Organizations that Submitted Written Comments for New York's Draft 1332 Waiver
February 9, 2023 - March 11, 2023

1. 1199SEIU (United Healthcare Workers East)
2. Center for the Independence of the Disabled, NY (CIDNY)
3. Citizen Action of New York
4. Coalition of New York State Public Health Plans
5. Community Health Care Association of New York State
6. Community Healthcare Network (CHN)
7. Community Service Society of New York (CSS)
8. CUNY Graduate School of Public Health and Health Policy (CUNY SPH)
9. Empire Justice Center
10. Greater New York Hospital Association
11. Health Care for All New York (HCFANY)
12. Healthcare Association of New York State (HANYS)
13. Labor-Religion Coalition of NYS
14. Make the Road New York (MRNY)
15. Medicaid Matters New York
16. Medical Society of the State of New York (MSSNY)
17. New York City Department of Health and Mental Hygiene
18. New York Health Foundation (NYHealth)
19. New York Health Plan Association (HPA)
20. New York State Nurses Association
21. NYC Family Advocacy and Information Resource (FAIR)
22. NYS Coalition for Children's Behavioral Health (CCBH)
23. NYU Wagner Graduate School of Public Service, Dean Sherry Glied and Professor Laura Wherry
24. Pharmaceutical Research and Manufacturers of America (PhRMA)
25. Planned Parenthood Empire State Acts (PPESA)
26. Primary Care Development Corporation (PCDC)
27. Schuyler Center for Analysis and Advocacy
28. The Legal Aid Society
29. United Hospital Fund (UHF)
30. Letter From Multiple Associations
    - American Heart Association
    - American Lung Association
    - Cancer Action Network
    - Epilepsy Foundation
    - Hemophilia Federation of American
    - Immune Deficiency Foundation
    - Leukemia & Lymphoma Society
    - National Multiple Sclerosis Society
    - National Organization for Rare Disorders

1199SEIU United Healthcare Workers East

1199SEIU Comments regarding the New York State 1332 Innovation Waiver Proposal

1199SEIU's 350,000 members work in nearly every healthcare settings across New York – hospitals, nursing homes, clinics, community based organizations, in clients' homes, and other locations. Our Union's mission has always been to provide high quality healthcare to all regardless of income or origin.

New York has done an admirable job of extending the Medicaid program to many New Yorkers. However, there continue to be gaps in coverage and the 1332 Innovation Waiver provides an opportunity to close one of the gaps by extending New York's Essential Plan to undocumented New Yorkers.

New York's 1332 waiver proposal does take positive steps to improve by making the Essential Plan more affordable for people between 200%-250% of the Federal Poverty Level (FPL). We strongly support this extension, which will benefit working people who are still struggling to afford healthcare. However, the proposal does not fulfill the state's commitment extend coverage to immigrants below 250% of FPL and We strongly encourage you to include these New Yorkers in the 1332 waiver proposal.

Providing coverage through the waiver for our neighbors who are currently unable to access coverage because of their immigration status will not only support these individuals, it will strengthen healthcare for all New Yorkers. The Emergency Medicaid system, while a vital safety net, is not comprehensive coverage. Coverage through the Essential Plan will ensure that enrollees are not waiting to seek care until they are sick enough to qualify for Emergency Medicaid and allow them to seek more care outside of our overcrowded emergency rooms. It will also ensure providers are paid at higher rates for the services.

Providing coverage to this population is not only the right thing to do, it will allow the state to reduce its spending on emergency Medicaid. It can also be paid for through the Essential Plan's ongoing surplus, without the need for additional state spending. The Essential Plan's annual surplus has averaged nearly $2 billion since 2019 and the estimated cost to extend coverage to this population is roughly $540 million including savings from state and local emergency Medicaid spending.

New York has a broad goal of providing access to care to all New Yorkers to keep our residents healthy and out of emergency rooms for their only access to care. Extending the Essential Plan to undocumented New Yorkers below 250% FPL will further these goals and is another step to close the remaining coverage gaps for New Yorkers.

Helen Schaub
Vice President, Interim Political Director
Helen.schaub@1199.org

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New York State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

RE: New York's 1332 Waiver

To NYSOH:

Center for the Independence of the Disabled, NY (CIDNY) is a non-profit organization founded in 1978 with the goal to ensure full integration, independence, and equal opportunity for all people with disabilities by removing barriers to full participation in the community. Our mission is to help people access the care and services people with disabilities need to live independently in the community and not in institutions like nursing facilities, psychiatric centers, prisons, and other congregate settings. We help people enroll in and use public and private health coverage which is very important to people with disabilities, including immigrants with disabilities, to live independently.

CIDNY opposes this waiver as submitted, because it excludes immigrants. CIDNY supports extension of the Essential Plan to provide health insurance for all income-eligible New Yorkers regardless of immigration status. Immigrants have some of the highest uninsured rates in New York. Some undocumented immigrants in New York State are eligible for Medicaid (pregnant women) or Child Health Plus (children under 19), but about 245,000 New Yorkers remain uninsured because of their immigration status.

Last year Governor Hochul promised to include immigrant coverage in a 1332 Waiver application to CMS that would use the Basic Health Plan/ Essential Plan Trust fund, which has a current surplus and increases $2 billion each year, to fund in immigrant coverage and increased income eligibility to 250% of the Federal Poverty Level. Inexplicably the Governor's Executive Budget and the waiver application submitted on February 9th excluded immigrants and only increased eligibility from 200% to 250% of the Federal Poverty Level (FPL). This waiver would only expand insurance to 20,000 additional New Yorkers out of the 1 million who remain uninsured.

We were surprised to hear for the first time some of the rationales for excluding immigrants from the waiver at the Joint Budget Hearing of the Senate Finance Committee and the Assembly Ways and Means Committee on the Executive Budget for Health.

It was alleged that CMS would not approve this inclusion through a 1332 waiver so New York should not bother asking. In 2022 CMS granted 1332 waivers for Colorado and Washington states. Both states have set up coverage programs for undocumented immigrants with their 1332 "passthrough" accounts. There is no harm in New York asking for immigrant coverage in its 1332 waiver. At worst it is denied and there would be an opportunity to negotiate.

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We have heard that New York cannot spend its $9 b. accumulated surplus on immigrants. While the $9 b. Essential Plan Trust Fund cannot be spent on new enrollees, the $2 b. surplus generated each year could. That is exactly what Colorado and Washington are doing with their "passthrough" accounts.

The administration has said that there are 300,000 immigrants in our existing Emergency Medicaid program which just goes to 138% of the Federal Poverty Level. This number is in inflated because no enrollee has been recertified for three due to the Public Health Emergency. In 2021 there were only 128,000 users of the Emergency Medicaid program.

The census indicates that there are only 685,000 foreign born New Yorkers with incomes below 200% FPL. Most (77%) are lawfully present and are already eligible for coverage. This means that there are only 158,000 undocumented immigrants in out state with incomes below 200% FPL. In New York City, 58% of people with disabilities have incomes below 200% of the Federal Poverty Level. Some of these New Yorkers with disabilities are undocumented immigrants. Even if 255,000 immigrants enroll in EP through the waiver, using the rates set by the NYS Department of Health actuaries it would cost just $1.2 billion. If a larger number of immigrants enroll, New York could cap the program at a certain number of enrollees

It is better for patients and for the public health to offer comprehensive coverage with preventive care and pharmacy than coverage for only emergency care when and immigrant's medical condition puts them into dire circumstances after they go without care. New York spends more than $500 million on Emergency Medicaid each year that could be repurposed for other budget priorities if we used the annual surplus instead Other savings that could be had are a reduction in uncompensated care spending for our vital safety net hospitals. And New York City could save $100 million by retiring its NYC Cares program, since the population would be eligible for health insurance.

Colorado and Washington have obtained permission from CMS to cover immigrants using 1332 Waivers. Expanding public health insurance has numerous benefits including keeping hospitals open in rural and underserved communities and protecting people from medical debt. New York should do the right thing and include immigrants in its waiver application to CMS.

Thank you for your consideration of our comments and those of our colleagues.

94 Central Avenue, Albany, NY 12206

March 7, 2023

The Honorable Kathy Hochul
Governor of New York State
New York State Capitol Building
Albany, NY 12224

The Honorable James McDonald, MD, MPH
Acting Commissioner of Health
Corning Tower, Empire State Plaza
Albany, NY 12237

Re: 1332 State Innovation Waiver -- federal funds should be used to pay for Healthcare Coverage for All

Dear Governor Hochul and Commissioner McDonald:

I represent Citizen Action of New York, a membership organization dedicated to social, racial, economic and environmental justice with eight chapters and affiliates across New York. Citizen Action for decades has advocated for expansion of health coverage in New York State and nationally.

We oppose the 1332 State Innovation Waiver application as drafted because it excludes immigrants.

Last year, the Administration said it would reach out to the federal government to file a federal Waiver to ask for funding to expand the Essential Plan to cover all low-income New Yorkers -- including immigrants.

Providing health insurance for immigrant communities -- including hundreds of thousands of essential workers who have kept our state functioning during a three-year pandemic -- is both morally and fiscally responsible. Expanding coverage would come at no cost to the state and would avoid $500 million in annual Emergency Medicaid costs incurred when uninsured immigrant patients seek emergency care at our hospitals. It would also increase revenues for our health care providers by providing them with Essential Plan rates instead of Medicaid rates, which are lower, and reduce the amount of uncompensated care they provide.

Including immigrants in the Waiver application will cost the state nothing, and in fact, generate budget savings. The State's Essential Plan Trust Fund Account is estimated to generate a $2 billion annual surplus annually for the foreseeable future (Empire Center, March 3, 2023). Federal rules say trust funds can only be used to pay for health insurance coverage. The state's waiver application should use the annual $2 billion surplus in federal funding to pay for expanded coverage for immigrants through its 1332 "passthrough account." Even using the most conservative assumptions, expanded coverage for ineligible immigrants is estimated to cost at the very most $1.2 billion for 255,000 enrollees, and so the surplus would be more than enough to cover the costs.

New York should join other states like Colorado, Illinois, Washington, and California in recognizing health insurance as a human right by extending coverage to immigrant communities.

We are all safer in the face of global public health threats when everyone has access to quality preventive healthcare. Including immigrants in the 1332 Wavier -- just like Colorado and Washington states have done -- is both economically sensible and the right thing to do.

Unless you revise the State Innovation Waiver application to include New York's immigrants and include this provision in the Fiscal Year 2023-24 state budget, Citizen Action opposes the State's Waiver application. If you have any questions concerning this letter, I may be reached at urozum@citizenactionny.org.

Sincerely,

Ursula Rozum
Statewide Healthcare Organizer

We are writing to submit comments on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition") regarding the State's proposed Section 1332 State Innovation Waiver.

The PHP Coalition represents eight health plans that serve more than 5.6 million New Yorkers enrolled in the State's government-sponsored healthcare programs: "Mainstream" Medicaid Managed Care (MMC), HIV Special Needs Plans (HIV SNPs), Health and Recovery Plans (HARPs), Child Health Plus (CHP), Essential Plan (EP), and subsidized Qualified Health Plan (QHP) coverage offered through the New York State of Health Marketplace. Three out of four New Yorkers enrolled in an EP or QHP are covered by a PHP Coalition plan.

The PHP Coalition is a committed partner to expanding health insurance coverage and access to health care services, while also improving healthcare quality, for the lowest-income New Yorkers. Coalition plans specialize in delivering high-quality services to populations that have traditionally faced barriers to care, with the goal of improving health and reducing health-related disparities.

In general, the Coalition strongly supports the State's many efforts in recent years to expand health care coverage – we share the State's goal to move toward universal, affordable, comprehensive coverage for all New Yorkers. The comments that follow on the 1332 State Innovation Waiver stem from the Coalition's extensive expertise managing care for people in EP and QHPs, and reflect our commitment to preserve, strengthen, and expand New York's public healthcare coverage programs.

Support for the Essential Plan Expansion

The PHP Coalition believes that the EP program is a fundamental, high quality, and popular component of New York's public healthcare coverage continuum, and we welcome the State's interest to expand it. The EP already provides low- to zero-cost coverage for comprehensive benefits (including dental and vision) to low-income New Yorkers through a robust and high quality network of providers. In addition, the flexibility and funding offered by the EP program has allowed health plans to make significant investments in advancing quality improvement and health equity and expanded health care access for people who traditionally face the most barriers to care.

Therefore, the PHP Coalition strongly supports the core goal of the 1332 State Innovation Waiver: expanding eligibility for EP beyond 200% of the federal poverty level (FPL), up to 250% FPL. Doing so will have a materially positive impact on consumers in that income range without impacting those who are already eligible for or enrolled in the EP now. As noted by the waiver application, the cost-sharing burden for this group may decrease by about $1,950 – improving overall affordability on average by $7,400 annually from 2024-2028, when coupled with the average $5,450 annual savings on premiums. The shift to EP for these consumers would also likely expand access to providers for a wider range of benefits, like vision and dental, access to which can be uniquely challenging for lower-income New Yorkers. **We also support the proposed waiver's continuation of the EP Quality Incentive Program that has allowed plans to make numerous investments in providers and services to advance health equity.**

Before the release of the draft waiver application, the PHP Coalition understood that the State had considered expanding EP up to 250% FPL for all New York residents, regardless of their immigration

status. However, the proposed waiver does not effectuate this change. There are approximately 245,000 New Yorkers between the ages of 19 and 64 who remain uninsured because of their immigration status. Expanding the EP to include these individuals would not only improve access to preventative care and more appropriate utilization of healthcare services, it could create a savings of over $500 million for the State which is currently being spent on emergency Medicaid and uncompensated care for those who are uninsured due to their immigration status.[1,2] **The PHP Coalition strongly supports adding eligibility for all New York residents up to 250% FPL, regardless of immigration status, as another step toward more equitable and comprehensive coverage.**

The necessary shift in federal authority itself (from 1331 Basic Health Program to a 1332 State Innovation Waiver) to accomplish the expansion up to 250% FPL does not significantly impact our comments, except that the shift could impact the availability of the EP Trust Fund, a significant pool of largely untapped resources that could be used for a variety of purposes, such as reducing cost-sharing and improving quality in the EP program. **The PHP Coalition strongly supports the State's request to maintain access to the EP Trust Fund for currently allowable uses and recommends that the State leverage these considerable dollars to improve consumer affordability for those already eligible for EP during the transition, where possible.**

Implications for Health Plans and Members in the QHP Market and Recommendations

While we support the proposed 1332 State Innovation Waiver, it raises important questions about the State's long-term vision for the QHP market. Namely, plans have existing concerns about the financial sustainability of the QHP product as membership shrinks statewide and adverse selection persists due to the program's monthly premium and high cost sharing expenses (despite premium tax credits and cost-sharing reductions). The proposed waiver would likely exacerbate these concerns without intervention.

Size of the QHP Market

The proposed 1332 waiver program, if approved, will further shrink the State's already small QHP market. A smaller market increases risk. Total enrollment in QHPs across the State in December 2022 was 209,854 – which is much smaller than other comparably large states.[3] According to the waiver, the State expects approximately 90,000 people currently enrolled in a QHP to transition to the new EP 200-250 group, which is nearly half of the current Marketplace. It appears the State took into consideration the people who would shift out of Medicaid to QHP (in 2023 before the launch of the new waiver) and then shift into the EP at the conclusion of the resumption of recertifications in 2024; however, any small shifts in an already small market will have significant impact. **We recommend the State monitor these shifts in the QHP population and make adjustments to manage risk in the QHP market, as needed**.

Risk Pool and Premiums in the QHP Market

Consumer premiums and cost-sharing in the QHP market are already high, especially compared to EP, and the expansion of EP will increase premiums for QHPs further. The draft waiver application indicates that those left in the QHP market will likely be higher acuity and increase premiums for the unsubsidized

[1] https://www.politico.com/newsletters/weekly-new-york-health-care/2023/02/13/lawmakers-continue-fight-to-extend-health-insurance-to-undocumented-new-yorkers-00082412
[2] https://www.nysenate.gov/sites/default/files/make_the_road_ny-_mrny_.pdf
[3] https://info.nystateofhealth.ny.gov/enrollmentdata

population in the Marketplace by an additional 2.2% in 2024, resulting in small coverage losses. While the draft waiver application demonstrates the reduction in affordability falls within the acceptable range for Affordable Care Act standards, it does add another layer to existing issues.

Recommendations

The Coalition agrees that there will likely be a net positive gain in coverage, but removing the 90,000 people in the 200-250% FPL population, combined with the increased premiums and coverage losses for the unsubsidized population, raises questions about whether the QHP market is sustainable for some carriers in the long-term.

The State should therefore consider steps to bolster the QHP market:

- The application currently assumes carrier participation will not diminish as a result of the waiver but the long-term implications are a point of concern for plans that operate a QHP now. **The PHP Coalition recommends the State proactively develop a plan to mitigate the QHP market impact, including structural changes to ensure that plans remain in the market over time.**
- **The PHP Coalition also recommends that the Department of Financial Services review rate filings and ensure future rates are sufficient, given the proposed 1332 waiver.**
- Related, **we recommend the State consider mid-year rate updates for QHPs,** especially as the proposed waiver unfolds and there is more uncertainty about the changing population and risk pool.

Implementation Considerations and Recommendations

In addition to the PHP Coalition's concerns about the QHP market, plans would like to raise crucial operational questions that are unaddressed in the waiver application for the State's consideration.

Implementation Timeline and Stakeholder Engagement – We appreciate the application's detailed timeline for implementation; however, if approved, the implementation timeline will be compressed. **The Coalition strongly recommends close engagement with health plans during the proposed transition.** We would like to underscore the importance and necessity for member and provider engagement, and the PHP Coalition plans are prepared to partner with the State to conduct outreach to consumers and provider networks.

Auto-Assignment and QHP to EP Transfer – Generally, the Coalition supports automatically shifting members from EP to QHP to reduce administrative and consumer burden. Due to the limited timeframe in which this would occur, **the PHP Coalition recommends the State provide more details regarding how auto-assignment from QHP to EP will work and how plans and consumers will be notified.** For example, whether plans will receive information on QHP 834 files or other sources, or if the State will circulate model member notices. New guidance regarding auto-assignment will be particularly important for the small population of members currently enrolled in QHP with an insurer that does not have EP. Related, while there currently exists a high degree of overlap, **the PHP Coalition also recommends that the State clarify any new expectations or requirements for network overlap between QHP and EP as a result of the proposed waiver.**

Premiums – The State recently eliminated the $20 premium for EP groups 1 & 2, therefore none of EP groups currently have a premium. However, the proposed EP 200-250 group (i.e., the expansion

population between 200-250% FPL) will have a $15 premium. The PHP Coalition requests new guidance regarding these proposed premiums, including on the binder payments. For example, the State should consider outlining how binder payments will work for members that transition between the groups (e.g., going from EP 4 to EP 200-250 as a person's income changes). The Coalition also requests additional guidance regarding consumers who miss premium payments. Will enrollees be terminated after a certain number of days for not paying their premium? Are there limits to the number of times an enrollee can be terminated for non-payment before they are no longer allowed to enroll? **Overall**, **the Coalition recommends – where possible – alignment of these rules with previous processes and as much consistency with the QHP program as possible, to reduce member confusion and administrative effort.**

Supplemental Newborn Capitation Payments (i.e., "Kick Payments") – Currently, plans offering EP coverage do not receive reimbursement for newborns born in the EP program but receive supplemental payments in Medicaid when children are born to people in EP. The draft waiver application raises some questions about the specific processes and payments for newborns in EP. **The PHP Coalition strongly recommends the State consider a supplemental kick payment for newborn whose birthing parent is covered under EP.** Given the added costs associated with child birth and post-partum services, this is crucial to the financial sustainability of covering this population in EP.

Vision, Dental, and Long-Term Services and Supports – In the past, consumers in EP 1 or 2 would buy-in for vision and dental benefits, in addition to the prior $20 premium. **The Coalition recommends, if possible, including vision and dental as standard for the new EP 200-250 group, in order to reduce confusion between the different EP levels and maintain a rich level of benefits for everyone in EP.**

Further, the Fiscal Year (FY) 2024 Executive Budget Legislation that modifies the State's authority to apply for the proposed 1332 waiver includes an expansion of long-term services and supports (LTSS) to all EP groups, without cost-sharing. However, the draft waiver application does not include any reference to these services. **The Coalition requests the State clarify if it will pursue LTSS benefits for all EP premium groups through the 1332 State Innovation Waiver.**

Concluding Remarks

The PHP Coalition strongly support the core goals of the proposed 1332 State Innovation Waiver, albeit with concerns about the impact on QHPs, and are eager to partner with the State to implement the transition. In summary, to enhance the State's proposed waiver program the PHP Coalition offers the following recommendations:

- To promote QHP market sustainability the Coalition recommends that the State:
    - Proactively develop a plan to mitigate the QHP market impact, including structural changes to ensure that plans remain in the market over time, including a review of rate sufficiency.
    - Consider mid-year rate updates for QHPs, especially as the proposed waiver unfolds and there is more uncertainty about the changing population and risk pool.
- The Coalition strongly supports expanding eligibility for <u>all</u> New York residents up to 250% FPL *regardless of immigration status* under the 1332 waiver program, as another step toward more equitable and comprehensive coverage.

- The Coalition supports the proposed waiver's continuation of the EP Quality Incentive Program that has allowed plans to make numerous investments in providers and services to advance health equity.
- The Coalition strongly recommends the State consider a supplemental kick payment for newborns whose birthing parent is covered under EP.
- The Coalition recommends, if possible, including vision and dental as standard for the new EP 200-250 group, to maintain a rich level of benefits for everyone in EP.
- The Coalition requests the State clarify if the proposed waiver will pursue LTSS benefits for all EP premium groups through the 1332 State Innovation Waiver, as contemplated in the related FY 24 Executive Budget legislation**.**
- The Coalition recommends that the State provide additional guidance on a number of operational aspects of the proposed waiver program, including: how auto-assignment from QHP to EP will work and how plans and consumers will be notified; any new expectations or requirements for network overlap between QHP and EP as a result of the proposed waiver; and rules related to binder payments and non-payment.
- The Coalition recommends, where possible, aligning premium-related rules with previous processes or with the QHP program, to reduce member confusion and administrative effort.

The PHP Coalition appreciates the opportunity to comment on this important change in the structure of New York's public healthcare coverage programs. We look forward to working in partnership with the State to effectuate this positive change for New Yorkers, while also finding ways to bolster the QHP market and ensure that consumers transition smoothly from QHPs to the EP program.

Community Health Care Association of New York State

3/11/2023

Supportive of the waiver. Attachment to follow via email to nysoh.team@health.ny.gov

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Affiliated with NewYork-Presbyterian Healthcare System

March 8, 2023

NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Attn: 1332 Waiver
Albany, NY 12237

Re: 1332 Waiver to Expand New York's Essential Plan

Community Healthcare Network (CHN) submits these comments on the proposed 1332 waiver to encourage the Department of Health to include undocumented immigrants in New York's Essential Plan expansion. CHN is a nonprofit network of 14 federally qualified health centers (FQHCs) in New York City providing primary care, family planning, dental, nutrition, social services, and behavioral health to nearly 80,000 New Yorkers, many of whom are undocumented immigrants in need of care.

It is a part of CHN's core mission, along with other FQHCs, to provide quality, comprehensive health services regardless of ability to pay. This includes caring for many of the nearly one million New Yorkers who lack insurance, about one in four of whom are undocumented. Undocumented immigrants have the highest rate of uninsurance of any group in New York, largely because they are excluded from nearly all publicly subsidized insurance.

New York State annually spends more than $500 million on Emergency Medicaid and the City of New York spends an additional $100 million on NYC Cares to cover undocumented adults. While these programs provide limited coverage, they lack comprehensive medical and financial protections and leave the vast majority of undocumented immigrants without reliable or affordable care.

The lack of health insurance is associated with significantly higher rates of mortality and morbidity. Those who are uninsured also suffer much higher rates of financial distress and report regularly delaying care due to cost. As a result, the uninsured are much more likely to be hospitalized for avoidable conditions. Community health centers and safety-net hospitals often bear the burden of caring for the uninsured, which is a contributing factor to the financial distress of many hospitals and clinics.

It is a testament to the success of the Essential Plan that it has managed to cover 1.1 million New Yorkers while generating program surpluses that now approach $10 billion. Under Federal law, this money can only be spent on health plans. While CHN is supportive of the DOH's intention to expand EP coverage up to 250% of the federal poverty level, these surpluses are large enough to also cover undocumented immigrants at little or no cost to the state, freeing up resources for other priorities.

Expanding coverage to undocumented immigrants, as Governor Hochul pledged to do last April, represents an exceedingly rare opportunity to increase the number of insured, reduce the cost of uncompensated care, promote health equity, and improve health outcomes, all while generating state savings. This is especially critical at a time when Federal funds are drawing down with the end of the Public Health Emergency. Four other states already cover undocumented immigrants, including Colorado and Washington who do so through approved 1332 waivers. New York is well-positioned to become the fifth.

At the height of the COVID-19 pandemic, thousands of undocumented immigrants served on the frontlines as essential workers, providing critical support services to millions of New Yorkers in need. Now, we have an opportunity to repay them for their sacrifices by providing them with comprehensive health insurance.

We strongly urge you to include undocumented immigrants in the Essential Plan's expansion. Thank you for your consideration of this request.

Sincerely,

Robert M. Hayes
President & CEO
Community Healthcare Network

Community Service Society

Powering a more equitable New York

President and Chief Executive Officer
David R. Jones, Esq.

Executive Vice President and Chief Operating Officer
Steven L. Krause

March 10, 2023

Danielle Holahan
Executive Director, NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Dear Ms. Holahan,

On behalf of the Community Service Society of New York (CSS), I would like to thank the Department of Health for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion draft submission. CSS has worked with and for New Yorkers since 1843 to promote economic opportunity and champion an equitable city and state. Through a strategic combination of research, services, and advocacy, we strive to make New York more livable for people facing economic insecurity. By expanding access to health care, affordable housing, employment, opportunities for individuals with conviction histories, debt assistance, and more, we make a tangible difference in the lives of millions. Annually, CSS's Health Initiatives Department—along with its extraordinary network of community-based partners throughout New York State—has the great honor of helping over 100,000 consumers enroll in and use health insurance coverage. This work is generously funded by Governor Hochul and the Legislature. These patients' experiences guide our health policy reports that seek to improve the health care system for all New Yorkers.

Background: CSS Experience Modeling Basic Health Plan/Essential Plan Enrollment and Costs Estimates

In 2012, CSS issued: "***Bridging the Gap: Exploring the Basic Health Insurance Option for New York***", the first report to model the benefit to New York in taking advantage of the Basic Health Program Section 1331 provision of the newly enacted Affordable Care Act. This report estimated that New York would enroll 617,500 enrollees, yielding nearly $1 billion per

annum in State savings by offering coverage to lawfully present immigrants who were previously ineligible for federal financial participation. With the adoption of the Basic Health Program option in 2015, New York has since surpassed these initial estimates with over 1.1 million enrollees in our BHP—now branded as the Essential Plan—generating a surplus of $2 billion per annum.

Since the State's adoption of the Basic Health Plan, CSS has issued two additional reports—the second in partnership with the Citizens Budget Commission—modeling the costs of including immigrants who are ineligible for federally funded Basic Health Plan coverage, using State-only funding: (1) E. Benjamin, *How Can New York Provide Health Insurance Coverage to its Uninsured Immigrant Residents?* (Community Service Society, January 2016); and (2) E. Benjamin, A. Dunker and P. Orecki, *Narrowing New York's Health Insurance Coverage Gap* (Citizens Budget Commission/Community Service Society, January 2022). Our 1332 Waiver comments leverage the findings from these reports.

Specific Comments on 1332 Waiver:

I. New York State's 1332 Waiver Application Should Include Immigrants for a Cost of $1.6 Billion to the "Passthrough" Account – Less $430 million Savings from the State's Medicaid Budget

In light of New York's tremendous success at securing federal financial participation for the coverage of lawfully present immigrants through the 1331 Basic Health Program provision, CSS strongly urges the Hochul Administration to keep its commitment made in last year's budget process and include immigrants in its 1332 Waiver request.[1] There are four important reasons for doing so: (1) fiscal prudence; (2) economic benefits to our state's providers; (3) other state precedents; and (4) patient physical and fiscal well-being, public health and health equity concerns.

1. Fiscal prudence

New York's State budget would benefit from substantial state savings were it to amend its 1332 Waiver request to include immigrants. New York spends at least $500 million annually on the Emergency Medicaid program for approximately 139,000 undocumented immigrants with incomes between 0-138 percent of the federal poverty level who are ineligible for any other form of coverage.[2] The 1332 waiver process could be used to cover all of these immigrants, thus saving the State approximately $500 million in state and local Medicaid funding. Just like with the adoption of the Basic Health Program in 2015, the inclusion of immigrants in the 1332 waiver would result in a substantial savings that can be used for other important budget priorities.

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[1] Governor Hochul, April 7 Budget Press briefing: https://www.youtube.com/watch?v=Ysb38zrpx6Q&t=2066s; NYS DOH "2022-23 Enacted Medicaid Budget Briefing and Questions & Answers (April 2022) PowerPoint Presentation.

[2] New York State Emergency Services Only Utilization (Medicaid Coverage Code 07), Service Dates Calendar Year 1/1//19-12/31/2021 (2021 data used above).

New York has accumulated a $9 billion surplus in its 1331 Basic Health Program Trust Fund account, which increases by an excess of $2 billion annually. Federal rules require that these funds must be spent on coverage for individuals and cannot be redeployed to other State budget priorities. CSS's past cost estimates for including immigrants who are currently ineligible for comprehensive coverage on an "opt in" basis were approximately $460 million per year.[3] Even if the State chose to automatically enroll immigrants from our Emergency Medicaid program and allow "opt in" for the remaining higher income ineligible immigrants, the State's on-going $2 billion Basic Health Program surplus would be more than adequate to cover ineligible immigrants through the funding that will be accumulating in the new 1331/1332 "passthrough" account.

CSS's current cost estimates for including undocumented immigrants leverage new health plan reimbursement data, included analysis of the State's draft 1332 Waiver document, and Emergency Medicaid utilization and spending data issued in the Spring of 2022. **We estimate the total charge to the 1332 Waiver passthrough fund would be $1.6 billion.**

These estimates are built on two rating cells. The first rating cell would be for covering the ineligible immigrant population below 138% of FPL reimbursed at the EP4 Rate, which is currently $480 per member per month (Table 1). Accordingly, the cost of enrolling 127,382 Emergency Medicaid utilizer would be $734 million. Simultaneously, the state would *save* $429 million in the Emergency Medicaid spending attributable to the enrollees population whose incomes are below 138% of FPL (Table 2).

The second rating cell would be for the population between 138-250% of the federal poverty level, which we estimate would be no more than 128,000 (double the existing Emergency Medicaid utilizers). This enrollment estimate is very conservative because it is unlikely that there will be as many higher income undocumented immigrants, since undocumented immigrants are well known to have very low incomes. The rating cell for this population would be the projected blended 2023 EP rate for 2024 of $567 per member per month (Table 3). Accordingly, the cost for enrolling the higher income ineligible immigrants would be $871 million. Combined the total charge to the 1332 passthrough account would be $1.6 billion. (Table 3). The total net cost of extending coverage to ineligible immigrants is $1.2 billion, assuming $430 million in savings to the State's Medicaid budget.

The State has a number of measures to mitigate its financial upside risk, including capping the program for a number of immigrants covered at a budgeted amount. A similar cap is being proposed by the Hochul Administration in its Article VII language seeking to expand the Medicaid Program for Working People with Disabilities at 30,000 enrollees.[4] Alternatively, the State could cap the program at a budgeted amount, e.g., $1.6 billion or set the eligibility at a lower income level (e.g., 138% of FPL.)

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[3] *See, e.g.,* https://www.cssny.org/publications/entry/covering-new-yorks-uninsured-immigrant-residents

[4] FY2004 NYS Executive Budget, Health and Mental Hygiene Article VII Legislation, Part N. https://www.budget.ny.gov/pubs/archive/fy24/ex/artvii/hmh-bill.pdf

2. Including immigrants would provide substantial financial benefits to our fiscally stressed provider community

New York's providers likewise would benefit substantially from including immigrants. Currently, providers are waging a major campaign to increase Medicaid reimbursement rates by as much as 20 percent.[5] Including immigrants in the 1332 Waiver means that providers would be paid Essential Plan reimbursement rates—which are far higher than the standard Emergency Medicaid rates. In addition, providers would be reimbursed for the full continuum of care included in the Essential Plan benefit package: emergency services, inpatient, outpatient, labs, pharmacy, specialty and primary care providers visits, vision and dental. By contrast, Emergency Medicaid just reimburses providers for emergency care necessary to stabilize a patient. Finally, providers have long complained of their uncompensated health care costs, which experts at the Urban Institute estimate to be as much as $1,174 per uninsured person.[6] New York City would benefit by including immigrants in the 1332 Waiver because it would no longer have to provide $100 million per year to self-fund its NYC Care program that provides "insurance-like" coverage to immigrants through NYC Health + Hospitals.[7]

3. Other states are moving forward with covering immigrants

Other states have moved forward with covering immigrants with no ill effects on their state budgets. For example, California has phased in Medicaid coverage regardless of immigration status: first with children under the age of 19 in May 2016; second, young adults, age 19-25 in January 2020; third, older immigrants, age 50 and above in 2021; and finally, for everyone else (ages 26-49) in January 2024.[8] Similarly, Illinois has moved to offer Medicaid to immigrants who are ineligible for federally funded health care, ages 42 and above, effective July 2022.[9]

Perhaps most relevant to the discussion at hand, Colorado has secured a 1332 Waiver that establishes "passthrough" funding in order to offer comprehensive health coverage to undocumented immigrants,[10] with Washington State following its lead.[11] With this combined

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[5] "Hochul's proposed 5% Medicaid bump 'just doesn't cut it' for struggling providers, they say," Crain's Health Pulse, February 3, 2023.

[6] Linda J. Blumberg, Matthew Buettgens, and John Holahan, *How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?* (Urban Institute, July 2018), www.urban.org/sites/default/files/publication/98805/2001925_state_based_individual_mandates.pdf.

[7] "New York City will cover illegal immigrants as part of $100 million-a-year health-care expansion," Associated Press, January 9, 2019, https://www.marketwatch.com/story/new-york-city-will-spend-100-million-a-year-on-health-care-expansion-covers-illegal-immigrants-2019-01-09.

[8] https://www.gov.ca.gov/2022/10/19/medi-cal-expansion-provided-286000-undocumented-californians-with-comprehensive-health-care/

[9] https://www.dhs.state.il.us/page.aspx?item=144320.

[10] https://www.commonwealthfund.org/blog/2022/hhs-approves-nations-first-section-1332-waiver-public-option-plan-colorado

[11] Through its 1332 Waiver, Washington will provide state-only funding to subsidize ineligible immigrants up to 250% of the federal poverty level to purchase Cascade Care. https://communitycatalyst.org/posts/washingtons-1332-waiver-presents-opportunities-for-health-

1331/1332 Waiver opportunity, New York should likewise include the coverage of its ineligible immigrants so that it is not left behind other states that have moved ahead.

4. Coverage benefits patients' fiscal and physical health, everyone's public health and reduces health disparities

Finally, ensuring that everyone has health insurance is good for all New Yorkers—regardless of their immigration status. Research shows insurance coverage reduces morbidity and mortality experienced by uninsured patients and improves economic security by reducing medical debt and bankruptcy.[12] In addition, increased coverage benefits the state as a whole. Public health efforts, including those to control COVID-19 and other epidemics, are undermined when uninsured people avoid health care because of financial barriers. People who are uninsured experience a loss of productivity and incur medical debt, which further damages our economy.[13] Finally, lack of coverage is a major factor exacerbating health disparities.[14] Combatting health disparities has been identified as a major objective for the Hochul Administration's heath strategy.[15]

II. Increasing Affordability

On a positive note, CSS has long encouraged the State to expand public coverage to individuals at higher income levels. The Waiver proposal underscores how powerful such steps can be. Beneficiaries of the Essential Plan expansion with incomes between 200 and 250 percent of the federal poverty level will save an estimated $4,183 in medical costs.[16] This affordability provision is an exciting consumer benefit and we encourage the state to consider seeking an even more ambitious agenda, such as increasing EP eligibility to 300% of the federal poverty level or offering a Buy-In program for those who wish to enroll in the Essential Plan.

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equity/#:~:text=This%20section%201332%20waiver%20authorizes,%2C%20beginning%20January%201%2C%202024.

[12] Benjamin Sommers, Atul A. Gawande, and Katherine Baicker, "Health Insurance Coverage and Health – What the Recent Evidence Tells Us," *New England Journal of Medicine*, vol. 377, no. 6 (August 10, 2017), pp. 586-593, www.nejm.org/doi/10.1056/NEJMsb1706645; Etienne Gaudette, Gwyn C. Pauley, and Julie M. Zissimopoulos, "Lifetime Consequences of Early-Life and Midlife Access to Health Insurance: A Review," *Medical Care Research and Review*, vol. 75, no. 6 (2018), pp. 655-720.

[13] Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, *Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach*," Working Paper 26533 (National Bureau of Economic Research, December 2019) www.nber.org/papers/w26533.pdf; Brian Gifford and Erin Peterson, "Health and Productivity Challenges for Lower-Income Workers: Health Insurance, Plan Design and Barriers to Care," *Integrated Benefits Institute* (July 2019), www.ibiweb.org/wp-content/uploads/2019/07/LowerIncome-Employees-Study.pdf; and Liam C. Malloy and Shanna Pearson-Merkowitz, "The Economic Impact of Expanding Medicaid," *The Collaborative* (2015), http://wp.collaborativeri.org/wp-content/uploads/2015/07/The-Economic-Impact-of-Expanding-Medicaid-.pdf.

[14] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

[15] https://www.governor.ny.gov/news/governor-hochul-signs-package-legislation-address-discrimination-and-racial-injustice

[16] New York State Department of Health Budget Briefing Webinar, February 23, 2023.

Thank you for the opportunity to provide our testimony.

Very truly yours,

Elisabeth R. Benjamin, MSPH, JD
Vice President, Health Initiatives
Community Service Society of NY

Appendix: Updated Ineligible Immigrant Enrollment and Cost Estimate Tables

Table 1. Actual & Projected Growth in Essential Plan Rates			
	EP 4	**Blended EP Rates**	**Percent Change Blended Rates**
2021	$425	$414	3.3%
2022	$470	$519	25.4%
2023	$480	$531	2.4%
2024	N/A	$567	6.7%
2025	N/A	$590	4.1%
2026	N/A	$613	3.9%
2027	N/A	$638	4.1%
2028	N/A	$663	3.9%

Table 2. Estimated cost to add Medicaid-eligible population (up to 138%)	
EP4 PMPM Rate (2023)	$480
EP4 Annual Per-Member Cost (2023)	$5,760
2021 Emergency Medicaid utilizers, 19-64*	127,382
Cost for 100% enrollment	$734 million
Offset: Emergency Medicaid state/local spending (2021)	-$429 million
Total net estimated cost for enrolling ineligible immigrants up to 138% of FPL	**=$305 million**

Table 3. Estimated cost to add people earning up to Essential Plan limit (250%)	
EP Blended PMPM Rate, 2024	$567
EP Blended Rate Per Member, Per Year	$6,804
New enrollees, 138% – 250%	128,000
Cost for new enrollees 138% – 250% ($6,804 * 128,000)	$871 million
Cost for new enrollees 0 – 138% (see prior slide)	+$734 million
Total gross cost to 1332 Waiver Passthrough Account, 0 – 250% (255,382 enrollees)	**= $1.6 billion**
Less Emergency Medicaid State Savings (-$429m)	**= $1.2 billion**

CUNY SPH GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

MARCH 9, 2023

Sent via email to: nysoh.team@health.ny.gov

The Honorable Kathy Hochul
Governor of New York State
NYS State Capitol Building
Albany, NY 12224

Dear Governor Hochul:

The CUNY Graduate School of Public Health and Health Policy (CUNY SPH) has a deep and broad-based commitment to ending health inequities. As part of its mission, CUNY SPH facilitates research, learning – and action – on migrant health. We host an MS program in Global and Migrant Health Policy, as well as the Center for Immigrant, Refugee and Global Health (CIRGH) and the Center for Innovation in Mental Health (CIMH). Detailed information about CUNY SPH's work related to immigrant and refugee health can be found here: https://cirgh.sph.cuny.edu/.

Health insurance coverage improves physical and mental health outcomes by providing access to healthcare and removing financial barriers. It increases life expectancy and stabilizes peoples' financial security by reducing medical debt. When more people have health insurance and access to care, the overall population becomes healthier. The creation of state-run health insurance exchanges under the Affordable Care Act caused a seismic shift in the health of the population and access to care. In particular, the success of our New York State of Health (NYSOH) marketplace over the past decade has made it a model for the nation. Today, nearly all New Yorkers have the opportunity to access comprehensive, affordable health care through the NYSOH, except for undocumented immigrants.

CUNY SPH, along with CIRGH, CIMH, and many migrant serving organizations (MSOs), welcomed your pledge last year to request a 1332 Waiver to expand Essential Plan eligibility to include low-income undocumented immigrants and to increase financial eligibility limits for applicants. It appears, though, that New York's most recent 1332 Waiver application, as well as the relevant sections of your FY24 Executive Budget, exclude specific mention of immigrants and undocumented people. This may result in New York missing a crucial opportunity to expand coverage to one of the most vulnerable populations in our state. Making care accessible and affordable to those least able to otherwise receive care protects the health of all New Yorkers. In addition, extending the Essential Plan to the undocumented would likely reduce fiscal spending for uncompensated care at safety net hospitals in our state and allow for a re-allocation of Emergency Medicaid Funds to other pressing needs.

In summary, we urge you to reinsert specific references to immigrants and undocumented people in the 1332 Waiver application. We hope that the Executive Chamber and NYS Legislature will work together to include financial support for access to health care, insurance, and other necessary services for immigrants and asylum seekers in the final enacted FY 24 budget.

CUNY SPH stands ready to collaborate with you to identify and implement solutions to protect the health of vulnerable populations and all residents of our State.

Respectfully,

Ayman El-Mohandes, MBBCh, MD, MPH,
Dean, CUNY Graduate School of Public Health and Health Policy

CC: Deputy Secretary for Health for New York Angela Profeta, PhD, MPH
Acting NYS Department of Health Commissioner James V. McDonald, MD, MPH
Executive Director New York State of Health Danielle Holahan, MPH
Acting Medicaid Director Amir Bassiri, MSW

Empire Justice Center's comments on the proposed 1332 State Innovation Waiver Application

Empire Justice Center is a statewide, multi-issue, multi-strategy non-profit law firm focused on improving the "systems" within which poor and low-income families live. With a focus on poverty law, Empire Justice Center undertakes research and training, acts as an informational clearinghouse, and provides direct representation and support to local legal services programs and community-based organizations. As an advocacy organization, we engage in legislative and administrative advocacy on behalf of those harmed by poverty and discrimination. As a non-profit law firm, we provide legal assistance to those in need and undertake impact litigation in order to protect and defend the rights of disenfranchised New Yorkers. The health law team is dedicated to ensuring access to quality, affordable health coverage for all New Yorkers.

Empire Justice Center opposes the State's 1332 Innovation Waiver application as currently drafted, because it excludes immigrants who are undocumented.

The proposed expansion of the Essential Plan eligibility from 200%, to 250% of the federal poverty level is an important step in increasing insurance coverage and expanding access to affordable healthcare. However, an estimated 245,000 New Yorkers between the ages of 19 and 64 are uninsured due to their immigration status. The only option available for undocumented immigrants is Emergency Medicaid. This is not comprehensive coverage – it cannot and does not meet the health care needs of our immigrant communities, many of whom delay or avoid seeking care.

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The State has the opportunity to use the 1332 Waiver process to seek federal approval to expand the Essential Plan to cover all low-income New Yorkers, regardless of immigration status. Providing access to comprehensive and affordable coverage will significantly improve the health and well-being of New Yorkers who, but for their immigration status, remain uninsured. Including immigrants in the 1332 Waiver proposal can help NYS combat health disparities, a key objective for Governor Hochul's Administration.

In addition, the State would stand to save money. New York incurs annual costs of approximately $500 million when people who are uninsured seek hospital emergency care. Rather than continued State spending on Emergency Medicaid, the 1332 Waiver process could be used to cover undocumented and insured immigrants with federal dollars.

Other states, including Colorado, Illinois, Washington, and California have recognized health insurance is a human right by extending affordable insurance coverage to all income-eligible immigrants. It is time for New York to do the same.

Empire Justice Center urges the Department of Health to amend its 1332 Innovation Waiver Application to include people who are undocumented and to agree to include this provision in this year's enacted state budget.

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March 9, 2023

Danielle Holahan
Executive Director, NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Re: NY State of Health Section 1332 Innovation Waiver Request

Dear Ms. Holahan:

Thank you for the opportunity to comment on the NY State of Health's Section 1332 State Innovation Waiver (the "Waiver"). GNYHA has been a strong supporter of New York's Essential Plan (EP) since its inception, and we applaud current efforts to further expand coverage to reach even more New Yorkers with access to affordable and comprehensive coverage.

We understand that given limitations on coverage expansion available under Section 1331 of the Affordable Care Act, the New York State Department of Health (DOH) is seeking Federal authority to expand EP coverage under Section 1332. It is also our understanding that the existing EP population will not experience any changes to benefits, choice of plans, premium, cost-sharing or eligibility, or enrollment processes as a result of the Waiver[1].

The EP has proven to be an invaluable vehicle for providing access to comprehensive coverage for low-income New Yorkers not eligible for Medicaid. Expanded coverage has enormous individual and public health benefits, and also provides a mechanism for more adequately reimbursing health care providers for the cost of delivering care.

GNYHA therefore supports the proposal to expand eligibility to residents with incomes up to 250% of the Federal Poverty Level (FPL). Based on information provided in the Waiver, we understand this population to encompass approximately 90,000 expected enrollees, the vast majority of whom will be able to seamlessly transition to EP plans offered by their existing Qualified Health Plan (QHP) insurers[2]. The EP plans newly available to this expansion population will offer lower cost-sharing and premiums relative to the currently available QHP marketplace plans. Importantly, the State projects sufficient Federal

[1] New York State DOH. (February 9, 2023). Retrieved from: https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf.

[2] New York State DOH. (February 9, 2023). Retrieved from: https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf.

passthrough funding for this new eligibility group such that no additional State funding will be required in extending coverage.[3]

In addition to this newly eligible population of individuals with incomes up to 250% of the FPL, GNYHA strongly urges DOH to amend the Waiver request to include New York's immigrant population under age 65. As DOH explains in the Waiver request, the Waiver is a key strategy for advancing health equity by reaching a group of residents "that have been left behind by previous policy efforts" and "represents a significant opportunity to extend coverage to communities…that are disproportionately uninsured when measured by racial/ethnic identity…"[4]. Today, New York residents ineligible for subsidized QHP and/or Medicaid coverage due to their immigration status receive Emergency Medicaid coverage. This Emergency Medicaid coverage is limited in scope, providing only "emergency services" pursuant to Federal law as compared to the robust essential health benefits offered by EP plans. Moreover, Emergency Medicaid coverage requires State Medicaid matching funds at a cost of approximately $440 million per year for individuals below age 65[5].

By shifting this population (approximately 128,000 non-aged individuals [up to age 65] who utilized emergency Medicaid services in 2021[6] and an additional approximately 128,000 individuals if broadened to include immigrants up to 250% of the FPL[7]) to EP coverage under a 1332 Waiver, New York has the opportunity to significantly improve individual and public health by providing comprehensive coverage, including access to inpatient, outpatient, preventive, behavioral health, and other benefits with no cost-sharing. In addition, New York would be able to reallocate approximately $440 million in State funds to other budget imperatives such as stabilizing the health care delivery system for Medicaid beneficiaries. Moreover, providers would benefit because they would receive reimbursement for services along the full continuum of care (not just for the limited scope of services covered by Emergency Medicaid) and at EP rates that generally cover a higher percentage of provider costs than Medicaid.

There appears to be sufficient 1332 Waiver passthrough funding to support EP expansion for this additional immigrant population. Based on estimates provided by Community Service Society, the estimated cost of enrolling the Emergency Medicaid population (up to 138% of the FPL) is $735 million and the estimated cost of enrolling immigrants between 138-250% of the FPL would be $871 million in 2024. Should the State have concerns about the number of potential immigrant enrollees and ensuring sufficient Waiver funds to support the existing EP population and the 200-250% FPL expansion group, it could consider fiscal mitigation strategies with respect to the new immigrant population. These strategies could include capping enrollment of the new immigrant population at a defined number of enrollees or budgetary spend, and/or limiting eligibility to immigrants below 138% of the FPL to align with Medicaid. These limits could be

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[3] New York State DOH. (n.d.). Retrieved from: https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Public_Notice.pdf.

[4] New York State DOH. (February 9, 2023). Retrieved from: https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf.

[5] New York State Emergency Services Only Utilization (Medicaid Coverage Code 07).

[6] New York State Emergency Services Only Utilization (Medicaid Coverage Code 07).

[7] Estimates from the Community Service Society based on U.S. Census Bureau data.

reassessed and modified after experience of actual enrollment, utilization, and funding under the Waiver is available.

As New York prepares to transition the EP for currently eligible populations and expand eligibility to additional residents under a 1332 Waiver, it will be important that provider reimbursement rates are adequate to ensure beneficiaries have access to care and providers participating in the program are not destabilized. DOH develops the EP premium rates, which plans then use to inform network participation and rate negotiations with participating providers. For EP expansion to be an ultimately effective coverage strategy, EP premium rates must be reflective of provider costs to deliver high-quality services to EP enrollees.

We look forward to continuing to work with DOH on EP expansion and operations. Please contact Emily Leish at (212) 506-5408 or eleish@gnyha.org with any questions.

Sincerely,

Kenneth E. Raske
President

Cc: Amir Bassiri

African Services Committee ☙ Actors Fund ☙ Children's Defense Fund-New York ☙ Community Service Society of New York ☙ Consumers Union ☙ Empire Justice Center
Make the Road New York ☙ Medicare Rights Center ☙ Metro New York Health Care for All Campaign
New Yorkers for Accessible Health Coverage ☙ New York Immigration Coalition ☙ Project CHARGE
Public Policy and Education Fund of New York/Citizen Action of New York
Raising Women's Voices-New York ○ Schuyler Center for Analysis and Advocacy ○ Young Invincibles

March 10, 2023

Submitted by:
Health Care For All New York

Health Care for All New York (HCFANY) would like to thank the Department of Health for the opportunity to comment on the Section 1332 Innovation Waiver. HCFANY is a statewide coalition of over 170 organizations dedicated to achieving quality, affordable health coverage for all New Yorkers.

Everyone in New York should have access to affordable health insurance. However, over one million New Yorkers are uninsured, including an estimated 245,000 who are unfairly excluded from public health insurance because of their immigration status. New York should ensure that immigration status is not a barrier to health insurance by including immigrants in its 1332 Waiver request.

The Essential Plan is one of New York's public health insurance programs and currently covers other New Yorkers who earn up to 200 percent of the federal poverty level. It is fully funded by the federal government and, in fact, the funding formula produces a surplus each year. The trust fund holding this surplus grows by $2 billion every year; it already contains $9 billion.[1] Under federal law, this funding can only be spent on health coverage.[2] The 1332 Innovation Waiver could be a vehicle for covering immigrants using the annual surplus. Colorado recently received permission to use passthrough funds to cover all income-eligible immigrants in its Medicaid program, and Washington State has a pending 1332 Waiver to do the same.[3] However,

[1] Bill Hammond, "The Essential Plan's accumulated surplus balloons to $8 billion, with no fix in sight," September 8, 2022, The Empire Center, https://www.empirecenter.org/publications/the-essential-plan-surplus-balloons-to-8-billion/.
[2] NY State of Health, 'Essential Plan Expansion 1332 Waiver Submission and Review of Public Comments," https://info.nystateofhealth.ny.gov/1332.
[3] Tara R. Straw, "Innovative 1332 Waivers Proceed in Colorado and Washington," Manatt Health, June 29, 2022, https://www.manatt.com/insights/newsletters/health-highlights/innovative-1332-waivers-proceed-in-colorado-and-wa and Katie Villeda, "Washington's 1332 Waiver Presents Opportunities for Health Equity," Community Catalyst, January 23, 2023, https://communitycatalyst.org/posts/washingtons-1332-waiver-presents-opportunities-for-health-equity/#:%7E:text=This%20section%201332%20waiver%20authorizes,%2C%20beginning%20January%201%2C%202024

the current draft proposed by New York does not seek permission from the federal government to do this.

Ensuring that all New Yorkers have health insurance would benefit everyone, not just the newly covered. The NYC Comptroller's office estimates that covering excluded immigrants through the Essential Plan would produce $710 million annually by preventing premature death, increasing labor productivity, reducing out-of-pocket health care expenses, and reducing uncompensated care.[4] Health insurance is especially important during a time of global pandemics. Families USA estimates that over 400,000 cases of Covid-19 were linked to a lack of health insurance in New York between February 2020 and February 2021, and over 10,000 deaths.[5]

Including immigrants in the 1332 waiver would also replace over $500 million currently used to fund Emergency Medicaid, because that program would no longer be needed. Currently, Emergency Medicaid covers undocumented people when they have health emergencies. The Essential Plan would give them comprehensive health coverage, with no cost to the State. More New Yorkers would have access to preventive and routine health care instead of only being able to access care after developing a serious health problem, and the State would have more resources for other budget items. Further, the Essential Plan rates paid to providers are higher than the rates they receive through Emergency Medicaid. That would mean more support for safety-net hospitals.

Thank you for the opportunity to submit comments.

Amanda Dunker
Health Care For All New York

[4] New York City Comptroller Brad Lander, "Economic Benefits of Coverage for All, March 2022, https://comptroller.nyc.gov/reports/economic-benefits-of-coverage-for-all/

[5] Stan Dorn and Rebecca Gordon, "The Catastrophic Cost of Uninsurance: Covid-19 Cases and Deaths Closely Tied to America's Health Coverage Gaps," Families USA, March 4, 2021, https://familiesusa.org/resources/the-catastrophic-cost-of-uninsurance-covid-19-cases-and-deaths-closely-tied-to-americas-health-coverage-gaps.

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March 10, 2023

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Attn: 1332 Waiver
Albany, NY 12237

Submitted electronically: nysoh.team@health.ny.gov

Re: Essential Plan Expansion 1332 Waiver

The Healthcare Association of New York State, on behalf of our member nonprofit and public hospitals, nursing homes, home health agencies and other healthcare providers, appreciates the opportunity to comment on New York's Section 1332 Innovation Waiver Essential Plan Expansion draft submission.

Expanding immigrant coverage

New York's Essential Plan has been successful in providing comprehensive healthcare coverage to New Yorkers, currently enrolling more than 1.1 million. The Essential Plan covers people who would have been eligible for state-only Medicaid prior to 2016 and those age 19 to 64 with incomes above the Medicaid ceiling (up to the 200% of the federal poverty level) who would otherwise be eligible to purchase Qualified Health Plans and receive premium tax credits on the New York State of Health exchange.

HANYS supports the state's proposal to apply for a waiver under Section 1332 to expand EP coverage to people at 200% to 250% of FPL. The move from Section 1331 of the Affordable Care Act to Section 1332 will likely have little to no noticeable impact on current enrollees and it will permit the state to expand affordable EP coverage to an additional population. Moving to Essential Plan coverage will decrease out-of-pocket costs substantially for those in the proposed cohort who had access to premium tax credits on the NYSOH.

However, HANYS urges the state to re-draft its waiver proposal to include immigrants who are currently ineligible for EP coverage in the proposed expansion. The EP already covers lawfully present immigrants, but various immigration statuses continue to be excluded from coverage.

New York's Emergency Medicaid program spends about $500 million annually on emergency coverage for undocumented immigrants who are ineligible for other coverage. Moving this population, undocumented immigrants with incomes between 0% and 138% of the FPL, into the EP would save those funds and increase access to healthcare for vulnerable populations, providing yet another step toward health equity in New York.

New York's hospitals and health systems face extremely difficult fiscal, workforce, infrastructure and marketplace conditions that threaten access to patient care. Despite our members' friction with insurers offering EP products, the reimbursement rates from EP carriers are higher than the standard Emergency Medicaid rates and cover the full scope of services. Moving this vulnerable population away from relying on Emergency Medicaid would ensure access to the full continuum of care and the increased reimbursement would help support providers.

Increasing affordability

HANYS supports the state's efforts to increase affordable coverage for people with higher income levels. The EP has proven to be a cost-effective, successful method of providing full-coverage health insurance in a manner that is fiscally responsible for both the state and federal governments. This proposal will ensure more New Yorkers have access to affordable, equitable healthcare services.

If you have questions regarding our comments, please contact me at 518.431.7889 or vaufiero@hanys.org.

Sincerely,

Victoria Aufiero
Vice President, Insurance, Managed Care and Behavioral Health

From: E. West McNeill
To: doh.sm.NYSOH.Team
Subject: Federal Funds Should be Used to Pay for Healthcare Coverage For All.
Date: Monday, February 27, 2023 5:09:05 PM

Department of Health ,

Dear Governor Hochul/Department of Health,

I am writing on behalf of the Labor-Religion Coalition of NYS to oppose the 1332 State Innovation Waiver application because it excludes immigrants.

Last year, you promised to reach out to the federal government to file a federal Waiver to ask for funding to expand the Essential Plan to cover all low-income New Yorkers—including immigrants. Including immigrants in the Waiver application will cost the state nothing, and in fact, generate budget savings. The State's Essential Plan Trust Fund Account has an existing $9 billion surplus and is estimated to generate an additional $2 billion annual surplus. The state's waiver application should use this $2 billion in federal funding to pay for expanded coverage for immigrants. As you are aware, federal rules say trust funds can only be used to pay for health insurance coverage.

Providing health insurance for immigrant communities – including hundreds of thousands of essential workers who have kept our state functioning during a three-year pandemic – is both morally and fiscally responsible. Expanding coverage would come at no cost to the state and would avoid $500 million in annual Emergency Medicaid costs incurred when uninsured patients seek emergency care at our hospitals. It would also increase revenues for our health care providers by providing them essential plan rates instead of Medicaid (which is lower) and reduce the amount of uncompensated care they provide.

New York should join leaders like Colorado, Illinois, Washington, and California in recognizing health insurance as a human right by extending coverage to immigrant communities.

We are all safer in the face of global public health threats when everyone has access to quality preventive healthcare. Including immigrants in the 1332 Wavier is both economically sensible and the right thing to do.

Unless you revise the State Innovation Waiver application to include New York's immigrants and include this provision in the FY24 state budget, we oppose the State's Waiver application.

E. West McNeill
emcneill@labor-religion.org
[redacted]

Make the Road New York Comments on the New York Section 1332 Innovation Waiver
March 11, 2023

We would like to thank the Department of Health for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver Essential Plan Expansion draft submission. Make the Road New York (MRNY) is a community-based membership organization with over 25,000 members that builds the power of immigrant and working class communities to achieve dignity and justice. We are the largest participatory immigrant organization in New York State, and have community centers in Brooklyn, Queens, Staten Island, Long Island and Westchester. Our work integrates four core methodologies: community organizing, policy innovation, transformative education, and the provision of legal and survival services. This holistic model enables us to meet immediate needs, cultivate leadership among low-income communities, design sophisticated, and innovative policy solutions grounded in real-life experiences, and use deep base-building and community organizing to win policy transformations that impact millions. Our health, legal, educational, and survival services reach up to 30,000 individuals annually. We also co-lead the Coverage4All campaign and are on the Steering Committee of Health Care for All New York.

Our members and clients were among the hardest hit by the pandemic, and health care inequities experienced by our communities have been greatly exacerbated due to the pandemic. The need for access to health care for our members and for all immigrants throughout New York State is dire. However, many of our members lack access to health insurance due to their immigration status. These are the same individuals we value as essential workers, family and friends. They pay taxes and are integral members of our communities. To put it simply, they are New Yorkers.

Last year, Governor Hochul made a promise to all of New York State that she would expand the essential plan and include all immigrants in the 1332 waiver, regardless of immigration status. However, the draft 1332 waiver inexplicably leaves out undocumented immigrants. **MRNY therefore strongly urges the Hochul Administration to keep its commitment made in last year's budget process and include all immigrants in its 1332 Waiver request, who have income up to 250% of the Federal Poverty Level (FPL).**

By excluding immigrants from the 1332 waiver, the state is missing out on an opportunity to advance the overall health of New York, and address some of the health equity issues that are apparent in our state. We are falling behind other states like Colorado and Washington who have expanded coverage to immigrants through their 1332 waiver, and also falling behind states like California and Illinois who are using state funds to provide coverage for undocumented immigrants. Through the 1332 waiver, New York has the opportunity to provide coverage using federal dollars to the approximate 255,000 undocumented immigrants between the ages of 19-64, who continue to remain one of the highest uninsured populations in all of New York State. The expansion would cost zero dollars to New York and furthermore, yield savings of approximately $500 million, which is currently spent on emergency Medicaid and uncompensated care.

New York has accumulated a $9 billion surplus in its 1331 Basic Health Program Trust Fund account, which increases by an excess of $2 billion annually. Federal rules require that these funds must be spent on coverage for individuals and cannot be redeployed to other State budget priorities. According to cost estimates by the Community Service Society of New York, the cost for including immigrants who are currently ineligible for comprehensive coverage on an "opt in" basis is approximately $550 million per year.[1] Even if the State chose to automatically enroll immigrants from our Emergency Medicaid program and allow "opt in" for the remaining higher income ineligible immigrants, the State's on-going $2 billion Basic Health Program surplus would be more than adequate to cover ineligible immigrants through the funding that will be accumulating in the new 1331/1332 "pass through" account.

Here is the experience of a MRNY member in Long Island who does not have health insurance due to her immigration status. Maria went to the emergency room after experiencing intense pain and later was diagnosed with cancer. She had a bill of over $23,000, which she could not afford to pay. Soon after, a sheriff from the General Attorney's office showed up to her home to give her a summons. This was a frightening

[1] https://www.cssny.org/publications/entry/covering-new-yorks-uninsured-immigrant-residents

experience for Maria, who needs to continue to seek services to battle her cancer. These situations could have been avoided if Maria had access to health insurance.

As we see with our members every day, people without health insurance are more likely to delay seeking preventive care for serious and chronic health conditions, avoid seeking care for fear of costs, and are at higher risk of incurring medical debt or bankruptcy. Research demonstrates that gaps in coverage lead to cost inefficiencies and waste. Individuals and families without access to coverage are more likely to be sicker and die sooner. Hospitals are asked to provide care for which they may not be reimbursed and which patients may not be able to afford on their own.

Extending health insurance to all, independent of immigration status would have a mutual benefit for community members, providers and the state, and makes the healthcare system work better for all New Yorkers. Providers would receive higher reimbursement rates through the Essential plan then they currently receive, and would be reimbursed for the full continuum of care included in the Essential Plan benefit package. By contract, Emergency Medicaid just reimburses providers for emergency care necessary to stabilize a patient. The Urban Institute estimates that providers' current uncompensated healthcare costs are as much as $1,174 per uninsured person.[2] Ensuring that everyone has access to quality, affordable care will make it easier for the state to control costs and improve health outcomes for all.

In these unprecedented times, New York has the opportunity to further cement its leadership by making a firm commitment to supporting immigrant communities' ability to stay healthy for years to come. Make the Road New York is therefore opposed to the current draft application for the 1332 waiver, because it leaves out immigrants. **MRNY recommends that the state submit a revised 1332 waiver that includes all immigrant New Yorkers, regardless of immigration status with income up to 250% FPL.**

Thank you for the opportunity to provide our testimony.

[2] www.urban.org/sites/default/files/publication/98805/2001925_state_based_individual_mandates.pdf.

Medicaid Matters New York

New York's Submission of a 1332 Waiver to Expand the Essential Plan: All New Yorkers Must Be Included, Regardless of Immigration Status

March 7, 2023

Medicaid Matters New York is the statewide coalition representing the interests of the 7.7 million people who are served by New York's Medicaid program. Our coalition includes self-advocates, family members, policy and advocacy organizations, community-based organizations, community-based providers, legal services agencies, and more. Since 2003, Medicaid Matters has worked to ensure the interests of consumers are understood, included, and met in any discussion on New York's public insurance coverage programs. **Medicaid Matters opposes the State's 1332 State Innovation Waiver application as drafted because it excludes immigrants who are undocumented.**

Last year, Governor Hochul indicated an interest in seeking federal approval to expand New York's Essential Plan to cover all low-income New Yorkers, regardless of immigration status. Including immigrants in the waiver application would not incur costs to the state. In fact, it would generate state savings. New York's Essential Plan Trust Fund Account has an existing $9 billion surplus and is estimated to generate an additional $2 billion annual surplus. The state's waiver application should use this $2 billion in federal funding to pay for expanded coverage for immigrants.

Providing health insurance for immigrant communities – including hundreds of thousands of essential workers who have kept our state functioning during a pandemic – is both morally and fiscally responsible. Expanding coverage would come at no cost to the state and would avoid $500 million in annual Emergency Medicaid costs incurred when people who are uninsured seek hospital emergency care. It would also increase revenues for our health care providers by providing them Essential Plan rates (which are higher than Medicaid rates) and reducing the amount of uncompensated care they provide.

Other states, including Colorado, Illinois, Washington, and California have recognized health insurance is a human right by extending affordable insurance coverage to all income-eligible immigrants. It is time for New York to do the same.

Medicaid Matters urges the Department of Health to amend its 1332 waiver application to include people who are undocumented and to agree to include this provision in this year's enacted state budget.

MEDICAL SOCIETY OF THE STATE OF NEW YORK
155 WASHINGTON AVENUE, SUITE 207, ALBANY, NY 12210
518-465-8085 • Fax: 518-465-0976 • E-mail: albany@mssny.org

TO: **The New York State Department of Health**

FROM: **The Medical Society of the State of New York**

DATE: **March 9, 2023**

RE: **Public Comment on New York State Draft Section 1332 Innovation Waiver on Essential Plan Expansion**

Summary: The Medical Society of the State of New York (MSSNY) is grateful to the New York State Department of Health (DOH) for the opportunity to comment on the draft of New York's Section 1332 Innovation Waiver for the Essential Plan. In short, MSSNY strongly supports the draft waiver, particularly regarding the expansion of coverage from 200% of the Federal Poverty Level (FPL) to 250% FPL. However, we would like DOH to add coverage of lawfully present immigrants through the Section 1331 Basic Health Program provision under the Affordable Care Act (ACA). Adding coverage for immigrants would be: (1) fiscally prudence; (2) beneficial to our strained New York physicians and other providers; (3) consistent with patient well-being, public health and health equity; and (4) consistent with other state precedents.

Background: MSSNY has consistently supported the Essential Plan. And New York's Essential Plan has been an astounding success. Over 1.1 million enrollees have had access to affordable, high quality coverage. And the state savings have been significant. The Essential Plan has a roughly $9 billion surplus, generating approximately $2 billion excess annually. In addition to helping consumers, the Essential Plan has helped physicians – particularly those in underserved communities and at safety-net hospitals – stay afloat through better reimbursement for treatment of populations that were previously uninsured or underinsured.

Fiscally Sound. New York's State budget would benefit from substantial state savings were we to amend our 1332 Waiver request to include immigrants. New York spends at least $500 million annually on the Emergency Medicaid program for approximately 139,000 undocumented immigrants with incomes between 0-138 percent of the federal poverty level who are ineligible for any other form of coverage.[1] The 1332 waiver process could be used to cover all of these immigrants, thus saving the State approximately $500 million in state and local Medicaid funding.

Support for Fiscally Stressed Physicians. New York's physicians could benefit from including immigrants in our 1332 Waiver. Including immigrants in the 1332 Waiver means that physicians and other providers would be paid Essential Plan reimbursement

[1] New York State Emergency Services Only Utilization (Medicaid Coverage Code 07), Service Dates Calendar Year 1/1//19-12/31/2021 (2021 data used above).

rates — which are far higher than the standard Emergency Medicaid rates. In addition, providers would be reimbursed for the full continuum of care included in the Essential Plan benefit package: emergency services, inpatient, outpatient, labs, pharmacy, specialty and primary care visits, vision and dental. By contrast, Emergency Medicaid just reimburses physicians and other providers for emergency care necessary to stabilize a patient. Indeed, physicians have long complained of their uncompensated health care costs, which experts at the Urban Institute estimate to be as much as $1,174 per uninsured person. Accordingly, funds obtained from adding immigrants to the 1332 Waiver could be used for many valuable and much needed programs, including but not limited to improving paltry Medicaid rates for physicians, further subsidies for New York State of Health eligible enrollees above 250% FPL, the Committee for Physician Health, Doctors Across New York, the Excess Medical Malpractice Insurance Program and more.

Consistent with Patient Health. MSSNY has long support ensuring that everyone has access to high quality and affordable health insurance coverage. It is good for all New Yorkers, patients as well as physicians and other providers. Health insurance coverage reduces morbidity and mortality experienced by uninsured patients and improves economic security by reducing medical debt and bankruptcy.[2] In addition, increased coverage benefits the state as a whole. Public health efforts, including those to control COVID-19 and other epidemics, are undermined when uninsured people avoid health care because of financial barriers. People who are uninsured experience a loss of productivity and incur medical debt, which further damages our economy.[3] Finally, lack of coverage is a major factor exacerbating health disparities.[4] Combatting health disparities has been identified as a major objective for the Hochul Administration's heath strategy[5] as it is for MSSNY.

Consistent with Other State Precedents. Lastly, other states have covered immigrants and appear to have had no negative impacts on their state fiscal status. California, Colorado and Washington have all extended coverage to immigrants. California phased in Medicaid coverage regardless of immigration status. Colorado and Washington have secured 1332 Waiver "passthrough" funding. While we recognize that there are some technical differences between those waivers and the one New York would seek, the basic principle applies – extending coverage to immigrants has not cause losses that impact state budgets.

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[2] Benjamin Sommers, Atul A. Gawande, and Katherine Baicker, "Health Insurance Coverage and Health – What the Recent Evidence Tells Us," *New England Journal of Medicine*, vol. 377, no. 6 (August 10, 2017), pp. 586-593, www.nejm.org/doi/10.1056/NEJMsb1706645; Etienne Gaudette, Gwyn C. Pauley, and Julie M. Zissimopoulos, "Lifetime Consequences of Early-Life and Midlife Access to Health Insurance: A Review," *Medical Care Research and Review*, vol. 75, no. 6 (2018), pp. 655-720.

[3] Jacob Goldin, Ithai Z. Lurie, and Janet McCubbin, *Health Insurance and Mortality: Experimental Evidence from Taxpayer Outreach*," Working Paper 26533 (National Bureau of Economic Research, December 2019) www.nber.org/papers/w26533.pdf; Brian Gifford and Erin Peterson, "Health and Productivity Challenges for Lower-Income Workers: Health Insurance, Plan Design and Barriers to Care," *Integrated Benefits Institute* (July 2019), www.ibiweb.org/wp-content/uploads/2019/07/LowerIncome-Employees-Study.pdf; and Liam C. Malloy and Shanna Pearson-Merkowitz, "The Economic Impact of Expanding Medicaid," *The Collaborative* (2015), http://wp.collaborativeri.org/wp-content/uploads/2015/07/The-Economic-Impact-of-Expanding-Medicaid-.pdf.

[4] https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/

[5] https://www.governor.ny.gov/news/governor-hochul-signs-package-legislation-address-discrimination-and-racial-injustice

Thank you for the opportunity to comment. Please feel free to reach out to Troy Oechsner, MSSNY Executive Vice President, at toechsner@mssny.org if you have questions or would like to discuss.

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Ashwin Vasan, MD, PhD
Commissioner

Ashwin Vasan, MD, PhD
Commissioner

Gotham Center
42-09 28th St.
Long Island City, NY 11101

March 11, 2023

via electronic submission: nysoh.team@health.ny.gov

Re: New York Essential Plan Expansion (Section 1332 State Innovation Waiver)

Dear New York State of Health Administrators:

The City of New York ("NYC" or "the City") appreciates the opportunity to respond to the New York State Department of Health's (NYSDOH) Section 1332 State Innovation Waiver application, which proposes to expand Essential Plan (EP) eligibility to individuals with incomes up to 250% of the Federal Poverty Level (FPL). The City supports the proposed waiver's intent to broaden affordable insurance access for low- and moderate-income New Yorkers. However, the City opposes the submission of this waiver without modification to include adults ages 19-64 who are currently ineligible for EP coverage because of immigration status.

Background

Insurance Coverage Landscape for Undocumented New Yorkers

Since passage of the Patient Protection and Affordable Care Act (ACA) in 2010 and subsequent launch of the New York State of Health (NYSOH) Marketplace in 2012, both New York State (NYS) and New York City have seen a steady reduction in the number of people without health insurance.[1] Between 2013 and 2019, the number of uninsured residents of all ages living in NYC declined by 50%.[2,3] However, over 1 million New Yorkers (4.7% of state population), including nearly 570,000 NYC residents (6.9% of city population), remained uninsured in 2019. While continuous Medicaid coverage under the federal COVID-19 public health emergency dampened the impact of private coverage loss during the pandemic and contributed to a slight drop in city and state

[1] New York State of Health. "Bucking national trends, New York's uninsured rate continues to decline, reaching a historic low of 4.7 percent [Press release]." 15 March 2019. https://info.nystateofhealth.ny.gov/news/press-release-bucking-national-trends-new-yorks-uninsured-rate-continues-decline-reaching
[2] U.S. Census Bureau. American Community Survey 1-Year Estimate Public Use Microdata Sample for 2019, as analyzed by New York City Department of Health and Mental Hygiene, Health Access and Policy Unit.
[3] Note: We reference 2019 ACS data because 2021 estimates for uninsured rates are likely elevated by continuous Medicaid coverage under the Federal Public Health Emergency.

uninsured rates, a significant portion of New Yorkers remain ineligible for insurance in 2023 due to immigration status.[4]

New York State has the fourth largest undocumented population in the United States, the vast majority of whom live in New York City.[5] The NYC Mayor's Office of Immigrant Affairs estimates that nearly 476,000 immigrants living in NYC are undocumented, of which 46% are uninsured and largely ineligible for coverage.[6]

In New York State, insurance coverage for undocumented populations is limited to pregnant people and children under age 19 living in low- to moderate-income households. Beginning in 2024, state Medicaid eligibility will expand to include low-income undocumented New Yorkers ages 65 and older – a change the City strongly supports. However, without further action, undocumented adults ages 19-64 remain ineligible for affordable coverage options and must rely on Emergency Medicaid, safety net providers, and direct access programs to receive services and cover out-of-pocket costs.

Recent Budgetary Action

The State's FY23 Enacted Budget authorizes the NYS Commissioner of Health to seek a Section 1332 State Innovation Waiver to increase the upper income limit for EP eligibility from 200% FPL to 250% FPL. Despite previous and public indication that the expansion request would extend EP eligibility to undocumented New Yorkers,[7,8] the proposed waiver application backtracks on such promises.[9]

Still, the waiver offers considerable value to moderate-income consumers who would otherwise be enrolled in a Qualified Health Plan (QHP). The Essential Plan offers year-round enrollment, meaning timelier access to coverage than with QHPs. Coverage also comes at minimal cost to the consumer, with no deductibles and $0 premiums for those who qualify. Further, the scope of covered services is more comprehensive than most other affordable plans on the market; in 2022, both dental and vision were added as permanent benefits, with no cost-sharing.[10]

The waiver as it currently stands will improve coverage for some low- and middle-income New Yorkers, but it will also deepen longstanding inequities based on immigration status and continue to relegate the health needs of undocumented people – the single largest population of remaining uninsured New Yorkers.

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[4] Conway D, Mykyta L. Decline in share of people without health insurance driven by increase in public coverage in 36 states. 15 September 2022. U.S. Census Bureau. https://www.census.gov/library/stories/2022/09/uninsured-rate-declined-in-28-states.html

[5] Pew Research Center. Unauthorized immigrant population trends for states, birth countries and regions. 12 June 2019. https://www.pewresearch.org/hispanic/interactives/unauthorized-trends/

[6] NYC Mayor's Office of Immigrant Affairs. State of Our Immigrant City: Mayor's Office of Immigrant Affairs (MOIA) Annual Report for Calendar Year 2020. 2021. https://www.nyc.gov/assets/immigrants/downloads/pdf/MOIA-Annual-Report-for-2020.pdf

[7] See: "Governor Hochul Announces Agreement on FY 2023 New York State Budget." 7 April 2022. Official YouTube Channel for Governor Kathy Hochul. https://www.youtube.com/watch?v=Ysb38zrpx6Q&t=2066s

[8] New York State Department of Health. 2022-23 Enacted Medicaid Budget Briefing and Questions & Answers. April 2022. Office of Health Insurance Programs. https://www.health.ny.gov/health_care/medicaid/redesign/2022/docs/2022-23_enacted_budget_brief_qa.pdf

[9] New York State Department of Health. New York Section 1332 Innovation Waiver Essential Plan Expansion: Draft for Public Comment. 9 February 2023. https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf

[10] New York State of Health. Fast Facts on the Essential Plan. 2022. https://info.nystateofhealth.ny.gov/sites/default/files/Essential%20Plan%20Fact%20Sheet%202022%20-%20English.pdf

Proposed Amendment – Justification and Impact

The City of New York strongly recommends that the draft waiver application be modified to expand coverage to adults ages 19-64 with incomes up to 250% FPL who are currently ineligible for Essential Plan coverage because of their immigration status. This recommendation aligns with the Hochul Administration's stated goal of reducing New York's uninsured population[11] and its earlier commitment to include undocumented individuals in expanding eligibility for the Essential Plan.[7,8]

The proposed amendment comes at no cost to the State and is expected to yield savings for providers and consumers and improve health outcomes for over 245,000 historically underserved New Yorkers.

Insurance coverage improves health outcomes and can decrease health care costs over time

Insurance coverage is a strong predictor of access to care and improved health outcomes. Numerous studies indicate that having a primary care provider (PCP) or usual source of care – both of which are strongly influenced by insurance status[12] – improves continuity of and access to preventive services.[13] Consequently, lack of insurance impedes a person's ability to access primary care and specialty services, including screenings and diagnostics linking patients to timely treatment and intervention.[14,15] For individuals with chronic conditions that require ongoing clinical management, living without health insurance can have critical consequences for both health outcomes and financial stability.[16] Indeed, barriers to primary care are associated with higher rates of preventable hospitalization and emergency department (ED) visits, which lead to greater costs for both patients and health care systems, especially when compared with regular primary care expenses.[17,18]

The Oregon Health Insurance Experiment provides an excellent example of how addressing barriers to care – in this case through the expansion of Medicaid coverage – can lead to measurable increases in primary care use. In surveying program participants, the study found that Medicaid coverage increased the probability that people reported themselves to be in "good to excellent" health by 25%.[19] The program also saw significant increases in critical preventive care services, including a 50% increase in cholesterol monitoring and a 100% increase in mammograms.[20]

The NYC Department of Health and Mental Hygiene's (DOHMH) ActionHealthNYC program also demonstrated how removing barriers to care can improve meaningful health care utilization while driving down unnecessary costs. Between 2016 and 2017, DOHMH collaborated with the city's public hospital system, NYC Health + Hospitals (H+H), and several federally qualified health centers to

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[11] Governor Kathy Hochul. 2022 State of the State. 2022. https://www.governor.ny.gov/sites/default/files/2022-01/2022StateoftheStateBook.pdf

[12] Glied S, Ma S, Borja A. Effect of the Affordable Care Act on health insurance access. 8 May 2017. The Commonwealth Fund. https://www.commonwealthfund.org/publications/issue-briefs/2017/may/effect-affordable-care-act-health-care-access

[13] Blewett LA, Johnson PJ, Lee B, Scal PB. When a usual source of care and usual provider matter: adult prevention and screening services. *J Gen Intern Med*. 2008;23(9):1354–1360.

[14] Bovbjerg RR, Hadley J. Why Health Insurance Is Important. Urban Institute. November 2007. DC-SPG no.1. https://www.urban.org/sites/default/files/publication/46826/411569-Why-Health-Insurance-Is-Important.PDF

[15] Institute of Medicine Committee on the Consequences of Uninsurance. "Care without coverage: too little, too late." Effects of Health Insurance on Health. Washington, DC: National Academies Press. 2002.

[16] Hatch B, Marino M, Killerby M, et al. Medicaid's impact on chronic disease biomarkers: a cohort study of community health center patients. *J Gen Intern Med.* 2017;32(8):940–947.

[17] Rosano A, Loha CA, Falvo R, et al. The relationship between avoidable hospitalization and accessibility to primary care: a systematic review. *Eur J Public Health.* 2013;23(3):356–360.

[18] Parchman ML, Culler S. Primary care physicians and avoidable hospitalizations. *J Fam Pract.* 1994;39(2):123–128.

[19] Finkelstein A et al. The Oregon Health Insurance Experiment: Evidence from the First Year. *Quarterly Journal of Economics.* 2012;127(3):1057-1106.

[20] Baicker K, Finkelstein A. Oregon Health Insurance Experiment. National Bureau of Economic Research. July 2011.

provide direct access to primary care and coordination services for over 1,300 insurance-ineligible New Yorkers. The program was highly successful: After the program year, participants were more likely than their counterparts to report having utilized primary care,[21] having a PCP, or seeing a health care provider within the last 9 months. A more recent analysis found that the program was also successful in reducing ED visits for primary care-treatable conditions by 23%, driven by a 32% reduction in high-risk individuals.[22]

Many of the learnings of ActionHealthNYC were subsequently implemented in NYC Care, NYC Health + Hospitals' health care access program for New York City residents who are ineligible for health insurance or cannot afford the health insurance for which they are eligible. The program has maintained over 100,000 enrollees since fall 2021 while performing health insurance eligibility screenings annually. Preliminary analyses have shown that after six months in the program, 53% of enrollees with diabetes have seen an improvement in their hemoglobin A1C readings, and 40% of enrollees with hypertension have seen an improvement in their blood pressure. A preliminary analysis showed that patients enrolled in NYC Care utilized the emergency room 21% less than the non-NYC Care NYC Health + Hospitals patients.

Immigrants tend to be healthier than U.S.-born individuals

ActionHealthNYC and NYC Care's outcomes are even more compelling when applied to an almost entirely undocumented patient population. A wealth of literature supports the notion that immigrants tend to be healthier than most U.S.-born people. This is captured in a phenomenon called "the healthy immigrant effect," wherein recent immigrants assess their health status more favorably and utilize fewer or comparable health care resources than U.S.-born populations.[23,24] In one study, researchers in California found that undocumented Mexicans had 1.6 fewer physician visits compared to U.S.-born Mexicans; other undocumented Latinos had 2.1 fewer visits compared to U.S.-born counterparts.[25]

These data directly refute the misconception that immigrants tend to overuse health care resources and that expanding insurance coverage to previously ineligible populations yields a spike in unnecessary utilization. Indeed, we would anticipate welcome growth in primary care use as a result of expanded access and decreased rates of unnecessary and costly utilization. Moreover, noting that roughly three-quarters of undocumented people in NYS reside in NYC, we expect that a significant portion of individuals who would benefit from more inclusive EP eligibility will have already established a pattern of primary care use through the NYC Care initiative. This means that expanding coverage to this population is unlikely to result in a sudden wave of acute health care needs or disproportionate utilization.

From a health economics perspective, expanding insurance access to a relatively healthy population is unlikely to incur disproportionate costs. On the contrary, it would ultimately yield savings through more meaningful health care use and better long-term health outcomes. A recent report from New

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[21] Sood RK, Bae JY, Sabety A, Chan PY, Heindrichs C., ActionHealthNYC: Effectiveness of a health care access program for the uninsured, 2016-2017. *AJPH.* 2021;111(7):1318-1327.
[22] Sabety A, Gruber J, Bae JY, Sood RK., Reducing Frictions in Healthcare Access: The ActionHealthNYC experiment for Undocumented Immigrants, 2023. Forthcoming. *American Economic Review: Insights.* https://www.aeaweb.org/articles?id=10.1257/aeri.20220126
[23] Hamilton TG. The healthy immigrant (migrant) effect: in search of a better native-born comparison group. *Social Science Research.* 2015;54:353-365.
[24] DeAnne K et al. The impact and implications of undocumented immigration on individual and collective health in the United States. *Nursing Outlook.* 2015;63(1):86-94.
[25] Ortega A et al. Health Care Access, Use of Services, and Experiences Among Undocumented Mexicans and Other Latinos. *JAMA Internal Medicine.* 2007;167(21):2354-2360.

York City Comptroller, Brad Lander, also found that expanding EP eligibility to undocumented people would provide an estimated $710 million in economic benefits.[26]

Essential Plan coverage shifts costs away from the City and State

In addition to lower hospitalization and ED utilization rates, the waiver application and our proposed amendment would shift costs away from state and local governments. Essential Plan coverage is federally funded through the Basic Health Plan Trust, which presently has an $8 billion surplus only to be used for coverage costs.[27] Consequently, the State would not bear any costs in expanding EP coverage to undocumented people.

New York City would also expect to see a financial benefit as Emergency Medicaid recipients and NYC Care enrollees transition to comprehensive Essential Plan coverage, allowing the City to recapture its local contributions to Emergency Medicaid (over $200 million annually) and lower NYC Care program costs.

Increasing access to insurance coverage for undocumented individuals would also bolster the state's safety net system. Providers would see a drop in uncompensated care costs ($1,174 per person covered each year), allowing more flexibility with resources,[28] and visits for EP-insured patients would afford higher reimbursement rates for the same services compared with Emergency Medicaid. The additional revenue would be helpful for essential safety net providers like NYC Health + Hospitals, which operate on the slimmest of financial margins.

Expanding coverage to undocumented people has public support and precedent in other jurisdictions

Finally, expanding insurance coverage to undocumented populations via the 1332 waiver pathway is not new. Other states, including Colorado and Washington, have already received permission from the Centers for Medicare and Medicaid Services to cover people regardless of immigration status.[29,30]

In addition to these historic precedents, public opinion also supports expansion of coverage for undocumented New Yorkers, with 8 out of 10 New Yorkers supporting quality health care for immigrants across all regions and political party affiliations, per a March 2022 poll conducted by non-partisan research firm PerryUndem.[31]

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[26] New York City Comptroller Brad Lander. "Economic Benefits of Coverage For All." 15 March 2022. https://comptroller.nyc.gov/newsroom/nyc-comptrollers-office-estimates-710-million-in-annual-economic-benefits-from-expanding-health-coverage-for-immigrant-new-yorkers/

[27] Hammond B. "The Essential Plan's accumulated surplus balloons to $8 million, with no fix in sight." Empire Center. 8 September 2022. https://www.empirecenter.org/publications/the-essential-plan-surplus-balloons-to-8-billion/

[28] Blumberg L, Cuetthens M, Holahan J. How would state-based individual mandates affect health insurance coverage and premium costs? The Urban Institute. July 2018. https://www.urban.org/sites/default/files/publication/98805/2001925_state_based_individual_mandates.pdf

[29] Villeda K. "Washington's 1332 waiver presents opportunities for health equity." 23 January 2023. Community Catalyst. https://communitycatalyst.org/posts/washingtons-1332-waiver-presents-opportunities-for-health-equity/

[30] Monahan C, Giovanelli J, Lucia K. "HHS Approves Nation's First Section 1332 Waiver for a Public Option-Style Health Care Plan in Colorado." 12 July 2022. The Commonwealth Fund. https://www.commonwealthfund.org/blog/2022/hhs-approves-nations-first-section-1332-waiver-public-option-plan-colorado

[31] "Results from a Statewide Survey: How New Yorkers Feel About Affordability and Healthcare Reform." May 2022. Prepared by PerryUndem for the Robert Wood Johnson Foundation. https://nyhealthfoundation.org/wp-content/uploads/2022/05/PerryUndem-Presentation-Slides.pdf

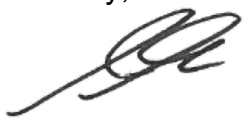
Conclusion

The City of New York strongly urges the New York State Department of Health to modify its existing waiver application to include eligibility for adults ages 19-64 who are currently ineligible because of their immigration status. The action comes at no cost to the State and will have a positive impact on health system efficiencies and patient outcomes. It would also contribute to the obligation we collectively have as the City and State to dismantle longstanding structural barriers, rooted in racism and bias, that perpetuate disparate health outcomes in immigrant communities.

The City is deeply committed to expanding insurance access and eliminating barriers to care for all New Yorkers. An investment in the health of a neighbor is an investment in the health of the community. The public health of all New Yorkers is better when everyone has access to comprehensive coverage – it is a question of public health preparedness as well as a question of rights.

We thank the State again for the opportunity to comment and look forward to working together to fulfill this mission.

Sincerely,



Dr. Michelle Morse, MD, MPH
Chief Medical Officer
Deputy Commissioner, Center for Health Equity and Community Wellness
New York City Department of Health and Mental Hygiene

New York Health Foundation Comments on the New York State Department of Health's Section 1332 State Innovation Waiver Application

March 9, 2023

The New York Health Foundation (NYHealth) appreciates the opportunity to provide comments in response to the New York State Department of Health's Section 1332 State Innovation Waiver application to expand the Essential Plan to New Yorkers with incomes up to 250% of the Federal Poverty Level (FPL).

NYHealth is a private, independent, statewide foundation dedicated to improving the health of all New Yorkers, especially people of color and others who have been historically marginalized. Since our inception, NYHealth has shared a goal with the State: to expand health insurance coverage to all New Yorkers. We have invested millions of dollars to do so and have proudly partnered with the State on many of these efforts. The Foundation and the State collaborated on numerous projects to successfully implement the Affordable Care Act and maximize its potential. Currently, we are partnering with the State to navigate the unwinding of the pandemic-era continuous enrollment provision and ensure that as many New Yorkers as possible maintain coverage.

A consistent theme of our work has been to maximize insurance coverage and expand access to care for immigrants. Immigrants have been an integral part of New York's rich cultural heritage and economy for centuries. To this day, they comprise a significant proportion of the population and are important contributors to the economy.[1] Of particular relevance, NYHealth and other private funders supported the Community Service Society of New York to examine the costs and feasibility of multiple insurance options for undocumented immigrants, including extending Essential Plan coverage. Those analyses demonstrated that offering comprehensive coverage through the Essential Plan to undocumented immigrants with incomes up to 200% of the Federal Poverty Level create coverage options for approximately 250,000 people—nearly 30% of the remaining uninsured.[2]

While the State's 1332 waiver proposal to expand public coverage is a step to improve access to and affordability of health care, we encourage the State to broaden its vision to all New Yorkers who are in need, including immigrants. New York State was successful in securing federal support to cover lawfully present immigrants when it established New York's Basic Health Plan, now called the Essential Plan, in 2015. State leadership last year committed to using the waiver process to build on this success and expand coverage to more immigrants. The 1332 Waiver application is an opportunity to fulfill this commitment and to provide the State with a mechanism for financing this coverage expansion.

The inclusion of immigrants in coverage expansion through the 1332 Waiver would:

[1] Center for Migration Studies. "Immigrants Comprise 31 Percent of Workers in New York State Essential Businesses and 70 Percent of the State's Undocumented Labor Force Works in Essential Businesses" (April 2020) https://cmsny.org/publications/new-york-essential-workers/, accessed March 2023.

[2] Benjamin ER. "How Can New York Provide Health Insurance Coverage to its Uninsured Immigrant Residents? An Analysis of Three Coverage Options." Community Service Society. (January 2016) https://nyhealthfoundation.org/wp-content/uploads/2017/12/covering-new-yorks-uninsured-immigrant-residents.pdf,, accessed March 2023.

- Contribute to the largest reductions in persistent uninsurance rates in New York, narrowing health care disparities and improving health for all New Yorkers;
- Save money for New York State's government while increasing reimbursement rates for our fiscally distressed health care providers by securing federal financial participation for coverage of immigrants;
- Bolster our health care system and public health preparedness by ensuring more people have comprehensive coverage when the next medical emergency occurs; and
- Preserve New York State's position as a leader in health care coverage access and innovation and leverage models from states that have successfully charted the course for immigrant coverage.

Broad Immigrant Coverage Benefits all New Yorkers and Advances Health Equity

New York State has been a leader in expanding health care coverage in many ways, including expanding coverage to children regardless of immigration status. But the State has left behind an important group of adult immigrants. Home to one of the largest and most diverse immigrant populations in the country, New York has nearly 2 million residents who are noncitizens, including more than 800,000 undocumented or unauthorized immigrants.[3,4] Estimates show that approximately 40% of this population is uninsured, making them one of the largest cohorts of uninsured New Yorkers.[5] Without coverage, many turn to the emergency room or delay needed care, which can lead to higher costs.

Ensuring that everyone has health insurance is good for all New Yorkers—regardless of their immigration status. Research shows insurance coverage reduces morbidity and mortality experienced by uninsured patients and improves economic security by reducing medical debt and bankruptcy.[6] In addition, broad coverage promotes a high-functioning health care system and benefits the State by creating access to preventive care and reducing reliance on emergency departments. Public health efforts, including those to control COVID-19 and other pandemics and epidemics, are also undermined when uninsured people avoid health care because of financial barriers. Lack of coverage is also a major factor exacerbating health disparities.[7] Combatting health disparities has been identified as a major objective for the Hochul Administration's health strategy; ensuring health care coverage for all New Yorkers is a strategy to achieve it.[8]

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[3] United States Census Bureau. Nativity and Citizenship Status in the United States (Table: B05001 2021 ACS 1-Year Estimated Detail Tables). https://data.census.gov/table?t=Citizenship&g=0400000US36&y=2021&tid=ACSDT1Y2021.B05001, accessed March 2023.

[4] Migration Policy Institute. "Profile of the Unauthorized Population: New York." https://www.migrationpolicy.org/data/unauthorized-immigrant-population/state/NY, accessed March 2023.

[5] Ibid.

[6] Benjamin Sommers, Atul A. Gawande, and Katherine Baicker, "Health Insurance Coverage and Health – What the Recent Evidence Tells Us," *New England Journal of Medicine*, vol. 377, no. 6 (August 10, 2017), pp. 586-593, www.nejm.org/doi/10.1056/NEJMsb1706645; Etienne Gaudette, Gwyn C. Pauley, and Julie M. Zissimopoulos, "Lifetime Consequences of Early-Life and Midlife Access to Health Insurance: A Review," *Medical Care Research and Review*, vol. 75, no. 6 (2018), pp. 655-720.

[7] Nambi Ndugga, Samantha Artiga. Disparities in Health and Health Care: 5 Key Questions and Answers. Kaiser Family Foundation. (May 2021). https://www.kff.org/racial-equity-and-health-policy/issue-brief/disparities-in-health-and-health-care-5-key-question-and-answers/, accessed March 2023.

[8] New York State Office of Governor Kathy Hochul. "Governor Hochul Signs Package of Legislation to Address Discrimination and Racial Injustice," https://www.governor.ny.gov/news/governor-hochul-signs-package-legislation-address-discrimination-and-racial-injustice, accessed March 2023.

Including Immigrants in the 1332 Waiver Request Would Save the State Money

New York State would benefit from substantial savings were it to amend its 1332 Waiver request to include immigrants. New York spends at least $500 million annually on the Emergency Medicaid program for approximately 139,000 undocumented immigrants with incomes 0–138% of the Federal Poverty Level who are currently ineligible for any other form of coverage.[9] The 1332 Waiver process could be used to cover all of these immigrants entirely with federal dollars from the estimated $2 billion surplus that will be deposited in the "passthrough account," saving New York approximately $500 million in State and local Medicaid funding.[10]

The State's 1332 Waiver application indicates that the combined Basic Health Program/1332 Waiver will continue to generate an annual surplus of $2 billion. The inclusion of undocumented immigrants in the 1332 Waiver could be entirely funded with those federal surplus funds. This would generate substantial Emergency Medicaid savings that may be used for other important budget priorities.

The 1332 Waiver would also provide needed financial support to New York's strained health care providers. Including previously ineligible immigrants would mean that providers would be paid Essential Plan reimbursement rates, which are far higher than the standard Emergency Medicaid rates. Providers would be reimbursed for the full continuum of care included in the Essential Plan benefit package: emergency services, inpatient, outpatient, labs, pharmacy, specialty and primary care provider visits, vision, and dental. By contrast, Emergency Medicaid only reimburses providers for emergency care necessary to stabilize a patient. Finally, providers have long raised issues with levels of uncompensated health care costs, which experts at the Urban Institute estimate to be as much as $1,174 per uninsured person.[11] Expanded coverage would help alleviate some of these cost burdens.

Other States Have Charted a Course for New York State

Other states have moved forward with covering all immigrants by securing federal financial participation in coverage expansions. For example, California has phased in Medicaid coverage regardless of immigration status for children, young adults, older adults, and now all people, inclusive of all ages and documentation status.[12] Similarly, Illinois provides Medicaid to adult immigrants, ages 42 and above, who are ineligible for federally funded health care.[13] Perhaps most relevant to New York's situation, Colorado has secured a 1332 Waiver that establishes "passthrough" funding in order to offer comprehensive health coverage to establish a public option,

[9] New York State Emergency Services Only Utilization (Medicaid Coverage Code 07), Service Dates Calendar Year 1/1//19-12/31/2021 (2021 data used above).

[10] New York State Department of Health, "New York Section 1332 Innovation Waiver Essential Plan Expansion, Draft for Public Comment," February 9, 2003.

[11] Linda J. Blumberg, Matthew Buettgens, and John Holahan, *How Would State-Based Individual Mandates Affect Health Insurance Coverage and Premium Costs?* (Urban Institute, July 2018), https://www.urban.org/sites/default/files/publication/98805/2001925_state_based_individual_mandates.pdf.

[12] Office of Governor Gavin Newsom. "Medi-Cal Expansion Provided 286,000 Undocumented Californians With Comprehensive Health Care". State of California. (October 2022), https://www.gov.ca.gov/2022/10/19/medi-cal-expansion-provided-286000-undocumented-californians-with-comprehensive-health-care/, accessed March 2023.

[13] Illinois Department of Human Services. "Health Benefit Coverage for Immigrant Adults: Ages 42 to 54 Years Old". State of Illinois. (July 2022), https://www.dhs.state.il.us/page.aspx?item=144320, accessed March 2023.

which provides coverage for undocumented immigrants, among others.[14] Washington State has also used its 1332 Waiver to provide coverage for immigrants in its Cascade Care program.[15]

New York should preserve its reputation as a pioneering state and use this opportunity to include health care coverage of currently ineligible immigrants. It will be a major step to expand access and promote equity while stabilizing our health care system at this critical moment.

Thank you for the opportunity to provide these comments. We look forward to continuing to partner with the New York State Department of Health to work toward our shared goal of coverage for all New Yorkers.

[14] Christine Monahan, Justin Giovannelli, Kevin Lucia. "HHS Approves Nation's First Section 1332 Waiver for a Public Option–Style Health Care Plan in Colorado" The Commonwealth Fund (July 2022), https://www.commonwealthfund.org/blog/2022/hhs-approves-nations-first-section-1332-waiver-public-option-plan-colorado, accessed March 2023.

[15] Through its 1332 Waiver, Washington will provide state-only funding to subsidize ineligible immigrants up to 250% of the federal poverty level to purchase Cascade Care, https://communitycatalyst.org/posts/washingtons-1332-waiver-presents-opportunities-for-health-equity/#:~:text=This%20section%201332%20waiver%20authorizes,%2C%20beginning%20January%201%2C%202024.

New York HPA Health Plan Association

41 State Street • Suite 900 Albany, NY 12207

www.nyhpa.org

March 10, 2023

Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Submitted online

Re: New York Section 1332 Innovation Waiver Essential Plan Expansion

Dear Ms. Holahan,

On behalf of our 11 member plans who participate in the Essential Plan, the New York Health Plan Association (HPA) submits the following comments in response to the Department of Health's (DOH) Section 1332 Innovation Waiver Essential Plan (EP) Expansion application.

HPA supports the State's proposed 1332 waiver application to expand eligibility for the Essential Plan from 200% to 250% of the federal poverty level, since it will make coverage more affordable to individuals up to 250% of the poverty level.

We also encourage the state to expand the application to include coverage for income-eligible undocumented immigrants, and will continue to work collaboratively toward the goal of affordable coverage for all New Yorkers.

We appreciate that the state recognizes the importance of funding a quality incentive pool for the Essential Plan to address health disparities and social determinants of health, and support the state's intention to continue to fund a quality incentive program in the Essential Plan.

Finally, we are concerned with the expectation that there will be a loss in coverage in the individual market resulting from the increased premiums projected as a result of movement of the expansion population from the individual market to the Essential Plan. We hope to work with the state over the coming year to address cost drivers in the system in a meaningful way in order to make coverage more affordable for all New Yorkers, and avoid any loss of coverage.

Sincerely,

Kathleen Preston
Executive Vice President
NY Health Plan Association

From: David Cohen <david.cohen@nysna.org>
Sent: Saturday, March 11, 2023 10:00 PM
To: doh.sm.NYSOH.Team <NYSOH.Team@health.ny.gov>
Subject: NYSNA Statement - Federal Funds Should be Used to Pay for Healthcare Coverage For All.

Department of Health ,

RE: NYSNA Letter of support for “Coverage for All 1332 Waiver” which expands the coverage and benefits of the Essential Plan (Article VII, HMH Legislation, Part H) to include ALL uninsured New Yorkers.

The Governor’s Executive Budget proposes to increase coverage and lift the income caps to expand the Essential Plan, but does not include any proposals to implement the commitment made last year to expand coverage to include all undocumented immigrants between the ages of 18 and 65. The Essential Plan receives significant federal funding under the ACA and currently holds unspent reserves of approximately $10 billion. At the same time, there are still about 1 million New Yorkers who are uninsured, including about 400,000 undocumented immigrants.

NYSNA strongly supports provisions to expand the Essential Plan to immediately include all uninsured New Yorkers, regardless of their ability to pay or immigration status. The State should seek federal approval and participation for such coverage, or in the alternative, it should pay for the coverage expansion by utilizing the unspent reserves or paying the costs with state funds.

New York State Nurses Association

David Cohen
david.cohen@nysna.org
131 West 33rd Street
New York, New York 10001

From: Rachelle Kivanoski <rkivanoski@gmail.com>
Sent: Thursday, March 9, 2023 11:43 PM
To: doh.sm.NYSOH.Team <NYSOH.Team@health.ny.gov>
Subject: NYC FAIR Comments in opposition to proposed 1322

NYC FAIR COMMENTS ON NEW YORK'S 1332 WAIVER TO EXPAND THE ESSENTIAL PLAN

NYC FAIR (Family Advocacy and Information Resource) is an organization of family members and others throughout New York City who advocate for the rights and needs of all people with Intellectual & Developmental Disabilities. We are committed to equity of access to health care services for all New Yorkers. While we applaud the impetus to expand the Essential Plan outlined in the State's 1332 Innovation Waiver, we are opposed to the exclusion of undocumented immigrants.

We are dismayed by this change to the initial conception of the Waiver which did include undocumented people. Hundreds of thousands of undocumented immigrants are essential workers who helped us, our families and all New Yorkers survive during the pandemic despite the great risk to their own and their families' health. In addition there are many people with Intellectual and Developmental Disabilities who are part of these undocumented families who lack access to basic health care.

This exclusion is particularly disturbing since including undocumented immigrants would not incur any additional costs to the State and could be funded by using part of the large existing surplus in the Essential Plan fund. Including them would potentially avoid $500 million in Emergency Medicaid costs and bolster the revenue of the health care providers who care for this population.

We call on the State to immediately amend the 1332 waiver application to include people who are undocumented and include this provision in this year's enacted state budget. It is both fiscally responsible and the right thing to do.

NYS Coalition for Children's Behavioral Health

3/2/2023

The New York State Coalition for Children's Behavioral Health (CCBH) is the voice of children, families, and providers in New York's children's behavioral healthcare continuum. The Coalition represents 47 provider agencies, serving tens of thousands of children and families throughout New York State, and we work collaboratively with families, State agencies, and other statewide advocates to support the implementation of policy that best serves the needs of children with mental, emotional, and behavioral health challenges, and their families.

CCBH supports the expansion of the Essential Plan (EP) to individuals earning up to 250% of the Federal poverty level (FPL), as proposed in this 1332 Waiver application. The more individuals and families have access to affordable and comprehensive health insurance, the better off we all are. The estimated $1,600 per year savings to enrollees who move from a qualified health plan (QHP) to the EP will certainly be a boon to the lower-income families this waiver will affect.

Inadequate insurance coverage is one of the primary reasons children and families with commercial insurance are unable to access the behavioral healthcare they need. "Inadequate" coverage takes many forms: a complete lack of insurance; a lack of available providers (network adequacy); and unaffordable copays, coinsurance, and deductibles, to name a few. Drawing more families into the EP, with its lower premiums and cost-sharing than QHPs, will reduce some of these barriers to care and be a step toward reducing healthcare inequities in underserved populations.

We appreciate the Department of Health's (DOH's) plan to automatically move individuals whose eligibility shifts from a QHP to the EP directly into an EP plan from the same carrier as their QHP to minimize network and care disruptions for those who are connected to care.

DOH stated in a presentation on the waiver application that "the State would use any excess pass-through funding for program improvements, including Social Determinants of Health interventions, further reductions in cost sharing and expanded access to services." The State is also requesting access to resources in the Trust Fund account. CCBH does not disagree with any of these uses of the funding, but we urge that investments in behavioral health services for children and families be prioritized. These services have long been largely ignored and underfunded, especially in the commercial insurance realm. A longstanding lack of investment in behavioral health is one of the driving forces behind the workforce shortage that inhibits access to care, even for those whose healthcare coverage would pay for services if they were available. It is critical that the State use available resources to support all aspects of enrollees' wellbeing, not least of all their mental and emotional health.

CCBH is concerned about the delay in moving certain people who are undocumented into the EP, as planned for in last year's budget. We understand that this delay is due in large part to a CMS denial, and we urge DOH to use every tool at their disposal to complete this transition as soon as possible.

We hope to see this waiver move forward expeditiously and with the long-term wellbeing of children and families in mind

NYU WAGNER

SHERRY GLIED
Dean

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March 11, 2023

Comments of Sherry Glied and Laura Wherry on Essential Plan Expansion/New York Section 1332 Innovation Waiver

We, Sherry Glied and Laura Wherry, are health economists and Professors at New York University's Robert F. Wagner Graduate School of Public Service. Sherry Glied is Dean of the School. She previously served as Assistant Secretary for Planning and Evaluation at the US Department of Health and Human Services (2010-2012). She is a nationally-recognized expert on health insurance reform and is a member of the National Academy of Medicine, the National Academy of Social Insurance, and the American Academy of Arts and Sciences. Laura Wherry is an Assistant Professor who has received national recognition for her research documenting health improvements resulting from expanded health insurance coverage.[1] We are commenting in our personal capacity.

We endorse the analysis of the Community Service Society (CSS), recommending that New York State include immigrants in its 1332 waiver request. As the CSS notes, this inclusion is fiscally prudent and would provide significant benefits to immigrants and to health care providers. Recent health economics analysis amplifies these points in three directions.

First, as Professor Wherry's research on a coverage expansion in California has shown,[2] expanded health insurance coverage for undocumented immigrants leads to better health outcomes for their future children, who are U.S. citizens by birthright. Analysis of a similar expansion in Oregon yielded similar results.[3] These studies focused specifically on expansions of prenatal care, but research literature, including by us, suggests that initiation of prenatal care is likely to occur earlier among women who have enrolled or believe that they can enroll in Medicaid before becoming pregnant.[4] In

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[1] Miller S, Johnson N, and Wherry LR. 2021. "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data" *Quarterly Journal of Economics* 136(3): 1783-1829 was a 2022 NIHCM Foundation Health Care Research Award finalist, https://nihcm.org/awards/research/finalists; Wherry LR and Meyer B. 2016. "Saving Teens: Using a Policy Discontinuity to Estimate the Effects of Medicaid Eligibility." *Journal of Human Resources* 51(3): 556-588 was 2017 Article of the Year winner at AcademyHealth;
Wherry LR, Miller S, Kaestner R, and Meyer B. 2018. "Childhood Medicaid Coverage and Later Life Health Care Utilization." *Review of Economics and Statistics* 100(2): 287-302 was 2018 HCUP Outstanding Article of the Year at AHRQ-AcademyHealth.

[2] Miller S and Wherry LR. 2022. "Covering Undocumented Immigrants: The Effects of a Large-Scale Prenatal Care Intervention." NBER Working Paper No. 30299. https://www.nber.org/papers/w30299]

[3] Swartz J, Haimueller J, Lawrence D, and Rodriguez MI. 2017. "Expanding Prenatal Care to Unauthorized Immigrant Women and the Effects on Infant Health." *Obstetrics & Gynecology* 130(5): 938-945. https://pubmed.ncbi.nlm.nih.gov/29016491/

[4] Rosenberg D, Handler A, Rankin KM, Zimbeck M, and Adams EK. 2007. "Prenatal Care Initiation Among Very Low-Income Women in the Aftermath of Welfare Reform: Does Pre-Pregnancy Medicaid Coverage Make a Difference?" *Maternal and Child Health Journal* 11: 11-17. Wherry LR. 2018. "State Medicaid expansions for parents led to increased coverage and prenatal care utilization among pregnant mothers." *Health Services Research* 53 (5): 3569-3591; Wang SS, Glied S Babcock

addition, new evidence from broader expansions in insurance coverage for adults under the Affordable Care Act finds declines in infant mortality rates as a result.[5]
Second, undocumented immigrants in New York State are already eligible for Emergency Medicaid, which largely covers services delivered in emergency facilities. Recent economic research suggests that broadening the scope of that coverage to include non-emergency services both improves access to preventive care, which is often highly cost-effective, and reduces reliance on emergency departments.[6] By reducing the use of emergency departments for services that can be effectively delivered in less intensive settings, expanding access to Medicaid could reduce emergency department overcrowding, which is a serious problem in parts of the state.

Third, a concern about expanding Medicaid to immigrants through a 1332 waiver is that such a waiver, while acceptable to the Biden administration, could be rescinded by a future Federal government. This is always a concern with any program that has Federal financial participation, but fiscal prudence supports using available Federal funds and adapting to future changes if and when they occur. Concerns about potential changes in Federal participation in the ACA Medicaid expansion led many states to delay participating in this expansion. In the 10 years since the expansions took place, these states have collectively left hundreds of billions of Federal Funds on the table, ostensibly in the name of fiscal prudence.

In sum, we strongly encourage New York State to include an expansion of coverage to immigrants in its 1332 waiver proposal.

Sincerely,

Sherry Glied

Laura R. Wherry

C & Chaudry A. 2022. “Changes in the Public Charge Rule and Health of Mothers and Infants Enrolled in New York State’s Medicaid Program, 2014–2019.” *American Journal of Public Health* 112(12): 1747-1756.

[5] Constantin J and Wehby GL. 2023. “Effects of Recent Medicaid Expansions on Infant Mortality by Race and Ethnicity.” *American Journal of Preventive Medicine* 64(3): 377-384.

[6] Sabety A, Gruber J, Bae JY, and Sood R. Forthcoming. "Reducing Frictions in Healthcare Access: The ActionHealthNYC Experiment for Undocumented Immigrants." *American Economic Review: Insights*.

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Kelly Ryan
Deputy Vice President, State Advocacy (Northeast Region)

Ms. Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Attn: 1332 Waiver
Albany, NY 12237

Submitted via email to nysoh.team@health.ny.gov

Dear Ms. Holahan:

The Pharmaceutical Research and Manufacturers of America (PhRMA) appreciates the opportunity to submit comments in support of New York's Section 1332 Innovation Grant Waiver application. PhRMA represents the country's leading innovative biopharmaceutical research companies, which are devoted to discovering and developing medicines that enable patients to live longer, healthier and more productive lives. Since 2000, PhRMA member companies have invested more than $1.1 trillion in the search for new treatments and cures, including $102.3 billion in 2021 alone.

Through a Section 1332 Innovation Waiver, New York seeks to expand eligibility for the Essential Plan, the state's Basic Health Program. The Essential Plan currently offers comprehensive coverage to Premium Tax Credit (PTC)-eligible individuals up to 200% of the Federal Poverty Level (FPL). This coverage is provided with no premium, no deductible and limited out-of-pocket expenses. Under this waiver proposal, New York would expand Essential Plan eligibility to PTC-eligible individuals up to 250% FPL, while maintaining a low premium, no deductible and low out-of-pocket costs for the expansion population.

Comprehensive, affordable, and accessible prescription drug coverage is important to preventing, treating, and curing acute and chronic medical conditions, as well as improving quality of life and reducing spending on other health care services[1]. Recent research shows that today, many Americans face affordability challenges in accessing the brand medicines they need in part because of health plans' increased use of benefit designs utilizing high deductibles and coinsurance. Across the seven therapeutic areas included in an analysis of IQVIA data, patients with deductibles and/or coinsurance paid as much as 30 times more out of pocket annually for brand medicines than patients with only copays.[2]

[1] Congressional Budget Office. Offsetting effects of prescription drug use on Medicare's spending for medical services. 2012. https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/MedicalOffsets_One-col.pdf.
[2] PhRMA. Faced with high cost sharing for brand medicines, commercially insured patients with chronic conditions increasingly use manufacturer cost-sharing assistance. July 2020.

The increasing use of deductibles and coinsurance by health plans disproportionately burdens patients with chronic conditions who are prescribed medicines, including some of the most disadvantaged in the health system.[3] For example, research from Harvard University shows that reduced cost sharing for cardiovascular medicines increased adherence and had a greater impact on reducing the risk of vascular events and medical costs among nonwhite patients.[4]

Delaying or not receiving medical care or treatments can have disastrous impacts on patient health and puts a tremendous strain on our health systems, as evidenced by recent studies of delayed care during the COVID-19 public health emergency. An analysis of projected cancer deaths during the public health emergency conservatively estimates those delays will result in 10,000 excess deaths over the next decade from breast and colorectal cancers alone.[5] On the other hand, a growing complementary body of evidence shows adherence to prescribed medicines is essential to improving outcomes for patients.[6,7,8] For example, at least one analysis has shown that improved adherence to diabetes medicines could prevent nearly 700,000 emergency department visits and 341,000 hospitalizations, and save nearly 5% billion annually.[9]

The recent public health emergency has also highlighted the impacts that gaps in access to coverage have on minority populations and disparities in both health and financial outcomes. Data show that Black and Hispanic individuals represent a disproportionate share of cases and deaths relative to their share of the population.[10] When adjusted for age, Hispanic, Black, and Native American and Alaskan Native people are about twice as likely to die from COVID-19 as their white counterparts.[11] These gaps have narrowed over time; previously, Americans in those communities were three times as likely to die from COVID-19.[12] These startling health disparities and the financial challenges that have resulted from the public health emergency have increased the financial burdens on minority communities and the uninsured. At least one study found that "more than 55% of Black people and nearly 44% of Hispanics reported

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https://phrma.org//media/Project/PhRMA/PhRMA-Org/PhRMAOrg/PDF/D-F/Faced-with-High-Cost sharing-for-Brand-Medicines.pdf.

[3] Megan B. Cole, PhD, MPH; Jacqueline E. Ellison, MPH; Amal N. Trivedi, MD, MPH; "Association Between High-Deductible Health Plans and Disparities in Access to Care Among Cancer Survivors," JAMA, June 2020.

[4] Choudhry, NK., Bykov, K., Shrank, WH., et al. Eliminating medication copayments reduces disparities in cardiovascular care. Health Affairs 2014 33:5, 863-870. https://www.healthaffairs.org/doi/10.1377/hlthaff.2013.0654.

[5] Norman E. Sharpless. COVID-19 and Cancer. Science. 19 Jun 2020. DOI: 10.1126/science.abd3377

[6] IMS Institute for Healthcare Informatics. Avoidable costs in US healthcare: the $200 billion opportunity from using medicines more responsibly. June 2013.

[7] MC Roebuck et al. "Medication Adherence Leads To Lower Health Care Use And Costs Despite Increased Drug Spending." Health Affairs 30 no. 1 (2011): 91-9.

[8] Lloyd, Jennifer T., et al. "How much does medication nonadherence cost the Medicare fee-for-service program?." Medical care 57.3 (2019): 218-224.

[9] Jha AK, Aubert RE, Yao J, Teagarden JR, Epstein RS. Greater adherence to diabetes drugs is linked to less hospital use and could save nearly $5 billion annually. Health Aff (Millwood). 2012;31(8):1836-1846. doi:10.1377/hlthaff.2011.1198

[10] Latoya Hill and Samantha Artiga. Kaiser Family Foundation. COVID-19 Cases and Deaths by Race/Ethnicity: Current Data and Changes Over Time. February 2022. https://www.kff.org/coronavirus-covid-19/issue-brief/covid-19-cases-and-deaths-by-race-ethnicity-current-data-and-changes-over-time/#:~:text=Discussion,across%20racial%20and%20ethnic%20groups.

[11] Id.

[12] Id.

problems with medical bills and debt, compared with 32% of white people."[13] Further, the study found that "more than one-half of uninsured adults reported having medical bill problems or were paying off medical debt."[14]

Expanding Essential Plan eligibility will help New Yorkers maintain affordable coverage and ease the challenges that may result from churn between Medicaid, the Essential Plan and QHPs on the New York State of Health. The proposed benefit design for the Essential Plan expansion population will include a $15/month premium, no deductible and a maximum out-of-pocket (MOOP) cost of $2000. This has the potential to provide significant savings for eligible individuals. For example, the standard non-HSA compliant Bronze qualified health plan currently carries a deductible of $4700 and a MOOP of $8700[15].

PhRMA supports policies that help individuals enroll and stay enrolled in coverage and policies that improve the affordability of and access to health care, particularly those that improve health equity. We believe New York's 1332 waiver application advances all of these goals and we applaud the state for this effort.

Sincerely,

Kelly A. Ryan
Deputy Vice President, State Policy

[13] Sara R. Collins, Gabriella N. Aboulafia, Munira Z. Gunja. Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021. https://www.commonwealthfund.org/publications/issue-briefs/2021/jul/as-pandemic-eases-what-is-state-coverage-affordability-survey

[14] Id.

[15] https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%202023%20Standard%20Plans%20revised%207-13-22.pdf

Planned Parenthood Empire State Acts

3/11/2023

Planned Parenthood Empire State Acts (“PPESA”) is grateful for the opportunity to provide comments on the proposed 1332 State Innovation Waiver (“the 1332 Waiver”). We appreciate the Department's commitment to expanding access to affordable quality health care coverage and believe this proposal provides an important opportunity to do so. We also believe for the proposal to truly advance health equity, it must include coverage for immigrants. Expanding this coverage will improve the health and well-being of our communities, and our state. Other states, including Colorado and Washington, have expanded affordable insurance coverage to all income-eligible immigrants, it is time for New York to similarly take action. PPESA urges the Department of Health to amend the proposed 1332 State Innovation Waiver to ensure it also provides coverage for immigrants. Thank you.

Primary Care Development Corporation

March 11, 2023

NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Attn: 1332 Waiver
Albany, NY 12237

VIA ELECTRONIC SUBMISSION

RE: Essential Plan Expansion 1332 Waiver Submission

To Whom it May Concern:

The Primary Care Development Corporation (PCDC) appreciates the opportunity to comment on the potential expansion of the Essential Plan coverage through New York State of Health. In 2022, New York State's enacted budget included a provision allowing the state's Department of Health to request a Section 1332 State Innovation Waiver from the Centers for Medicare & Medicaid Services (CMS) to expand eligibility for health insurance coverage under the state's Essential Plan to include residents with incomes up to 250 percent of the federal poverty level, up from the existing 200 percent of the federal poverty level. If approved, this change would ensure that more New Yorkers have access to quality and affordable insurance, which in turn will give them access to vital primary care.

As background, PCDC is a national non-profit organization and Community Development Financial Institution (CDFI) founded and based in New York City. We work to expand access to quality primary care and increase health equity for disinvested communities through capital investment, technical assistance, research, and policy advocacy. Since 1993, PCDC has leveraged more than $1.4 billion to finance over 218 primary care projects, with strategic community investments that have built the capacity to provide 4.7 million primary care visits annually, created or preserved more than 19,362 jobs in low-income communities, and transformed more than 2.6 million square feet of space into fully functioning primary care and integrated behavioral health practices. Our capacity-building programs have also trained and coached thousands of health workers to deliver superior patient-centered care.

All told, PCDC's work has impacted more than 60 million primary care patients across 45 states as well as the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and American Samoa. In New York State alone, we have worked with health care organizations, systems, and providers across the state on over 3,200 financing and technical assistance projects to build, strengthen, and expand primary care operations and services.

High quality, integrated, patient-centered primary care saves lives, leads to better individual and community health, and is central to health equity. Primary care is the foundation of our health care system and is key to preventing treatable outpatient diseases like diabetes from turning into life threatening conditions. It is the ongoing care that everyone needs in their lives, it keeps people healthy while also saving money, and it's critical to achieving health equity. PCDC is dedicated to expanding affordable healthcare access, while improving the quality of primary care for patients across the country. Our organization advocates for policies that will help achieve those goals, including reducing barriers and administrative burdens on our society's most vulnerable.

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For these reasons, PCDC supports the expansion of coverage under the Essential Plan. CMS's approval of the New York State Department of Health's 1332 Waiver would increase coverage for the some of the state's most vulnerable populations and presents an opportunity to expand access to primary care. Investments in care similar to the waiver have proven to save the healthcare system money but more importantly have also been shown to be a key factor in building healthier communities.[i]

Low income, communities of color and other disinvested communities have the least access to primary care and the worst outcomes.[ii] New Yorkers saw the tragic effects that lack of care had during the height of the COVID-19 pandemic, when communities that had the least access to primary care before the pandemic ended up with the worst outcomes. For example, since the onset of the pandemic, New York City's neighborhoods with the lowest incomes and lower rates of those insured have seen the highest rates of infection and death.[iii]

Many New Yorkers who are under-insured, uninsured or simply cannot access a primary care provider for a variety of reasons often put off seeking care until they must seek emergency care at a hospital. Many times, these emergency or hospital visits are the results of chronic diseases like heart disease or diabetes that would have been preventable and treatable if the patient had the ability to regular access a primary care physician[iv].

Expanding access to the Essential Plan to those who fall within 250 percent of the federal poverty level will increase access to health care overall and to critical primary care in particular. With the right public education and support, encouraging new members to find a primary care provider and seek regular care, this waiver could have a positive impact on health outcomes in many communities across the state and, as a result, improve health equity.

While PCDC does supports expanding the Essential Plan to those who fall within 250 percent of the federal poverty level, we strongly oppose the State's decision not to include expansion of access to the Essential Plan for otherwise qualified undocumented individuals as well, which could have been accomplished through this waiver.[v] In 2022, both the legislature and Governor agreed explore this opportunity as a critical way to provide needed health care access for New Yorkers who are currently uninsured due to immigration status. Other states, including Washington and Colorado, have already used the 1332 waiver process to expand coverage in this way.[vi] PCDC strongly supports, and urges the State to adopt, policies that make health insurance coverage accessible to and affordable for as many New Yorkers as possible, including those who are undocumented. Everyone deserves access to affordable health insurance. Affordable insurance increases access to primary care, among other health care services, and is critical to achieving health equity.

Once again, PCDC thanks New York State of Health for the opportunity to provide these comments on key sections of the 1332 Waiver that are within our expertise. We encourage the New York State Department of Health and CMS to adopt policies most likely to decrease barriers to insurance coverage and increase access to quality primary care. We would be happy to follow up on any of these key points if more information would be useful – feel free to reach out to our Director of Policy, Jordan Goldberg, at jgoldberg@pcdc.org or (212) 437-3947, for any further information.

Sincerely,

Louise Cohen
Chief Executive Officer
Primary Care Development Corporation

[i] *See, e.g.* Center for Budget and Policy Priorities, The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion, October 2020, https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion (last visited March 7, 2023).

[ii] *See,e.g.* Primary Care Development Corporation, *Primary Care Access and Equity in New York's City Council Districts*, July 2021, available for download at https://www.pcdc.org/resources/nyc-council-district-primary-care-access-and-equity-report/.

[iii] X. Zhong et al., *Neighborhood disparities in COVID-19 outcomes in New York city over the first two waves of the outbreak*. 70 Ann Epidemiol. 45, June 2022, *available at* https://pubmed.ncbi.nlm.nih.gov/35487451/.

[iv] Testimony, , David. NYHealth Testimony on Expanding and Strengthening Primary Care. March 2023, available at: https://nyhealthfoundation.org/2023/03/02/nyhealth-testimony-on-expanding-and-strengthening-primary-care/

[v] Joel Ario, *The ACA's Section 1332 Waivers: Will We See More State Innovation in Health Care Reform?,* Expert Voices, Manatt Health, August 2016, https://www.manatt.com/getattachment/3543c06f-daeb-4912-94ea-e72980618745/attachment.aspx (last visited March 7, 2023).

[vi] See Centers for Medicaid and Medicare Services, Fact Sheet, *Washington: State Innovation Waiver*, December 2022, *available at* https://www.cms.gov/files/document/1332-wa-fact-sheet.pdf

Schuyler Center for Analysis and Advocacy

3/12/2023

The Schuyler Center for Analysis and Advocacy (SCAA) is a 150-year-old statewide, nonprofit organization dedicated to policy analysis and advocacy in support of public systems that meet the needs of disenfranchised populations and people living in poverty. Schuyler Center helps lead and serves as the home of Medicaid Matters New York and serves on Steering Committee of Health Care for All New York.

Schuyler Center for Analysis and Advocacy opposes this 1332 waiver. We urge the Department of Health to amend the waiver to include people who are undocumented and include the provision in the 2023-24 enacted State budget.

The 2023-24 Executive Budget excludes immigrants, only seeking authority to expand the Essential Plan to higher income levels, from 200% to 250% of the federal poverty level. As written, the current waiver proposal would only expand insurance to 20,000 of the 1 million New Yorkers who remain uninsured.

Including immigrants in the waiver application would not incur costs to the State. In fact, it would generate savings. New York's Essential Plan Trust Fund Account has an existing $9 billion surplus and is estimated to generate an additional $2 billion annual surplus. The State's waiver application should use this federal funding to pay for expanded coverage for immigrants.

Providing health insurance for immigrant communities is both morally and fiscally responsible and expanding coverage would avoid $500 million in annual Emergency Medicaid costs incurred when people who are uninsured seek hospital emergency care.

New York should join Colorado, Illinois, Washington, and California in recognizing that health insurance is a human right by extending affordable insurance coverage to all income-eligible immigrants.

THE LEGAL AID SOCIETY

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March 10, 2023

New York State of Health
Empire State Plaza
Corning Tower, Room 2580
Attn: 1332 Waiver
Albany, NY 12237

VIA EMAIL to nysoh.team@health.ny.gov and VIA ONLINE SUBMISSION

Re: February 9, 2023 New York State of Health Notice of Public Hearings: New York Essential Plan Expansion (Section 1332 State Innovation Waiver)

Dear Commissioner McDonald:

On behalf of The Legal Aid Society, we submit the following comments opposing the New York State of Health's ("NYSOH" or "the Marketplace") proposed amendment to the Affordable Care Act ("ACA") Section 1332 State Innovation Waiver ("1332 Waiver") for the expansion of the Essential Plan to New Yorkers up to 250 percent of the Federal Poverty Level ("FPL"),[1] which excludes Essential Plan expansion to low-income undocumented immigrants.

The Legal Aid Society is a private, not-for-profit legal services organization, the oldest and largest in the nation, dedicated since 1876 to providing quality legal representation to low-income New Yorkers. It is dedicated to one simple but powerful belief: that no New Yorker should be denied access to justice because of poverty. The Legal Aid Society's Health Law Unit ("HLU") provides direct legal services to low-income health care consumers from all five boroughs of New York City. The HLU operates a statewide helpline and assists clients and advocates with a broad range of health-related issues. We also participate in state and federal advocacy efforts on a variety of health law and policy matters.

The Legal Aid Society strongly opposes the exclusion of undocumented immigrants from the state's proposed 1332 Waiver request.[2] We recognize that the winddown of Medicaid extensions put in place during the COVID-19 pandemic has put a strain on NYSOH and Department of Health

[1] N.Y. Reg. at 108 (March 1, 2023).
[2] NY sec. 1332 Innovation Waiver Essential Plan Expansion, Draft for Pub. Comment (NYS Dep't of Health Feb. 9, 2023), *available at* https://info.nystateofhealth.ny.gov/sites/default/files/NY_1332_Waiver_Draft_Application_Actuarial.pdf.

("DOH") resources. However, this is a crucial expansion of coverage to vulnerable New Yorkers that should be prioritized. Last year, we were pleased to hear Governor Hochul state that New York would pursue a goal of covering all otherwise-eligible New Yorkers, regardless of immigration status, under New York's Essential Plan. Not only does the draft 1332 Waiver application retract this commitment, it is also hugely shortsighted from both a fiscal and public health perspective.

As we start to make our way out of the COVID-19 pandemic, The Legal Aid Society sees the devastating effects the pandemic has had and continues to have on our client communities, including immigrant New Yorkers. Undocumented New Yorkers are only eligible for Medicaid for the Treatment of an Emergency Condition (i.e., Emergency Medicaid). This means that those New Yorkers who qualify for Emergency Medicaid can seek covered care only once their condition becomes an emergency. This needlessly limits access to health care, which affects all New Yorkers, regardless of where they are born.

I. The 1332 Waiver application Essential Plan expansion inexplicably excludes immigrants

The draft 1332 Waiver application cruelly ignores a population who might otherwise be eligible for expanded Essential Plan coverage. This population is made up of 250,000 New Yorkers ages 19-64, who pay rent, pay taxes, live and work in New York. New York has shown its commitment to providing coverage for otherwise-eligible undocumented New Yorkers up to age 18 through its Child Health Plus program, and plans to extend Medicaid coverage to individuals 65 and over, regardless of immigration status, as of January 2024.[3] Nonsensically, the exclusion of undocumented New Yorkers from the State's draft 1332 Waiver application requires those ages 19-64 to go without health coverage for a huge portion of their lives and subjects them to limited care and to potentially astronomical medical debt.

This coverage age-gap has real consequences. The Legal Aid Society recently worked with a client from Harlem who had a bad fall and became comatose. He had a wife and a young daughter. He was hospitalized in Manhattan and his hospital stay was covered by Emergency Medicaid. His health eventually improved and the hospital determined it was appropriate to discharge him with rehabilitation services, which Emergency Medicaid does not cover. His wife and daughter, too, wished for his discharge from the hospital with the goal of eventually getting him home with proper home care in place, something that Emergency Medicaid also does not cover. This left this client in limbo at the hospital, when he could have otherwise been safely discharged. Emergency Medicaid also does not cover organ transplants of any kind – whether solid organ, stem cell or bone marrow – including the immunosuppressants and other follow-up care needed for organ transplantation. This makes it nearly impossible for people without immigration status to receive organs because they cannot get onto organ waiting lists. In addition, The Legal Aid Society has worked with a client who

[3] NY SSL § 366(1)(g)(4).

needed an organ transplant and whose sister was an eager match. Unfortunately, our client's sister was unable to make a direct, living donation to our client because she was undocumented and therefore uninsured.

II. Excluding immigrant coverage expansion in the 1332 Waiver application makes no fiscal sense

The Legal Aid Society also opposes the 1332 Waiver application as it currently stands because it squanders money that could be used in other ways to benefit The Legal Aid Society's client population:

- If New York submits its current 1332 Waiver application that does not include an immigrant coverage expansion to the Essential Plan, the state will miss out on $544 million in savings that it currently spends each year on Emergency Medicaid. This money could be used for other state initiatives.

- Moreover, the pandemic made clear the vital care that New York hospitals, particularly our critical safety net hospitals, provide to New Yorkers. The demand (costing roughly $1,174 per person per year[4]) for uncompensated care spending for these hospitals would drop under an Essential Plan that includes coverage for undocumented New Yorkers. A decline in uncompensated care would benefit safety net providers and hospitals.

- The state has an approximately $8 billion surplus in its Basic Health Plan/Essential Plan Trust Fund,[5] funded by the federal government, which increases by $2 billion each year and can only be used to pay for health coverage.[6] Including immigrant New Yorkers in DOH's 1332 Waiver request would come at no cost to the state.

- Finally, here in New York City – where The Legal Aid Society operates – if the DOH were to seek and were granted a 1332 Waiver to expand Essential Plan coverage to undocumented New Yorkers, New York City could save $100 million each year on the

[4] LINDA J. BLUMBERG, MATTHEW BUETTGENS & JOHN HOLAHAN, URBAN INST., HOW WOULD STATE-BASED INDIVIDUAL MANDATES AFFECT HEALTH INSURANCE COVERAGE AND PREMIUM COSTS? (July 2018), https://www.urban.org/sites/default/files/publication/98805/2001925_state_based_individual_mandates.pdf.
[5] Bill Hammond, Empire Center, The Essential Plan's accumulated surplus balloons to $8 billion, with no fix in sight (Sept. 8, 2022), https://www.empirecenter.org/publications/the-essential-plan-surplus-balloons-to-8-billion/.
[6] Medicaid and CHIP FAQs: The Basic Health Program (Centers for Medicare & Medicaid Services May 8, 2014), *available at* https://www.medicaid.gov/sites/default/files/2019-11/basic-health-program-faqs-5-7-14.pdf.

NYC Care program,[7] which provides access to primary care and other health services outside of Emergency Medicaid for undocumented New Yorkers who live in New York City.

In conclusion, The Legal Aid Society opposes DOH's narrow 1332 Waiver application, which inexplicably excludes undocumented New Yorkers. New York can and should catch up to other states like Colorado and Washington, which have covered their undocumented residents through 1332 Waivers, and like California and Illinois, which have extended affordable health insurance coverage to all income-eligible immigrants regardless of immigration status. New York can become a progressive exemplar for other large, diverse states that want to use 1332 Waiver capacity to improve their health coverage landscape. Colorado, Washington, Illinois and California have recognized that access to health coverage and care is a human right; there is no reason that New York should not do the same on its own terms. As it currently stands, the 1332 Waiver application is fiscally irresponsible and inhumane. Thank you for the opportunity to comment and for your consideration of our perspective and input. If you need any additional information, please contact Lillian Ringel at (917) 581-2730 or lringel@legal-aid.org and/or Rebecca Antar Novick at (212) 577-7958 or ranovick@legal-aid.org.

Sincerely,

Lillian Ringel
Staff Attorney
Health Law Unit
The Legal Aid Society

Rebecca Antar Novick
Director
Health Law Unit
The Legal Aid Society

[7] NYC Care, https://www.nyccare.nyc/?utm_medium=G1Search&utm_source=Google&utm_campaign=NYCHH%2CNYCCare1Q23&gclid=EAIaIQobChMI0PvAzPrH_QIVYRtlCh32dACiEAAYASAAEgI1_vD_BwE.

Comments of United Hospital Fund
to New York State of Health
on New York Section 1332 Innovation Waiver
Essential Plan Expansion Draft for Public Comment

United Hospital Fund
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March 10, 2023

United Hopsital Fund (UHF) appreciates the opportunity to comment on the State's draft proposal seeking a Section 1332 State Innovation Waiver to expand the Essential Plan (EP). We applaud the State for its long history of innovative coverage expansion, and this latest proposal aimed at more affordable coverage for an important subset of low- and moderate-income individuals. We also believe the 1332 Waiver vehicle provides a unique opportunity for consideration of additional coverage expansion for immigrants under age 65 otherwise ineligible for Medicaid or subsidized coverage due to their immigration status.

UHF is an independent non-profit that works to build an effective and equitable health care system for every New Yorker. As part of that mission, we have worked for decades to ensure all New Yorkers have access to comprehensive, affordable health insurance, with a special focus on public programs for the underserved. UHF has been a key parter with the State, providers, and other stakeholders on coverage issues ranging from the creation of Child Health Plus, the provision of distater relief Medicaid following 9/11, and implementation of the Affordable Care Act expansions. Most recently we've partnered with the State and philanthropic colleagues to help ensure New Yorkers maintain coverage during the unwind of the COVID-19 related continuous enrollment requirement.

UHF supports the proposal to expand EP eligibility to New Yorkers between 200-250 percent of the Federal Poverty Level (FPL). The EP provides comprehensive, affordable coverage for low-income New Yorkers. According to the State's own actuarial analysis, the true out-of-pocket cost savings for the estimated 90,000 beneficiaries of the proposed EP expansion are significant to say the least, at $7,400 per year. The modest $15 dollar per month premium would not seem to be a barrier given those affordability gains, but expereince in New York State and across the country consistently shows even modest premiums can reduce coverage enrollment.[i] New York State of Health should assess its own data from the 2021 elimination of the $20 EP premium for enrollees with incomes between 150 and 200 percent FPL, and consider amending the waiver to eliminate the $15 premium for the expansion population. It is clear from the waiver draft that sufficient fincial resources would exist to streamline the waiver program by providing a $0 premium regardless of income level.

The transition of Qualified Health Plan enrollees to expanded EP will have an effect on the individual market which is well detailed in the waiver proposal actuarial analysis. We are concerned about the resulting individual market premium increases leading to coverage reductions in that market, especially if the Inflation Reducation Act expanded premium tax credits are not extended beyond 2025. We would welcome and support an ongoing dialogue with the State and stakeholders over the next 24 months around ways to solidify individual market coverage gains and ensure the stability and affordability of that market for New Yorkers over the longer-term.

UHF strongly encourages New York State to expand its waiver application to include immigrants under age 65 otherwise ineligible for Medicaid or subsidized coverage due to their immigration status. In 2015-16 we partnered with other philanthropies to support the seminal analysis of health insurance coverage options for uninsured immigrant New Yorkers.[ii] UHF's own 2019 analysis of the uninsured in Western and Central New York highlighted pockets of uninsured noncitizens that could greatly benefit from affordable coverage options.[iii] As the State and the health care field broadly increase the focus on health equity, it is imperative that we leverage this unique 1332 Waiver opportunity to try and ameliorate the single biggest remaining coverage disparity in the state. New York will never fully meet its health equity and Prevention Agenda[iv] goals without facilitating comprehensive, affordable coverage that provides uninsured immigrants access to services otherwise very difficult to obtain.

UHF looks forward to continuing its long partnership with the State on coverage for low- and moderate-income New Yorkers. Please contact Chad Shearer at cshearer@uhfnyc.org with any questions.

Sincerely,

Oxiris Barbot, MD
President and CEO

[i] https://www.brookings.edu/essay/eliminating-small-marketplace-premiums-could-meaningfully-increase-insurance-coverage/
[ii] https://www.cssny.org/publications/entry/covering-new-yorks-uninsured-immigrant-residents
[iii] https://uhfnyc.org/publications/publication/uninsured-in-western-and-central-ny/
[iv] https://www.health.ny.gov/prevention/prevention_agenda/2019-2024/docs/ship/overview.pdf

March 10, 2023

Danielle Holahan
Executive Director
NY State of Health
Empire State Plaza
Corning Tower, Room 2580
Albany, NY 12237

Attn: New York 1332 Waiver

Dear Executive Director Holahan:

Thank you for the opportunity to provide feedback on the New York 1332 waiver application.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions. We have a unique perspective on what individuals and families need to prevent disease, cure illness and manage chronic health conditions. The diversity of our organizations and the populations we serve enable us to draw upon a wealth of knowledge and expertise that is an invaluable resource regarding any decisions affecting the Affordable Care Act, the Basic Health Program and the people that they serve.

Our organizations are committed to ensuring that New York's healthcare programs provide quality and affordable healthcare coverage. We believe the state's proposal to use a Section 1332 waiver to expand its Essential Plan to more New Yorkers will advance these objectives. Once implemented, New York's waiver should reduce the number of people without insurance, substantially lower healthcare costs for at least 65,000 individuals each year, and improve health equity, while satisfying the federal guardrail protections governing waivers.

New York's proposal will lower healthcare costs for individuals between 200-250% of the federal poverty level. For example, compared to being enrolled in a standard silver plan with cost sharing reductions through the New York State of Health marketplace, an individual newly covered by the Essential Plan under this waiver would see their individual deductible decrease

from $1,625 to $0 and their maximum out of pocket limit fall from $7,250 to $2,000.[1] Research consistently shows that higher cost-sharing is associated with decreased use of preventive services and medical care among low-income populations.[2] The state estimates that at least 65,000 individuals in the target group will save about $7,400 per year from the waiver's anticipated changes, a decrease in costs equal to an average of about 20% of household income for these New Yorkers.

At the same time, the state represents that the waiver will not affect eligibility requirements, benefits, or costs for existing categories of Essential Plan enrollees. We appreciate this commitment to preserving affordability and access to comprehensive coverage for the more than one million current enrollees of the program — a commitment we understand to be essential to the success of the proposed waiver. In a similar vein, we know the state expects the waiver proposal to have limited effects on coverage in the individual market. We encourage the state to closely monitor these impacts, including effects on consumers who do not qualify for subsidized coverage.

We understand that, due to the affordability benefits of the waiver, New York's plan would also improve take-up of comprehensive coverage. The state projects that the waiver will increase combined enrollment in the Essential Plan and marketplace by 1.6% in 2024, and from 2.1%-2.2% (or about 28,000 people) in each year through 2028. In addition, we understand that the waiver would increase covered benefits for the target population — those who could have obtained coverage through the marketplace in the absence of the waiver but who instead will enroll through the Essential Plan — because their coverage will include the same essential health benefits covered by marketplace plans, plus vision and dental care. We are encouraged by and support all of these expected improvements.

Our organizations appreciate the state's efforts to minimize disruptions in coverage for individuals who will be shifting from individual market coverage to the Essential Plan, including reasonable approaches to mapping current Qualified Health Plan (QHP) enrollees into closely-matched Essential Plan alternatives. While the state notes that there is more than 95% overlap between existing QHP and Essential Plan provider networks, even the most minimal disruption in providers or networks could lead to significant harm for patients with serious or chronic medical conditions. We urge the state to work closely with consumers, carriers, providers, and patient and consumer organizations through the transition process to ensure that enrollees, particularly those mapped from an existing plan into a different product, experience minimal disruption in their access to existing providers and existing provider networks. We suggest that the state consider whether there are ways to mitigate any impact, such as enhanced temporary flexibilities for certain enrollees to continue receiving care at formerly in-network providers who are now out-of-network.

Finally, our organizations support the positive effect that this waiver is expected to have on health equity in New York. Adult Black and Hispanic New Yorkers experience lower levels of health insurance coverage and higher incidences of preventable hospitalizations.[3] The state expects that the increase in affordability of coverage under the waiver will help to address

these disparities. Our organizations encourage the state to continue to work towards improving health equity in New York by increasing access to affordable healthcare.

Our organizations support this proposal as a method to improve affordability of healthcare for lower income individuals in New York, as well as equitable access to care, while complying with the 1332 waiver statutory guardrails.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Epilepsy Foundation
Hemophilia Federation of America
Immune Deficiency Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
The Leukemia and Lymphoma Society

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[1] New York State of Health, "Standard Benefit Design Cost Sharing Description Chart." July 13, 2022. Available at: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20-%202023%20Standard%20Plans%20revised%207-13-22.pdf

[2] Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[3] Department of Health, New York State. New York State Prevention Agenda Dashboard-State Level, 2023. Available at: https://webbi1.health.ny.gov/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=sh

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
DEDUCTIBLE (single)	$0	$600	$1,750	$1,625	$250	$0	$4,700	$6,100	$9,100	$0
MAXIMUM OUT OF POCKET LIMIT (single) Includes the deductible	$2,000	$4,750	$9,100	$7,250	$2,800	$1,000	$8,700	$6,900	$9,100	$0
COST SHARING – MEDICAL SERVICES										
Inpatient facility/SNF/Hospice	$500 per admission	$1,000 per admission	$1,500 per admission	$1,500 per admission	$250 per admission	$100 per admission	$1,500 per admission	50% coinsurance	0% cost sharing	0% cost sharing
Outpatient facility – surgery, including freestanding am/surg centers	$100	$100	$150	$150	$75	$25	$150	50% coinsurance	0% cost sharing	0% cost sharing
Surgeon – inpatient facility, outpatient facility, including freestanding am/surg centers	$100	$100	$150	$150	$75	$25	$150	50% coinsurance	0% cost sharing	0% cost sharing
	One such copay per surgery and applies only to surgery performed in a hospital inpatient or a hospital outpatient facility setting, including freestanding am/surg centers, not to office surgery. See also "Maternity delivery and post-natal care - physician/midwife" under "physician services".									
PCP	$15	$25	$30	$30	$15	$10	$50	50% coinsurance	0% cost sharing	0% cost sharing
Specialist	$35	$40	$65	$65	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
PT/OT/ST – rehabilitative & habilitative therapies	$25	$30	$30	$30	$25	$15	$50	50% coinsurance	0% cost sharing	0% cost sharing
ER	$100	$150	$500	$275	$75	$50	$500	50% coinsurance	0% cost sharing	0% cost sharing
Ambulance	$100	$150	$150	$150	$75	$50	$300	50% coinsurance	0% cost sharing	0% cost sharing
Urgent care	$55	$60	$70	$70	$50	$30	$75	50% coinsurance	0% cost sharing	0% cost sharing
DME/Medical supplies	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
Hearing aids	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
Eyewear	10% coinsurance	20% coinsurance	30% coinsurance	25% coinsurance	10% coinsurance	5% coinsurance	50% coinsurance	50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – INPATIENT HOSPITAL SERVICES										
Observation stay/care unit	ER copay per case; copay is waived if direct transfer from outpatient surgery setting to an observation care unit.							50% coinsurance	0% cost sharing	0% cost sharing
Hospital services – non-maternity	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Maternity care stay (covers mother and newborn combined)	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Substance abuse disorder services	Inpatient facility copay per admission #							50% coinsurance	0% cost sharing	0% cost sharing
Skilled nursing facility	Inpatient facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting to skilled nursing facility.							50% coinsurance	0% cost sharing	0% cost sharing
Hospice (inpatient)	Inpatient facility copay per admission # Indicated copay per admission is waived if direct transfer from hospital inpatient setting or skilled nursing facility to hospice facility.							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – EMERGENCY MEDICAL SERVICES										
Facility charge – emergency room	ER copay per case; copay is waived if patient is admitted as an inpatient (including as an observation stay or to an observation care unit) directly from the emergency room.							50% coinsurance	0% cost sharing	0% cost sharing
Physician charge – emergency room visit	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Facility charge – freestanding urgent care center	Urgent care copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Physician charge – freestanding urgent care visit	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Pre-hospital emergency services, transportation, includes air ambulance	Ambulance copay per case							50% coinsurance	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – OUTPATIENT HOSPITAL/FACILITY SERVICES										
Outpatient facility surgery – facility charge, including freestanding am/surg centers	Outpatient facility - surgery copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Pre-admission/Pre-operative testing	$0 copay							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	Specialist copay per visit		$50	$50	Specialist copay per visit		$50	50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	$35	$40	$75	$75	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	$35	$40	$175	$175	$35	$20	$175	50% coinsurance	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative & habilitative	PT/OT/ST copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Home care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hospice	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PREVENTIVE AND PRIMARY CARE SERVICES	NOTE: For preventive care visits/services as defined in 42 USC § 300gg-13 or as required by state law, no cost-sharing (including deductible) applies. Such preventive care visits/services include, but are not limited to, those found in this section.									
Bone mineral density testing										
Gynecological exams / cervical cancer screening										
Immunizations										
Mammograms / breast cancer screening										
Prostate cancer screening										
Routine / annual exams										
Women's preventive health, including prenatal care										
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES										
Inpatient hospital surgery - surgeon	Surgeon copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Outpatient hospital and freestanding am/surg centers – surgeon	Surgeon copay per case							50% coinsurance	0% cost sharing	0% cost sharing
Office surgery	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Anesthesia (any setting)	Covered in full, no deductible and no cost sharing apply							50% coinsurance	0% cost sharing	0% cost sharing
Covered therapies (PT, OT, ST) – rehabilitative and habilitative	PT/OT/ST copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Additional surgical opinion	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Second medical opinion for cancer	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Maternity delivery and post natal care – physician or midwife	Surgeon copay per case for delivery and post-natal care services combined (only one copay per pregnancy)							50% coinsurance	0% cost sharing	0% cost sharing
In-hospital physician visits	$0 copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic office visits	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Diagnostic and routine laboratory and pathology	PCP/Specialist copay per visit (based on type of physician performing the service)		PCP copay if performed by PCP/ $50	PCP copay if performed by PCP/ $50	PCP/Specialist copay per visit (based on type of physician performing the service)		$50	50% coinsurance	0% cost sharing	0% cost sharing

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.

Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).

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TYPE OF SERVICE	Platinum AV = 0.88 to 0.92	Gold AV = 0.78 to 0.82	Silver AV = 0.70 to 0.72	Silver CSR 200 - 250% FPL AV = 0.73 to 0.74	Silver CSR 150 - 200% FPL AV = 0.87 to 0.88	Silver CSR 100 - 150% FPL AV = 0.94 to 0.95	Bronze AV = 0.58 to 0.65	Bronze HSA Compliant* AV = 0.58 to 0.65	Catastrophic	AI/AN CSR 100 - 300% FPL $0 Cost Sharing
COST SHARING – PHYSICIAN/PROFESSIONAL SERVICES (CONTINUED)										
Diagnostic and routine imaging services, including X-ray, excluding CAT/PET scans, MRI	$35	$40	$75	$75	$35	$20	$75	50% coinsurance	0% cost sharing	0% cost sharing
Imaging: CAT/PET scans, MRI	$35	$40	$175	$175	$35	$20	$175	50% coinsurance	0% cost sharing	0% cost sharing
Allergy testing	PCP/Specialist copay per visit(based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Allergy shots	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Office/Outpatient consultations	PCP/Specialist copay per visit (based on type of physician performing the service)							50% coinsurance	0% cost sharing	0% cost sharing
Mental/Behavioral health care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Substance use disorder services	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Chemotherapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Radiation therapy	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Hemodialysis/Renal dialysis	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Chiropractic care	Specialist copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – ADDITIONAL BENEFITS/SERVICES										
ABA treatment for Autism Spectrum Disorder	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Assistive communication devices for Autism Spectrum Disorder	PCP copay per device							50% coinsurance	0% coinsurance	0% cost sharing
Durable medical equipment and medical supplies	DME/Medical supplies coinsurance cost sharing applies							50% coinsurance	0% coinsurance	0% cost sharing
Hearing evaluations/testing	Specialist copay per visit							50% coinsurance	0% coinsurance	0 cost sharing
Hearing aids	Hearing aid coinsurance cost sharing applies							50% coinsurance	0% coinsurance	0% cost sharing
Diabetic drugs and supplies	PCP copay per 30-day supply but no more than $100 (including deductible) paid for a 30-day supply of insulin								0% coinsurance	0% cost sharing
Diabetic self-management education	PCP copay per visit							50% coinsurance	0% coinsurance	0% cost sharing
Home care	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Exercise facility reimbursements	Deductible does not apply. $200/$100 reimbursement every six months for member/spouse. Partial reimbursement for facility fees every six months if member attains at least 50 visits.									
COST SHARING – PEDIATRIC DENTAL SERVICES										
Dental office visit	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PEDIATRIC VISION SERVICES										
Eye exam visit	PCP copay per visit							50% coinsurance	0% cost sharing	0% cost sharing
Prescribed lenses and frames	Eyewear coinsurance cost sharing applies to combined cost of lenses and frames							50% coinsurance	0% cost sharing	0% cost sharing
Contact lenses	Eyewear coinsurance cost sharing applies							50% coinsurance	0% cost sharing	0% cost sharing
COST SHARING – PRESCRIPTION DRUGS										
Generic or Tier 1	$10	$10	$15	$15	$9	$6	$10	$10	0% cost sharing	0% cost sharing
Formulary brand or Tier 2	$30	$35	$40	$40	$20	$15	$35	$35	0% cost sharing	0% cost sharing
Non-formulary brand or Tier 3	$60	$70	$75	$75	$40	$30	$70	$70	0% cost sharing	0% cost sharing

Above are retail copay amounts; mail order copays are 2.5 times retail (except for Catastrophic plans) for a 90-day supply.

Attachment B STANDARD BENEFIT DESIGN COST SHARING DESCRIPTION CHART - FINAL AV CALCULATOR (7/13/2022)

NOTE: Standard plan design descriptions are based on current HHS Regulations and the Actuarial Value Calculator (Final for 2023) and NY Laws/Regulations.
Non-HSA Compliant Bronze plan allows a total of three primary care or specialist visits before the deductible (PCP/Specialist copayment applies).
The Standard Silver and Silver CSR 73 and 87 plans allow one primary care or specialist visit before the deductible (PCP/Specialist copayment applies).

ADDITIONAL INSTRUCTIONS:

1. The following applies to the Platinum, Gold, Silver, Silver CSR, and non-HSA compliant Bronze plans:
   For an inpatient admission, the only copay that applies for an inpatient stay is the inpatient facility per admission copay; and if surgery is performed, a surgeon copay; and if a maternity delivery is performed, a maternity delivery copay (which is the same as the surgeon copay) if this copay has not already been collected as part of another maternity related claim.
   There are no additional copays for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc.
   For a maternity stay, the inpatient per admission copay covers charges for the mother and newborn.
   # The inpatient facility copay per admission is waived for a readmission within 90 days of a previous discharge for the same or a related condition.

2. For the Gold and HSA-compliant Bronze plans, the deductible must be met first, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached.

3. For the non-HSA compliant standard Bronze plan, any combination of three visits indicated below are covered before the deductible, subject to the applicable copays. The copays paid for the three visits count towards the deductible. After the first three visits and for all other services, the deductible must be met, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached. These three visits are in addition to the ACA mandated preventive services for which no cost-sharing can apply. The following visits (or any combination), performed in person or using telehealth, are counted towards the three visits: primary care visits, specialist visits (including allergy visits and visits for second opinions), outpatient mental health visits, outpatient substance use disorder visits, ABA visits, and chiropractic care visits. Urgent care and office surgery do not count towards the three visits.

4. For the standard Silver plan and Silver 73 and 87 CSR plans, one visit indicated below is covered before the deductible, subject to the applicable copay. The copay paid for the one visit counts towards the deductible. After the first visit and for all other services, the deductible must be met, and then the copay or coinsurance is applied to the remainder of the allowed amount until the maximum out-of-pocket limit is reached. This visit is in addition to the ACA mandated preventive services for which no cost-sharing can apply. Any of the following types of visits, performed in person or using telehealth, counts towards the one pre-deductible visit: a primary care visit, specialist visit (including allergy visit and a visit for second opinions), outpatient mental health visit, outpatient substance use disorder visit, ABA visit, or chiropractic care visit. Urgent care and office surgery do not count towards the one visit.

5. If the copay payable is more than the allowed amount, the copay is reduced to the allowed amount.

6. The maximum out-of-pocket limit is an aggregate over all covered services (medical, pediatric dental, pediatric vision, and prescription drugs) and includes the deductible.

7. The deductible is over a calendar year for individual products and over the calendar year or plan year (an option of the insurer) for small group products.
   For the Platinum, Gold, Silver and Silver CSR plans, the deductible applies only to medical, pediatric dental, and pediatric vision services (including lenses/frames) and does not apply to prescription drugs. For the Bronze and Catastrophic plans, the deductible applies to all services combined (medical, pediatric dental, pediatric vision (including lenses/frames) and prescription drugs).

8. No deductible or cost sharing applies to the preventive care visits/services defined in section 2713 of ACA but additional services, like laboratory tests, which are delivered at the preventive care visit may be subject to the deductible or cost sharing.

9. Per ACA, the Catastrophic plan must include three primary care visits per calendar year to which the deductible does not apply. These three primary care visits are in addition to the ACA mandated preventive services for which no cost sharing can apply. These three primary care visits are covered in full (i.e., no deductible and no cost sharing). For purposes of using these three primary care visits to which the deductible does not apply, a primary care visit is defined as a visit to a provider whose primary specialty is in family medicine, internal medicine, pediatric medicine, obstetrics/gynecology, or outpatient mental/behavior health services or substance use disorder services.

10. The family deductible is two times the single deductible; the family out-of-pocket limit is two times the single maximum out-of-pocket limit. For plan designs that are non-HSA plan designs, each family member is subject to a maximum deductible equal to the single deductible and to a maximum out-of-pocket limit equal to the single out-of-pocket limit. Once all members of the family in aggregate meet the family deductible amount (or family out-of-pocket limit amount), then no family member needs to accumulate any more dollars toward the deductible (or out-of-pocket limit).

11. The pediatric dental cost-sharing indicated is when pediatric dental is included as part of the standard design medical QHP plan. A stand-alone pediatric dental plan may have its own deductible , cost-sharing, and associated premium.

* Bronze HSA Compliant plan satisfies the maximum out-of-pocket limit of $7,050 set by IRS for calendar year 2022.

The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings

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Petry Ubri , and Julia Zur

Published: Jun 01, 2017

Issue Brief

Key Findings

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. This brief reviews research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. This research has primarily focused on how premiums and cost sharing affect coverage and access to and use of care; some studies also have examined effects on safety net providers and state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts. Together, the research finds:

- **Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals.** These effects are largest among those with the lowest incomes, particularly among individuals with incomes below poverty. Some individuals losing Medicaid or CHIP coverage move to other coverage, but others become uninsured, especially those with lower incomes. Individuals who become uninsured face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.
- **Even relatively small levels of cost sharing in the range of $1 to $5 are associated with reduced use of care, including necessary services.** Research also finds that cost sharing can result in unintended consequences, such as increased use of the emergency room, and that cost sharing negatively affects access to care and health outcomes. For example, studies find that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia and reduced treatment for children with asthma. Additionally, research finds that cost sharing increases financial burdens for families, causing some to cut back on necessities or borrow money to pay for care.
- **State savings from premiums and cost sharing in Medicaid and CHIP are limited.** Research shows that potential revenue gains from premiums and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses. Studies also show that raising premiums and cost sharing in Medicaid and CHIP increases pressures on safety net providers, such as community health centers and hospitals.

Introduction

Recently, there has been increased interest at the federal and state level to expand the use of premiums and cost sharing in Medicaid. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. Proponents of increasing premiums and cost sharing in Medicaid indicate that doing so will promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions.[1]

This brief, which updates an earlier brief "*Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (https://www.kff.org/medicaid/issue-brief/premiums-and-cost-sharing-in-medicaid-a-review-of-research-findings/)," reviews research on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. It draws on findings from 65 papers published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations. This research has primarily focused on how premiums and cost sharing affect coverage and access to care; some studies also have examined effects on state savings. The effects on individuals, providers, and state costs reflect varied implementation of premiums and cost sharing across states as well as differing premium and cost sharing amounts.

Premiums and Cost Sharing in Medicaid and CHIP Today

Currently, states have options to charge premiums and cost sharing in Medicaid and CHIP that vary by income and eligibility group (Box 1). Reflecting these options, premiums and cost sharing in Medicaid and CHIP vary across states and groups. As of January 2017, 30 states charge premiums or enrollment fees and 25 states charge cost sharing for children in Medicaid or CHIP.[2] Most of these charges are limited to children in CHIP since the program covers children with higher family incomes than Medicaid and has different premium and cost sharing rules. States generally do not charge premiums for parents in Medicaid, but 39 states charge cost sharing for parents and 23 of the 32 states that implemented the Affordable Care Act (ACA) Medicaid expansion to low-income adults charge cost sharing for expansion adults.[3] Six states have waivers to charge premiums or monthly contributions for adults that are not otherwise allowed.[4]

Box 1: Medicaid and CHIP Premium and Cost Sharing Rules

Medicaid

- States may charge premiums for enrollees with incomes above 150% of the federal poverty level (FPL), including children and adults. Enrollees with incomes below 150% FPL may not be charged premiums.
- States may charge cost sharing up to maximums that vary by income (Table 1). States cannot charge cost sharing for emergency, family planning, pregnancy-related services, preventive services for children, or preventive services defined as essential health benefits in Alternative Benefit Plans in Medicaid. In addition, states generally cannot charge cost sharing to children enrolled through mandatory eligibility categories. The minimum eligibility standard for children is 133% FPL, although some states have higher minimums.
- Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income. This 5% cap is applied on a monthly or quarterly basis.

CHIP

- States have somewhat greater flexibility to charge premiums and cost sharing for children in CHIP, although there are limits on the amounts that states can charge, including an overall cap of 5% of household income.

Table 1: Maximum Allowable Cost Sharing Amounts in Medicaid by Income

	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	$4	10% of state cost	20% of state cost
Non-Emergency use of ER	$8	$8	No limit (subject to overall 5% of household income limit)
Prescription Drugs			
Preferred	$4	$4	$4
Non-Preferred	$8	$8	20% of state cost
Inpatient Services	$75 per stay	10% of state cost	20% of state cost

Notes: Some groups and services are exempt from cost sharing, including children enrolled in Medicaid through mandatory eligibility pathways, emergency services, family planning services, pregnancy related services, and preventive services for children. Maximum allowable amounts are as of FY2014. Beginning October 1, 2015, maximum allowable amounts increase annually by the percentage increase in the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U).

Effects of Premiums (Table 1 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/))

A large body of research shows that premiums can serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals. Studies show that premiums in Medicaid and CHIP lead to a reduction in coverage among both children and adults.[5,6,7,8,9,10] Numerous studies find that premiums increase disenrollment from Medicaid and CHIP among adults and children, shorten lengths of Medicaid and CHIP enrollment, and deter eligible adults and children from enrolling in Medicaid and CHIP.[11,12,13,14,15,16,17,18,19,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39]

Although some individuals who disenroll from Medicaid or CHIP following premium increases move to other sources of coverage, others become uninsured and face negative effects on their access to care and financial security. Those with lower incomes and those without a worker in the family are more likely to become uninsured compared to those with relatively higher incomes or with a worker in the family, reflecting less availability of employer coverage.[40,41,42,43,44,45,46,47,48,49] Studies also show that those who become uninsured following premium increases face increased barriers to accessing care, have greater unmet health needs, and face increased financial burdens.[50,51,52] ,[53,54] Several studies suggest that these negative effects on health care are largest among individuals with greater health care needs.[55,56]

Premium effects are largest for those with the lowest incomes, particularly among those with incomes below poverty. Given that most states limit premium charges to children in CHIP, most studies of premium effects have focused on children in CHIP, who generally have incomes above 100% or 150% of the federal poverty level. A range of these studies show that premium effects are larger among children at the lower end of this income range, who have greater disenrollment and increased likelihood of becoming uninsured.[57,58,59,60,61,62,63,64,65] Reflecting the more limited use of premiums among Medicaid enrollees with incomes below poverty, fewer studies have focused on this population. However, studies that have focused on poor Medicaid enrollees found substantial negative effects on enrollment from premiums.[66,67,68,69] For example, in Oregon, nearly half of adults disenrolled from Medicaid after a premium increase with a maximum premium amount of $20, with many becoming uninsured and facing barriers to accessing care, unmet health needs, and increased financial burdens.[70,71,72] Similarly, a more recent study of the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138% FPL, which requires premiums that range from $1-$100 to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[73] Research also finds that premium effects may vary by other factors beyond income. For example, one study finds larger effects of premiums among families

without an offer of employer-sponsored coverage.[74] Some research also suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[75,76,77]

Research finds varying implications of premiums for individuals with significant health needs. Overall, individuals with greater health needs are less likely to disenroll from Medicaid or CHIP coverage and are more likely to have longer periods of Medicaid or CHIP coverage compared to those with fewer health needs.[78,79,80,81] However, findings vary regarding how individuals with health needs respond to premium increases. Some studies show that individuals with greater health needs are less sensitive to premium increases compared to those with fewer health needs, reflecting their increased need for services.[82,83] These findings suggest that individuals with greater health needs are more likely than those with less significant health needs to remain enrolled following premium increases, but then face increased financial burdens to maintain their coverage. Other studies find that children with increased health needs are as likely or more likely than those with fewer health needs to disenroll from coverage following premium increases, suggesting premiums may lead to children going without coverage despite ongoing health needs.[84,85]

Effects of Cost Sharing (Table 2 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/))

A wide range of studies find that even relatively small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The RAND health insurance experiment (HIE), conducted in the 1970s and still considered the seminal study on the effects of cost sharing on individual behavior, shows a reduction in use of services after cost sharing increased, regardless of income.[86] Since then, a growing body of research has found that cost sharing is associated with reduced utilization of services,[87] including vaccinations,[88] prescription drugs,[89,90,91,92] mental health visits,[93] preventive and primary care,[94,95,96,97,98] and inpatient and outpatient care,[99,100] and decreased adherence to medications.[101,102,103] In many of these studies, copayment increases as small as $1-$5 can effect use of care. Some studies find that lower-income individuals are more likely to reduce their use of services, including essential services, than higher-income individuals.[104,105] Research also suggests that copayments can result in unintended consequences, such as increased use of other costlier services like the emergency room.[106] Two studies have found that copayments do not negatively affect utilization.[107,108] In one case, the

authors suggest that increases in provider reimbursement may have negated effects of the copayment increases, particularly if not all copayments were being collected by providers at the point of care.[109]

Research points to varying effects of cost sharing for people with significant health needs. Some studies find that utilization among individuals with chronic conditions or significant health needs is less sensitive to copayments compared to those with fewer health needs. As such, these individuals face increased cost burdens associated with accessing care because of copayment increases.[110,111] Other research finds that even relatively small copayments can reduce utilization among individuals with significant health needs.[112,113,114]

Numerous studies find that cost sharing has negative effects on individuals' ability to access needed care and health outcomes and increases financial burdens for families.[115,116,117,118,119,120,121,122] For example, studies have found that increases in cost sharing are associated with increased rates of uncontrolled hypertension and hypercholesterolemia[123] and reduced treatment for children with asthma.[124] Increases in cost sharing also increase financial burdens for families, causing some to cut back on necessities or borrow money to pay for care. In particular, small copayments can add up quickly when an individual needs ongoing care or multiple medications.[125,126]

Findings on how cost sharing affects non-emergent use of the emergency room are limited. One study found that these copayments reduce non-urgent visits.[127] Other studies find that these copayments do not affect use of the emergency room.[128,129]

Effects on State Budgets and Providers (Table 3 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/))

Research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited. Studies find that potential increases in revenue from premium and cost sharing are offset by increased disenrollment; increased use of more expensive services, such as emergency room care; increased costs in other areas, such as resources for uninsured individuals; and administrative expenses.[130,131,132,133,134,135,136] One state study found increased revenues from premiums without significant effects on enrollment, but authors note a range of program-specific factors that may have contributed to this finding, including it being limited to a Medicaid-buy in program for individuals with disabilities with incomes above 150% FPL who may be less price-sensitive to the increase and the state implementing administrative processes designed to minimize disenrollment.[137]

Studies also show that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety net providers, such as community health centers and hospitals. Several studies show that coverage losses following premium increases lead to increases in the share of uninsured patients seen by providers[138,139,140] and increased emergency department use by uninsured individuals.[141,142] One study also found that increases in copayments led to community health centers having to divert resources for medications for uninsured individuals to help people who could not afford copayments and that copayments increased the rate of "no shows" for appointments at community health centers.[143]

Conclusion

Recently, there has been increased interest at the federal and state levels to expand the use of premiums and cost sharing in Medicaid as a way to promote personal responsibility, prepare beneficiaries to transition to commercial and private insurance, and support consumers in making value-conscious health decisions. Current rules limit premiums and cost sharing in Medicaid to facilitate access to coverage and care for the low-income population served by the program, who have limited resources to spend on out-of-pocket costs. This review of a wide body of research provides insight into the potential effects of increasing premiums and cost sharing for Medicaid enrollees. It shows that premiums serve as a barrier to obtaining and maintaining coverage for low-income individuals, particularly those with the most limited incomes, and that even relatively small levels of cost sharing reduce utilization of services. As such, increases in premiums and cost sharing result in increased barriers to coverage and care, greater unmet health needs, and increased financial burdens for families. Further, the research suggests that state savings from premiums and cost sharing in Medicaid and CHIP are limited and that increases in premiums and cost sharing in Medicaid and CHIP can increase pressures on safety-net providers.

Study Tables

The three tables below support the Kaiser Family Foundation Issue Brief titled, "*The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*." The tables highlight findings from 65 studies published between 2000 and March 2017, including peer-reviewed studies and freestanding reports, government reports, and white papers by research and policy organizations on the effects of premiums and cost sharing on low-income populations in Medicaid and CHIP. Each table corresponds to one of three sections in the brief: (1) effects of premiums; (2) effects of cost sharing; and (3) effects on state budgets and providers. The table lists studies in reverse chronological order, with the most recent studies first, and groups

the studies by nationwide and state-specific studies. Studies that apply to multiple sections are included in more than one table but list only the relevant findings for that section.

Table 1: Effects of Premiums

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
National Studies			
Gery P Guy, et. al., "The Role of Public and Private Insurance Expansions and Premiums for Low-Income Parents: Lessons from State Experiences," *Medical Care* 55, 3 (March 2017):236-243.	2000-2013 Current Population Survey (CPS) and Medical Expenditure Panel Survey (MEPS) data	Nonelderly parents with incomes at or below 300% FPL	• Estimates effects of different types of coverage expansions and premiums on parent coverage. • Higher public premiums were associated with a reduction in public insurance, and increased the likelihood of private insurance or being uninsured. A $500 increase in annual public premiums decreased the probability of public insurance by 1.9 percentage points, increased the probability of private insurance by 1.2 percentage points, and increased the probability of being uninsured by 0.6 percentage points. • Public premiums were a significant deterrent to coverage for parents in non-worker households and had effects on public coverage that were over 10 times as large as the effects among families with a worker. Among parents without a worker in the household, a $500

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			increase in annual public premiums decreased the probability of public insurance by 9.8 percentage points, increased the probability of private insurance by 2.9 percentage points, and increased the probability of being uninsured by 6.9 percentage points. Among parents with a worker in the household, both public and private premiums had a significant impact on insurance status.
Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, 8 (August 2014): 1353-1360.	1999-2010 Medical Expenditure Panel Surveys (MEPS) data	Children eligible for Medicaid or CHIP with incomes above 100% FPL	• Simulates the relationship between premiums and coverage by income level and by parental access to employer coverage. • Among eligible children in families with incomes between 101-150% of poverty, a $10 increase in monthly premiums is associated with a 6.7 percentage point reduction in having Medicaid or CHIP coverage and a 3.3 percentage point increase in being uninsured. The increase in likelihood of being

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			uninsured is larger among children whose parents lack offers of employer coverage. • Among eligible children in families with incomes above 150% of poverty, a $10 increase in monthly premiums is associated with a 1.6 percentage point reduction in Medicaid or CHIP coverage. In this income range, the increase in being uninsured may be higher among children whose parents lack an offer of employer sponsored coverage than among those whose parents have an offer.
Silviya Nikolova and Sally Stearns, "The Impact of CHIP Premium Increases on Insurance Outcomes among CHIP Eligible Children," *BMC Health Services Research* 14 (March 2014):101-107.	2003 Medical Expenditure Panel Surveys (MEPS) data in 19 states	Children assumed eligible for CHIP in the income range subject to premiums	• Simulates the effect of premium differences for children in states that have a tiered premium structure for CHIP, in which families at higher incomes pay higher premiums than families in a lower income group. • A $1 increase in premium for those in the higher income group was associated with a 1.7 to 2.2 percentage point

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			increase in the likelihood of being privately insured. • Premium increases were not associated with uninsurance rates.
Carole R Gresenz, Sarah E Edgington, Miriam J Laugesen and Jose J Escarce, "Income Eligibility Thresholds, Premium Contributions, and Children's Coverage Outcomes: A Study of CHIP Expansions," *Health Services Research* 48:2, Part II (April 2013):884-902.	2002-2009 Current Population Survey data	Children with family incomes 200%- 400% FPL	• Simulates effects of varying premium schedules (no, low, medium, and high premiums) for individuals with incomes between 200-400% FPL. • Across the examined income levels, premiums decrease enrollment in public coverage and increase enrollment in private coverage, with greater effects as premium contributions increase. Changes in uninsured rates are less sensitive to premiums at these income levels, particularly among those with incomes at 300% and 400% FPL, likely reflecting the greater availability of employer coverage at these income levels.
Gery P Guy, Jr., E. Kathleen Adams, and Adam Atherly, "Public and Private Health Insurance Premiums: How do they Affect Health Insurance Status of Low-Income	2000-2008 Current Population Survey data	Low-income childless adults (age 19-64) eligible for public coverage	• Estimates effects of public and private health insurance premiums on

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Childless Adults?," *Inquiry* 49 (Spring 2012):52-64.		expansions or premium assistance programs in 16 states and DC	insurance status of low-income childless adults eligible for public coverage or premium assistance programs. • Higher public premiums are associated with a decrease in the probability of having public insurance and an increase in the probability of being uninsured. A $1,000 increase in annual public premiums was associated with a 14.2 percentage-point reduction in the probability of public insurance and an 8.2 percentage point increase in the probability of being uninsured. • Increased private premiums decrease the probability of having private insurance. A $1,000 increase in annual private premiums was associated with a 3.3 percentage point reduction in the probability of private insurance. • Eligibility for premium assistance programs and increased subsidy levels are associated with lower uninsured rates. A $1,000 increase in

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the annual subsidy level for premium assistance was associated with a 3.4 percentage point reduction in the likelihood of being uninsured.
Jack Hadley, et. al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43, 4 (Winter 2006/2007).	1996-2003 Community Tracking Study Household Survey data	Children in families with incomes between 100%-300% FPL	• Estimates the effects of premiums on children's coverage. • Higher public premiums are significantly associated with a lower probability of public coverage and higher probabilities of private coverage and being uninsured. An increase in the public premium that leads to a 1% decrease in public coverage increases the probability of private coverage by .62%, while the probability of being uninsured increases by .38%. • Higher private premiums are significantly related to a lower probability of private coverage and higher probabilities of public coverage and being uninsured. If the probability of private coverage decreases by 1%,

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the probability of public coverage will increase by .55% and the probability of being uninsured will increase by .45%.
Genevieve Kenney, Jack Hadley, and Fredric Blavin, "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003," *Inquiry* 43 (Winter 2006/ 2007):345-361.	2000-2004 Current Population Survey data	Children with family incomes between 100% to 300% FPL and who meet the eligibility requirements for either Medicaid or CHIP coverage	• Simulates the effects of premiums on children's coverage. • Raising public premiums reduces enrollment in public programs, and increases the odds of having private coverage or being uninsured relative to having Medicaid or CHIP coverage. Public premiums have larger effects on lower income families. • For children with family incomes between 100%-300% FPL, increasing per-child public premiums by an average of $120 annually reduces public coverage by 1.4 percentage points, increases private coverage by 1.1 percentage points, and increases uninsured rates by .3 percentage points. • Larger reductions in public coverage were found among

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			lower income eligible children whose family incomes are between 100%-200% FPL. For these children, a $120 annual increase in public premiums would result in a 4.2 percentage point reduction in public coverage, a 3.2 percentage point increase in private coverage, and a 1.0 percentage point increase in the share uninsured. • Data also suggest that increases in public premiums may have more pronounced effects on uninsured rates when applied to Black or Hispanic children, whose families have lower levels of educational attainment. • A 10% increase in private coverage costs would lower private coverage by 1.4 percentage points, raise public coverage by .6 percentage points, and increase the share uninsured by .8 percentage points.
State Studies Back to top			

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
The Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, Prepared for Indiana Family and Social Services Administration (FSSA), (Washington, DC: Lewin Group, March 2017).	December 2016-January 2017 Surveys of enrolled, disenrolled, and not enrolled individuals, February 2015-December 2016 Indiana Family and Social Services Administration (FSSA) enrollment data and administrative data, and January-September 2016 data from 3 managed care entities (MCE)	**Indiana:** Medicaid expansion enrollees with incomes between 0-138% FPL	• Assesses the affordability of the Healthy Indiana Plan (HIP) 2.0's POWER Account Contribution (PAC) policy, which contains contributions that range from $1-$100 per month, depending on income. • Between February 1, 2015 and November 30, 2016, 55% of the 590,315 individuals eligible to pay PAC either never made a first payment or missed a payment during their enrollment. Individuals with incomes at or below poverty were more likely to not make a payment that those with incomes above poverty. • 15% of survey respondents reported that they are always or usually worried about having enough money to pay their PAC. • 44% of those who missed a payment cited not being able to afford to pay the contribution as the main reason for nonpayment and 17% indicated confusion regarding

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the payment process. Among those who never made a payment, 22% cited not being able to afford the contribution and 22% cited being confused about the payment process. • Individuals who disenrolled due to nonpayment or those who never enrolled because they did not make their first payment were less likely than those enrolled in HIP to report making appointments for both routine and specialty care. They were also less likely to report filling a prescription in the past six months or since leaving HIP. • 47% of those who disenrolled due to nonpayment and 41% of those who never enrollment because they did not make their first payment reported that they had insurance coverage, which was most commonly employer sponsored coverage.
MaryBeth Musumeci, et. al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, (Washington, DC: Kaiser Family	State administrative data	**Michigan and Indiana:** Adults enrolled in the Medicaid	• Examines early implementation experiences of

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Foundation, January 2017), https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/ (https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/).		expansion waiver programs	Michigan and Indiana Section 1115 Medicaid expansion waivers to low-income adults. • State data show that premium costs may deter eligible adults from enrolling in coverage. Particularly for very low-income adults, even very low premiums may be unaffordable. • In Michigan, from October 2014-July 2016, about 38% of beneficiaries who owed premiums had paid them. As of July 2016, over 112,000 Michigan beneficiaries owed past due premiums or copayments; about 44,200 (less than 40%) of these were in "consistent failure to pay" status, subjecting them to garnishment of their state income tax refunds. • 37% of Healthy Indiana Plan (HIP) 2.0 enrollees with incomes below poverty were not paying monthly premiums and, therefore, were enrolled in HIP Basic, the more limited benefit package with point-

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			of-service copayments, as of October 2016. To date, a limited number of Indiana beneficiaries with incomes above poverty have been locked out of coverage for failure to pay monthly premiums. Between August and October 2016, 4,621 HIP 2.0 beneficiaries were disenrolled and locked out of coverage for 6 months for failing to pay premiums.
James Marton et. al., "Estimating Premium Sensitivity for Children's Public Health Insurance Coverage: Selection but No Death Spiral," *Health Services Research* 50, 2 (April 2015): 579-598.	State administrative data, 2003-2006	**Georgia:** Children enrolled in PeachCare, Georgia's CHIP program	• Estimates the effects of premium increases on the probability that near-poor and moderate income children disenroll from public coverage. • A $1 increase in per child premium is associated with a 7.7-7.83% increase in the probability of a child disenrolling from CHIP. • The data suggest that families with children in poor health do not respond much differently than families with children in medium or good health to premium increases,

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			despite having a lower baseline probability of disenrolling from coverage.
Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (May 2014): 1-12.	State administrative data, 2008-2010	**Wisconsin:** Children and parents enrolled in BadgerPlus, Wisconsin's Medicaid and CHIP program	• Estimates the effects that premiums in Medicaid have on the length of enrollment. • A monthly premium increase from $0 to $10 results in 1.4 fewer months of continuous enrollment for both adults and children and increases the probability of disenrollment by 12-15 percentage points. • No or relatively small effects are found for other large discrete changes in premiums, suggesting that the premium requirement itself, more than the specific dollar amount, discourages enrollment.
Michael Hendryx, et al., "Effects of a Cost-Sharing Policy on Disenrollment from a State Health Insurance Program," *Social Work in Public Health* 27, 7 (2012):671-686.	Survey of adults who stayed enrolled and disenrolled following premium changes.	**Washington State:** Low-income adults in Washington's Basic Health Plan	• Examines the effects of increased premiums and cost sharing in Washington's state-funded coverage program for adults

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			on enrollment and possible health care consequences of disenrollment. Effective January 2004, Washington made policy changes that increased average monthly premiums for adults from $27 to $35 and average monthly out-of-pocket costs from $29 to $52. • About 5% of enrollees disenrolled after the policy changes. Disenrollees were more likely to be younger adults, male, and have fewer children. Among all disenrollees, 39% indicated that they left because they obtained other coverage, 35% reported that they were no longer eligible, while 21% indicated that they left the program because they could not afford it. Middle-income enrollees were the most likely to have left because they had trouble paying for coverage. • 63% of disenrollees were aware of the changes in premiums and cost sharing. Among all disenrollees who

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			were aware of the changes, 26% cited the changes as a reason for disenrolling. Among disenrollees who were aware of the changes and left voluntarily, 34% cited the changes as a reason for disenrolling. Among those citing the changes as a disenrollment reason, the increase in the monthly premium was the most important change that affected their decision. • Overall, 37% of disenrollees had no health insurance when surveyed. Disenrollees reported less access to care, greater subsequent out-of-pocket costs, and more difficulty providing coverage for children than people who stayed enrolled.
Michael M Morrisey, et.al., "The Effects of Premium Changes on ALL Kids, Alabama's CHIP Program," *Medicare & Medicaid Research Review* 2,3 (2012):E1-E17.	State administrative data, 1999 and 2009	**Alabama:** Children enrolled in ALL Kids, Alabama's CHIP program	• Examines the effects of an annual premium increase as well as increases in copayments on enrollment and renewal in Alabama's CHIP program, ALL Kids. In October 2003, premiums for

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			individual coverage increased by $50 per year and copays by $1-$3 per visit. • The increases in premiums and copays are estimated to have reduced renewals that are completed within 12 months by 6.1% annually. This reduction is over one-third larger—up to 8.3%—if only immediate renewals are considered. • Families with a child who has a chronic condition were more likely to renew coverage overall. However, those with chronic conditions, African Americans, and those with lower family incomes were more sensitive to the premium increase.
Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs* 29, 12 (December 2010):2311-2316.	State administrative data and a mail survey, November 2003, 2004, and 2005	**Oregon:** Adults enrolled in Medicaid with income below 100% FPL	• Examines effects of premium and cost sharing increases for poor adults enrolled in Oregon's Medicaid program. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • During the study period between 2003 and2005, only 33% of OHP Standard plan enrollees remained continuously enrolled following the policy changes, compared to 69% of OHP Plus enrollees. Most disenrollment occurred in the first six months following the changes, when 44% of OHP Standard enrollees left the program. • Premium increases and rigid premium payment deadlines were a major reason why members reported disenrolled from the OHP Standard plan, accounting for nearly half of the disenrollment over the first six months. • At the end of the study, 32% of those who had left OHP Standard had become uninsured compared to 8% of those who had left OHP Plus.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Michael R Cousineau, Kai-Ya Tsai, and Howard A Kahn, "Two Responses to a Premium Hike in a Program for Uninsured Kids: 4 in 5 Families Stay In as Enrollment Shrinks by a Fifth," *Health Affairs* 31, 2 (February 2012):360-366.	L.A. Care Health Plan enrollment data, 2009-2011	**California:** Children enrolled a health insurance program for low-income immigrant children in Los Angeles County and those whose income exceeded 250% FPL	• Examines the effects of premium increases on disenrollment from a health insurance program for low-income immigrant children in Los Angeles County. In July 2010, L.A. Care Health Plan increased premiums for older children (age 6-18) to $15 per month for each child, with a maximum of $45 per family. Premium increases did not apply to younger children (ages 0-5). • After premiums increased, the retention rate among older children dropped by nearly five percentage points from an average of 98.1% to 93.8%. Much of the decline occurred in the first two months after the premium increase. As a result, monthly enrollment among older children declined by 39% after the premium increase. In contrast, the average retention rate for younger children did not change over the period.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• At the end of the study period, 59% of the older children subject to the premiums were still enrolled. Without the premium increase, it was expected that 80% of the children in this group would still be enrolled. As such, it is estimated that the increase resulted in an enrollment decline of 20%.
James Marton, Patricia G Ketsche, and Mei Zhou, "SCHIP Premiums, Enrollment, and Expenditures: A Two State, Competing Risk Analysis," *Health Economics* 19 (2010):772-791.	State administrative data for Kentucky, 2001-2004 and Georgia, 2003-2005	**Kentucky and Georgia**: Children enrolled in Medicaid and CHIP in Kentucky and Georgia	• Compares the effects of introducing new premiums and increasing premiums for children enrolled in CHIP in two states on enrollment in public coverage through CHIP or Medicaid. Kentucky introduced a $20 monthly premium for children in CHIP for the first time in 2003. In mid-2004, Georgia increased existing premiums in its CHIP program from $10 per family to sliding scale premiums ranging from $20-$40 for one child and $35-$70 for two or more children. • In both states, premium increases

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			lead to increases in children leaving CHIP and having no public health insurance in the two months immediately following the premium changes. In both states, data also show increases in the probability of children moving to lower income eligibility categories of CHIP that have lower premiums following the premium increase. In Kentucky, there also was an increase in the likelihood of children moving to Medicaid in the two months following the increase; however, this was not observed in Georgia. • Not all changes persisted over the longer term. However, in Kentucky, children continued to be more likely to exit to no public health insurance in the remaining seven months of the study period.
James Marton and Jeffery C Talbert, "CHIP Premiums, Health Status, and the Insurance Coverage of Children," *Inquiry* 47, 3 (Fall 2010):199-214.	State administrative data 2001-2005 and a survey of families that disenrolled from CHIP due to	**Kentucky:** Children enrolled in CHIP	• Examines whether the effects of new premiums in Kentucky's CHIP program on enrollment varied

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
	premium nonpayment		by children's health status and the extent to which children find alternative coverage after disenrolling due to premium nonpayment. In late 2003, Kentucky introduced a $20 per family per month premium for children in CHIP with family incomes between 151%-200% FPL. • Overall, the data show that children with a chronic condition are significantly less likely to disenroll from CHIP than children without a chronic condition. • The data suggest that introduction of the premium reduces the duration of CHIP coverage for the average child. However, the data suggest little differential impact of the premium increase by health status of children. • Survey results find 56% of families report alternative private or public health coverage for their children after losing CHIP coverage, while 44% had no insurance for their children

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			following disenrollment.
Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," *Health Affairs* 28, 2, (2009):w335-w345.	State administrative data; Current Population Survey (CPS) data, 2005-2007; provider utilization and financial reports; and structured interviews	**Missouri:** Nonelderly adults and children in Medicaid and CHIP	• Examines the effects of a broad range of policy changes in Missouri Medicaid and CHIP coverage, including new monthly premiums for CHIP. In 2005, Missouri adopted large policy changes to Medicaid and CHIP, including new monthly premiums of 1-5% of family income for children in CHIP with incomes above 150% FPL. • CHIP enrollment fell 30% between June 2004 and June 2006. In contrast, nationally, CHIP enrollment rose 3.4% over the same time period. • The share of low-income children in Missouri with Medicaid or CHIP coverage fell from 50.2% in 2004 to 40.5% in 2006, but increases in other types of insurance coverage prevented an increase in the share that were uninsured.
Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," *Health*	State administrative data, 2002-2004	**Florida**: Children enrolled in CHIP	• Examines the impact of premium changes in Florida's

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Services Research 43, 2 (April 2008):458-477.			CHIP program on enrollment duration. Florida increased CHIP premiums for enrollees with incomes between 101-200% FPL by $5 per family per month in July 2002. These increases were reversed in October 2003 for those with incomes between 101-150% FPL, but maintained for those with incomes above 150% FPL. • Enrollment lengths decreased significantly immediately following the premiums increase, and the decrease was larger among lower income children (61%) than higher income children (55%). Enrollment lengths partially recovered in the longer term for both the temporary and permanent policy changes. • Children with significant acute or chronic health conditions had longer enrollment lengths and were less sensitive to premium changes than healthy children. Among

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			lower income children, healthy children experienced a 61% decline in enrollment within the first three months compared to a 39% decline for children with significant acute conditions.
James Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," *Journal of Policy Analysis and Management* 26 (2007):237-255.	State administrative data, 2001-2004	**Kentucky:** Children enrolled in CHIP	• Examines the impact of new premiums on enrollment duration for CHIP children in Kentucky. Kentucky introduced a $20 premium for children in CHIP with family incomes between 151-200% FPL in December 2003. • Results suggest that a premium reduces the length of enrollment, with the impact concentrated in the first three months after the introduction of the premium.
Genevieve Kenney, et. al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Part 2 (2007):2354-2372.	State administrative data, 2001 to 2004/2005	**Arizona and Kentucky:** Children enrolled in CHIP with family incomes between 101-150% FPL in Arizona and 151-200% FPL in Kentucky.	• Assesses whether new premiums in CHIP affect rates of disenrollment and reenrollment in CHIP and whether they have spillover enrollment effects on Medicaid. In July

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			2004, Arizona introduced CHIP premiums ranging from $10-$15 per month for families with incomes between 101-150% FPL. In December 2003, Kentucky introduced a premium of $20 per month per family for children in CHIP with family incomes between 151-200% FPL. • In both states, the premiums increased the rate of disenrollment among children subject to the premiums. The rate of disenrollment increased by 52% in Kentucky and by 38% in Arizona. All of the increases in disenrollment occurred during the first two or three months after introduction of the premium. Almost all the disenrollment is caused by children leaving public insurance rather than moving to Medicaid or other non-premium paying categories of CHIP. Findings also indicate a relatively small reduction in the rate of re-enrollment in both states.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• In both states, the premiums were associated with a decline in overall enrollment among children subject to the premiums. The premium reduced enrollment in the premium paying group by 18% in Kentucky and by 5% in Arizona, with some of the children leaving public coverage all together. Unlike the impacts on disenrollment, these effects are not limited to the first 2–3 months following the introduction of the premium, suggesting that the premium may have dampened new enrollment into the premium-paying category over a longer period of time.
Gina A Livermore, et. al., "Premium Increases in State Health Insurance Programs: Lessons from a Case Study of the Massachusetts Medicaid Buy-in Program," *Inquiry* 44 (Winter 2007):428-442.	2002-2003 Medicaid Management Information System (MMIS) and administrative data	**Massachusetts:** Enrollees in the Massachusetts CommonHealth-Working (CH-W) Medicaid buy-in program for people with disabilities	• Evaluates the impact of premium increases on disenrollment from a state-funded Medicaid buy-in program for people with disabilities in Massachusetts. In 2003, monthly premiums for the Massachusetts CommonHealth-Working (CH-W)

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			program increased from $37 to $51. • After a period of steady growth, CH-W enrollment decreased marginally (.5% decrease) in the months surrounding the premium change (February-August 2003) compared with 12.4% increase during the same period in the previous year. • The premium increase increased the likelihood of enrollees leaving Medicaid (MassHealth) altogether, but had no effect on the likelihood of moving to another Medicaid (MassHealth) eligibility category. Although statistically significant, the effect is rather modest. All else held constant, a $10 increase in the premium would increase the odds of leaving Medicaid (MassHealth) by 3%. • The analysis suggests that the premium changes had a relatively small impact on disenrollment and alone cannot explain the decline observed between

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			February and August 2003. Authors suggest that several aspects of the program may contribute to the limited impact on disenrollment, including it being a longstanding program, the changes increasing existing premiums rather than introducing new premiums, the exemption of enrollees with incomes under 150% FPL from premiums, the analysis accounting for the movement of enrollees to other categories of Medicaid coverage, and administrative procedures, including processes designed to minimize disenrollment due to nonpayment. Further, people with disabilities may be less price-sensitive to premiums given their significant health care needs.
Genevieve Kenney, et. al., "The Effects of Premium Increases on Enrollment in SCHIP Programs: Findings from Three States," *Inquiry* 43, 4 (Winter 2006-2007):378-92.	State administrative data, 2001-2004/2005.	**Kansas, Kentucky, and New Hampshire:** Children enrolled in CHIP with incomes between 150-200% FPL in Kansas and Kentucky and	• Examines the effects of new and higher premiums on CHIP enrollment in Kansas, Kentucky, and New Hampshire. In 2013, Kansas and

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
		with family incomes between 185-300% FPL in New Hampshire.	Kentucky increased premium levels, while Kentucky introduced new premiums. Kansas increased premiums from $10 to $30 per family per month for families with incomes between 151-175% FPL and from $15 to $45 per family per month for those with incomes between 176-200% FPL. New Hampshire increased premiums for families with incomes between 185% to 249% FPL from $20 to $25 per child per month and from $40 to $45 for families with incomes between 250-300% FPL. Kentucky introduced a $20 premium per family per month for 151-200% FPL. • In all three states, caseload growth rates in the six months prior to the premium increase were consistently higher than those in the six months after the increase. In Kentucky, the caseload of children subject to premiums decreased by 16.4% following the premium's introduction. The caseload stabilized

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			after several months but did not return to pre-premium levels nine months after the premium was introduced. In Kansas and New Hampshire, small declines in the caseload occurred immediately following the premium increase. The caseload resumed growing three to five months after the premium increase, though at lower rates than before the increase. In contrast, caseloads among other categories of public coverage without premiums grew over the period. • Premiums were found to reduce new enrollment by 10.1% and 17.7% in Kansas and New Hampshire, respectively. They also led to faster disenrollment in Kentucky and New Hampshire. • In Kentucky, larger disenrollment effects were found for nonwhite children relative to white children while in New Hampshire, disenrollment effects were

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			concentrated among children at the lower end of the income group subject to premiums.
Tricia J Johnson, Mary Rimsza, and William G Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* 96, 4 (April 2006):709-715.	Yuma HealthQuery (YHQ) community health data, 2001	**Arizona:** Children in Yuma County, Arizona who received non-traumatic care at an emergency room who were enrolled in CHIP or uninsured	• Simulates the effects of increasing CHIP premiums on health care use and public costs using data for children in Yuma, Arizona. • Estimates that a $10 increase in monthly premiums for CHIP would induce 10% of CHIP children to disenroll.
Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.	Survey of enrollees, 2003 and analysis of Medicaid eligibility files	**Oregon**: Adults enrolled in Medicaid	• Examines longitudinal effects on enrollees of a range of policy changes that were made in Oregon's Medicaid program. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			similar to the original OHP. • Nearly half (44%) of the OHP Standard members disenrolled in the six months after the program changes were implemented. • The increased premiums and cost sharing disproportionately affected the most economically vulnerable OHP members; for the vast majority of those who disenrolled, leaving OHP meant becoming uninsured. This was particularly true for those who left because of the increased costs. • Those who left OHP because of cost were more likely than those who left for other reasons not to have received needed care in the previous six months. Similarly, those who left because of cost were more likely to have skipped buying prescription medicines because of cost and were significantly less likely than those who left for other reasons to have a

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			usual source of care. • Those who left because of cost were significantly less likely than those who left for other reasons to have had a least one primary care visit in the past six months and significantly more likely to have had at least one emergency department visit in those same six months. • Those who left OHP because of cost were significantly more likely to owe $500 or more in medical debt than those who left for other reasons. The increased debt burden may have negatively affected their access to care.
Matthew J Carlson and Bill Wright, "The Impact of Program Changes on Enrollment, Access, and Utilization in the Oregon Health Plan Standard Population," Prepared for the Office for Oregon Health Policy and Research, *Sociology Faculty Publications and Presentations,* Paper 14 (March 2005).	Survey conducted between November 2003 and February 2004	**Oregon:** Adult Medicaid enrollees with incomes below 100% FPL	• Assesses the impact of policy changes made to Oregon's Medicaid program on enrollment, health care access, and use. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • 44% of individuals who disenrolled from OHP Standard following the changes reported that increased costs, including premiums, copays, and back-owed premiums, contributed to disenrollment; OHP Standard disenrollees with incomes between 0-10% FPL were significantly more likely to report difficulty paying premiums and copays than those with higher incomes. • Two-thirds of OHP Standard disenrollees became uninsured. • Disenrollees with very low incomes (43%) were more likely to have an emergency department visit than those still covered (35%); the difference was larger for those with chronic conditions.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Rachel Solotaroff, et. al., "Medicaid Programme Changes and the Chronically Ill: Early Results from a Prospective Cohort Study of the Oregon Health Plan," *Chronic Illness* 1, (2005): 191-205.	Mail survey of OHP beneficiaries, October 2003	**Oregon:** Nonelderly adults enrolled in Medicaid	• Assess the impacts of policy changes in Oregon's Medicaid program on individuals living with chronic illness. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • Nearly half (46.3%) of OHP Standard beneficiaries disenrolled in the 10 months after the policy changes. Rates of disenrollment were lower among the chronically ill (42.8%) than those without chronic illness (49.6%). However, 68% of the chronically ill that did disenroll remained uninsured at the time of the survey.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• When asked why they disenrolled, 45% of the chronically ill and 43% of those without a chronic illness identified a reason related to the increase in cost sharing, such as inability to afford the new premiums or copays and/or owing premiums. • Increased costs disproportionately affected enrollment for those with lower incomes. Among those who lost coverage, 68.2% of those with zero income indicated cost sharing as the major reason for their loss, compared to 38.7% of those with incomes between 26%-100% FPL and 23.9% of those with income above 100% FPL. • Chronically ill persons who became uninsured after leaving OHP fared worse in terms of access to care, use of care, and financial burden than those who became uninsured but did not have a chronic illness.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).	Focus groups, 2004	**Oregon:** Medicaid adults with incomes under 100% FPL.	• Assesses the impact of policy changes made to Oregon's Medicaid program on poor adults who were subject to benefit reductions and premium and cost sharing increases. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • Increased premiums and stricter payment policies led many to face difficult decisions such as paying other bills late or skipping meals. For many, the new premiums and the stricter payment policies led to loss of coverage, and they had significant problems accessing care after losing coverage.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
Utah Department of Health Center for Health Data, *Utah Primary Care Network Disenrollment Report*, (Salt Lake City, UT: Utah Department of Health Center for Health Data, Office of Health Care Statistics, August 2004).	State administrative and survey data, July and September 2003	**Utah:** Adults with incomes below 150% FPL who disenrolled from Medicaid	• Examines the effect of an enrollment fee and cost sharing on adults enrolled in a Medicaid limited benefit waiver program in Utah. In 2003, Utah implemented an annual enrollment fee and cost sharing in its Primary Care Network (PCN) waiver program for low-income adults. • During July-September 2003 (renewal period after first year), 27% were disenrolled. A survey of disenrollees found that 63% were uninsured at the time of the survey. Nearly half of surveyed disenrollees indicated that they were still eligible for the PCN program. • Nearly 30% of survey respondents indicated financial barriers to reenrollment. Most of those reporting financial barriers cited the $50 reenrollment fee as the barrier (63%) and 26% cited the copays. Over 75% of respondents who reported financial barriers to reenrollment

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			reported being uninsured after exiting the program. • Of those indicating they did not reenroll because the program did not meet their health needs, 20% reported copays were too high to use services. • About half of all respondents who disenrolled, regardless of reason for disenrollment, indicated not having seen a health care provider in the previous 12 months. Many disenrollees reported difficulty accessing needed care, particularly mental health care, alcohol/drug treatment, and dental services.
Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).	State administrative data, key informant interviews, a focus group, and interviews, September 2002-September 2003	**Washington State:** Immigrant families moved from Medicaid to Basic Health in Washington State	• Assesses the impact of changes in coverage options for low-income immigrants in Washington State. In 2002, Washington State eliminated three state-funded programs for individuals whose immigration status prevented them from qualifying for Medicaid. Instead, "slots" were set aside for them in

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			the state's Basic Health program, which charges premiums and has more limited benefits than Medicaid. • 48% of families in the transition population did not make the transition and disenrolled during the first few months of the transition. • Premiums were a significant barrier to families obtaining and maintaining Basic Health coverage; 35.9% of those from the transition group who disenrolled from Basic Health in the first 11 months did so because they did not pay premiums. • Most (61%) of the group that successfully transitioned to Basic Health relied on assistance from third parties to pay premiums.
Maryland Department of Health and Mental Hygiene, *Maryland Children's Health Insurance Program: Assessment of the Impact of Premiums*, (Baltimore, MD: Department of Health and Mental Hygiene, April 2004).	State administrative and survey data, February 2004	**Maryland:** Children disenrolled from CHIP with incomes between 185-200% FPL	• Studies the effects of a new monthly premium in Maryland's CHIP program on program enrollment and health coverage. In 2003,

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			Maryland made several changes to its CHIP program, including requiring families with incomes between 185-200% FPL to pay a new monthly premium of $37 per family. • Enrollment data showed about one-quarter of families subject to the new premiums disenrolled. • In surveys conducted with parents, the most common reason given was gaining other coverage (41%), but 20% cited a premium related reason.
John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.	State administrative data, January 2002 – October 2003	**Oregon:** Adults with incomes below 100% FPL who disenrolled from Medicaid in Oregon	• Examines the effects of changes to Oregon's Medicaid program on enrollment and highlights the effects for enrollees at different income levels. In 2003, Oregon made a range of policy changes to its Medicaid program, the Oregon Health Plan (OHP), which included benefit reductions, increased premiums and cost sharing and stricter premium payment

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			policies for adults enrolled in its OHP Standard program. Enrollees in OHP Plus continued to receive benefits similar to the original OHP. • OHP Standard experienced a nearly 50% drop in enrollment, with the largest declines experienced by those with no income (58% drop in October 2003 from 2002 levels). • Of those that left between May and October, 47% were disqualified for not paying premiums.
Norma I Gavin, et. al., *Evaluation of the BadgerCare Medicaid Demonstration*, Prepared by RTI International and MayaTech Corp. for the Centers for Medicare & Medicaid Services, (Research Triangle Park, NC: RTI International and MayaTech Corporation, December 2003).	Case study, including site visit interviews, focus groups, and document review; administrative enrollment data 1997-2002; and surveys of BadgerCare participating, eligible nonparticipating, and disenrolled families.	**Wisconsin:** Families enrolled in Medicaid/CHIP	• Evaluates Wisconsin's BadgerCare Medicaid/CHIP program for low-income families. BadgerCare, includes premiums for families with incomes over 150% FPL who must pay monthly premiums of approximately 3% of their income. • Premium paying families were less likely to remain enrolled over time, but the difference from families not subject to premiums was small.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			Premiums delayed reenrollment of families. • Of those disenrolled, 26% listed a problem with paying premiums as a reason for leaving BadgerCare. This was the most common reason for leaving the program.
Monette Goodrich, Joan Alker, and Judith Solomon, *Families at Risk: The Impact of Premiums on Children and Parents in Husky A, Policy Brief* (Washington, DC: Georgetown Center for Children and Families, November 2003), http://ccf.georgetown.edu/wp-content/uploads/2012/03/Far%20-%20impact%20of%20premiums.pdf (http://ccf.georgetown.edu/wp-content/uploads/2012/03/Far%20-%20impact%20of%20premiums.pdf).	State administrative data, August 2003	**Connecticut**: Children and adults enrolled in Medicaid	• Models potential effects of adding new premiums to Connecticut's Medicaid program. In 2003, Connecticut was planning to charge premiums for families with monthly incomes ranging from 50%-185% FPL for a family of three enrolled in Medicaid. • Estimates that premiums would contribute to an enrollment decline of by 86,744 adults and children. Of these persons who could be expected to lose coverage, 59,638 – approximately 69% – would be children; the remaining 27,106 would be parents or pregnant women.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• Of the adults that could be expected to lose coverage, 1,006 would be pregnant women. • Just under half of those who could be expected to lose coverage would be children and parents whose income falls below the poverty level – 26,212 children and 15,070 adults – with monthly incomes ranging from $604 to $1,196 a month. • The remaining 33,426 children and 12,036 adults who could be expected to lose coverage come from families whose incomes range from 100-184% of the poverty line.
Elizabeth Shenkman, et. al., "Disenrollment and Re-Enrollment Patterns in a SCHIP Program," *Health Care Financing Review* 23, 3 (Spring 2002:47-63.	Census of all children enrolled in CHIP program for at least 1 month from October 1, 1997-September 30, 1999.	**Florida**: Children enrolled in CHIP	• Examines the impact of four policy changes made to Florida's CHIP program on enrollment and re-enrollment, including a reduction in premiums. Prior to 1998, families paid $5-$27 per child per month (depending on the county where they lived) and family income while families above 186% FPL paid $55-$65

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			per child per month. In 1998, Florida changed its CHIP program, including extending subsidized premiums which reduced premiums to $15 per family per month for those 185%-200% FPL. Families above 200% FPL paid about $75 per child per month. • Larger decreases in monthly premiums had larger effects on reducing the likelihood of disenrollment. While an average of $5 per month decrease in premiums resulted in families being only 2% less likely to disenroll their children from the program, a $45 per month reduction in premiums meant that families were 17-20% less likely to disenroll their children from the program. • Families experiencing the mean premium change were slightly more likely to re-enroll their children following a disenrollment episode. For example, families experiencing the mean premium

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			change were 6-7% more likely to re-enroll post- versus pre-April 1998.
Leighton Ku and Teresa A Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36, 4 (Winter 1999/2000).	Interviews with state officials, review of state documents, and 1995 state data	**Washington**, **Tennessee**, **Hawaii**, and **Minnesota**: Medicaid/CHIP enrollees	• Examines the experiences in four states that implemented Medicaid expansion programs that include sliding-scale premiums for families. In the 1990s, Washington, Tennessee, Hawaii, and Minnesota initiated Medicaid expansion programs using sliding-scale premiums. • Participation in public health programs fell from 57% when premiums were equal to 1% of family income to 35% when premiums grew to 3% of family income. Participation continued to fall to 18% when premiums rose to 5% of family income.

Table 2: Effects of Cost Sharing

National Studies
State Studies

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
National Studies		
Charles Stoecker, Alexandra M Stewart, and Megan C Lindley, "The Cost of Cost-Sharing: The Impact of Medicaid Benefit Design on Influence Vaccination Uptake," *Vaccines* 5, 8, (March 2017).	Behavioral Risk Factor Surveillance System (BRFSS) data, 2003-2012	Nonelderly adult Medicaid enrollees receiving care on a fee-for-service basis
Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care* published ahead of print (February 2017).	National Health and Nutrition Examination Survey (NHANES) data, 1999-2012.	Adults age 20-64 enrolled in Medicaic in 18 states and those not enrolled i Medicaid with family incomes at or below 250% FPL who were identified to have hypertension or hypercholesterolem

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Lindsay M. Sabik and Sabina Ohri Gandhi, “Copayments and Emergency Department Use Among Adult Medicaid Enrollees,” *Health Economics* 25 (May 2016):529-542.	National Hospital Ambulatory Medical Care Survey (NHAMCS) and state-level data, 2001-2009	Nonelderly adult Medicaid enrollees

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Mona Siddiqui, Eric T Roberts, and Craig E Pollack, "The Effects of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005," *JAMA Internal Medicine* 175,3 (March 2015):393-398.	Medical Expenditure Panel Survey (MEPS) data, January 2001 to December 2010	Adult Medicaid enrollees

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Vicki Fung, et. al., "Financial Barriers to Care Among Low-Income Children with Asthma: Health Care Reform Implications," *JAMA Pediatrics* 168, 7 (July 2014):649-656.	2012 Telephone survey of 769 parents	Children between ages 4-11 with asthma

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Jessica Greene, Rebecca M Sacks, and Sara B McMenamin, "The Impact of Tobacco Dependence Treatment Coverage and Copayments in Medicaid," *American Journal of Preventive Medicine* 46, 4 (April 2014):331-336.	Current Population Survey (CPS) Tobacco Use supplement data, 2001-2003, 2006-2007, and 2010-2011	Adults enrolled in Medicaid who reported smoking 1 months prior to the survey and lived in 2 states with consiste tobacco dependenc treatment coverage across Medicaid fee for-service and managed care.

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Gery P Guy Jr., "The Effects of Cost Sharing on Access to Care among Childless Adults." *Health Services Research* 45, 6 Pt. 1 (December 2010): 1720-1739.	Behavioral Risk Factor Surveillance System (BRFSS) data, 1997–2007	Nonelderly adults

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Karoline Mortensen, "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments," *Health Affairs* 29, 9 (September 2010): 1643-1650 .	Medical Expenditure Panel Surveys (MEPS) data, 2001-2006	Nonelderly adults enrolled in Medicaic
State Specific Studies Back to top		
Leah Zallman, et. al., "Affordability of Health Care Under Publicly Subsidized Insurance After Massachusetts Health Care Reform: A Qualitative Study of Safety Net Patients," *International Journal for Equity in Health* 14 (October 2015):112.	Face to face interviews with 12 individuals	**Massachusetts:** Individuals with Medicaid or subsidized coverage (Commonwealth Care) at a safety net hospital emergency department

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Leah Zallman, et.al., "Perceived Affordability of Health Insurance and Medical Financial Burdens Five Years in to Massachusetts Health Reform," *International Journal for Equity in Health* 14 (October 2015):113.	Face to face surveys	**Massachusetts:** A sample of 976 patients seeking car at three hospital emergency departments

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Daniel A Lieberman, et. al., "Unintended Consequences of a Medicaid Prescription Copayment Policy," *Medical Care* 52, 5 (May 2014):422-427.	State-level aggregate medication utilization data from the Center for Medicare and Medicaid Services (CMS), 2007-2011	**Massachusetts:** Prescription medication utilizatic in Massachusetts Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Bisakha Sen, et. al., "Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?," *Medicare & Medicaid Research Review* 4, 2 (May 2014).	State administrative and claims data, 1999-2007	**Alabama:** Children enrolled in CHIP

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Amitabh Chandra, Jonathan Gruber and Robin McKnight, "The Impact of Patient Cost-Sharing on Low-Income Populations: Evidence from Massachusetts," *Journal of Health Economics* 33 (2014): 57-66.	State enrollment and claims data, July 2007-June 2009	**Massachusetts:** Adults enrolled in Massachusetts Commonwealth Car a state-funded program that subsidizes insuranc for families with incomes <300% FPL

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
James Marton, et. al., "The Effects of Medicaid Policy Changes on Adults' Service Use Patterns in Kentucky and Idaho," *Medicare & Medicaid Research Review* 2, 4 (February 2013).	State administrative data, 2004-2008	**Kentucky:** Nonelderly, non-institutionalized adults enrolled in Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Bisakha Sen, et. al., "Did Copayment Changes Reduce Health Service Utilization among CHIP Enrollees? Evidence from Alabama," *Health Services Research* 47, 4 (September 2012):1303-1620.	State administrative data, 1999-2009	**Alabama:** Children enrolled in CHIP
Sujha Subramanian, "Impact of Medicaid Copayments on Patients with Cancer," *Medical Care* 49, 9 (September 2011): 842-847.	Medicaid administrative data linked with cancer registry data, 1999-2004	**Georgia:** Low-incom nonelderly adult Medicaid enrollees diagnosed with cancer

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Marisa Elena Domino, et. al., "Increasing Time Cost and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment," *Health Services Research* 46, 3 (June 2011):900-919.	Medicaid claims data from CMS, 2000- 2002	**North Carolina:** Nonelderly adults enrolled in Medicaic

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Bill J Wright, et. al., "Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out," *Health Affairs* 29, 12 (December 2010):2311-2316.	Survey, 2003, 2004, and 2005	**Oregon:** Low-incom adult Medicaid recipients with incomes under 100 FPL
Robert A Lowe, et. al., "Impact of Policy Changes on Emergency Department Use by Medicaid Enrollees in Oregon," *Medical Care* 48,7 (July 2010): 619-627.	State administrative	**Oregon**: Low-incom nonelderly adults enrolled in Medicaic

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
	data, 2001-2004.	

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
Joel F Farley, “Medicaid Prescription Cost Containment and Schizophrenia: A Retrospective Examination,” *Medical Care* 48, 5 (May 2010): 440-447.	CMS Medicaid Analytical Extract Data Files, 2001-2003	**Mississippi**: Medicaid patients with schizophrenia

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Citation	Data	Study Population(
Daniel M Hartung, et. al., "Impact of a Medicaid Copayment Policy on Prescription Drug and Health Services Utilization in a Fee-for-service Medicaid Population," *Medical Care* 46, 6 (June 2008):565-572.	State claims data, 2002-2004	**Oregon:** Non-pregnant adults (parents receiving Temporary Assistance for Need Families, individuals with disabilities, and elderly individuals) enrolled in Medicaid receiving care on a fee-for-service basis

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

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Citation	Data	Study Population(
Gene LeCouteur, Michael Perry, Samantha Artiga and David Rousseau, *The Impact of Medicaid Reductions in Oregon: Focus Group Insights,* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, December 2004).	Focus groups, 2004	**Oregon**: Adults enrolled in Medicaic with incomes under 100% FPL
Leighton Ku, et. al., *The Effects of Copayments on the Use of Medical Services and Prescription Drugs in Utah's Medicaid Program*, (Washington, DC: Center on Budget and Policy Priorities, November 2004).	Utah Department of Health (UDOH) data, 2001-2002	**Utah:** Adults enrolle in Medicaid

Citation	Data	Study Population(
Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003), http://www.hpm.umn.edu/ ambul db/db/pdflibrary/ DBfile 49007.pdf (http://www.hpm.umn.edu/ambul db/db/pdflibrary/DBfile 49007.pdf)	Medicaid Administrative Data 2001-2003 and Medicaid Benefits Survey 2003	**Utah**: Adults enrolle in Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

State Studies

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
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Bisakha Sen, et. al., "Health Expenditure Concentration and Characteristics of High-Cost Enrollees in CHIP," *Inquiry* 53 (May 2016):1-9.	Claims data, 1999 – 2011	**Alabama:** Children enrolled in CH

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Citation	Data	Study Population(
Marisa Elena Domino, et. al., "Increasing Time Cost and Copayments for Prescription Drugs: An Analysis of Policy Changes in a Complex Environment," *Health Services Research* 46, 3 (June 2011):900-919.	Medicaid claims data from the Centers for Medicare & Medicaid Services (CMS), 2000-2002	**North Caroli** Nonelderly adults enrolle in Medicaid

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Citation	Data	Study Population(
Maryland Department of Health and Mental Hygiene, *Estimated Medicaid Savings and Program Impacts of Service Limitations, Copayments, and Premiums,* (Baltimore, MD: Maryland Department of Health and Mental Hygiene, December 2010), https://mmcp.dhmh.maryland.gov/ (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf) Documents/ (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf) medicaidsavingsJCRfinal12-10.pdf (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf).	2009 state Medicaid data	**Maryland:** Medicaid and CHIP enrollee

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Citation	Data	Study Population(
Stephen Zuckerman, Dawn M Miller, and Emily Shelton Page, "Missouri's 2005 Medicaid Cuts: How Did they Affect Enrollees and Providers?," *Health Affairs* 28, 2, (2009):w335-w345.	State administrative data; Current Population Survey (CPS) data, 2005-2007; provider utilization and financial reports; and structured interviews	**Missouri:** Nonelderly adults and children in Medicaid and CHIP

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Citation	Data	Study Population(
Robert A Lowe, et. al. "Impact of Medicaid Cutbacks on Emergency Department Use: The Oregon Experience," *Annals of Emergency Medicine* 52, 6 (December 2008):626-534.	Hospital billing data from 26 Oregon emergency departments, 2002-2004	**Oregon:** Emergency department visits

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Citation	Data	Study Population(
Health Management Associates, *Co-pays for Nonemergent Use of Hospital Emergency Rooms: Cost Effectiveness and Feasibility Analysis*, Prepared for the Texas Health and Human Services Commission, (Austin, TX: Health and Human Services Commission, May 2008).	N/A	**Texas:** Medic enrollees

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Neal T Wallace, et. al., "How Effective are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan," *Health Services Research* 43, 3 (April 2008):515-530.	Medicaid eligibility, claims and encounter data, November 2001-October 2002 and May 2003-April 2004	**Oregon:** Nonelderly adults enrolle in Medicaid

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Gina A Livermore, et. al., "Premium Increases in State Health Insurance Programs: Lessons from a Case Study of the Massachusetts Medicaid Buy-in Program," *Inquiry* 44 (Winter 2007):428-442.	2002-2003 Medicaid Management Information System (MMIS) and administrative data	**Massachuset** Enrollees in th Massachusett CommonHeal Working (CH- Medicaid buy program for people with disabilities

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Genevieve Kenney, et. al., "Assessing Potential Enrollment and Budgetary Effects of SCHIP Premiums: Findings from Arizona and Kentucky," *Health Services Research* 42, 6 Part 2 (2007):2354-2372.	State administrative data, 2001 to 2004/2005	**Arizona and Kentucky:** Children enrolled in CH with family incomes between 101-150% FPL in Arizona and 151-200% FPL Kentucky.

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Citation	Data	Study Population(
Arizona Health Care Cost Containment System, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005,* (Phoenix, AZ: Arizona Health Care Cost Containment System, December 2006), http://citeseerx.ist.psu.edu/viewdoc/ (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf) download?doi=10.1.1.482.6057 (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf) &rep=rep1&type=pdf (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf).	N/A	**Arizona**: Medicaid program

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Citation	Data	Study Population(

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Citation	Data	Study Population(
Tricia J Johnson, Mary Rimsza, and William G Johnson, "The Effects of Cost-Shifting in the State Children's Health Insurance Program," *American Journal of Public Health* 96, 4 (April 2006):709-715.	Yuma HealthQuery (YHQ) community health data, 2001	**Arizona:** Children in Yuma County Arizona who received non-traumatic car at an emergency room and we enrolled in CH or uninsured
Mark Gardner and Janet Varon, *Moving Immigrants from a Medicaid Look-Alike Program to Basic Health in Washington State: Early Observations*, (Washington, DC: Kaiser Family Foundation, May 2004).	State administrative data, key informant interviews, a focus group, and interviews, September 2002-	**Washington State:** Immigrant families move from Medicai to Basic Healt in Washingtor State

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Citation	Data	Study Population(
	September 2003	
John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Prepared for the Office for Oregon Health Policy & Research, (Portland, OR: Oregon Health & Science University, February 2004.	State administrative data, January 2002 – October 2003	**Oregon:** Adul with incomes below 100% F who disenroll from Medicai

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Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
Steven Crawford and Garth L Splinter, *It's Health Care, Not Welfare: Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program,* Prepared for the Oklahoma Health Care Authority, (Oklahoma City, OK: Oklahoma Health Care Authority, January 2004).	Survey of physicians and other providers in Oklahoma	**Oklahoma:** Physicians an other health care provider
Pamela Hines, et. al., *Assessing the Early Impacts of OHP2: A Pilot Study of Federally Qualified Health Centers Impact in Multnomah and Washington Counties*, Prepared for Office for Oregon Health Policy & Research, (Salem, OR: Office for Oregon Health Policy & Research, December 2003).	Interviews with health center administrators and physicians in the Portland, Oregon metropolitan area.	**Oregon:** Heal center administrator and physician in the Portlan Oregon metropolitan area.

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Endnotes

Issue Brief

1. See Maine Department of Health and Human Services, 1115 Waiver Application, http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf (http://www.maine.gov/dhhs/oms/documents/Draft_MaineCare_1115_application.pdf); State of Wisconsin BadgerCare Reform Demonstration Project, Coverage of Adults Without Dependent Children with Income at or Below 100 Percent of the Federal Poverty Level, Draft 1115 Demonstration Waiver Amendment Application, https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-app.pdf (https://www.dhs.wisconsin.gov/badgercareplus/clawaiver-app.pdf); Office of the Governor, Kentucky Health: Helping to Engage and Achieve Long Term Health, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf (https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf); and Indiana Family and Social Services Administration, Health Indiana Plan (HIP) Section 1115

Waiver Extension Application, https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf (https://www.in.gov/fssa/hip/files/HIP_Extension_Waiver_FINAL1.pdf).

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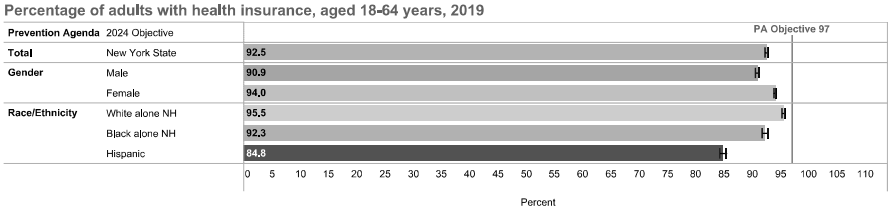
Select Year
2019

Select Group(s)
All

Percent
84.8 95.5

Percentage of adults with health insurance, aged 18-64 years, 2019



Percentage of adults with health insurance, aged 18-64 years, 2019

Group	Characteristics	Percent (90% CI)
Prevention Agenda	2024 Objective	97
Total	New York State	92.5 (92.3 - 92.7)
Gender	Male	90.9 (90.6 - 91.2)
	Female	94.0 (93.8 - 94.2)
Race/Ethnicity	White alone NH	95.5 (95.3 - 95.7)
	Black alone NH	92.3 (91.8 - 92.8)
	Hispanic	84.8 (84.2 - 85.4)

White Alone NH = White non-Hispanic. Black Alone NH = Black or African American non-Hispanic.

CI denotes confidence interval.

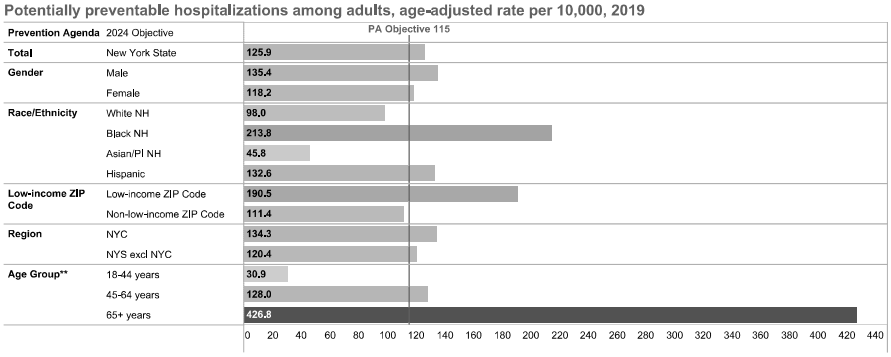
Data Source: U.S. Census Bureau, data as of July 2021

Select Year
2019

Select Group(s)
All

Age-adjusted rate
30.9 — 426.8

Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000, 2019



Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000, 2019

Group	Characteristics	Age-adjusted rate
Prevention Agenda	2024 Objective	115
Total	New York State	125.9
Gender	Male	135.4
	Female	118.2
Race/Ethnicity	White NH	98.0
	Black NH	213.8
	Asian/PI NH	45.8
	Hispanic	132.6
Low-income ZIP Code	Low-income ZIP Code	190.5
	Non-low-income ZIP Code	111.4
Region	NYC	134.3
	NYS excl NYC	120.4
Age Group**	18-44 years	30.9
	45-64 years	128.0
	65+ years	426.8

NYC = New York City. NYS excl NYC = New York State excluding New York City.

White NH = White non-Hispanic. Black NH = Black or African American non-Hispanic. Asian/PI NH = Asian, Pacific Islander non-Hispanic.

** Age group rates are crude rates

Data Source: SPARCS, data as of November 2021