May 13, 2022

VIA ELECTRONIC SUBMISSION

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

Re: Covered Connecticut Section 1115 Demonstration Application

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Connecticut's proposal for a section 1115 demonstration. The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax, and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

As directed by its 2023 state budget, Connecticut is requesting expenditure authority to provide additional premium subsidies and benefits for certain low-income adults in the Marketplace.[1] If approved and implemented, the demonstration would cover all premiums and cost-sharing as well as provide free dental and non-emergency medical transportation (NEMT) benefits to adults without dependent children with incomes between 138 and 175 percent of the poverty line and parents with incomes between 160 and 175 percent of poverty through enhanced Qualified Health Plans (QHPs). The state estimates that the program would help approximately 39,000 people afford coverage by its fifth year. *The demonstration would promote the objectives of Medicaid by increasing access to affordable coverage and we urge CMS to approve the proposal, subject to the recommendations below.* We also suggest some limits that CMS should apply to Medicaid demonstrations that wrap around Marketplace coverage.

Affordable coverage would support the objectives of Medicaid and promote health equity.

Prior to the implementation of the Affordable Care Act, Connecticut was one of just eight states that provided Medicaid to low-income parents with dependent children with incomes above 138

[1] Public Act No. 21-2, June Special Session (Connecticut 2021).

percent of poverty.[2] In 2015, the state lowered its eligibility level for parents on the assumption that they could enroll in subsidized Marketplace coverage. However, the Marketplace's complex enrollment process and the requirement to pay premiums and cost sharing, which did not apply to their Medicaid coverage, meant that a large share of parents did not successfully make the transition; only 61 percent of the affected parents were documented as retaining some form of coverage after the eligibility reduction.[3]

Seven years later, coverage remains out of reach for many low-income parents and other adults. The cost of employer-sponsored family coverage rose 22 percent between 2016 and 2021, with employees shouldering the majority of the premium increase.[4] From 2016 to 2020, the Connecticut uninsured rate for adults with incomes under 200 percent of the poverty line rose from 12.7 to 14.6 percent.[5] Connecticut's demonstration application proposes to support parents left behind after ACA implementation and increase affordable coverage for other adults by building on the enhanced federal subsidies enacted in the American Rescue Plan Act of 2021. *We believe that subject to the conditions set out below, making Marketplace coverage free and more comprehensive for these adults would support the objectives of the Medicaid program by helping them obtain affordable, quality coverage.*

By facilitating access to coverage, this proposal has the potential to play an important role in reducing racial disparities.[6] According to data from 2019, nonelderly Black individuals in Connecticut had an uninsured rate of 7.0 percent compared to 4.8 percent for nonelderly white individuals; the uninsured rate for nonelderly Hispanic individuals was more than double the rate for white or Black individuals at 14.4 percent.[7] Periods of uninsurance lead to both delayed and missed care, contributing to stark disparities in health outcomes.[8] Stable access to coverage, on the other hand, promotes continuous access to care and reduces hospitalizations.[9] Further, coverage protects

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[2] Tricia Brooks *et al.,* "Medicaid and CHIP Eligibility and Enrollment Policies as of January 2022: Findings from a 50-State Survey," Kaiser Family Foundation, March 16, 2022, https://www.kff.org/medicaid/report/medicaid-and-chip-eligibility-and-enrollment-policies-as-of-january-2022-findings-from-a-50-state-survey/.

[3] "Potential Consequences of Proposal to Further Reduce Eligibility for HUSKY Insured Parents," Connecticut Health Foundation, April 2016, https://www.cthealth.org/wp-content/uploads/2016/04/CT-Health-HUSKY-Parents-2016-2.pdf.

[4] "2021 Employer Health Benefits Survey," Kaiser Family Foundation, November 10, 2021, https://www.kff.org/report-section/ehbs-2021-summary-of-findings/#figurea.

[5] "Health Insurance Coverage of Low Income Adults 19-64 (under 200% FPL) (CPS)," Kaiser Family Foundation, https://www.kff.org/other/state-indicator/health-insurance-coverage-of-low-income-adults-19-64-under-200-fpl-cps/?activeTab=graph&currentTimeframe=0&startTimeframe=2&selectedDistributions=uninsured&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[6] "Request for Action on Pending Section 1115 Demonstrations to Reduce Racial Disparities," Letter to Secretary of Health and Human Services, July 2020, https://ccf.georgetown.edu/wp-content/uploads/2020/12/Medicaid_Supporting-Black-Women-Sign-On-Letter.pdf.

[7] "Uninsured Rates for the Nonelderly by Race/Ethnicity," Kaiser Family Foundation, https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

[8] Sarah Sugar *et al.*, "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic," April 2021, https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//199881/medicaid-churning-ib.pdf.

[9] Ibid; Harry H. Liu *et al.*, "New York State 1115 Demonstration Independent Evaluation: Interim Report," Rand Corporation, 2021, https://www.health.ny.gov/health_care/medicaid/redesign/mrt2/ext_request/docs/2021-08-03_1115_demo_eval.pdf#page=110.

against the accrual of medical debt, which disproportionately burdens individuals of color.[10] Improved financial security, in turn, leads to lower levels of toxic stress and its associated physiological symptoms.[11] Through the demonstration, Connecticut proposes to test if making Marketplace coverage more accessible and comprehensive helps ameliorate coverage and cost-burden disparities. *Thus, the demonstration presents a promising hypothesis and serves a valid experimental purpose. The state should be applauded for proposing to study the equity impact of the demonstration in its evaluation.*

In order to further the experimental purpose, the state should also include a robust evaluation of NEMT services. In addition to measuring the NEMT ride-days per beneficiary, the state should conduct a difference-in-difference survey of perceived access to care for individuals with incomes above and below 175 percent of the poverty line.

Access to affordable coverage is especially critical for parents and other adults as the COVID-19-related Public Health Emergency unwinds.

The continuous eligibility protection enacted as part of the Families First Coronavirus Response Act has successfully protected many beneficiaries in Connecticut from losing coverage due to changes in income since March 2020. Between February 2020 and December 2021, Connecticut's adult enrollment in Medicaid grew by 18.7 percent to 609,488.[12] However, national estimates predict that when the PHE ends and eligibility redeterminations resume up to 20 percent of beneficiaries will have to find a new source of coverage or become uninsured.[13] For adults, the Marketplace will be the most likely source of affordable coverage. If the state conducts robust outreach informing beneficiaries transitioning off Medicaid of the opt-in enrollment procedure for Marketplace coverage, *Connecticut's proposed zero-dollar premium and cost-sharing wrap in the Marketplace could help parents and other adults stay covered.* Children with parents in the income range targeted by the demonstration will remain eligible for Medicaid, and the state should take great care to ensure that they are not erroneously enrolled in the Marketplace which does not offer children the Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit.

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[10] Sara R. Collins, Munira Z. Gunja, and Gabriella N. Aboulafia, "U.S. Health Insurance Coverage in 2020: A Looming Crisis in Affordability—Findings from the Commonwealth Fund Biennial Health Insurance Survey," The Commonwealth Fund, August 2020, https://www.commonwealthfund.org/sites/default/files/2020-08/PDF_Collins_looming_crisis_affordability_biennial_2020_exhibits.pdf#page=6; Matthew Rae *et al.*, "The Burden of Medical Debt in the United States," Kaiser Family Foundation, March 10, 2022, https://www.kff.org/health-costs/issue-brief/the-burden-of-medical-debt-in-the-united-states/.

[11] Jack P. Shonkoff, Natalie Slopen, and David R. Williams, "Early Childhood Adversity, Toxic Stress, and the Impacts of Racism on the Foundations of Health," *Annual Review of Public Health* 42, no. 1, April 2021, https://www.annualreviews.org/doi/abs/10.1146/annurev-publhealth-090419-101940; Daniel Brisson, "A Systematic Review of the Association between Poverty and Biomarkers of Toxic Stress," *Journal of Evidence-Based Social Work* 17, no. 6, July 12, 2020, https://www.tandfonline.com/doi/abs/10.1080/26408066.2020.1769786.

[12] Georgetown University Center for Children and Families analysis of Centers for Medicare and Medicaid Services' "State Medicaid and CHIP Applications, Eligibility Determinations, and Enrollment Data," April 28, 2022, https://data.medicaid.gov/dataset/6165f45b-ca93-5bb5-9d06-db29c692a360.

[13] Matthew Buettgens and Andrew Green, "What Will Happen to Medicaid Enrollees' Health Coverage after the Public Health Emergency?: Updated Projections of Medicaid Coverage and Costs," Urban Institute, March 9, 2022, https://www.urban.org/research/publication/what-will-happen-medicaid-enrollees-health-coverage-after-public-health-emergency.

CMS should only approve benefit wraps selectively, and only for expansion populations or services.

Medicaid provides a robust, congressionally-designed benefit package and set of beneficiary protections that are unavailable in private coverage. For example, Medicaid's unique open formulary requirement ensures that low-income beneficiaries with complex needs have access to *all* Food and Drug Administration-approved prescription drugs, while QHPs in the Marketplace are permitted to restrict their formularies.[14] And, in managed care states, federal Medicaid regulations grant beneficiaries strong network adequacy protections not present in the Marketplace including the right to family planning services from out-of-network providers and the right to leave a plan with an inadequate network.[15] Medicaid beneficiaries also possess due process protections and appeal rights which help substantiate and enforce these benefits and other protections. Furthermore, attempts to wrap Medicaid around private coverage generally create inefficiencies and confusion that results in barriers to care.[16] Therefore, full Medicaid coverage without wraps is the best way to provide health coverage to lower income populations. (We note that in this regard, Connecticut's demonstration differs from other wrap designs in that the benefits of dental and NEMT are discrete additions, so it may cause less confusion than other wraps.) CMS policy should generally prioritize full Medicaid coverage and minimize use of wraps to support private coverage.

CMS should also maintain clear limits on how expenditure authority can be used to subvert minimum Medicaid standards, such as using a benefit wrap. Regardless of what CMS decides for Connecticut's request to *expand* coverage using a wrap, CMS should not grant expenditure authority for a Medicaid wrap around private coverage for a mandatory Medicaid group or individuals with income below 138 percent of the poverty line. For such populations, Congress has spoken clearly as to how their Medicaid coverage should be administered, to the exclusion of other possibilities. For wrap requests relating to uncovered groups (classic "expansion populations") or expanded services, CMS should also consider the context and timing of the request: CMS should not approve requests immediately after a state has dropped Medicaid coverage. In other words, CMS should not do anything that might allow or encourage states to move optional groups to the Marketplace and then wrap with Medicaid. Ultimately, CMS should approve benefit wraps very rarely, and only if, like Connecticut's proposal, they clearly increase coverage, have experimental value, and do not create barriers for mandatory populations (or individuals with incomes below 138 percent of the poverty line).

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[14] 45 C.F.R. § 156.122(b).

[15] Adam Sonfield, "A Fragmented System: Ensuring Comprehensive Contraceptive Coverage in All U.S. Health Insurance Plans," Guttmacher Institute, February 2, 2021, https://www.guttmacher.org/gpr/2021/02/fragmented-system-ensuring-comprehensive-contraceptive-coverage-all-us-health-insurance; Sabrina Corlette *et al.,* "Assessing Federal and State Network Adequacy Standards for Medicaid and the Marketplace," The Robert Wood Johnson Foundation, March 30, 2022, https://www.rwjf.org/en/library/research/2022/03/assessing-federal-and-state-network-adequacy-standards-for-medicaid-and-the-marketplace.html.

[16] Joan Alker *et al.*, "Medicaid Premium Assistance Programs: What Information is Available About Benefit and Cost-Sharing Wrap-Around Coverage?" Kaiser Family Foundation, December 1, 2015, https://www.kff.org/medicaid/issue-brief/medicaid-premium-assistance-programs-what-information-is-available-about-benefit-and-cost-sharing-wrap-around-coverage/.

CMS should clarify that the demonstration populations are Medicaid enrollees, that must receive due process and cannot be subject to coverage caps.

Any CMS approval should clarify that demonstration enrollees are Medicaid enrollees entitled to Medicaid benefits and standards. More specifically, we make two recommendations. First, CMS should clarify that demonstration enrollees are Medicaid enrollees, and that the additional benefits in the demonstration (dental benefits, NEMT, and premium and cost-sharing elimination) are Medicaid benefits, and that all relevant Medicaid standards and due process protections apply.

Second, CMS should not allow any coverage caps in the demonstration. Although the legislative language mandating the creation of the program does not mention currently enhanced federal premium tax credits, the demonstration application predicates the coverage expansion on the continuation of the enhanced premium subsidies included in the American Rescue Plan Act of 2021 (P.L. 117-2). The state's application lists several contingency options in case the enhanced subsidies sunset at the end of 2022, including using more state funds, terminating the demonstration, lowering the eligibility level, cutting benefits, *or capping enrollment in the demonstration*. If the enhanced subsidies expire, ideally the state would appropriate more money to continue the demonstration. Though less desirable, the state could also reduce income eligibility or benefits. However, capping enrollment should not be permitted for these Medicaid populations. Caps would also lead to an unfair and arbitrary situation in which some individuals have access while others who are similarly positioned do not. Moreover, CMS should not give Connecticut permission to make major changes in eligibility and benefits after approval of the demonstration without following the process for amending its demonstration, including notice and comment.

Conclusion

Our comments include numerous 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.

Thank you for consideration of our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).