours.

Many of those who are working would have trouble meeting a strict 80-hour per month work requirement. As noted, most non-elderly adult Medicaid beneficiaries already work, but in low-wage jobs that generally do not offer health insurance. The two industries that employ the most Medicaid enrollees potentially subject to work requirements are restaurant/food services and construction,

⁹ Rachel Garfield, Robin Rudowitz, and Anthony Damico, “Understanding the Intersection of Medicaid and Work,” Kaiser Family Foundation, January 5, 2018, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

¹⁰ Benjamin Sommers *et al.*, “Medicaid Work Requirements — Results from the First Year in Arkansas,” *New England Journal of Medicine*, June 2019, <https://www.nejm.org/doi/full/10.1056/NEJMSr1901772>.

with large numbers also working in grocery stores, department and discount stores, and the home health industry.¹¹

These industries are characterized by volatile hours and little flexibility. This creates two problems for beneficiaries. First, low-wage workers may have difficulty meeting the hours requirement each month. Nationally 46 percent of low-income *working* adults who could be subject to Medicaid work requirements would be at risk of losing coverage for one or more months because they wouldn't meet the 80-hour requirement in every month according to an analysis by the Center on Budget and Policy Priorities.¹²

The volatility in hours for low wage work would also create confusion for any beneficiaries who are exempt from the reporting requirements after meeting them for six months. The penalty for failure to report a change in employment status is significant. The proposal states that beneficiaries who do not report an employment status change would be liable for all incurred capitation rate expenses paid on the member's behalf, as well as any cost-sharing expenses. In addition, penalties such as these violate Medicaid rules.¹³

Premiums Will Decrease Coverage and Create Additional Barriers to Health Care

Georgia's proposal would charge monthly premiums to enrollees with incomes above 50 percent of the poverty line ranging from \$7 per month to \$23 per month based on income, household composition, and tobacco usage.

Georgia's premium requirement goes farther than most other states, requiring premium payment as a condition of enrollment. Coverage would not begin until the first month following the payment of premiums. Once enrolled, beneficiaries would have to pay premiums each month or be disenrolled after three months of non-payment.

Extensive research (including research from Medicaid demonstration projects conducted prior to health reform) shows that premiums significantly reduce low-income people's participation in health coverage programs.¹⁴ These studies show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. People who lose coverage most often end up uninsured and unable to obtain needed health care services.

In proposing these premiums, Georgia is claiming to be preparing enrollees for a transition to commercial coverage. Evidence from experiments in other states, however, clearly shows that charging premiums makes it more likely that Medicaid beneficiaries lose their health coverage and become uninsured, or that they are less likely to sign up for coverage in the first place. Further, the

¹¹ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 5, 2018, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

¹² Judith Solomon, "Medicaid Work Requirements Can't Be Fixed," Center on Budget and Policy Priorities, January 10, 2019, https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed#_ftn17

¹³ Recovery would violate section 1913 of the Social Security Act, which limits recovery of benefits paid to Medicaid beneficiaries.

¹⁴ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," The Kaiser Family Foundation, June 2017, <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>.

“central objective” of the Medicaid program is to furnish Medicaid assistance to enrollees, *not* to prepare enrollees for commercial health insurance. An experiment that is likely to fail and result in people losing coverage and create barriers to care shouldn’t be approved under section 1115 of the Act.

Premiums and work requirements would both have a disparate impact on individuals with mental health and substance use conditions. Access to coverage and care is essential for these individuals to successfully manage and get on a path of recovery. Medicaid is the nation’s largest payer of behavioral health services, providing health coverage to 27 percent of adults with a serious mental illness. Medicaid delivers effective clinical and community-based supports to children and adults that allow people with mental health and substance use disorders to be successful at work, at school and at home. Because people with mental health conditions may experience periods of acute illness that impedes their ability to work during these times, work requirements and premium payments may interrupt their ability to quickly resolve an episode and return to work and maintain their recovery.

Georgia’s Proposal Includes Other Harmful Cuts That Do Not Promote the Objectives of Medicaid

Georgia’s proposal seeks to eliminate retroactive eligibility and the non-emergency medical transportation (NEMT) benefit for demonstration enrollees. Eliminating retroactive coverage is likely to result in increased uncompensated care for Medicaid providers and unaffordable medical bills for patients, **and** eliminating coverage for NEMT will reduce access to care. Nearly 4 million people miss or delay medical care each year because they lack access to affordable transportation, according to one study.¹⁵

Georgia’s Proposal Falls Short of Addressing the High Maternal Mortality Rate in Georgia

Women of reproductive age in Georgia would be far better served by full expansion of Medicaid up to 138 percent of the poverty line without a work requirement and other coverage restrictions. Medicaid expansion was associated with improved postpartum coverage and likely results in reductions in maternal mortality – a major crisis facing Georgia, according to a recent Harvard.¹⁶ States that haven’t expanded Medicaid already face higher rates of infant and maternal mortality.¹⁷ Georgia’s maternal mortality crisis is disproportionately affecting African American women in the state. Between 2012 and 2014, there were 101 pregnancy-related deaths in Georgia according to Georgia’s Maternal Mortality Review Committee; of these sixty percent of pregnancy-related deaths were among Black, non-Hispanic women.¹⁸

¹⁵ P. Hughes-Cromwick and R. Wallace, *et al.*, *Cost-Benefit Analysis of Providing Non-Emergency Medical Transportation*, Transit Cooperative Research Program (Oct. 2005), http://onlinepubs.trb.org/onlinepubs/tcrp/tcrp_webdoc_29.pdf.

¹⁶ Sarah H. Gordon *et al.*, “Effects of Medicaid Expansion on Postpartum Coverage and Outpatient Utilization,” *Health Affairs*, January 2020, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2019.00547>.

¹⁷ Adam Searing and Donna Cohen Ross, “Medicaid Expansion Fills Gaps in Maternal Health Coverage Leading to Healthier Moms and Babies,” Georgetown Center for Children and Families, May 2019, <https://ccf.georgetown.edu/wp-content/uploads/2019/05/Maternal-Health-3a.pdf>.

¹⁸ House Budget & Research Office, “Maternal Mortality in Georgia,” April 2019, [http://www.house.ga.gov/budget/Documents/2019 Session/2019 Policy Brief Maternal Mortality in Georgia.pdf](http://www.house.ga.gov/budget/Documents/2019%20Session/2019_Policy_Brief_Maternal_Mortality_in_Georgia.pdf).

By failing to expand Medicaid, Georgia not only places numerous restrictions on women who would be eligible under its proposal, it fails to follow recommended standards of care as recommended by the American College of Obstetricians and Gynecologists – that women are covered continuously before, during and after pregnancy.

Georgia’s HIPP Program Violates Federal Rules and Shouldn’t Be Expanded

Georgia currently operates an employer sponsored insurance (ESI) premium assistance program under its Medicaid State plan, the Health Insurance Premium Payment (HIPP) program. HIPP is authorized under section 1906 of the Act which allows states to enroll beneficiaries with access to ESI into their employer’s plan if it’s cost-effective to the Medicaid program.¹⁹ Under this authority, states can elect to make enrollment voluntary or mandatory, but federal law requires that participants receive all benefits and cost-sharing protections, including “all deductibles, coinsurance and other cost-sharing obligations” that would be afforded to them under Medicaid state plan coverage.²⁰ In the case of children, as you know, these cost-sharing protections are virtually absolute and prohibit coinsurance and deductibles for all mandatory coverage categories.²¹

Georgia’s HIPP program is voluntary for beneficiaries, and includes families where any member, including a child, is Medicaid eligible. However, the state is not operating its HIPP program in accordance with federal law. Specifically, the state’s “current HIPP program does not pay coinsurance or deductibles.”²² This violates the “wrap around” cost-sharing protections the state is required to provide. While outside the scope of the state’s section 1115 demonstration application, we urge CMS to review this matter, and take action on a potential compliance issue as outlined in 42 CFR 430 subpart C.

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.

Deductibles and coinsurance in private insurance can present serious barriers to care for low income families and individuals. Moreover, ensuring access to benefits guaranteed by Medicaid law is important to ensuring access and improving health outcomes. The state’s request should be denied.

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 purposes of the Administrative Procedure Act.

¹⁹ It is worth noting that “cost-effective” in this context, according to the state, refers to cost savings for the state and federal governments of a minimum of one dollar.

²⁰ See §1906(a)(3) of the Social Security Act

²¹ Centers for Medicare and Medicaid Services, “Cost Sharing,” accessed on January 23, 2020, <https://www.medicaid.gov/medicaid/cost-sharing/index.html>.

²² Georgia Medicaid, “Health Insurance Premium Payment Program (HIPP),” accessed on January 23, 2020, <https://medicaid.georgia.gov/third-party-liability/health-insurance-premium-payment-program-hipp>.

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

Autistic Self Advocacy Network
Center for Reproductive Rights
Center on Budget and Policy Priorities
Community Catalyst
Families USA
First Focus on Children
Georgetown University Center for Children and Families
Guttmacher Institute
Mental Health America
National Alliance on Mental Illness
National Health Care for the Homeless Council
National Multiple Sclerosis Society
Professor Pamela Herd, Professor of Public Policy, Georgetown University
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