CUNY SPH GRADUATE SCHOOL OF PUBLIC HEALTH & HEALTH POLICY

DECEMBER 1, 2023

Sent via email to: stateinnovationwaivers@cms.hhs.gov

The Honorable Elizabeth Fowler, Ph.D., J.D.
Deputy Administrator and Director of the Center for Medicare & Medicaid Innovation
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Deputy Administrator Fowler:

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 healthcare 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. The 1332 Waiver offers New York 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.

Currently, Emergency Medicaid – which is only for serious, life-threatening health issues, and not for primary care – may be used for the undocumented population. Asylum seekers meet this criterion immediately upon entry, until such time that they are provided with all documents needed to establish an official status. There have been numerous inquiries to confirm that the federal government will allow the 1332 Waiver to provide healthcare to the undocumented population, including in a response to representatives from New York's Legislature. Furthermore, the fact that the majority of public comments on the first filing of the draft waiver were in favor of this expansion indicate significant public support.

At a time when both New York City and New York State face a budget crisis due to the ongoing assistance provided to migrants and asylum seekers, the 1332 Waiver would allow New York State to use money from the Essential Plan

Trust Fund *prospectively*, which currently has a net positive $2 billion annual inflow that is not being used. Once asylum seekers receive an official federal status, they would then be eligible to receive healthcare services that can be paid through state and federal Medicaid funding, or if their federal status includes temporary work authorization, they may even be eligible for employment-based healthcare – taking them off state-supported insurance altogether.

As you embark on a revision of the initial draft, we urge you to reinsert specific references to immigrants and undocumented people in the 1332 Waiver application. 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: New York State of Health (nysoh.team@health.ny.gov)

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

November 30, 2023
The Honorable Xavier Becerra, Secretary of the Treasury
Chiquita Brooks-LaSure, Administrator, Centers for Medicare & Medicaid Services
Submitted by: Health Care For All New York (HCFANY)

Re: Revised 1332 Waiver Submission, dated November 2023

Dear Secretary Becerra and Administrator Brooks-LaSure,

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.

HCFANY is a strong supporter of the Coverage4All campaign, whose goal is to expand coverage to all New Yorkers, regardless of immigration status. 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.

HCFANY would like to offer comments on the following three issues in response to the State's proposed Amended 1332 Waiver submission, dated November 13, 2023: (1) the elimination of the $15 per member per month premium; (2) the opportunity to use the $7.5 billion surplus to cover immigrants, including people with Deferred Action for Childhood Arrival status; and (3) the Insurer Reimbursement Implementation Plan (IRIP).

1. **HCFANY applauds the State for proposing to eliminate the $15 per member per month premium.**

As consumer advocates, we know all too well how even a small premium can create a financial burden for consumers. Further, failure to pay insurance premiums can lead to coverage gaps for patients, and medical debt if unexpected medical issues or emergencies arise during these gaps. HCFANY urges the Centers for Medicare and Medicaid Services (CMS) to approve this change as eliminating the $15 premium will result in better continuity of care and a lower medical debt burden for New Yorkers.

2. **CMS and New York State policymakers should revise the Waiver to use part of the $7.8 billion surplus cover immigrants.**

The State's revised estimates in the November 1332 Waiver proposal indicate that there will be a $7.8 billion surplus generated in the passthrough account over the five-years waiver period. HCFANY urges the State and CMS to use some or all of this $7.5 billion surplus to cover immigrants, including people with Deferred Action for Childhood Arrival status (regardless of the approval of the pending federal regulations).

It is important for the federal and state governments to use the 1332 State Innovation program to ensure coverage for people, not just funding increases to the healthcare industry. The State's 1332 Waiver proposal has already allocated $5.8 billion in industry spending in the final Waiver proposal submitted in May. HCFANY urges the State and CMS to work together to ensure that these funds are used to cover immigrants who are not otherwise eligible for health insurance coverage.

3. **CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price instead of providing an additional $297 million to the insurance industry through the Insurer Reimbursement Implementation Plan.**

The latest 1332 Waiver proposal seeks to provide approximately $60 million per year to the insurance industry in an effort to offset the lost premiums it will incur as 70,000 New Yorkers (with incomes between 200-250 percent of the federal poverty level) move from individual market Qualified Health Plans to Essential Plans. Operating like a reinsurance program, the IRIP would support a climate in which carriers have less incentive to use their bargaining power to control costs—essentially creating "health plan moral hazard." Carriers should not receive windfalls, unless they are progressively targeted to those most in need.

The IRIP solely benefits individuals with incomes over 600 percent of the FPL, who are ineligible for subsidies (people earning over $180,000 a year for a family of four). The IRIP does nothing to target moderate-income individuals—between 251-600 percent of FPL. Instead of approving the IRIP addendum, CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price – consistent with the goals of the 1332 Wavier program.

On behalf of HCFANY, I would like to thank you for the opportunity to present our comments about the 1332 Waiver proposal.

Very truly yours,

Mia Wagner, MPA
Health Care For All New York

July 5, 2023

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

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

Re: New York Section 1332 State Innovation Waiver

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide feedback on the New York 1332 State Innovation Waiver.

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. We urge the Department of the

Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

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 $4,200 per year from the waiver's anticipated changes, a decrease in costs equal to an average of about 11% 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. The Departments should work with the state to establish a plan to 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 2.0%-2.1% (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 Departments to work with the state 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 provider networks through close cooperation with consumers, carriers, providers, and patient and consumer organizations through the transition process. The Departments should ensure that the state has considered 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 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. We urge the Departments to approve this proposal.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Cancer Support Community
Cancer*Care*
Crohn's & Colitis Foundation
Epilepsy Foundation
Hemophilia Federation of America
Lupus Foundation of America
National Hemophilia Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Pulmonary Hypertension Association
Susan G. Komen
The Leukemia & Lymphoma Society

[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

THE LEGAL AID SOCIETY

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(212) 577-3300
https://www.legalaidnyc.org

November 28, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

VIA ONLINE SUBMISSION: stateinnovationwaivers@cms.hhs.gov

Re: New York's Section 1332 Innovation Waiver Essential Plan Expansion submission

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of The Legal Aid Society, we would like to thank the U.S. Department of Health and Human Services and the Centers for Medicare and Medicaid Services ("CMS") for the opportunity to provide the following comments about New York's second addendum to its Section 1332 Innovation Waiver Essential Plan Expansion ("Waiver") submission.

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.

With these diverse communities of New Yorkers with whom we work in mind, The Legal Aid Society writes to: (I) welcome the proposed Waiver's expansion of Essential Plan coverage to consumers with incomes from 200 to 250 percent of the federal poverty level ("FPL") and the elimination of its previously proposed $15 per member, per month premium; and (II) urge CMS to review the Waiver carefully to determine if there is a way to expand Essential Plan eligibility to low-income, undocumented immigrants who are currently ineligible for public coverage for anything but emergencies.

I. The proposed Waiver's expansion of Essential Plan coverage from 200 to 250 percent FPL will benefit New Yorkers; New York State's second addendum's elimination of the $15 monthly premium is beneficial for consumers.

Many of The Legal Aid Society's clients benefit from New York's adoption of the Basic Health Program (BHP) provision of the Affordable Care Act. Our state's BHP, the Essential Plan, has been a demonstrable success: not only are over 1.1 million New Yorkers enrolled in the program, but the Essential Plan will run a surplus of $7.8 billion after 5 years.[1]

The Essential Plan provides quality, affordable health coverage to those who qualify. Expanding the income eligibility limit from 200 to 250 percent FPL would benefit those New Yorkers whom Legal Aid serves (i.e., those who are low-income and qualify for free legal services) by allowing them to access the same quality, affordable health coverage that their neighbors do. Right now, individual market coverage remains out-of-reach for New Yorkers whose incomes fall between 200 and 250 percent FPL. Individual market plans can cost $1,200/year for a Silver plan with a $1,700 deductible. The Legal Aid Society thus applauds New York for seeking to expand coverage to the population who may otherwise forego unaffordable coverage.

We are pleased that New York's updated proposal eliminates the $15 monthly premium. It is well-documented that even a small premium causes coverage churn among low- and moderate-income enrollees and can lead to medical debt and coverage gaps. The population whom the Essential Plan expansion will benefit will have additional money to spend on food, school supplies, utilities and rent. We are pleased that New York has recognized the totality of low-income families' budgetary needs.

II. The Legal Aid Society urges CMS to review -- and New York State to revise accordingly – the Waiver and the second addendum carefully to determine if there is a way to expand Essential Plan eligibility to low-income, undocumented immigrants who are currently ineligible for public coverage for anything but emergencies.

The Legal Aid Society continues to strongly oppose the exclusion of undocumented immigrants from the state's Waiver proposal. While we laud the expansion of Essential Plan eligibility to New Yorkers between 200 and 250 percent FPL, this expansion covers just 2% of our state's uninsured population. New York's 1332 Waiver proposal cruelly ignores a population who might otherwise be eligible for expanded Essential Plan coverage (25% of our state's uninsured immigrant population). 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,

[1] 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/.

as of January 2024.[2] Nonsensically, the exclusion of undocumented New Yorkers from the State's 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 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.

New York's final Waiver proposal ignored the vast majority of comments submitted from the public, including from The Legal Aid Society, on its draft Waiver proposal. To gather the required public comments, New York State held two public hearings and accepted online comments. As noted in the final Waiver proposal, 26 out of 30 organizational comments from labor interests, providers, academics, consumer coalitions and legal services providers, and over 1,500 individual comments, sought to include immigrants. These comments stated that there was adequate surplus pass-through funding in the draft submission to cover undocumented immigrants and urged the State to follow the lead of Colorado and Washington states in their 1332 Waiver programs. The comments also noted that the federal and state governments stood to save over $1 billion per year in Emergency Medicaid funding if New York State were to include immigrants in its 1332 Waiver program.

The State's second addendum to its final Waiver submission does not expand coverage for immigrants. New York State and CMS should address immigrants and their need for coverage as part of the 1332 Waiver process to respond to the overwhelming majority of comments the State received on its Waiver proposal. As we 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. While undocumented New Yorkers age 65 and older will be eligible for Medicaid coverage in 2024, undocumented New Yorkers between the ages of 19-64 will remain eligible only 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

[2] NY SSL § 366(1)(g)(4).

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. Instead, using some of the $7.8 billion surplus funding to cover New Yorkers who are otherwise ineligible for coverage will pull a healthy population of working-age people into the insurance risk pool, generating savings for the federal government.

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

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

VIA ONLINE SUBMISSION to NYSOH.team@health.ny.gov

November 28, 2023

Re: Revised 1332 Waiver Submission, dated November 2023

Make the Road New York (MRNY) is a community-based membership organization 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, with over 27,000 members 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 are also one of the co-leads of the Coverage for All campaign whose mission is to expand health insurance coverage to all New Yorkers regardless of their immigration status.

Our members' experiences guide our health policy work to improve healthcare access for all New Yorkers. In 2017, we conducted a research study and issued a report **"Safeguarding Immigrant Coverage: Protecting and Expanding Health Coverage for all Immigrants in New York State"** to explore how New York State could increase health insurance coverage for the remaining uninsured immigrants. The offering of a low premium health insurance product was one of the key research findings.

These members are from marginalized communities, with a high percentage lacking access to health insurance due to their immigration status. While our members were among the hardest hit by the pandemic, the inequities and hardships that surfaced during this period, unfortunately, weren't new. Undocumented New Yorkers and certain immigrants considered PRUCOL under NYS law for benefit access, remain one of the highest uninsured populations in New York State. Being uninsured is linked to higher rates of chronic disease and less access to health care providers. What is new this year, in comparison to years prior, is the New York State's opportunity to advance healthcare for all vulnerable New Yorkers with the use of federal funds through the innovative 1332 waiver. We were enraptured last spring when Governor Hochul promised to use this waiver to expand coverage to undocumented New Yorkers. However, the 1332 waiver application inexplicably omitted this population from the expansion of the Essential Plan.

Make the Road New York (MRNY) is grateful for the opportunity to comment on the proposed 1332 waiver to expand Essential Plan eligibility. New York should maintain its stance as a progressive state and take the appropriate steps to revise the waiver and expand coverage to all immigrants, regardless of immigration status; including DACA recipients.

In the amended 1332 Waiver proposal, the State anticipates that throughout the 5-year waiver period there will be a 7.8 billion surplus generated in the 1332 Waiver pass through account.

Earlier this year, state officials, including the Commissioner of Health, reached out to CMS for clarification on the use of the surplus funds. We were pleased the State had received confirmation that the funds could be used innovatively to provide insurance coverage for individuals not lawfully present. Expanding coverage to all immigrants, regardless of their immigration status is both fiscally and morally the right thing to do. It would help thousands of New Yorkers who are currently forgoing vital access to care, and would help prevent chronic conditions which normally plague our communities.

To quote one of the NYS commissioners of health, as stated in her testimony during the first comment period on February 23, 2023, Dr. Mary Bassett said, "A guiding principle of public health is to do the most good for the most people". A $7.5 billion surplus is anticipated to be generated into the pass-through account over the five-year Waiver period. Expanding health insurance coverage to the remaining uninsured should be the priority for the state through the use of these funds. There continue to remain nearly 1 million uninsured New Yorkers, many who would otherwise be eligible for coverage but lack the necessary immigration or protective status. This means that thousands of New Yorkers, on a daily basis, forgo necessary care due to lack of health insurance.

Our community members continue sharing their experience and inability to obtain basic healthcare, such as a primary care visit for a physical to ensure their health is up to par, and rationing or going without medication. Every day they put their health at risk as they prolong access to the medical care they need, all while attempting to avoid an emergency room visit and falling into medical debt. Take for instance our member Rosalia, a single mother who lives in Long Island and is a chronic asthmatic and diabetic. She is currently unemployed, and can't access her life saving medication on a monthly basis. Instead, she rations her insulin and reuses her needles, despite her doctor's recommendation. Or our member Olga, a healthy middle-aged woman who needs to access routine care, but struggles to access services otherwise covered under the 10 essential health benefits, including a mammogram, all because of her immigration status.

The State, and its residents, would greatly benefit by increasing the Essential Plan eligibility pool to include undocumented New Yorkers, and other immigrants with protective statuses, such as DACA. While the State's proposal indicates that it would provide coverage to DACA recipients through the 1332 Waiver, it would only do so if the proposed federal regulations are adopted, and once again misses the opportunity for innovation and the mission of advancing public health and health equity. Instead, the state should revise the waiver and adopt the inclusion of DACA

recipients regardless of the federal regulations; aiming to provide continuity of care and expand eligibility for DACA recipients after they exceed the Medicaid income threshold up to 250% FLP as these young dreamers succeed in their professional lives.

Allowing immigrants, regardless of status, to access insurance would increase the surplus generated in the 1332 waiver pass through account, and NYS could shift current state-only dollars from its emergency Medicaid program and Medicaid coverage for DACA individuals and reinvest it into other state priorities. A fiscally smart move in a moment of crisis where the city and state are facing major budget cuts. This common-sense solution would also aid in the state's response to new migrants arriving to NY by accessing federal funds for this population, where it may otherwise use state funds.

Make the Road NY is supportive of the State seeking to eliminate the proposed $15 monthly premium, and commends the state for pursuing further affordable options for individuals and families. We believe the state should revise the waiver to cover more people, including immigrants up to 250% of the federal poverty level, regardless of their immigration status. Thank you so much for the chance to make these comments.
Sincerely,
Arline Cruz Escobar
Director of Health Programs, Mae the Road NY

New York HPA Health Plan Association

41 State Street, Suite 900
Albany, NY 12207

December 1, 2023

Re: Addendum to New York 1332 Waiver: Insurer Reimbursement Implementation Plan (IRIP)

Sent via email: stateinnovationwaivers@sms.hhs.gov

On behalf of the New York Health Plan Association (HPA), which represents 26 health plans that serve more than eight million New Yorkers, we are writing to submit the following comments in regard to the November 13, 2023 addendum to New York's 1332 waiver submission.

HPA strongly supports the State's efforts to mitigate the impact on individual market premiums as a result of the population with incomes between 200% -250% of the Federal Poverty Level (FPL) being transitioned out of the market and into the Essential Plan (EP) under the 1332 waiver application, through the proposed Insurer Reimbursement Implementation Plan (IRIP).

HPA appreciates the State's partnership in addressing the industry's concerns related to the impact of the 1332 waiver on premiums in the individual market, and supports efforts to make coverage more affordable for consumers in the individual market and avoid a decline in individual market enrollment (aside from the transition of the 200%-250% FPL population) through the IRIP. We believe that the IRIP is a beneficial, critically important and necessary use of pass-through funding under the 1332 waiver.

HPA also supports the elimination of the proposed $15 monthly premium for the EP expansion group of individuals with incomes above 200% up to 250% of the FPL, to make coverage more affordable for more consumers, and the revised implementation date of April 1, 2023 for the expansion, along with the State's revised implementation timeline.

Finally, we continue to strongly support the State's 1332 waiver application to expand eligibility in EP from 200% to 250% of the FPL, and will continue to collaborate with State partners to work toward coverage for all New Yorkers, including undocumented immigrants and those with Deferred Action for Childhood Arrival (DACA) immigration status.

Sincerely,

President & CEO

NATIONAL KIDNEY FOUNDATION®

30 E. 33rd Street
New York, NY 10016
212.889.2210

November 30, 2023

On behalf of approximately 37 million people in the United States with chronic kidney disease, the more than 800,000 living with kidney failure, and those in need of kidney transplant access in New York, the National Kidney Foundation writes to express our support of expanding the 1332 waiver. We steadfastly support advancing equity in transplantation and advocate for all people to have adequate healthcare coverage, a fundamental first step in equitable transplant access.

Thank you for the opportunity to provide commentary on such a critical public health matter. Please contact Morgan Reid, Director of Transplant Policy and Strategy, at Morgan.Reid@kidney.org if we can answer any questions.

Sincerely,

Kevin Longino
CEO and Transplant Patient

Sylvia E. Rosas MD, MSCE
President

NYLPI
JUSTICE THROUGH COMMUNITY POWER

December 1, 2023

Re: New York Section 1332 State Innovation Waiver

Dear Secretary Becerra and Administrator Brooks-LaSure,

On behalf of New York Lawyers for the Public Interest (NYLPI), I would like to thank the U.S. Department of Health and Human Services and the Center for Medicare and Medicaid Services (CMS) for the opportunity to provide the following comments about New York's Section 1332 Innovation Waiver addendum submission.

NYLPI's Health Justice program works to provide comprehensive screenings and legal representation to individuals, particularly those who are in health emergencies, including holistic support by providing our clients information on financial assistance, food banks and housing relief to meet their intersecting needs. The experiences of our clients inform our policy advocacy, and our commitment to seeking health care coverage for all New Yorkers.

With our client communities in mind, we write to: (1) Urge CMS and New York State policymakers to revise the Waiver to use part of the $7.8 billion surplus to cover immigrants; (2) Urge CMS and New York State policymakers to consider policy vehicles that cover more New Yorkers at an affordable price; and (3) Support the State's decision to eliminate the $15 monthly premium.

(1) <u>NYLPI urges CMS and New York State policymakers to revise the Waiver to use part of the $7.8 billion surplus to cover immigrants.</u>

The State's revised estimates indicate that there will be a $7.8 billion surplus after five years. The State proposes using the majority of this surplus for provider and carrier rate increases. Instead of funneling this money to providers and plans, the State and CMS should revise the Waiver to cover uninsured immigrant New Yorkers. This would be consistent with the overwhelming majority of public comments received by the State on its Waiver proposal. The surplus pass-through funds easily cover over 150,000 immigrants per year, and would still provide over $5.8 billion in funding for the healthcare industry imbedded into the 1332 Waiver proposal.

Additionally, the State proposes providing an additional $297 million to the insurance industry through the Insurer Reimbursement Implementation Plan. This seeks to provide over $60 million per year to the insurance industry in an effort to offset the lost premiums it will incur as 70,000 New Yorkers (with incomes between 200-250% of FPL) move from individual market Qualified Health Plans to Essential Plans. Operating like a reinsurance program, the IRIP would support a climate in which carriers have less incentive to use their bargaining power to control costs—essentially creating "health plan moral hazard." Carriers should not receive such windfalls.

This is a regressive proposal benefiting those with incomes over 600 percent of the FPL, who are ineligible for subsidies (people earning over $180,000 a year for a family of four). The IRIP does nothing to target moderate-income individuals—between 251-600 percent of FPL. They will have to pay anywhere from 4 percent to 8.5 percent of their family income on coverage that has a huge barrier to entry to care (a $2,100 deductible for a Silver plan).

(2) <u>Instead of approving the IRIP addendum, CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price.</u>

A health care system that is truly just and equitable must also ensure comprehensive coverage for all New Yorkers, including undocumented immigrants. Authorization of the Waiver while it excludes hundreds of thousands of immigrants New Yorkers is a major missed opportunity to support equitable access to healthcare through a fiscally responsible public health initiative that was promised nearly two years ago. We urge CMS and policymakers to ensure the Waiver is inclusive to immigrants, which would save lives, save money, and improve health across the city. The surplus funding can be used to cover some or all New York immigrants who are otherwise ineligible for coverage. Under New York's current and inequitable health care system, immigrants are forced to resort to emergency care and costly treatments that they would be able to avoid if they were eligible for primary and preventative care. Increasing access to healthcare would bring better risk and would drive down premiums, generating savings for the federal government and for health systems across New York State.

(3) <u>NYLPI supports the State's decision to eliminate the originally proposed $15 monthly premium for new enrollees with incomes between 200-250% of the Federal Poverty Level.</u>

These premiums would have provided an administrative burden for consumers, plans, and patients that would have led to coverage gaps, medical debt, and fiscal uncertainty. Removing the premium increases accessibility for enrollees, many of which constitute the client communities that NYLPI serves.

NYLPI has represented numerous clients whose ability to work, spend time with loved ones, and engage meaningfully in their communities is severely limited by serious and life-threatening health conditions. We believe that health is a human right, and that our clients' need for medical care can be met through access to comprehensive healthcare insurance and expansion of the Essential Plan. We hope the concerns we have identified above will help inform a close examination of New York's proposed addendum to the Section 1332 Waiver to determine if there is a path forward to covering immigrants who are otherwise ineligible for public coverage.

Thank you for the opportunity to provide public comment.

Noelle Peñas
Health Justice Community Organizer
New York Lawyers for the Public Interest

December 1, 2023

Submitted Electronically

The Honorable Xavier Becerra
Secretary
United States Department of Health and Human Services

The Honorable Janet Yellen
Secretary
United States Department of the Treasury

Re: New York State's Section 1332 Waiver Comments, Revised November 2023

We are writing to submit comments on behalf of the Coalition of New York State Public Health Plans ("PHP Coalition" or "the Coalition") regarding New York State's updated materials for the proposed Section 1332 State Innovation Waiver Addendum shared with the Coalition on November 14, 2023.

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 Coalition's comments stem from our collective, extensive expertise managing care for people enrolled in publicly-funded insurance programs. Our comments also reflect our commitment to preserve, strengthen, and expand New York's healthcare coverage programs.

The Coalition has twice previously submitted public comments on the State's 1332 State Innovation Waiver application strongly supporting the State's plans to expand EP from 200% of the federal poverty level (FPL) up to 250% FPL for those who are eligible.

A major area of concern for Coalition plans in the state's initial application in June, however, was the impact this expansion would have on the individual market. Specifically, we expressed concern in our first comments that the State's relatively small individual market would be negatively affected by the projected increase in consumer premiums that would result from lower-income members shifting out of QHPs and into EP. **We greatly appreciated the State's response to our concerns about the individual market impact in the form of the Insurer Reimbursement Implementation Plan (IRIP), which has been included in the updated August and November 2023 applications.** As we have discussed with the State and have mentioned in previous comments to the State, the Coalition still believes it is important for New York to continue to explore rigorous, long-term solutions – such as reinsurance or risk adjustment – to ensure a strong and stable individual market.

In addition, **the Coalition would like to voice strong support for the elimination of the $15 monthly premium for EP consumers with incomes 200% to 250% FPL funded by anticipated pass-through funding surplus included in the November updated application**. This change will remove financial and administrative burden for consumers and support enrollment into the EP expansion. The State notes that if pass-through funding is insufficient to fully fund these monthly premiums, it could explore other

state funds. We are supportive of the State exploring other avenues beyond the pass-through funding surplus to offset the elimination of the $15 monthly consumer premium but do not support doing so through adjusting the size of the Quality Incentive Pool. The Quality Incentive Pool is an important tool for driving quality and value in the EP program by incentivizing plans to meet specified quality measures in line with the State's broader health care agenda. Plans use quality incentive dollars to invest in providers and their members by funding programs addressing health-related social needs, closing gaps in health equity, supporting primary care, maternal care, and behavioral health care, and improving health outcomes for enrollees.[1]

The PHP Coalition continues to strongly support expanding eligibility for the 1332 state innovation waiver program to all New York residents up to 250% FPL, regardless of immigration status, as another step toward more equitable and comprehensive coverage. 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 also create a savings of over $500 million for New York State which is currently being spent on emergency Medicaid and uncompensated care for those who are uninsured due to their immigration status.[2,3]

The PHP Coalition supports the State's intent to extend eligibility to the Deferred Action for Childhood Arrivals (DACA) population under the waiver program, and would urge New York to include this population regardless of the federal government's adoption of proposed federal regulations clarifying eligibility for coverage. Currently, New York provides State-only funded Medicaid coverage to DACA recipients with incomes below 138% of FPL. Including DACA recipients in the 1332 waiver program will allow the State to leverage funding under the 1332 state innovation waiver and expand coverage to the DACA population up to 250% of FPL.

The Coalition is also supportive of the mid-year implementation and appreciative of the additional implementation details the State has reflected in the updated November 2023 application. Coalition plans are already preparing operationally for the expansion to occur April 1, 2024 and we look forward to working closely with the State on ensuring a smooth implementation of EP 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. We look forward to continuing our partnership with the State and tackling a long-term solution for individual market stability in the new year.

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[1] https://info.nystateofhealth.ny.gov/sites/default/files/Health%20Insurance%20Coverage%20Update%20-%20April%202023.pdf

[2] 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

[3] https://www.nysenate.gov/sites/default/files/make_the_road_ny-_mrny_.pdf

Medicaid Matters New York

Comments on New York Revised 1332 Waiver Application, November 2023
December 1, 2023

Medicaid Matters New York, the statewide coalition representing the interests of New Yorkers served by Medicaid, offers the comments herein on New York State's revised 1332 Waiver application, dated November 13, 2023.

1. **The new Waiver proposal eliminates the $15 monthly premium – this proposal is a positive outcome for consumers and should be adopted**

The November 1332 Waiver filing indicates that the State seeks to eliminate the initially proposed $15 per member per month premium. Medicaid Matters commends the State and urges the Centers for Medicare and Medicaid Services (CMS) to approve this change.

Premiums provide an administrative burden for consumers, plans and patients. Even a small premium can lead to coverage disruptions. Families with incomes below 250 percent of the federal poverty level (FPL), or $75,000 for a family of four, often face difficult choices in the face of an unexpectedly high heating bill, car repair or unexpected financial emergency. Failure to pay health insurance premiums results in coverage gaps for patients. During these coverage gaps, unexpected medical issues and emergencies can arise, leading to medical debt and fiscal uncertainty. According to the Urban Institute, families with median incomes below $88,500 are more than twice as likely to face medical debt than their higher income counterparts.[1] Disruptions in coverage also impact the healthcare industry – both in lost premium revenues for insurance carriers and an increased uncompensated care burden for providers.

Medicaid Matters is grateful for the State's elimination of the proposed $15 per member per month premium. This measure will result in better continuity of care and a lower medical debt burden for patients.

2. **CMS and New York State policymakers should revise the Waiver to use part of the $7.8 billion surplus to cover immigrants.**

The State's revised estimates in the November 1332 Waiver proposal indicate that there will be a $7.8 billion surplus generated in the 1332 Waiver pass-through account over the five-year Waiver period. (See Table 1 below.) Medicaid Matters urges the State and CMS to work together to ensure that some or all of these funds are used to cover immigrants who are not otherwise eligible for coverage, consistent with correspondence between CMS and the Hochul Administration, dated June 6, 2023, in which Administrator Brooks-LaShure stated that there is "no prohibition on using section 1332 Waiver pass-through funding to fund state affordability

[1] https://www.urban.org/sites/default/files/2023-07/Medical%20Debt%20in%20New%20York%20State%20and%20Its%20Unequal%20Burden%20across%20Communities.pdf

programs (such as state subsidies) under the Waiver plan for health insurance coverage for individuals not lawfully present…."[2]

Offering coverage to immigrants through the 1332 Waiver would help secure federal financial support that can help offset some of the costs of assisting new migrants that have arrived in our State. Covering immigrants simultaneously would help the Hochul Administration keep its 2022 promise to include coverage for immigrants in the Waiver proposal,[3] and address its fiscal concerns regarding the cost of caring for new migrants.[4]

It is important for the federal and State government to use the 1332 State Innovation program to ensure coverage for people, not just funding increases to the healthcare industry. The State's 1332 Waiver proposal has already allocated $5.8 billion in industry spending in the final Waiver proposal submitted in May, including:

- $800 million a year, $4 billion over five years on provider rate increases;
- $225 million a year, $1.125 billion on insurance companies ("quality incentive pool");
- $571 million over five years on Long Term Services and Supports (LTSS)
- $125 million over five years for an unspecified behavioral health "grant program."

The chart below, derived from the State's November 1332 Waiver filing, indicates that the projected five-year surplus for the 1332 pass-through account will increase to $7.8 billion ($4.6 billion more than projected in the State's May 1332 Waiver filing) over five years. The revenue formula for the 1332 Waiver program is based on the premium rates in New York's individual market. The projected increase described in the State's filing for the 1332 pass-through account is due to the substantial increases for the individual market premium rates for the 2024 plan year approved by the New York State Department of Financial Services.[5] These increases were more than double those originally projected in the State's May filings (13.5 percent (actual) vs. six percent (projected)).[6] The new $7.8 billion surplus would be generated even after spending $5.8 billion on providers and carriers. Government officials should ensure that the 1332 Waiver keeps to its intended purpose, which is to innovatively expand affordable coverage for people, not just funnel funding to the State's healthcare industry.

Assuming immigrants were included in 2024, the surplus pass-through funds would easily cover over 150,000 immigrants per year – and still provide over $5.8 billion in the industry funding previously embedded into the 1332 Waiver proposal. Should immigrants be included beginning in 2025, there would be enough funding to cover 200,000 immigrants per year. Importantly, these estimates do not include the $500 million annual savings offsets that the federal and State would yield by providing comprehensive coverage in lieu of Emergency Medicaid spending for this same population.

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[2] https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/ny-bhp-1332-request-response-letter.pdf

[3] https://www.youtube.com/watch?v=Ysb38zrpx6Q&t=2149s

[4] https://www.politico.com/newsletters/new-york-playbook/2023/10/30/some-good-budget-news-but-migrant-cost-concerns-00124139

[5] https://myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/summary-of-2024-requested-rate-actions#:~:text=Insurers%20requested%20an%20average%20rate,eligible%20for%20federal%20tax%20credits.

[6] https://info.nystateofhealth.ny.gov/sites/default/files/NY%201332%20Waiver%20Application_5.12.2023.pdf.

Table 1: Using the 1332 November Waiver Surplus to Cover Immigrants

	2024	2025	2026	2027	2028	Total
Federal Funding (Requested pass-through)	$9,796	$13,184	$13,351	$14,280	$15,274	$65,885
Program Costs, Scenario C, All investments	$8,358	$11,621	$12,061	$12,677	$13,328	$58,045
Annual Surplus	**$1,438**	**$1,563**	**$1,290**	**$1,603**	**$1,946**	**$7,840**
PMPY ($629-$729 pmpm)	$7,548	$7,860	$8,136	$8,436	$8,748	
Number of immigrants that could be covered with pass-through funding	190,514	198,855	158,555	190,019	222,451	

At a minimum, New York should revise the 1332 Waiver to cover DACA immigrants regardless of the federal government's adoption of proposed federal regulations clarifying eligibility for coverage.

The State's November 1332 Waiver proposal indicates that it would provide coverage to New York residents that have Deferred Action for Childhood Arrival (i.e., "DACA" or "dreamers") immigration status, but only if proposed federal regulations are adopted.[7]

Excluding DACA recipients from the 1332 Waiver program is fiscally illogical for the State. New York already provides 100 percent State-only funded comprehensive Medicaid to DACA recipients with incomes below 138 percent of FPL. Including DACA recipients will ensure that New York saves this State-only allocation and provides coverage to DACA immigrants up to 250 percent of FPL.

3. **CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price instead of providing an additional $297 million to the insurance industry through the Insurer Reimbursement Implementation Plan.**

The latest draft 1332 Waiver proposal seeks to provide over $60 million per year to the insurance industry in an effort to offset the lost premiums it will incur as 70,000 New Yorkers (with incomes between 200-250 percent of FPL) move from individual market Qualified Health Plans to Essential Plans. Operating like a reinsurance program, the IRIP would support a climate in which carriers have less incentive to use their bargaining power to control costs—essentially creating "health plan moral hazard."[8] Carriers should not receive such windfalls.

The IRIP is a regressive proposal because it solely benefits individuals with incomes over 600 percent of the FPL, who are ineligible for subsidies (people earning over $180,000 a year for a

[7] *See* Commissioner McDonald cover letter, dated November 13, 2023.

[8] Jeah Jung & Roger Feldman, "Growing Reinsurance Payments Weaken Competitive Bidding in Medicare Part D," *Health Services Research*, 10.1111/1475-6773.12866 (2018).

family of four).[9] The IRIP does nothing to target moderate-income individuals—between 251-600 percent of the FPL. These moderate-income individuals will have to pay anywhere from four percent to eight and a half percent of their family income on coverage that has a huge barrier to entry to care (a $2,100 deductible for a Silver plan).[10]

Instead of approving the IRIP addendum, CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price – consistent with the goals of the 1332 Wavier program. Policy vehicles for doing so include the following:

- Using surplus funding to cover some or all New York immigrants who are otherwise ineligible for coverage—an inflow of this healthy population would bring better risk and drive down premiums, generating savings for the federal government;
- Implementing an enrollee assistance program that brings the deductibles for a Silver plan down to $600 from the proposed $2,100 for the 2024 plan year;
- Adopting a State premium assistance program, such as the one California has implemented that would target funding for middle income consumers who still have trouble affording coverage.[11]

Thank you for the opportunity to comment on the State's submission. We are available to answer any questions.

[9] https://aspe.hhs.gov/sites/default/files/documents/1c92a9207f3ed5915ca020d58fe77696/detailed-guidelines-2023.pdf.
[10]https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20Standard%20Schedule%20of%20Benefits%202024%207.20.2023.pdf
[11] https://cbcny.org/research/narrowing-new-yorks-health-insurance-coverage-gap

Primary Care Development Corporation

November 30, 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 Entity founded and based in New York City. Our mission is to strengthen communities and build health equity through strategic primary care investment, expertise, and advocacy. Over the past three decades, PCDC has leveraged more than $1.7 billion to finance 250 primary care projects, with strategic community investments that have created or preserved nearly 20,000 jobs in low-income communities and transformed more than 2.8 million square feet of space into fully functioning primary care and integrated behavioral health practices. Our staff have also trained and coached thousands of health workers to deliver superior patient-centered care.

Over 30 years, PCDC's work has created capacity for more than 4.8 million estimated medical visits for over 1.4 million estimated 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.

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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.

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 some of the state's most vulnerable populations while also presenting 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]. This is even after the State recently chose to make other changes to the plan. While PCDC supports other updates made to the State's 1332 application, including the establishment of a new income tier whose members will not have to pay $15 monthly premiums, we were disappointed that coverage for qualified undocumented individuals was not included yet again.

In 2022, both the legislature and Governor agreed to explore this opportunity as a critical way to provide needed health care access for New Yorkers who are currently uninsured due to immigration status. Despite this, a proposal to allow undocumented adults living in New York the ability to access the Essential Plan for health insurance was ultimately not included in the State's Fiscal Year (FY) 2023 budget.

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

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[i] See, e.g. The Far-Reaching Benefits of the Affordable Care Act's Medicaid Expansion, October 2020, available at: https://www.cbpp.org/research/health/chart-book-the-far-reaching-benefits-of-the-affordable-care-acts-medicaid-expansion

[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] Zhong X, Zhou Z, Li G, Kwizera MH, Muennig P, Chen Q. Neighborhood disparities in COVID-19 outcomes in New York city over the first two waves of the outbreak. Ann Epidemiol. 2022 Jun;70:45-52. doi: 10.1016/j.annepidem.2022.04.008. Epub 2022 Apr 27. PMID: 35487451; PMCID: PMC9042413.

[iv] Sandman, 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] Ario, Joel. The ACA's Section 1332 Waivers: Will We See More State Innovation in Health Care Reform?, Manatt Health, August 2016, available at: https://www.manatt.com/getattachment/3543c06f-daeb-4912-94ea-e72980618745/attachment.aspx

[vi] See, e.g. Washington: State Innovation Waiver, December 2022, available at: https://www.cms.gov/files/document/1332-wa-fact-sheet.pdf

Planned Parenthood
Act. No matter what.
Planned Parenthood Empire State Acts

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www.PPESacts.org

Centers for Medicare and Medicaid Services
State Innovation Waivers
New York State of Health

RE: New York State 1332 Waiver

On behalf of Planned Parenthood Empire State Acts ("PPESA") and New York's five Planned Parenthood affiliates that PPESA represents, we write to provide comments on the proposed 1332 Waiver to expand Essential Plan Eligibility to all New Yorkers up to 250% of the Federal Poverty Level, including individuals currently ineligible for coverage due to their immigration status.

Planned Parenthood is a critical resource within the health care system of New York State. Across 54 health centers, Planned Parenthood affiliates offer primary and preventive sexual and reproductive health services to roughly 200,000 patients. Services include, but are not limited to, abortion, gender affirming care, prenatal care, wellness exams, health insurance enrollment assistance, cervical and breast cancer screenings, contraception and contraception education, and testing and treatment for STIs and HIV. The majority of Planned Parenthood patients are low-income with more than half living at or below 100% of the Federal Poverty Level, and more than 55% of patients seen at Planned Parenthood are insured by Medicaid or Medicare. Our health centers are a vital source of care for uninsured patients and low-income individuals who would otherwise forgo care due to lack of resources.

We strongly support efforts to expand access to affordable health coverage and are grateful for the State's decision to increase the eligibility level up to 250% of the federal poverty level. We also appreciate the elimination of the originally proposed $15 per member per month premium for new enrollees with incomes between 200-250% of the Federal Poverty Level. The removal of this premium will help consumers, plans, and patients avoid gaps in coverage, increasing medical debt and fiscal uncertainty.

However, the State's current Waiver proposal has failed to include immigrants in the expanded eligibility pool despite over 1,500 comments submitted in the last public comment period calling for the inclusion of this population.[1] [2]Many immigrants are

[1]New York State Department of Health, p.24 "New York Section 1332 Innovation Waiver Essential Plan Expansion" https://info.nystateofhealth.ny.gov/sites/default/files/NY%201332%20Waiver%20Application_5.12.2023.pdf (May 12, 2023)
[2] New York State of Health, "New York Section 1332 Innovation Waiver Essential Plan Expansion Updates" https://www.cms.gov/files/document/1332-ny-waiver-updated-application-11142023.pdf (November 13, 2023)

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eligible for "Emergency Medicaid," but that coverage is limited to emergency care and does not cover primary care and other non-emergency services. New York State currently spends roughly $500 million annually on coverage for medical expenses of undocumented immigrants through the Emergency Medicaid Program.[3] The State's revised estimates accompanying the Waiver proposal indicate there will be a $7.8 billion surplus after five years, resources we believe should be used to provide this critical coverage.

Achieving Essential Plan coverage for these excluded individuals will make an enormous difference in the health and ability of New Yorkers to support themselves and their families while simultaneously benefitting the health care providers who care for them. New York should follow the lead of Colorado and Washington by expanding the 1332 Waiver program to ensure anyone living in New York can access the health care they need no matter their income or immigration status.

[3] Mellins, S., New York Focus, "Hochul Inches Toward Health Insurance for Undocumented Immigrants" https://nysfocus.com/2023/05/19/health-insurance-undocumented-immigrants-hochul (May 19, 2023)

New York's Proposed 1332 Waiver to Expand Essential Plan Eligibility
November 22, 2023

The Community Health Care Association of New York State (CHCANYS) is grateful for the opportunity to comment on the proposed 1332 waiver to expand Essential Plan eligibility. CHCANYS is the primary care association for New York's more than 70 federally qualified health centers (FQHCs), also known as community health centers (CHCs), serving 2.3 million patients at over 800 sites each year.

CHCs are the standard bearers of primary and preventive care for medically underserved communities across the state. CHCs are non-profit, community run clinics that provide high-quality, cost-effective primary care as well as behavioral health, dental care, and social support services, to everyone, regardless of their insurance status or ability to pay. The majority of CHC patients are extremely low income; 89% live below 200% of the federal poverty level (FPL). CHCs serve populations that the traditional healthcare system has historically failed: 69% are Black, Indigenous, or People of Color (BIPOC), 28% speak limited or no English, 12% are uninsured, and 5% are unhoused. Nearly 62% of our CHCs' patients are enrolled in public health insurance programs including Medicaid, Medicare, and CHP. In short, CHCs are a crucial safety net for New York's residents of both rural and urban areas, working tirelessly to provide healthcare and social services for people who experience poverty, racism, and discrimination that inhibits their health, well-being, and ability to survive.

CHCANYS is generally supportive of the goals of the 1332 Waiver which strives to expand coverage of the Essential Plan to more low- and moderate-income New Yorkers. We appreciate New York's goal to reduce the uninsured population in New York by increasing access to high quality, affordable health insurance for low and moderate-income individuals; inclusion of residents with incomes up to 250% of the FPL; and to continue to use the Essential Plan Trust Fund surplus to fund the program for consumer benefit. CHCANYS is supportive of the revised version of New York's 1332 Waiver that proposes to eliminate the $15 monthly Essential Plan premiums for new enrollees with incomes between 200-250% of the FPL.

New York can do more to ensure all New Yorkers can access high-quality health care by expanding coverage to all immigrant New Yorkers and fully reimbursing CHCs for all Essential Plan enrollees. CHCANYS submits the following comments addressing these topics.

Expand Essential Plan Coverage to All Immigrant New Yorkers
CHCANYS supports providing healthcare coverage for all immigrant New Yorkers under the 1332 Waiver. CHCs serve populations that, historically, the traditional healthcare system has failed. Our communities are at the highest risk for negative health consequences resulting from income inequality, discrimination, racism, and a lack of access to healthcare and social services. Currently, 12% of CHC patients are uninsured – more than 2 times the statewide average. Because CHCs have robust outreach, enrollment, and navigation services, it is highly likely that most of those individuals are ineligible for health insurance due to their immigration status. CHCs are providing care for asylum seekers arriving in New York, and even though many believed these individuals would be PRUCOL and therefore eligible for insurance, CHCs are seeing many asylum seekers that are ineligible for any insurance program beyond emergency Medicaid. Although CHCs treat everyone regardless of whether they are insured, uninsured individuals experience the most barriers in accessing care outside of CHCs.

Everyone deserves meaningful ongoing access to affordable high quality healthcare services but there are currently hundreds of thousands of low-income New Yorkers who are excluded from accessing health insurance due to their immigration status. Even though immigrants make up 31% of workers in New York's essential businesses and 70% of New York's undocumented labor force work in essential businesses, they are unable to access affordable healthcare.[1] People who are uninsured are more likely to receive an initial diagnosis in the advanced stages of a disease or live with unmanaged chronic conditions. According to Families USA,[2] more than 8,200 New Yorkers died from COVID-19 because they lacked health insurance coverage.

CHCANYS supports expanding healthcare coverage to all immigrants under the 1332 Waiver. Expanding coverage would not only avoid $500 million in annual emergency Medicaid costs when uninsured immigrant patients seek emergency care at hospitals, it would also increase revenues for community health centers through Essential Plan reimbursements. Currently, health centers fund care for the uninsured through their uncompensated care programs, bolstered in part by sliding fee scales and other sources of funding cobbled together, but even those programs leave health centers incomplete for the full costs of providing services to the uninsured.

The State's proposal indicates that DACA recipients would be eligible for coverage under the 1332 waiver only if Federal regulations are adopted. Currently, New York covers DACA recipients up to 138% FPL with state only Medicaid dollars. New York should expand coverage for DACA recipients, in addition to other undocumented immigrants, up to 250% FPL regardless of the promulgation of federal regulations and availability of federal matching funds.

Reimburse the Community Health Center Bundled Rate for All Essential Plan Enrollees in Alignment with Medicaid and Medicare

In recognition of the comprehensive services health centers provide to patients – from primary care, behavioral health, and dental care, to enabling services such as transportation and case management services – health centers receive an all-inclusive, bundled rate under Medicaid and Medicare, the Prospective Payment System (PPS). This payment methodology is critical to health centers' ability to provide high-quality health care in low-income and underserved communities. However, today, CHCs receive their all-inclusive, bundled rate only for "lawfully present" immigrants under the Essential Plan, previously covered under Medicaid, despite providing the same level of care and services to all Essential Plan patients.

Reimbursement at the health center bundled rates for all Essential Plan enrollees is crucial to health centers' continued viability as they face unprecedented financial hardship due to rising costs. CHCANYS encourages the State to align Essential Plan reimbursement with Medicaid and Medicare by reimbursing health centers at the community health center bundled rate (PPS) for all Essential Plan enrollees, based on today's costs.

[1] https://cmsny.org/publications/new-york-essential-workers/

[2] https://familiesusa.org/wp-content/uploads/2021/03/COV-2021-64_Loss-of-Lives-Report_Report_v2_4-20-21.pdf

Thank you for the opportunity to comment on the proposed 1332 Waiver to expand Essential Plan eligibility. We appreciate New York's goal of expanding Essential Plan coverage and hope to see that extend to all New Yorkers. For questions, please contact Marie Mongeon, Vice President of Policy, at mmongeon@chcanys.org.

Community Service Society

Powering a more equitable New York

November 28, 2023

The Honorable Xavier Becerra
Secretary of the Treasury

Chiquita Brooks-LaSure
Administrator
Centers for Medicare & Medicaid Services

Re: Revised 1332 Waiver Submission, dated November 2023

Dear Secretary Becerra and Administrator Brooks-LaSure,

The Community Service Society of New York (CSS) has worked with and for New Yorkers since 1843 to promote economic opportunity and champion an equitable state. 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, saving them over $80 million per year. These patients' experiences guide our health policy reports that seek to improve the health care system for all New Yorkers. For example, 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 Section 1331 Basic Health Program (BHP) provision of the Affordable Care Act.[1] CSS and its partners successfully advocated for the launch of BHP (branded as the "Essential Plan") in 2015, and over 1.1 million New Yorkers have since enrolled, generating a surplus of $2 billion per annum.

CSS would like to offer comments on the following three issues in response to New York State's proposed Amended 1332 Waiver submission, dated November 13, 2023: (1) the elimination of the $15 per member per month premium; (2) the opportunity to use the $7.5 billion surplus to cover immigrants, including people with Deferred Action for Childhood Arrival status; and (3) the Insurer Reimbursement Implementation Plan (IRIP).

1. **The new Waiver proposal eliminates the $15 monthly premium – this proposal is a positive outcome for consumers and should be adopted.**

[1] https://www.cssny.org/publications/entry/bridging-the-gapJune2011RevisedJanuary2012

The November 1332 Waiver filing indicates that the State seeks to eliminate the initially proposed $15 per member per month premium. CSS commends the State and urges the Centers for Medicare and Medicaid Services (CMS) to approve this change.

Premiums provide an administrative burden for consumers, plans and patients. Even a small premium can lead to coverage disruptions. Families with incomes below 250 percent of the federal poverty level (FPL), or $75,000 for a family of four, often face difficult choices in the face of an unexpectedly high heating bill, car repair or unexpected financial emergency. Failure to pay health insurance premiums results in coverage gaps for patients. During these coverage gaps, unexpected medical issues and emergencies can arise, leading to medical debt and fiscal uncertainty. According to the Urban Institute, families with median incomes below $88,500 are more than twice as likely to face medical debt than their higher income counterparts.[2] Disruptions in coverage also impact the healthcare industry – both in lost premium revenues for insurance carriers and an increased uncompensated care burden for providers.

This modification to the original 1332 Waiver filing will result in better continuity of care and a lower medical debt burden for patients. Accordingly, CSS is grateful for the State's elimination of the proposed $15 per member per month premium and urges CMS to approve this change.

2. **CMS and New York State policymakers should revise the Waiver to use part of the $7.8 billion surplus to cover immigrants.**

The State's revised estimates in the November 1332 Waiver proposal indicate that there will be a $7.8 billion surplus generated in the 1332 Waiver pass-through account over the five-year Waiver period. (See Table 1 below.) CSS urges the State and CMS to work together to ensure that some or all of these funds are used to cover immigrants who are not otherwise eligible for coverage, consistent with correspondence between CMS and the Hochul Administration, dated June 6, 2023, in which Administrator Brooks-LaShure stated that there is "no prohibition on using section 1332 Waiver pass-through funding to fund state affordability programs (such as state subsidies) under the Waiver plan for health insurance coverage for individuals not lawfully present…."[3]

Offering coverage to immigrants through the 1332 Waiver would help secure federal financial support that can help offset some of the costs of assisting new migrants that have arrived in our State. Covering immigrants simultaneously would help the Hochul Administration

[2] https://www.urban.org/sites/default/files/2023-07/Medical%20Debt%20in%20New%20York%20State%20and%20Its%20Unequal%20Burden%20across%20Communities.pdf

[3] https://www.cms.gov/cciio/programs-and-initiatives/state-innovation-waivers/downloads/ny-bhp-1332-request-response-letter.pdf

keep its 2022 promise to include coverage for immigrants in the Waiver proposal,[4] and address its fiscal concerns regarding the cost of caring for new migrants.[5]

It is important for the federal and State government to use the 1332 State Innovation program to ensure coverage for people, not just funding increases to the healthcare industry. The State's 1332 Waiver proposal has already allocated $5.8 billion in industry spending in the final Waiver proposal submitted in May, including:

- $800 million a year, $4 billion over five years on provider rate increases;
- $225 million a year, $1.125 billion on insurance companies ("quality incentive pool");
- $571 million over five years on Long Term Services and Supports (LTSS)
- $125 million over five years for an unspecified behavioral health "grant program."

The chart below, derived from the State's November 1332 Waiver filing, indicates that the projected five-year surplus for the 1332 pass-through account will increase to $7.8 billion ($4.6 billion more than projected in the State's May 1332 Waiver filing) over five years. The revenue formula for the 1332 Waiver program is based on the premium rates in New York's individual market. The projected increase described in the State's filing for the 1332 pass-through account is due to the substantial increases for the individual market premium rates for the 2024 plan year approved by the New York State Department of Financial Services.[6] These increases were more than double those originally projected in the State's May filings (13.5 percent (actual) vs. 6 percent (projected)).[7] The new $7.8 billion surplus would be generated even after spending $5.8 billion on providers and carriers. Government officials should ensure that the 1332 Waiver keeps to its intended purpose, which is to innovatively expand affordable coverage for people, not just funnel funding to the State's healthcare industry.

Assuming immigrants were included in 2024, the surplus pass-through funds would easily cover over 150,000 immigrants per year – and still provide over $5.8 billion in the industry funding previously embedded into the 1332 Waiver proposal. Should immigrants be included beginning in 2025, there would be enough funding to cover 200,000 immigrants per year. Importantly, these estimates do not include the $500 million annual savings offsets that the federal and State would yield by providing comprehensive coverage in lieu of Emergency Medicaid spending for this same population.

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[4] https://www.youtube.com/watch?v=Ysb38zrpx6Q&t=2149s

[5] https://www.politico.com/newsletters/new-york-playbook/2023/10/30/some-good-budget-news-but-migrant-cost-concerns-00124139

[6] https://myportal.dfs.ny.gov/web/prior-approval/ind-and-sg-medical/summary-of-2024-requested-rate-actions#:~:text=Insurers%20requested%20an%20average%20rate,eligible%20for%20federal%20tax%20credits.

[7] https://info.nystateofhealth.ny.gov/sites/default/files/NY%201332%20Waiver%20Application_5.12.2023.pdf.

Table 1: Using the 1332 November Waiver Surplus to Cover Immigrants

	2024	2025	2026	2027	2028	Total
Federal Funding (Requested pass-through)	$9,796	$13,184	$13,351	$14,280	$15,274	$65,885
Program Costs, Scenario C, All investments	$8,358	$11,621	$12,061	$12,677	$13,328	$58,045
Annual Surplus	**$1,438**	**$1,563**	**$1,290**	**$1,603**	**$1,946**	**$7,840**
PMPY ($629-$729 pmpm)	$7,548	$7,860	$8,136	$8,436	$8,748	
Number of immigrants that could be covered with pass-through funding	**190,514**	**198,855**	**158,555**	**190,019**	**222,451**	

At a minimum, New York should revise the 1332 Waiver to cover DACA immigrants regardless of the federal government's adoption of proposed federal regulations clarifying eligibility for coverage.

The State's November 1332 Waiver proposal indicates that it would provide coverage to New York residents that have Deferred Action for Childhood Arrival (i.e., "DACA" or "dreamers") immigration status, but only if proposed federal regulations are adopted.[8]

Excluding DACA recipients from the 1332 Waiver program is fiscally illogical for the State. New York already provides 100 percent State-only funded comprehensive Medicaid to DACA recipients with incomes below 138 percent of FPL. Including DACA recipients will ensure that New York saves this State-only allocation and provides coverage to DACA immigrants up to 250 percent of FPL.

3. **CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price instead of providing an additional $297 million to the insurance industry through the Insurer Reimbursement Implementation Plan.**

The latest draft 1332 Waiver proposal seeks to provide over $60 million per year to the insurance industry in an effort to offset the lost premiums it will incur as 70,000 New Yorkers (with incomes between 200-250 percent of FPL) move from individual market Qualified Health Plans to Essential Plans. Operating like a reinsurance program, the IRIP would support a climate

[8] *See* Commissioner McDonald cover letter, dated November 13, 2023.

in which carriers have less incentive to use their bargaining power to control costs—essentially creating "health plan moral hazard."[9] Carriers should not receive such windfalls.

The IRIP is a regressive proposal because it solely benefits individuals with incomes over 600 percent of the FPL, who are ineligible for subsidies (people earning over $180,000 a year for a family of four).[10] The IRIP does nothing to target moderate-income individuals—between 251-600 percent of the FPL. These moderate-income individuals will have to pay anywhere from 4 percent to 8.5 percent of their family income on coverage that has a huge barrier to entry to care (a $2,100 deductible for a Silver plan).[11]

Instead of approving the IRIP addendum, CMS and New York State policymakers should work together to cover more New Yorkers at an affordable price – consistent with the goals of the 1332 Wavier program. Policy vehicles for doing so include the following:

- Using surplus funding to cover some or all New York immigrants who are otherwise ineligible for coverage—an inflow of this healthy population would bring better risk and drive down premiums, generating savings for the federal government;
- Implementing an enrollee assistance program that brings the deductibles for a Silver plan down to $600 from the proposed $2,100 for the 2024 plan year;
- Adopting a State premium assistance program, such as the one California has implemented that would target funding for middle income consumers who still have trouble affording coverage.[12]

CSS would like to thank you for the opportunity to present our comments about the November 1332 Waiver proposal.

Very truly yours,

Elisabeth Ryden Benjamin, MPSH, JD
Vice President, Health Initiatives
Community Service Society of NY

[9] Jeah Jung & Roger Feldman, "Growing Reinsurance Payments Weaken Competitive Bidding in Medicare Part D," *Health Services Research*, 10.1111/1475-6773.12866 (2018).
[10] https://aspe.hhs.gov/sites/default/files/documents/1c92a9207f3ed5915ca020d58fe77696/detailed-guidelines-2023.pdf.
[11] https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20Standard%20Schedule%20of%20Benefits%202024%207.20.2023.pdf
[12] https://cbcny.org/research/narrowing-new-yorks-health-insurance-coverage-gap

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December
Two
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The Honorable Janet Yellen
Secretary of the Treasury

The Honorable Xavier Becerra
Secretary of Health and Human Services

Re: NY 1332 Innovation Waiver: Essential Plan Expansion Updates

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to comment on the New York State Department of Health (DOH) State Innovation Waiver Application Addendum, which was submitted to the Departments of Treasury and Health and Human Services (the Departments) on November 13, 2023 (Addendum). As expressed in our July 5 and August 30, 2023, comments to the 1332 Innovation Waiver Application and Addendum (collectively, the Waiver), Greater New York Hospital Association (GNYHA) has strongly supported New York's Essential Plan (EP) since its inception, and we encourage current efforts to further expand eligibility so even more New Yorkers can access affordable and comprehensive coverage.

Through the Waiver, DOH seeks Federal authority to expand EP coverage under Section 1332 to residents with incomes up to 250% of the Federal Poverty Level (FPL). The EP options available to this expansion population will offer lower cost sharing and premiums relative to the currently available Qualified Health Plan (QHP) marketplace plans. The existing EP population will not experience any changes to benefits, choice of plans, premiums, cost sharing, eligibility, or enrollment processes as a result of the Waiver, and consumers with incomes above 250% of FPL will experience no change in affordability[1,2].

This most recently filed Addendum, *New York Section 1332 Innovation Waiver Essential Plan Expansion Updates*, addresses DOH's plans for transitioning the expected approximately 100,000[3] newly eligible EP enrollees from QHPs to EP coverage via a mid-year implementation (April 1, 2024, rather than the initially envisioned January 1, 2024). We appreciate DOH's careful analysis and planning to ensure a smooth transition, including proposals to implement IT system changes and outreach to consumers, and the offer of an exceptional circumstances Special Enrollment Period. We further support the proposal to encourage participating QHP issuers to carry over maximum out-of-pocket spending accumulators for expansion population individuals switching from QHP to EP coverage with the same issuer mid-year. The Waiver's

[1] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, page 4.
[2] New York Section 1332 Innovation Waiver Essential Plan Expansion Updates, November 13, 2023, page 8.
[3] November 13, 2023 Addendum Cover Letter, New York State Department of Health to Secretaries of Treasury and Health and Human Services.

goals of providing access to lower cost sharing and premiums for the expansion population should not be undermined by subjecting these same individuals to extra cost sharing.

GNYHA continues to strongly support the Waiver's proposal to expand eligibility to residents with incomes up to 250% of the FPL. We urge the Departments to approve the Waiver as expeditiously as possible to enable implementation by April 1, 2024, and aid in smoothing affordability and enrollment transitions during the unwinding of continuous coverage requirements in effect since the Families First Coronavirus Response Act.

In addition to addressing DOH's plans for operationalizing an April 1, 2024, implementation, the Addendum proposes eliminating premiums for the new expansion population, and revises certain actuarial analysis based on updated data, including the impact of the proposed Insurer Reimbursement Implementation Plan (IRIP) on premiums and enrollment.

Specifically, the proposed $15 monthly premium for the expansion population has been eliminated. GNYHA supports this enhancement, which removes an additional potential barrier to coverage.

As we previously commented, the IRIP is intended to address an important potential implication of the Waiver—an increase in individual market premiums due to moving the 200-250% FPL group from the QHP marketplace to EP eligibility. As the Waiver is a vehicle for facilitating access to affordable, comprehensive coverage for New Yorkers, we appreciate DOH's thorough consideration of unintended consequences and strongly support efforts to ensure that New Yorkers in the QHP individual market do not face increased premiums because of the Waiver.

DOH proposes to use pass-through funding to reimburse insurers directly for the Waiver's impact on the individual market (an estimated $45 for 2024 and $63 million per year thereafter) rather than approve increased individual market premium rates that would pass the costs on to consumers. DOH requests a waiver of Section 1312(c) of the Affordable Care Act (ACA), as implemented at 45 CFR 156.80, to enable health insurers to set rates as if the individual market risk pool continued to include residents with incomes between 200-250% of the FPL and proposes instead to make retrospective reimbursement calculations and quarterly payments to insurers. These calculations will be based on data provided by insurers to the Department of Financial Services (DFS) that supports the estimated losses. DOH anticipates sufficient surplus in pass-through funding to absorb the costs of this IRIP, but also notes that it would identify other State funds to cover the balance through annual budget making if needed.[4] We note that depending on the frequency and magnitude of such an occurrence, GNYHA would suggest that the IRIP be re-evaluated rather than automatically continued for the duration of the Waiver through alternative funding.

We strongly support shielding consumers from increased premium costs, especially during this period of the continuous coverage unwind and Medicaid recertifications. In expanding EP eligibility to residents with incomes up to 250% FPL and providing them with access to lower cost sharing and premiums, New York should not inadvertently create financial burdens in the form of increased premiums for New Yorkers above 250% of the FPL who will remain in the individual QHP market. Many individuals are exploring

[4] New York Section 1332 Innovation Waiver Essential Plan Expansion Updates, November 13, 2023, pages 8-10.

marketplace options for the first time since the pandemic began, and it is imperative not to exacerbate sticker shock that could potentially discourage enrollment.

We caution, however, that the premium rate-setting process for New York insurers is established and includes the opportunity for stakeholder comment. While we appreciate that the proposed IRIP reimbursement methodology includes reconciliation and reflects actual market experience[5], and that DOH and DFS anticipate ongoing refinement of the data collection and calculation methodology[6], we underscore the need for consistent stakeholder input and transparency as processes are refined and guidance developed.

We also take this opportunity to once again urge DOH to continue exploring eligibility expansion for New York State's immigrant populations. We emphatically support DOH's stated intent to both include the Deferred Action for Childhood Arrivals (DACA) population under the Waiver when the Department of Health and Human Services proposed rule extending ACA coverage to DACA recipients is finalized, and to seek new Federal solutions to support coverage of undocumented New Yorkers. At a minimum, DOH could consider expanding the Waiver to include the DACA population now rather than waiting for implementation of the proposed Federal rule. As DOH explained in its initial May 12, 2023, Waiver application, the Waiver is a key strategy for advancing health equity and "represents a significant opportunity to extend coverage to communities…that are disproportionately uninsured when measured by racial/ethnic identity…". [7]

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 substantial individual and public health benefits and provides a mechanism for more adequately reimbursing health care providers for the cost of delivering care. We look forward to continuing to work with DOH and the Centers for Medicare & Medicaid Services on EP expansion and operations. Please contact Emily Leish if you have any questions.

Sincerely,

Kenneth E. Raske
President

[5] New York Section 1332 Innovation Waiver Essential Plan Expansion Updates, November 13, 2023, page 14.
[6] New York Section 1332 Innovation Waiver Essential Plan Expansion Updates, November 13, 2023, page 11.
[7] New York Section 1332 Innovation Waiver Essential Plan Expansion, May 12, 2023, page 19.

November 29, 2023

The Honorable Janet Yellen
Secretary
Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, DC 20220

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

Re: New York Section 1332 State Innovation Waiver Essential Plan Extension Updates

Dear Secretary Yellen and Secretary Becerra:

Thank you for the opportunity to provide feedback on the New York 1332 State Innovation Waiver Essential Plan Extension Updates.

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. We urge the Department of the

Treasury and the Department of Health and Human Services (Departments) to make the best use of the recommendations, knowledge and experience our organizations offer here.

Our organizations are committed to ensuring that New York's healthcare programs provide quality and affordable healthcare coverage. We believe that New York's revised proposal to use a Section 1332 waiver to expand its Essential Plan to more New Yorkers will advance these objectives. Once fully implemented, New York's waiver should reduce the number of people without insurance, provide affordable access to healthcare for nearly 100,000 new Essential Plan enrollees, and improve health equity, while satisfying the federal guardrail protections governing waivers.

New York's waiver will lower healthcare costs for individuals between 200-250% of the federal poverty level, even more so as the revised proposal removes the $15 monthly premium for this group entirely. 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 $1,925 to $0 and their maximum out of pocket limit fall from $7,550 to $2,000.[i] Research consistently shows that higher cost-sharing, including premiums, is associated with decreased use of preventive services and medical care among low-income populations.[ii] The state estimates that enrollees in the expanded Essential Plan will save about $4,700 per year (relative to their expected costs in a marketplace plan, absent the waiver), a decrease equal to an average of about 12% 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.

Furthermore, we understand that, due to the affordability benefits of the waiver and its updates, New York's plan would also improve take-up of comprehensive coverage. The state now projects that the waiver will increase combined enrollment in the Essential Plan and the individual market by 1% in 2024, and from 2.1%-2.2% thereafter (equal to about 34,000 more enrollees in 2028, for example). 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 these expected improvements.

Our organizations also 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.[iii] The state expects

that the increase in affordability of coverage under the waiver will help to address these disparities.

Our organizations previously commented on the state's efforts to minimize disruptions in coverage for individuals who will be shifting from individual market coverage to the Essential Plan and urged the Departments to work with the state to ensure that the impact of this shift is mitigated for enrollees.[iv] We support the state's additional work to minimize disruptions in coverage in response to the updated implementation date of April 1, 2024, including a public education campaign and carrying over consumers' out-of-pocket spending to date from individual market coverage to the Essential Plan. We continue to urge the Departments to work with the state to ensure that those eligible to shift between plans are properly identified and experience minimal disruption in their access to existing providers and provider networks through close cooperation with consumers, carriers, providers, and patient and consumer organizations through the transition process. The Departments should ensure that the state has considered 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.

Our organizations support this updated 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. We urge the Departments to approve this proposal.

Thank you for the opportunity to provide comments.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Arthritis Foundation
Asthma and Allergy Foundation of America
Epilepsy Foundation of American
Hemophilia Federation of America
Lutheran Services in America
Lupus Foundation of America
National Kidney Foundation
National Multiple Sclerosis Society
National Organization for Rare Disorders
National Patient Advocate Foundation
Susan G. Komen
The Leukemia & Lymphoma Society
WomenHeart

[i] New York State of Health, "Standard Plan Cost-Sharing Chart." July 20, 2023. Available at: https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20B%20Standard%20Schedule%20of%20Benefits%202024%207.20.2023.pdf

[ii] 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/.

[iii] 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.

[iv] Health Partner Comments re NY 1332 State Innovation Waiver. July 5, 2023. Available at: https://www.lung.org/getmedia/57a66676-ca79-4243-956e-9887ee9a84fa/Health-Partner-Comments-re-NY-1332-State-Innovation-Waiver.pdf.

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Deductible • Individual • Family	None None	$600 $1,200	$2,100 $4,200	$1,925 $3,850	$275 $550	None None	$4,600 $9,200	$6,100 $12,200	$9,450 $18,900	None None	
Out-of-Pocket Limit • Individual • Family	$2,000 $4,000	$5,900 $11,800	$9,450 $18,900	$7,550 $15,100	$3,150 $6,300	$1,000 $2,000	$9,450 $18,900	$7,150 $14,300	$9,450 $18,900	$0 $0	
OFFICE VISITS											
Primary Care Office Visits (or Home Visits)	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); 0% Coinsurance after Deductible for additional visits	$0 Copayment	See benefit for description
Specialist Office Visits (or Home Visits)	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]			Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits		Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits				
PREVENTIVE CARE											**Limits**
• Well Child Visits and Immunizations *	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Adult Annual Physical Examinations*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Adult Immunizations *	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Routine Gynecological Services/Well Woman Exams*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Mammograms, Screening and Diagnostic Imaging for the Detection of Breast Cancer	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Sterilization Procedures for Women*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
• Vasectomy	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	See Surgical Services Cost-Sharing	
• Bone Density Testing*	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Screening for Prostate Cancer	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Colon Cancer Screening	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• All other preventive services required by USPSTF and HRSA	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• *When preventive services are not provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA **[Referral required]**	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and Diagnostic Testing)	
EMERGENCY CARE											**Limits**
Pre-Hospital Emergency Medical Services (Ambulance Services)	$100 Copayment	$150 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$50 Copayment	$300 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
Non-Emergency Ambulance Services **[[Preauthorization; Referral] required]**	$100 Copayment	$150 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$50 Copayment	$300 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Emergency Department [Cost-Sharing; Copayment; Coinsurance] waived if admitted to Hospital	$100 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$150 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$500 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$275 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$75 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$50 Copayment Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Cost-Sharing	$500 Copayment after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to[Cost-Sharing	50% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Coinsurance	0% Coinsurance after Deductible Health care forensic examinations performed under Public Health Law § 2805-i are not subject to Coinsurance	$0 Copayment	See benefit for description
Urgent Care Center **[Preauthorization required for out-of-network Urgent Care; Referral required]**	$55 Copayment	$60 Copayment after Deductible	$70 Copayment after Deductible	$70 Copayment after Deductible	$50 Copayment after Deductible	$30 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
PROFESSIONAL SERVICES and OUTPATIENT CARE											**Limits**
Advanced Imaging Services											See benefit for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$175 Copayment after Deductible	$175 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$175 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed in a Freestanding Radiology Facility	$35 Copayment	$40 Copayment after Deductible	$175 Copayment after Deductible	$175 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$175 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
• Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$175 Copayment after Deductible	$175 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$175 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Allergy Testing and Treatment • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) after first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, or Specialist, Allergy Testing	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, outpatient MH/SUD	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]			and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits		or any combination thereof); $75 Copayment after Deductible for additional visits				
Ambulatory Surgical Center Facility Fee **[[Preauthorization; Referral] required]**	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Anesthesia Services (all settings) **[[Preauthorization; Referral] required]**	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Cardiac and Pulmonary Rehabilitation											See benefit for description
• Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed as Inpatient	Included as part of inpatient	Included as part of inpatient	Included as part of inpatient	Included as part of inpatient	Included as part of inpatient	Included as part of inpatient Hospital	Included as part of inpatient Hospital	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Hospital Services **[[Preauthorization; Referral] required]**	Hospital service Cost-Sharing	Hospital service Cost-Sharing	Hospital service Cost-Sharing	Hospital service Cost-Sharing	Hospital service Cost-Sharing	service Cost-Sharing	service Cost-Sharing				
Chemotherapy and Immunotherapy • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• [Performed at Home] **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Chiropractic Services	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or	$65 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or	$35 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or	$20 Copayment	$75 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment,	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]			outpatient MH/SUD) $65 Copayment after Deductible for additional visits	outpatient MH/SUD) $65 Copayment after Deductible for additional visits	outpatient MH/SUD) $35 Copayment after Deductible for additional visits		outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits				
Clinical Trials **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	Use Cost-Sharing for appropriate service	See benefit for description
Diagnostic Testing • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Dialysis • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	[Dialysis performed by Non-Participating Providers is limited
• Performed in a Freestanding	$15 Copayment	$25 Copayment	$30 Copayment	$30 Copayment	$15 Copayment	$10 Copayment	$50 Copayment	50% Coinsurance	0% Coinsurance	$0	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Center • Performed as Outpatient Hospital Services • [Performed at Home] **[[Preauthorization; Referral] required]**	 $15 Copayment $15 Copayment	after Deductible $25 Copayment after Deductible $25 Copayment after Deductible	after Deductible $30 Copayment after Deductible $30 Copayment after Deductible	after Deductible $30 Copayment after Deductible $30 Copayment after Deductible	after Deductible $15 Copayment after Deductible $15 Copayment after Deductible	 $10 Copayment $10 Copayment	after Deductible $50 Copayment after Deductible $50 Copayment after Deductible	after Deductible 50% Coinsurance after Deductible 50% Coinsurance after Deductible	after Deductible 0% Coinsurance after Deductible 0% Coinsurance after Deductible	Copayment $0 Copayment $0 Copayment	to 10 visits per calendar year. Cost-Sharing for the visits is the same as for a Participating Provider. See benefit description for more information.]
Habilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy) **[[Preauthorization; Referral] required]**	$25 Copayment	$30 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$25 Copayment after Deductible	$15 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	60 visits per condition, per Plan Year combined therapies
Home Health Care **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	40 visits per Plan Year
Infertility Services **[[Preauthorization; Referral] required]**	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory & Diagnostic Procedures)	Use Cost-Sharing for appropriate service (Office Visit; Diagnostic Radiology Services; Surgery; Laboratory	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
										& Diagnostic Procedures)	
Infusion Therapy • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	Home infusion counts toward home health care visit limits
• Performed as Outpatient Hospital Services	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Home Infusion Therapy **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Inpatient Medical Visits **[[Preauthorization; Referral] required]**	$0 Copayment	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment	$0 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Interruption of Pregnancy • Abortion Services	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full after Deductible	Covered in full after Deductible	Covered in full	See benefit for description
Laboratory Procedures • Performed in a PCP Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed in a Freestanding Laboratory Facility	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$50 Copayment after Deductible	$50 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Maternity and Newborn Care • Prenatal Care provided in accordance with the comprehensive guidelines supported by USPSTF and HRSA	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	See benefit for description
• Prenatal Care that is not provided in accordance with the comprehensive guidelines supported by USPSTF and	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services;	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory Procedures and	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit; Diagnostic Radiology Services; Laboratory	Use Cost-Sharing for appropriate service (Primary Care Office Visit; Specialist Office Visit;	

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
HRSA	Procedures and Diagnostic Testing)]	Laboratory Procedures and Diagnostic Testing)	Procedures and Diagnostic Testing)	Procedures and Diagnostic Testing)	Procedures and Diagnostic Testing)	Procedures and Diagnostic Testing)	Diagnostic Testing)	Procedures and Diagnostic Testing)	Procedures and Diagnostic Testing)	Diagnostic Radiology Services; Laboratory	One (1) home care visit[s] is Covered at no Cost-Sharing if mother is discharged from Hospital early
• Inpatient Hospital Services [and Birthing Center]	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Physician and Midwife Services for Delivery	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	Covered for duration of breast feeding
• Breastfeeding Support, Counseling and Supplies, Including Breast Pumps	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	Covered in full	
• Postnatal Care **[Preauthorization required] [for inpatient services; breast pump]**	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	Included in Physician and Midwife Services for Delivery Copayment	
Outpatient Hospital Surgery Facility Charge **[[Preauthorization; Referral] required]**	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Preadmission Testing	$0 Copayment	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	$0 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]											description
Prescription Drugs Administered in Office [or Outpatient Facilities] • Performed in a PCP Office	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	Included as part of the PCP office visit Cost-Sharing	See benefit for description
• Performed in Specialist Office	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	Included as part of the Specialist office visit Cost-Sharing	
• [Performed in Outpatient Facilities] **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Diagnostic Radiology Services • Performed in a PCP Office	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in a Specialist Office	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed in a Freestanding Radiology	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Facility • Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$75 Copayment after Deductible	$75 Copayment after Deductible	$35 Copayment after Deductible	$20 Copayment	$75 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Therapeutic Radiology Services • Performed in a Specialist Office	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
• Performed in a Freestanding Radiology Facility	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Performed as Outpatient Hospital Services **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Rehabilitation Services (Physical Therapy, Occupational Therapy or Speech Therapy)	$25 Copayment	$30 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$25 Copayment after Deductible	$15 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	60 visits per condition, per Plan Year combined therapies Speech and physical therapy are only

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	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
[[Preauthorization; Referral] required]											Covered following a Hospital stay or surgery
[Retail Health Clinic Care) **[[Preauthorization; Referral] required]**	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	[See benefit for description]
Second Opinions on the Diagnosis of Cancer, Surgery and Other **[[Preauthorization; Referral] required]**	$35 Copayment	$40 Copayment after Deductible	$65 Copayment not subject to Deductible for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	$65 Copayment not subject to Deductible for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $65 Copayment after Deductible for additional visits	$35 Copayment not subject to Deductible for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $35 Copayment after Deductible for additional visits	$20 Copayment	$75 Copayment not subject to Deductible for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $75 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Surgical Services (including Oral Surgery; Reconstructive Breast Surgery; Other Reconstructive and Corrective Surgery; and Transplants) • Inpatient Hospital Surgery	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description **[All transplants must be performed at designated Facilities]**

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	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
• Outpatient Hospital Surgery	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Surgery Performed at an Ambulatory Surgical Center	$100 Copayment	$100 Copayment after Deductible	$150 Copayment after Deductible	$150 Copayment after Deductible	$75 Copayment after Deductible	$25 Copayment	$150 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• Office Surgery **[[Preauthorization; Referral] required]**	$15 Copayment when performed by PCP; $35 Copayment when performed by Specialist	$25 Copayment after Deductible when performed by PCP; $40 Copayment after Deductible when performed by Specialist	$30 Copayment after Deductible when performed by PCP; $65 Copayment after Deductible when performed by Specialist	$30 Copayment after Deductible when performed by PCP; $65 Copayment after Deductible when performed by Specialist	$15 Copayment after Deductible when performed by PCP; $35 Copayment after Deductible when performed by Specialist	$10 Copayment when performed by PCP; $20 Copayment when performed by Specialist	$50 Copayment after Deductible when performed by PCP; $75 Copayment after Deductible when performed by Specialist	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
[Telemedicine Program]	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	Optional	[See benefit for description]
ADDITIONAL SERVICES, EQUIPMENT and DEVICES											**Limits**
Diabetic Equipment, Supplies and Self-Management Education • Diabetic Equipment, Supplies and Insulin (30-day supply)	$15 Copayment	$25 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$30 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$30 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$15 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	$10 Copayment	$50 Copayment after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	50% Coinsurance after Deductible but no more than $100 (including before the Deductible) for a 30-day supply of insulin	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
• Diabetic Education **[[Preauthorization; Referral] required] [for insulin pump]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Durable Medical Equipment and Braces **[[Preauthorization; Referral] required]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
External Hearing Aids • Prescription Hearing Aids • [Over-the-Counter Hearing Aids] **[[Preauthorization; Referral] required]**	10% Coinsurance [Optional]	20% Coinsurance after Deductible [Optional]	30% Coinsurance after Deductible [Optional]	25% Coinsurance after Deductible [Optional]	10% Coinsurance after Deductible [Optional]	5% Coinsurance [Optional]	50% Coinsurance after Deductible [Optional]	50% Coinsurance after Deductible [Optional]	0% Coinsurance after Deductible [Optional]	$0 Copayment	Single purchase once every three (3) years [Describe limits for OTC hearing aids]
Cochlear Implants	[10% Coinsurance] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical	[20% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical	[30% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services;	[25% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services;	[10% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services;	[5% Coinsurance] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia	[50% Coinsurance after Deductible] See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services; Ambulatory	[50% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia Services;	[0% Coinsurance after Deductible] [See [Surgical Services; Internal Prosthetic Devices] Cost-Sharing] [Use Cost-Sharing for appropriate service (Surgical Services; Anesthesia	$0 Copayment	One (1) per ear per time Covered

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	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
[[Preauthorization; Referral] required]	Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Services; Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Anesthesia Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge]	Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]	Services; Ambulatory Surgical Center Facility Fee; Outpatient Hospital Surgery Facility Charge)]		
Hospice Care • Inpatient • Outpatient **[[Preauthorization; Referral] required]**	$500 Copayment per admission $15 Copayment	$1,000 Copayment after Deductible per admission $25 Copayment after Deductible	$1,500 Copayment after Deductible per admission $30 Copayment after Deductible	$1,500 Copayment after Deductible per admission $30 Copayment after Deductible	$250 Copayment after Deductible per admission $15 Copayment after Deductible	$100 Copayment per admission $10 Copayment	$1,500 Copayment after Deductible per admission $50 Copayment after Deductible	50% Coinsurance after Deductible 50% Coinsurance after Deductible	0% Coinsurance after Deductible 0% Coinsurance after Deductible	$0 Copayment $0 Copayment	210 days per Plan Year] Five (5) visits for family bereavement counseling
Medical Supplies **[[Preauthorization; Referral] required]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Prosthetic Devices • External	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	One (1) prosthetic device, per limb, per lifetime with coverage for repairs and replacements

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	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
• Internal **[[Preauthorization; Referral] required]**	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	Included as part of inpatient Hospital Cost-Sharing	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	Unlimited; See benefit for description
INPATIENT SERVICES and FACILITIES											**Limits**
Autologous Blood Banking **[[Preauthorization; Referral] required [in outpatient settings]]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Inpatient Hospital for a Continuous Confinement (including an Inpatient Stay for Mastectomy Care, Cardiac and Pulmonary Rehabilitation, and End of Life Care) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or services provided in a neonatal intensive care unit**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
of a Hospital certified pursuant to Article 28 of the Public Health Law.]]											
Observation Stay	$100 Copayment	$150 Copayment after Deductible	$500 Copayment after Deductible	$275 Copayment after Deductible	$75 Copayment after Deductible	$50 Copayment	$500 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Skilled Nursing Facility (including Cardiac and Pulmonary Rehabilitation) **[[Preauthorization; Referral] required]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	200 days per Plan Year]
Inpatient Habilitation Services (Physical, Speech and Occupational Therapy) **[[Preauthorization; Referral] required]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	60 days per Plan Year combined therapies
Inpatient Rehabilitation Services (Physical, Speech and Occupational Therapy) **[[Preauthorization; Referral]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	60 days per Plan Year combined therapies Speech and physical therapy are only Covered following a Hospital stay or surgery

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	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
required]											
MENTAL HEALTH and SUBSTANCE USE DISORDER SERVICES											**Limits**
Inpatient Mental Health Care for a continuous confinement when in a Hospital (including Residential Treatment) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for admissions at Participating OHM-licensed Facilities for Members under 18.]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Outpatient Mental Health Care (including Partial Hospitalization and Intensive Outpatient Program Services)	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA	50% Coinsurance after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); 0% Coinsurance after Deductible for additional visits	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
[[Preauthorization; Referral] required]			Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits		Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits				
ABA Treatment for Autism Spectrum Disorder **[[Preauthorization; Referral] required]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Assistive Communication Devices for Autism Spectrum Disorder **[[Preauthorization; Referral]**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
required]											
Inpatient Substance Use Services for a continuous confinement when in a Hospital (including Residential Treatment) **[[Preauthorization; Referral] required. However, Preauthorization is not required for emergency admissions or for Participating OASAS-certified Facilities.]**	$500 Copayment per admission	$1,000 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$1,500 Copayment after Deductible per admission	$250 Copayment after Deductible per admission	$100 Copayment per admission	$1,500 Copayment after Deductible per admission	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Outpatient Substance Use Services (including Partial Hospitalization, Intensive Outpatient Program Services, and Medication Assisted Treatment)	$15 Copayment	$25 Copayment after Deductible	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$30 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $30 Copayment after Deductible for additional visits	$15 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) $15 Copayment after Deductible for additional visits	$10 Copayment	$50 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, outpatient MH/SUD or any combination thereof); $50 Copayment after Deductible for additional visits	50% Coinsurance after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); 0% Coinsurance after Deductible for additional visits	$0 Copayment	Unlimited; Up to [20] visits per Plan Year may be used for family counseling

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
Opioid Treatment Programs **[[Preauthorization; Referral] required. However, Preauthorization is not required for Participating OASAS-certified Facilities.]**	Covered in full	Covered in full after Deductible	$0 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	$0 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	$0 Copayment not subject to Deductible (and does not count towards the Deducible) for first visit (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	Covered in full	$0 Copayment not subject to Deductible (and does not count towards the Deducible) for first 3 visits (PCP, Specialist, Allergy Testing and Treatment, Chiropractic Services, Second Opinions, ABA Treatment, or outpatient MH/SUD) Covered in full after Deductible for additional visits	Covered in full after Deductible	$0 Copayment not subject to Deductible for first 3 visits (PCP, outpatient MH/SUD or any combination); Covered in full after Deductible	$0 Copayment	
PRESCRIPTION DRUGS *Certain Prescription Drugs are not subject to Cost-Sharing when provided in accordance with the comprehensive guidelines supported by HRSA or if the item or service has an "A" or "B" rating from the USPSTF [and obtained at a participating pharmacy].											**Limits**

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
Retail Pharmacy											
30-day supply Tier 1	$10 Copayment	$10 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$9 Copayment not subject to Deductible	$6 Copayment	$10 Copayment after Deductible	$10 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Tier 2	$30 Copayment	$35 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$20 Copayment not subject to Deductible	$15 Copayment	$35 Copayment after Deductible	$35 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Tier 3 Preauthorization is not required for a Covered Prescription Drug used to treat a substance use disorder, including a Prescription Drug to manage opioid withdrawal and/or stabilization and for opioid overdose reversal.	$60 Copayment	$70 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$30 Copayment	$70 Copayment after Deductible	$70 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
[Up to a 90-day supply for Maintenance Drugs] [Tier 1	$30 Copayment	$30 Copayment not subject to Deductible	$45 Copayment not subject to Deductible	$45 Copayment not subject to Deductible	$27 Copayment not subject to Deductible	$18 Copayment	$30 Copayment after Deductible	$30 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	[See benefit for description]
Tier 2	$90 Copayment	$105 Copayment not subject to Deductible	$120 Copayment not subject to Deductible	$120 Copayment not subject to Deductible	$60 Copayment not subject to Deductible	$45 Copayment	$105 Copayment after Deductible	$105 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Tier 3]	$180 Copayment	$210 Copayment not subject to Deductible	$225 Copayment not subject to Deductible	$225 Copayment not subject to Deductible	$120 Copayment not subject to Deductible	$90 Copayment	$210 Copayment after Deductible	$210 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
[Mail Order Pharmacy]											

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	**Gold**	**Silver**	**Silver 73**	**Silver 87**	**Silver 94**	**Bronze**	**Bronze HSA**	**Catastrophic**	**AI/AN CSR 100-300% FPL**	**Limits**
[Up to a 30-day supply											
Tier 1	$10 Copayment	$10 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$9 Copayment not subject to Deductible	$6 Copayment	$10 Copayment after Deductible	$10 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Tier 2	$30 Copayment	$35 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$20 Copayment not subject to Deductible	$15 Copayment	$35 Copayment after Deductible	$35 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Tier 3]	$60 Copayment	$70 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$30 Copayment	$70 Copayment after Deductible	$70 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
[Up to a 90-day supply Tier 1	$25 Copayment	$25 Copayment not subject to Deductible	$37.50 Copayment not subject to Deductible	$37.50 Copayment not subject to Deductible	$22.50 Copayment not subject to Deductible	$15 Copayment	$25 Copayment after Deductible	$25 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	[See benefit for description]
Tier 2	$75 Copayment	$87.50 Copayment not subject to Deductible	$100 Copayment not subject to Deductible	$100 Copayment not subject to Deductible	$50 Copayment not subject to Deductible	$37.50 Copayment	$87.50 Copayment after Deductible	$87.50 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Tier 3]	$150 Copayment	$175 Copayment not subject to Deductible	$187.50 Copayment not subject to Deductible	$187.50 Copayment not subject to Deductible	$100 Copayment not subject to Deductible	$75 Copayment	$175 Copayment after Deductible	$175 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Enteral Formulas Tier 1	$10 Copayment	$10 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$15 Copayment not subject to Deductible	$9 Copayment not subject to Deductible	$6 Copayment	$10 Copayment after Deductible	$10 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	See benefit for description
Tier 2	$30 Copayment	$35 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$20 Copayment not subject to Deductible	$15 Copayment	$35 Copayment after Deductible	$35 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	
Tier 3	$60 Copayment	$70 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$75 Copayment not subject to Deductible	$40 Copayment not subject to Deductible	$30 Copayment	$70 Copayment after Deductible	$70 Copayment after Deductible	0% Coinsurance after Deductible	$0 Copayment	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
WELLNESS BENEFITS											
[Gym Reimbursement]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]] [Not applicable]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]] [Not applicable]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]	[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]		[Up to $200 per six (6) month period; up to an additional $100 per six (6) month period for [Spouse; covered Dependents]]
PEDIATRIC [DENTAL and] VISION CARE											**Limits**
[Pediatric Dental Care] • [Preventive Dental Care]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	[One (1) dental exam and cleaning per six (6) month period]
• [Routine Dental Care]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	
• [Major Dental Care (Oral Surgery, Endodontics, Periodontics and Prosthodontics)]	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	[Full mouth x-rays or panoramic x-rays at 36-month intervals and bitewing x-rays at six (6) month intervals]
• [Orthodontics] **[Orthodontics and major dental**	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

	Platinum	Gold	Silver	Silver 73	Silver 87	Silver 94	Bronze	Bronze HSA	Catastrophic	AI/AN CSR 100-300% FPL	Limits
require [Preauthorization; Referral]]											
Pediatric Vision Care • Exams	$15 Copayment	$25 Copayment after Deductible	$30 Copayment after Deductible	$30 Copayment after Deductible	$15 Copayment after Deductible	$10 Copayment	$50 Copayment after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	One (1) exam per [12-month period; Plan Year; calendar year]
• Lenses and Frames	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	One (1) prescribed lenses and frames per [12-month period; Plan Year; calendar year]
• Contact Lenses **[Contact lenses require [Preauthorization; Referral]]**	10% Coinsurance	20% Coinsurance after Deductible	30% Coinsurance after Deductible	25% Coinsurance after Deductible	10% Coinsurance after Deductible	5% Coinsurance	50% Coinsurance after Deductible	50% Coinsurance after Deductible	0% Coinsurance after Deductible	$0 Copayment	

{Drafting Note: Insert the provision below regarding eligible American Indians for individual schedules of benefits only if separate schedules of benefits are not used for American Indians over 300% of the federal poverty level (known as the limited cost-sharing plan variation).}
[Eligible American Indians, as determined by the NYSOH, are exempt from Cost-Sharing requirements when Covered Services are rendered by an Indian Health Service, Indian Tribe, Tribal Organization or Urban Indian Organization, or through Referral under contract health services.]

[All in-network Preauthorization requests are the responsibility of Your Participating Provider. You will not be penalized for a Participating Provider's failure to obtain a required Preauthorization. However, if services are not Covered under the [Certificate; Contract; Policy], You will be responsible for the full cost of the services.]
{Drafting Note: HMOs and gatekeeper EPO products may not impose preauthorization requirements on the member for in-network coverage. Only include preauthorization language if applicable. If plans only require preauthorization for certain services or items (e.g., specific DME items), they must list those specific services or items in the schedule.}

ATTACHMENT B: STANDARD PLAN COST-SHARING CHART (7/20/2023)

ADDITIONAL STANDARD PLAN INSTRUCTIONS:

1. **Platinum, Gold, Silver, Silver CSR, and non-HSA Compliant Bronze Plans:**
   - For an inpatient admission, the inpatient facility copayment applies per admission. If surgery is performed, a surgeon copayment applies. If a maternity delivery is performed, a maternity delivery copayment applies (if this copayment has not already been collected as part of another maternity claim). There are no additional copayments for diagnostic tests, medical supplies, in-hospital physician visits, anesthesia, assistant surgeon, other staff doctors, etc. For a maternity stay, the inpatient facility copayment 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. **Gold and HSA Compliant Bronze Plans:** The deductible must be met first, and then the copayment or coinsurance is applied to the remainder of the allowed amount until the out-of-pocket limit is reached.

3. **Non-HSA Compliant Standard Bronze Plan:** Any combination of three visits indicated below are covered before the deductible, subject to the applicable copayments. The copayments paid for the three visits does not count towards the deductible. After the first three visits and for all other services, the deductible must be met, and then the copayment or coinsurance is applied to the remainder of the allowed amount until the 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. **Standard Silver Plan and Silver 73 and 87 CSR Plans:** One visit indicated below is covered before the deductible, subject to the applicable copayment. The copayment paid for the one visit does not count towards the deductible. After the first visit and for all other services, the deductible must be met, and then the copayment or coinsurance is applied to the remainder of the allowed amount until the 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. **Catastrophic Plan:** The plan must include three primary care visits per calendar year not subject to the deducible. 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 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.

6. If the copayment payable is more than the allowed amount, the copayment is reduced to the allowed amount.

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

8. **Deductibles:** The deductible is per calendar year for individual plans and per calendar year or plan year (an option of the insurer) for small group plans.
   - Platinum, Gold, Silver and Silver CSR Plans: The deductible applies to medical, pediatric dental, and pediatric vision services and does not apply to prescription drugs.
   - Bronze and Catastrophic plans: The deductible applies to all services combined (medical, pediatric dental, pediatric vision, and prescription drugs).
   - The family deductible is two times the single deductible; the family out-of-pocket limit is two times the single out-of-pocket limit. For non-HSA compliant plans, each family member is subject to a maximum deductible equal to the single deductible and to a 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).

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

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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 (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-1/)
Table 2: Effects of Cost Sharing (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/)
Table 3: Effects on State Budgets & Providers (https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-3/)

Table 1: Effects of Premiums

National Studies
State Studies

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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			parents without a worker in the household, a $500 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			percentage point increase in being uninsured. The increase in likelihood of being 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.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• A $1 increase in premium for those in the higher income group was associated with a 1.7 to 2.2 percentage point 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 Childless Adults?," *Inquiry* 49 (Spring 2012):52-64.	2000-2008 Current Population Survey data	Low-income childless adults (age 19-64) eligible for public coverage expansions or premium assistance programs in 16 states and DC	• Estimates effects of public and private health insurance premiums on 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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%, 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.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• 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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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			
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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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/).	State administrative data	**Michigan and Indiana:** Adults enrolled in the Medicaid expansion waiver programs	• Examines early implementation experiences of 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.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• 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-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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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, 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	• Estimates the effects that premiums in Medicaid have on

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
		Medicaid and CHIP program	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 on enrollment and possible health care consequences of disenrollment. Effective January 2004, Washington made policy changes that

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 were aware of the changes, 26% cited the changes as a reason for disenrolling. Among

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 individual coverage increased by $50

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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

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. • 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			become uninsured compared to 8% of those who had left OHP Plus.
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.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			In contrast, the average retention rate for younger children did not change over the period. • 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			to sliding scale premiums ranging from $20-$40 for one child and $35-$70 for two or more children. • In both states, premium increases 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 premium nonpayment	**Kentucky:** Children enrolled in CHIP	• Examines whether the effects of new premiums in Kentucky's CHIP program on enrollment varied 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• 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 Services Research* 43, 2 (April 2008):458-477.	State administrative data, 2002-2004	**Florida**: Children enrolled in CHIP	• Examines the impact of premium changes in Florida's 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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%

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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. • 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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) 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.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• 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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 with family incomes between 185-300% FPL in New Hampshire.	• Examines the effects of new and higher premiums on CHIP enrollment in Kansas, Kentucky, and New Hampshire. In 2013, Kansas and 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 after several months but did not return to pre-premium levels nine months after the premium was introduced. In Kansas and New Hampshire, small

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 concentrated among children at the lower end of the income group subject to premiums.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
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 similar to the original OHP. • Nearly half (44%) of the OHP Standard

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 usual source of care.

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			• 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			difference was larger for those with chronic conditions.
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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			did disenroll remained uninsured at the time of the survey. • 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			who became uninsured but did not have a chronic illness.
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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			payment policies led to loss of coverage, and they had significant problems accessing care after losing coverage.
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

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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,	State administrative data, key informant interviews, a focus	**Washington State:** Immigrant families moved from Medicaid to	• Assesses the impact of changes in coverage options for low-income

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
DC: Kaiser Family Foundation, May 2004).	group, and interviews, September 2002-September 2003	Basic Health in Washington State	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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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, 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,	State administrative data, January	**Oregon:** Adults with incomes below 100% FPL who disenrolled	• Examines the effects of changes to Oregon's Medicaid

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
(Portland, OR: Oregon Health & Science University, February 2004.	2002 – October 2003	from Medicaid in Oregon	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 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 l Gavin, et. al., *Evaluation of the BadgerCare Medicaid Demonstration*, Prepared by RTI International and	Case study, including site visit interviews, focus	**Wisconsin:** Families enrolled in Medicaid/CHIP	• Evaluates Wisconsin's

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
MayaTech Corp. for the Centers for Medicare & Medicaid Services, (Research Triangle Park, NC: RTI International and MayaTech Corporation, December 2003).	groups, and document review; administrative enrollment data 1997-2002; and surveys of BadgerCare participating, eligible nonparticipating, and disenrolled families.		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. 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-	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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
content/uploads/2012/03/Far%20-%20impact%20of%20premiums.pdf).			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. • 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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 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

Table 1: Effects of Premiums

Citation	Data	Study Population(s)	Study Focus and Major Findings
			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(

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
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

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
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

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
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 data, 2001-2004.	**Oregon**: Low-incom nonelderly adults enrolled in Medicaic

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

Table 2: Effects of Cost Sharing

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, anc elderly individuals) enrolled in Medicaic 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

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(

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Citation	Data	Study Population(
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
Office of the Executive Director, *2003 Utah Public Health Outcome Measures Report,* (Salt Lake City, UT: UT Department of Health, December 2003),	Medicaid Administrative Data 2001-	**Utah**: Adults enrolle in Medicaid

Table 2: Effects of Cost Sharing

Citation	Data	Study Population(
http://www.hpm.umn.edu/ ambul_db/db/pdflibrary/ DBfile_49007.pdf (http://www.hpm.umn.edu/ambul_db/db/pdflibrary/DBfile_49007.pdf)	2003 and Medicaid Benefits Survey 2003	

Table 3: Effects on State Budgets & Providers

State Studies

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
State Specific Studies		

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
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

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
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(
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 CommonHea 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.

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

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

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
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 move from Medicai to Basic Healt in Washingtor State

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(
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

Table 3: Effects on State Budgets & Providers

Citation	Data	Study Population(

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

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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).

← Return to text

2. Tricia Brooks, et. al., *Medicaid and HCIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2017: Findings form a 50-State Survey,* (Washington, DC: Kaiser Family Foundation, January 2017), https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-introduction/ (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-renewal-and-cost-sharing-policies-as-of-january-2017-introduction/).

← Return to text

3. Ibid.

← Return to text

4. Ibid.

← Return to text

5. 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.

← Return to text

6. Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, no.8 (August 2014): 1353-1360.

← Return to text

7. 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.

← Return to text

8. 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 Childless Adults?" *Inquiry* 49 (Spring 2012):52-64.

← Return to text

9. Jack Hadley, et. al., "Insurance Premiums and Insurance Coverage of Near-Poor Children," *Inquiry* 43, 4 (Winter 2006/2007).

← Return to text

10. 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.

← Return to text

11. 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).

← Return to text

12. MaryBeth Musumeci, et. al., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, (Washington, DC: Kaiser Family 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/).

← Return to text

13. 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.

← Return to text

14. Laura Dague, "The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach," *Journal of Health Economics* 37 (May 2014): 1-12.

← Return to text

15. 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.

← Return to text

16. 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.

← Return to text

17. 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.

← Return to text

18. 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.

← Return to text

19. 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.

← Return to text

20. James Marton and Jeffery C Talbert, "CHIP Premiums, Health Status, and the Insurance Coverage of Children," *Inquiry* 47, 3 (Fall 2010):199-214.

← Return to text

21. 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.

← Return to text

22. Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," Health Services Research 43, 2 (April 2008):458-477.

← Return to text

23. James Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," *Journal of Policy Analysis and Management* 26 (2007):237-255.

← Return to text

24. 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.

← Return to text

25. 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.

← Return to text

26. 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.

← Return to text

27. 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.

← Return to text

28. Bill J Wright et. al., “The Impact of Increased Cost Sharing on Medicaid Enrollees,” *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

← Return to text

29. 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).

← Return to text

30. 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.

← Return to text

31. 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).

← Return to text

32. 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).

← Return to text

33. 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).

← Return to text

34. Maryland Department of Health and Mental Hygiene, *Maryland Children's Health Insurance Program: Assessment of the Impact of Premium*s, (Baltimore, MD: Department of Health and Mental Hygiene, April 2004).

← Return to text

35. 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.

← Return to text

36. Norma l 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).

← Return to text

37. 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).

← Return to text

38. Elizabeth Shenkman, et. al., "Disenrollment and Re-Enrollment Patters in a SCHIP Program," *Health Care Financing Review* 23, 3 (Spring 2002):47-63.

← Return to text

39. Leighton Ku and Teresa A Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry* 36, 4 (Winter 1999/2000).

← Return to text

40. 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.

← Return to text

41. Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, no.8 (August 2014): 1353-1360.

← Return to text

42. 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.

← Return to text

43. 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.

← Return to text

44. 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.

← Return to text

45. 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.

← Return to text

46. Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

← Return to text

47. 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).

← Return to text

48. 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).

← Return to text

49. 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).

← Return to text

50. 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.

← Return to text

51. Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

← Return to text

52. 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).

← Return to text

53. 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).

← Return to text

54. 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).

← Return to text

55. 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).

← Return to text

56. 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.

← Return to text

57. 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.

← Return to text

58. 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.

← Return to text

59. 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.

← Return to text

60. Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," Health Services Research 43, 2 (April 2008):458-477.

← Return to text

61. 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.

← Return to text

62. Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

← Return to text

63. 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).

← Return to text

64. 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.

← Return to text

65. 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.

← Return to text

66. 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).

← Return to text

67. Bill J Wright et. al., "The Impact of Increased Cost Sharing on Medicaid Enrollees," *Health Affairs* 24, no. 4 (Jul/Aug 2005):1106-1116.

← Return to text

68. 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).

← Return to text

69. 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/%20ambul_db/db/pdflibrary/%20DBfile_49007.pdf)

← Return to text

70. 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.

← Return to text

71. 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).

← Return to text

72. 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.

← Return to text

73. 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).

← Return to text

74. Salam Abdus, et. al., "Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children," *Health Affairs* 33, no.8 (August 2014): 1353-1360.

← Return to text

75. 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.

← Return to text

76. 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.

← Return to text

77. 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.

← Return to text

78. 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.

← Return to text

79. 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.

← Return to text

80. James Marton and Jeffery C Talbert, "CHIP Premiums, Health Status, and the Insurance Coverage of Children," *Inquiry* 47, 3 (Fall 2010):199-214.

← Return to text

81. Jill B Herndon, W Bruce Vogel, Richard L Bucciarelli and Elizabeth A Shenkman, "The Effect of Premium Changes on SCHIP Enrollment Duration," Health Services Research 43, 2 (April 2008):458-477.

← Return to text

82. Ibid.

← Return to text

83. 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.

← Return to text

84. 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.

← Return to text

85. 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.

← Return to text

86. Joseph P Newhouse and the Insurance Experiment Group, *Free For All? Lessons from the RAND Health Insurance Experiment*, (Arlington, VA, RAND, 1993).

← Return to text

87. 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.

← Return to text

88. 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).

← Return to text

89. Bisakha Sen, et. al., "Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?" *Medicare & Medicaid Research Review* 4, 2 (May 2014).

← Return to text

90. 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.

← Return to text

91. 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.

← Return to text

92. 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/%20ambul_db/db/pdflibrary/%20DBfile_49007.pdf)

← Return to text

93. Ibid.

← Return to text

94. 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.

← Return to text

95. 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.

← Return to text

96. 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).

← Return to text

97. 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.

← Return to text

98. 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.

← Return to text

99. 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/%20ambul_db/db/pdflibrary/%20DBfile_49007.pdf)

← Return to text

100. 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).

← Return to text

101. Deliana Kostova and Jared Fox, “Chronic Health Outcomes and Prescription Drug Copayments in Medicaid,” *Medical Care*, published ahead of print (February 2017).

← Return to text

102. 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.

← Return to text

103. Joel F Farley, “Medicaid Prescription Cost Containment and Schizophrenia: A Retrospective Examination,” *Medical Care* 48, 5 (May 2010): 440-447.

← Return to text

104. Bisakha Sen, et. al., “Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?” *Medicare & Medicaid Research Review* 4, 2 (May 2014).

← Return to text

105. Michael Chernew, et. al., “Effects of Increased Patient Cost Sharing on Socioeconomic Disparities in Health Care,” *Journal of General Internal Medicine* 23, 8 (August 2008):1131-1136.

← Return to text

106. Sujha Subramanian, “Impact of Medicaid Copayments on Patients with Cancer,” *Medical Care* 49, 9 (September 2011): 842-847.

← Return to text

107. 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/%20ambul_db/db/pdflibrary/%20DBfile_49007.pdf)

← Return to text

108. 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).

← Return to text

109. Ibid.

← Return to text

110. Bisakha Sen, et. al., “Can Increases in CHIP Copayments Reduce Program Expenditures on Prescription Drugs?” *Medicare & Medicaid Research Review* 4, 2 (May 2014).

← Return to text

111. 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.

← Return to text

112. Deliana Kostova and Jared Fox, “Chronic Health Outcomes and Prescription Drug Copayments in Medicaid,” *Medical Care,* published ahead of print (February 2017).

← Return to text

113. Sujha Subramanian, "Impact of Medicaid Copayments on Patients with Cancer," *Medical Care* 49, 9 (September 2011): 842-847.

← Return to text

114. 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.

← Return to text

115. Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care,* published ahead of print (February 2017).

← Return to text

116. 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.

← Return to text

117. 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.

← Return to text

118. 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.

← Return to text

119. 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.

← Return to text

120. 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.

← Return to text

121. 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).

← Return to text

122. 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/%20ambul_db/db/pdflibrary/%20DBfile_49007.pdf)

← Return to text

123. Deliana Kostova and Jared Fox, "Chronic Health Outcomes and Prescription Drug Copayments in Medicaid," *Medical Care,* published ahead of print (February 2017).

← Return to text

124. 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.

← Return to text

125. Peter J Cunningham, *Affording Prescription Drugs: Not Just a Problem for the Elderly,* (Washington, DC: Center for Studying Health System Change, April 2002), http://www.hschange.org/CONTENT/430/430.pdf (http://www.hschange.org/CONTENT/430/430.pdf).

← Return to text

126. 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.

← Return to text

127. Lindsay M Sabik and Sabina Ohri Gandhi, "Copayments and Emergency Department use Among Adult Medicaid Enrollees," *Health Economics* 25 (May 2016):529-542.

← Return to text

128. Karoline Mortensen, "Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments," *Health Affairs* 29, 9 (September 2010): 1643-1650.

← Return to text

129. 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.

← Return to text

130. Bisakha Sen, et. al., "Health Expenditure Concentration and Characteristics of High-Cost Enrollees in CHIP," *Inquiry* 53 (May 2016):1-9.

← Return to text

131. 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.

← Return to text

132. 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/Documents/medicaidsavingsJCRfinal12-10.pdf (https://mmcp.dhmh.maryland.gov/Documents/medicaidsavingsJCRfinal12-10.pdf).

← Return to text

133. 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).

← Return to text

134. 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.

← Return to text

135. 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/download?doi=10.1.1.482.6057&rep=rep1&type=pdf (http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf).

← Return to text

136. 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).

← Return to text

137. 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.

← Return to text

138. 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.

← Return to text

139. 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).

← Return to text

140. 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).

← Return to text

141. 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.

← Return to text

142. 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).

← Return to text

143. 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).

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Department of Health

Prevention Agenda Tracking Dashboard

Reports

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

Prevention Agenda	2024 Objective	
Total	New York State	92.5
Gender	Male	90.9
	Female	94.0
Race and Ethnicity	White alone NH	95.5
	Black alone NH	92.3
	Hispanic	84.8

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 and 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 September 2022

Department of Health

Prevention Agenda Tracking Dashboard

Reports

New York State Prevention Agenda Socio-Demographics Dashboard

State: Main State Dashboard | State Socio-Demographics

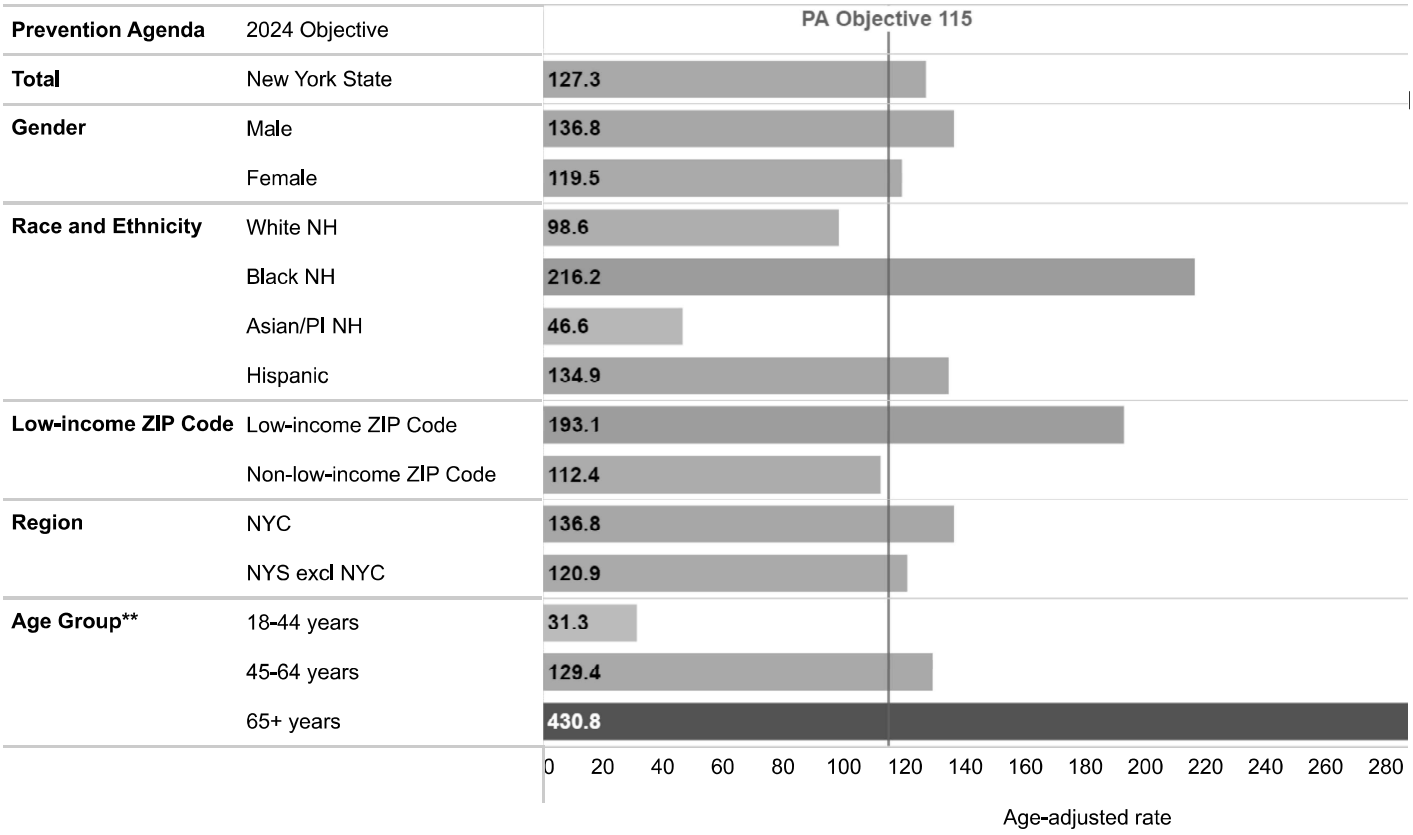
County: Main County Dashboard | County/Region Comparison | Map/Bar/Table | Sub

*Select a priority area **then** an indicator **then** a year.*

Select Priority Area	Select Indicator	Select Year
Improve Health Status and Reduce Disparities	2 - Potentially preventable hospitalizations among adults, age-adjusted rate per 10,000	2019

Annual View | Trend View

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	127.3
Gender	Male	136.8
	Female	119.5
Race and Ethnicity	White NH	98.6
	Black NH	216.2
	Asian/PI NH	46.6
	Hispanic	134.9
Low-income ZIP Code	Low-income ZIP Code	193.1

Low-income ZIP Code	Low-income ZIP Code	193.1
	Non-low-income ZIP Code	112.4
Region	NYC	136.8
	NYS excl NYC	120.9
Age Group**	18-44 years	31.3
	45-64 years	129.4
	65+ years	430.8

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

Comments Received from Individuals During Federal Public Comment Period on New York's Section 1332 Waiver Application Addendum |November 17 through December 2, 2023

……..

#1

11/29/23

Good morning,
I'm a transplant infectious diseases physician at Mount Sinai Hospital and I wanted to voice my support for expanding the 1332 waiver to include coverage of kidney transplantation for undocumented patients. At our institution, we care for a diverse array of patients in need, including those who are undocumented, and this legislation is essential for us to be able to provide the same quality of care for everyone. Please help us care for our patients who need kidney transplantation to enable a better quality of life for them and allow them to contribute fully to our community.
Best regards,
EB, MD

……..

#2

12/1/23

I am writing to you in support of the new changes enacted in the 1332 waiver application for increased equitable access of transplanted organs in New York City. As a current 4th year medical student at Mount Sinai, I cannot stress enough the importance of having equitable access to transplanted organs, especially for those in undocumented communities, who are in need and are unable to obtain one with the current legislation. I believe this bill will open doors for them and help them navigate a system that for the most part is not even in their native language. A transplanted organ can help so much and provide less burden in the long-term to the healthcare system. I've seen firsthand how patients build their lives around, for example, attending a dialysis center to receive emergency dialysis, when in reality a transplanted kidney could help them significantly more. Please consider this bill and give these communities an equal opportunity to live as their wealthier counterparts.

Best,

M

……..

#3

11/28/23

Hi,
I am a nephrologist and the medical director of a large dialysis unit in Manhattan. We are currently dialyzing a number of undocumented patients with emergency medicaid coverage. Many of these patients are relatively young and are doing fairly well on dialysis. They often remain on dialysis for many

years if not decades in some cases since their health tends to be better than the average patient with end stage renal disease. There is no hope for them to ever get off dialysis under the current rules. I find it illogical that they would receive coverage for one form of renal replacement therapy (dialysis) but not another (renal transplantation). From a purely financial standpoint, an undocumented patient on dialysis indefinitely (often over 10 years) will cost the medicaid system far more than transplantation. And from a compassionate standpoint, if we have decided that it is appropriate to keep them alive on dialysis this should also be extended to renal transplantation.
SS, MD

……..

#4

11/29/23

I am a social worker and support expanding the 1332 waiver to include undocumented people, because as a Social Worker I have seen firsthand how kidney disease impedes the quality of life and over all wellbeing of a person. Thus, it affects their ability to provide for themselves and their families.
I recall the story of a dialysis undocumented patient who solely supported his 3 young children, as his partner/ mother to his children walked out on them. This patient was greatly motivated by his family, however due to his illness and the straining side effects of dialysis he often had to miss work which affected his earnings, thus, hindered the ability to properly feed and shelter his family. This patient always dreamed about a transplant with the hopes he would regain some of his health so he can return to work and be able to properly care and live for his children. This story is one of many who with the Emergency Medicaid drain the medical system more than if they were granted the ability to receive an organ so they can regain health and continue to contribute to society.

PE-M, LMSW

……..

#5

11/25/23

To Whom It May Concern:

I am a Brooklyn, NY resident writing to ask that New York State include immigrants in New York State's 1332 waiver proposal. I personally do not benefit from this, as I am not an immigrant, nor are my children or parents. I am writing because so modifying the 1332 waiver proposal is the right thing to do. Besides the moral argument for providing health care for all, there is more than enough money in the estimated budget surplus to cover the estimated 150,000 undocumented immigrants who would apply and qualify for the Medicaid Essential Plan. Additionally, I believe the waiver proposal should include DACA recipients, regardless of the federal government's adoption of proposed federal regulations clarifying their eligibility for coverage. Since New York already pays for comprehensive Medicaid to DACA recipients with incomes below 138% of the federal poverty level out of state funds, this will save the state money. It will also provide coverage to DACA immigrants with incomes up to 250% of the federal poverty level.

Please do the right thing and amend the 1332 waiver proposal, and keep me informed of your progress. Thank you.

Sincerely yours,

TS

……..

#6

11/28/23

Dear SIr,
In NYS, I support coverage for kidney transplant for patients with emergency Medicaid as it is:
1. more cost effective that maintenance dialysis
2. offers a better quality of life and some patients are then able to return to work
Thank You,
AV, MD

……..

#7

12/5/23

Dear DOH,
I am a nephrologist who has taken care of many undocumented immigrants on dialysis for many years. Providing coverage for transplant is not only morally the right thing to do, it is also cost-effective.
Thank you,
EL, MD

……..

#8

11/30/23

I support the expansion of the Essential Plan as soon as possible.
The open marketplace insurance is set up to penalize the ill with copays and high deductibles.
If a family is in the 200-250% salary poverty range it will be difficult to get affordable healthcare. We need to
expand the essential plan asap. The cost of living has spiked and family's health is being affected.
There are studies regarding the recovery time of people who are ill and people who are ill coupled with financial stress. A double whammy.

If the essential plan is expanded, we will be protected and helping our entire community. We will be saving money for everyone because the families in the 200-250% poverty range will be able to seek doctor appointments at onset of illness and most likely prevent emergency room and hospital visits.
I support the expansion asap.

PK

……..

#9

11/28/23

I am a nurse, and I support expanding the 1332 waiver to include undocumented people because hemodialysis carries a significant risk of morbidity and mortality. This increased disease risk affects individual patients, patient families, and the general population.
JA, BSN, RN, CCTC

……..

#10

11/29/23

Hello,
I am a social worker at Mount Sinai Hospital in NY and support expanding the 1332 waiver to include undocumented people because transplantation is a means to improve people's overall health and quality of life. All people in USA should has access to this opportunity regardless of immigration status.
Thank you,
LZ, LCSW

……..

#11

11/29/23

I am a social worker writing to support expanding the 1332 waiver to include kidney transplantation. Kidney transplants are life saving measures that should be available to all those who qualify. An expansion of services would be a godsend to families who otherwise feel trapped by their options.
MHA, LMSW