

CLOSING THE HEALTH INSURANCE AFFORDABILITY GAP: TWO OPTIONS FOR CONNECTICUT

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Connecticut has a strong history of working to make health care coverage affordable and accessible to its residents. Yet while significant gains have been made, coverage remains unaffordable to many, including some of the state's lowest-income families. As a result, Connecticut residents earning just above the poverty level are at high risk of poor health outcomes and medical debt. The COVID-19 pandemic is almost certain to increase the number of people balancing health care costs against other urgent expenses, heightening the imperative to develop more affordable coverage options for Connecticut residents least able to afford coverage.

THE CHALLENGE: AFFORDABLE COVERAGE FOR THE NEAR-POOR

Individuals with incomes between 100% and 200% of the federal poverty level (FPL) made up 13% of Connecticut's population, but 26% of the state's uninsured residents in 2018; approximately 48,000 people in this income range were uninsured.¹ Among this income group, those earning just above the Medicaid eligibility levels (138% of FPL for childless adults and 160% of FPL for parents) are hardest hit by affordability challenges and are the focus of this paper. For a single individual, this is the equivalent of earning between approximately \$17,600 and \$25,000 annually, or about \$12 an hour at a full-time job. At that wage level, expenses related to housing, utilities, food, and transportation leave little room to pay a monthly health care premium. (See Figure 1 for more information about income ranges and uninsured rates in Connecticut.)

Figure 1. Health Coverage Landscape by Monthly Income Level and Household Status in Connecticut⁵

Income Level	Childless Adults*		Parents		Percent of CT Population ⁶	Percent of CT's Uninsured ⁷
	Coverage Available	Monthly Income for Individual at Upper Limit	Coverage Option	Monthly Income for Family of 4 at Upper Limit		
<100% FPL	Medicaid	\$1,063	Medicaid	\$2,183	10%	17%
100–138% FPL	Medicaid	\$1,467	Medicaid	\$3,013	13%	26%
139–160% FPL	Exchange with subsidies	\$1,701	Medicaid	\$3,493		
161–199% FPL	Exchange with subsidies	\$2,116	Exchange with subsidies	\$4,345		
200–399% FPL	Exchange with subsidies	\$4,243	Exchange with subsidies	\$8,712	23%	31%
≥400% FPL	Exchange, no subsidies	Above \$4,253	Exchange, no subsidies	≥\$8,733	53%	26%

*For Medicaid eligibility purposes, “Childless Adults” includes individuals with adult children and those not living with their children.

Focus of This Report

The high level of uninsurance among people between 100% and 200% of poverty is generally not the result of a lack of coverage options, but rather a lack of affordable coverage choices for people above Medicaid eligibility levels.² Individuals who are not eligible for Medicaid can buy coverage on Connecticut’s health insurance exchange, Access Health CT. That coverage is subsidized, but still costly for these low-income residents:

- At 139% of poverty, a single individual earns \$1,478 monthly and would pay, on average, monthly premiums of \$56 for the most commonly selected plan.³ Some insurance plans have lower premiums but a significant deductible while others have higher premiums but no deductible;
- At 200% of poverty, a single individual earns \$2,127 monthly and would pay, on average, \$143 in monthly premiums for the most commonly selected plan, with an annual deductible of \$650.⁴

Research shows that monthly premiums can deter low-income individuals straining to meet their basic needs from enrolling in health care coverage.⁸ These findings are particularly relevant to Connecticut, which is one of the costliest places to live.

- In 2018 Connecticut ranked eighth across states for cost of living, leaving the near-poor in this state particularly cost-sensitive when it comes to affording health coverage.⁹

- Analyses have shown that people in Connecticut must have incomes well above the federal poverty threshold just to meet their basic needs, including housing, childcare, food, transportation, and taxes, as well as to afford health care and other items.¹⁰

The cost of coverage can be a particular issue for individuals who lose Medicaid eligibility when their income rises due to a new job or a wage increase; these individuals are exposed to a significant jump in cost for coverage (and out-of-pocket costs when they get care) even with subsidized exchange insurance.¹¹ This situation is especially relevant for Connecticut, since the hourly minimum wage is slated to rise from \$12 to \$15 incrementally by 2023; the increase will push many individuals above Medicaid eligibility levels. The approaches discussed here could smooth out this “cliff,” helping to preserve the value of the wage increase for low-income families while avoiding an unintended rise in the uninsured rate for the near-poor.

THE SOLUTION: AFFORDABILITY OPTIONS TO PROMOTE COVERAGE

This issue brief offers a starting point for considering ways to promote coverage and improve equity for low-income people in Connecticut. It presents two main policy options that Connecticut could adopt—separately or in combination—to improve the affordability of health

insurance and increase access to care for Connecticut residents with incomes below 200% FPL:

1. Building on Medicaid to offer affordable coverage to more people, and

2. Providing additional subsidies to help make insurance plans sold through the exchange more affordable.

While initiatives to reduce Connecticut's uninsured rate will require state investment, over time they offer substantial benefits to the state by promoting a healthier workforce and contributing to its tax base. Ensuring stable coverage can also bolster efforts to lower overall health care costs, since gaps in coverage often lead to delayed and more expensive care down the line. In addition, addressing uninsurance among low-income parents could help improve coverage—and the health status—of their children.¹²

The sections that follow provide:

- An overview of the health coverage and uninsurance landscape in Connecticut;
- Key considerations for the state as it contemplates affordability options;
- A detailed look at and comparison of two promising coverage expansion options; and
- A brief overview of additional affordability options.

CONNECTICUT'S HEALTH CARE COVERAGE LANDSCAPE

CURRENT COVERAGE LANDSCAPE

In 2018, slightly more than half of Connecticut residents (54%) were covered through their employer—higher than the national average of 49%. An additional 21% of state residents were covered through Medicaid, which is on par with the national average in 2018; the share has risen since then.¹³ In 2018, 5% of the state's population was covered in the non-group (or individual) market; according to state-level data from 2020, Access Health CT covers nearly 110,000 of those, or 3% of the state's residents. Medicare and the military's TRICARE insurance also cover state residents.¹⁴

THE UNINSURED IN CONNECTICUT

Of Connecticut's more than 3.5 million residents, nearly 190,000 were uninsured in 2018; this results in a state uninsured rate of about 5%, which is on par with the average across New England but lower than the national average.^{15,16} Approximately 48,000 of Connecticut's

uninsured residents in 2018 had incomes between 100% and 200% FPL,¹⁷ accounting for a quarter of the state's uninsured population even though this income range makes up just 13% of the state's population.¹⁸ Some of these uninsured individuals are eligible for Medicaid—childless individuals with income under 138% FPL and parents earning less than 160% FPL. People earning above those levels are likely to be eligible for subsidized coverage through Access Health CT.

Even before the COVID-19 pandemic, the uninsured situation in Connecticut was worsening. Multiple data sources—which look at different and sometimes overlapping segments of the low-income population—indicate an increase in uninsured levels among those not eligible for Medicaid.

- The number of uninsured individuals in Connecticut with incomes between 100% and 199% of the FPL increased from 36,300 (10% of individuals in this income range) in 2016 to 48,000 (13%) in 2018; this group includes both Medicaid and marketplace-eligible individuals.¹⁹ For individuals between 139% and 250% of the FPL (a group that includes many adults not eligible for Medicaid), the number of uninsured grew from approximately 42,000 to 48,000 people during the same period.
- Between 2016 and 2018, for people with incomes between 139% and 250% of the FPL, employer coverage declined by approximately 6,700 and enrollment in individual market coverage (both on and off-exchange) dropped by approximately 7,400.
- During this same period (2016-2018), the share of individuals between 139% and 250% of the FPL who were covered by Medicaid grew modestly (from approximately 128,500 to 132,000), suggesting that the drops in coverage noted above have mostly occurred among those with incomes above Medicaid eligibility levels.

Looking ahead, Connecticut's uninsured rate for the near-poor is almost certain to rise: Since the start of the COVID-19 pandemic, more than 400,000 state residents have filed for unemployment.^{21,22} Some people losing jobs and job-based coverage will qualify for Medicaid, while others will have family incomes that put them over Medicaid eligibility limits, and their sudden loss of income will mean a diminished ability to pay premiums. **Recent estimates suggest that the uninsured rate in states like Connecticut that have expanded Medicaid will grow by 12% on average and that an additional 36,000 to 77,000 state residents may become uninsured as a result of the COVID-related economic downturn.**²³ Those with the least ability to afford new coverage will be the people with incomes below 200% FPL but above the Medicaid threshold.

EXISTING COVERAGE OPTIONS FOR LOW-INCOME STATE RESIDENTS

For low-income people who are not covered through an employer, the primary sources of coverage are Medicaid and private insurance purchased through Access Health CT.

MEDICAID COVERAGE IN CONNECTICUT

Most of the lowest-income state residents are eligible for coverage through HUSKY, Connecticut’s Medicaid program. Connecticut has a strong history of using Medicaid to provide comprehensive health coverage to low-income residents. According to monthly data reported to the federal government, Connecticut’s Medicaid program currently covers approximately 848,000 people in Connecticut, or about one out of four state residents.²⁴

Before the Affordable Care Act (ACA), federal Medicaid rules allowed states considerable flexibility to cover parents but not childless adults. The ACA created a new eligibility pathway and enhanced federal matching funds for states to expand coverage to all adults (subject to immigration requirements) up to 138% of FPL (currently \$1,467 monthly for an individual). Connecticut had already expanded coverage for parents before the ACA but it was the first state to begin implementing the ACA coverage expansion for other adults.

Over the years, Connecticut made several changes to its Medicaid parent eligibility levels. Before the ACA, parents could qualify for Medicaid in Connecticut if they earned up to 201% FPL. After Access Health CT began offering insurance in 2014, state lawmakers reduced eligibility for this group to 155% FPL, reasoning that parents above that income level could buy coverage through the exchange. However, few parents who became ineligible for HUSKY

signed up for exchange insurance.²⁵ Since then, lawmakers have raised the Medicaid eligibility limit for parents; as of October 2019, it is 160% FPL.²⁶ For adults in a family of four, that equates to a Medicaid income limit of \$3,493 per month (Figure 2). Because of their low incomes, the state does not charge Medicaid enrollees premiums or impose deductibles or cost-sharing.²⁷

EXCHANGE COVERAGE IN CONNECTICUT

Access Health CT is a marketplace for private insurance plans. State residents can qualify for federal financial assistance to buy insurance through Access Health CT if they do not qualify for Medicaid or Medicare and do not have access to affordable insurance through a job.²⁹ The federal subsidies, which take the form of tax credits, are available to those with incomes below 400% FPL (or \$8,733/month for an individual). People with incomes below 250% FPL are eligible to buy plans with lower cost-sharing.

In February 2020, enrollment in Access Health CT was approximately 110,000; at the time, 21% of state residents enrolled in Access Health CT earned between 139% and 200% of poverty (Figure 3).³⁰ As of June 2020, enrollment already had grown by 37,000 during the COVID-19 pandemic.^{31,32}

COSTS OF ACCESS HEALTH CT COVERAGE

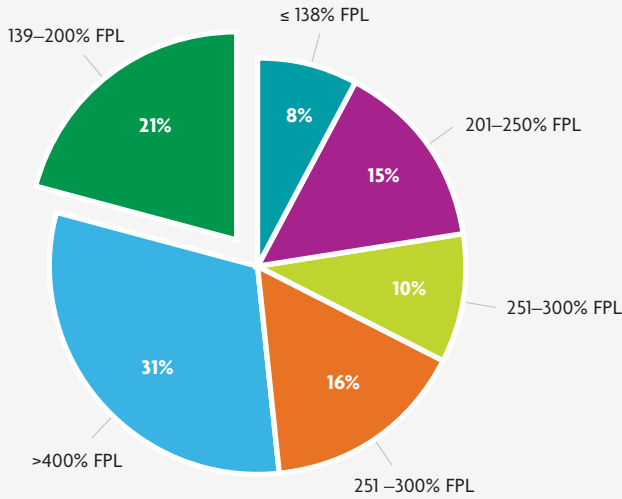
People who enroll in Access Health CT have different costs depending primarily on their income, age, where they live, and the plan they select.³⁴ Tax credits established by the ACA to help lower premiums are available to individuals with income under 400% FPL on a sliding-scale basis. Approximately half of households enrolled in Access

Figure 2. Medicaid and Children’s Health Insurance Program (CHIP) Eligibility by Population and Monthly Income in Connecticut as of October 2019²⁸

Because the Medicaid eligibility limit for children is higher than for parents, in some families, children receive Medicaid coverage while their parents do not. CHIP—known as HUSKY B in Connecticut—is available to children whose family incomes are too high for Medicaid.

Population	Eligibility Limits	Monthly Income Equivalents	Annual Income Equivalents
Medicaid for Children (0-19)	<201% FPL	Family of Four: <\$4,389	Family of Four: <\$52,662
CHIP for Children (0-19)	201-323% FPL	Family of Four: \$4,389 – \$7,052	Family of Four: \$52,662 – \$84,626
Medicaid for Pregnant Women	≤263% FPL	Family of Two: ≤\$3,778	Family of Two: ≤\$45,341
Medicaid for Parents	≤160% FPL	Family of Four: ≤\$3,493	Family of Four: ≤\$41,920
Medicaid for Childless Adults (19-64)	≤138% FPL	Single Individual: ≤\$1,467	Single Individual: \$17,609

Figure 3. Access Health CT Exchange Participation, by FPL (2020)³³



Health CT qualify for tax credits that cover 80% or more of the cost of their premium.³⁵ People with incomes under 250% FPL also qualify for cost-sharing subsidies if they choose a silver plan on the exchange.

For individuals buying coverage through Access Health CT who have incomes between 139% and 200% of the FPL, the average monthly premium for the benchmark silver plan ranges from \$56 to \$143, respectively.³⁶ (The benchmark silver plan refers to the second-lowest cost silver plan offered by Access Health CT; individuals who are eligible for the federal cost-sharing subsidies if they do not enroll in silver coverage.)

Out-of-pocket costs also vary based on people's income levels, based on differing levels of subsidies that can lower deductibles and other cost-sharing. For example:

- Individuals with incomes between 139% and 150% of poverty do not have annual deductibles and have their annual out-of-pocket spending capped at \$900.³⁷
- Individuals with incomes between 150% and 199% of poverty who enroll in a silver plan also have reduced annual deductibles of \$650, and have their out-of-pocket spending capped at \$2,500.
- Individuals with incomes at 200% FPL who enroll in a silver plan have annual deductibles of \$3,950 and have their out-of-pocket spending capped at \$6,500.³⁸

To put these sums in context, a single individual with an income of 200% FPL earns \$25,520 (before taxes) annually, or \$2,127 monthly. If they faced average premium and deductible costs for the benchmark plan, approximately 22% of their annual income would be dedicated to health care.³⁹

Figure 4 provides additional examples of average health care coverage costs for those earning up to 200% FPL using statewide average costs for an individual and a family purchasing the benchmark 2020 silver plan through Access Health CT. Actual costs would vary across the state.

Given the share of income for health care costs on the exchange, and how difficult it is for someone in this income range to stretch their budget to meet basic needs other than health care, it is not surprising that many in this income range go without coverage. The cost of living in Connecticut is particularly high.

Figure 4. Illustrative Example of Average Access Health CT Health Care Costs in 2020 for the Benchmark Silver Plan⁴⁰

Income by FPL	139% FPL		165% FPL		200% FPL	
	Single	Single	Two Parents in a Family of Four	Single	Two Parents in a Family of Four	Two Parents in a Family of Four
Monthly Income	\$1,478	\$1,755	\$3,603	\$2,127	\$4,367	\$4,367
Annual Income	\$17,736	\$21,054	\$43,200	\$25,520	\$52,400	\$52,400
Monthly Premium After Subsidies	\$56	\$91	\$184	\$143	\$295	\$295
Annual Premium After Subsidies	\$672	\$1,092	\$2,208	\$1,716	\$3,540	\$3,540
Annual Deductible	\$0	\$650	\$1,300	\$3,950	\$7,900	\$7,900
Health Care Spending as a Percentage of Income	4%	8%	8%	22%	22%	22%

For example:

- A family of four—two adults and two young children—residing in New Britain face monthly housing, childcare and food costs that total close to \$3,700 as calculated by the Connecticut Office of Health Strategy.
- This leaves little room for a family of this size earning a monthly income of \$4,236 (i.e., 200% FPL) to pay monthly subsidized premium costs of approximately \$295 or to afford to actually seek care when they must meet an annual deductible of \$1,300 before coverage kicks in.
- Their monthly income falls far short of the projected \$6,056 monthly income that is needed to meet all of their basic needs.⁴¹

AFFORDABILITY OPTIONS TO PROMOTE COVERAGE

Connecticut could consider multiple options to increase affordability of coverage and care for state residents with incomes below 200% FPL, leveraging either Medicaid or the exchange. Two approaches appear to be particularly well-suited to Connecticut's coverage landscape:

- Increasing Medicaid eligibility for adults
- Providing a state-sponsored subsidy for exchange coverage to supplement the federal subsidy

Each of these options could effectively address affordability issues for Connecticut residents. They could also be employed in combination.

KEY CONSIDERATIONS FOR CONSUMERS, THE STATE, AND HEALTH CARE PROVIDERS

As policymakers consider options for affordability, it is important to recognize the tradeoffs involved in any changes to the health care system. Affordability options often impact consumers, the state, and health care providers in different ways.

The cost of health care coverage—and by extension, affordability—is largely determined by the prices paid to health care providers for delivering care, the level at which the government subsidizes the cost of care or coverage, and the level of risk in the insurance pool – that is, the health needs and costs likely to be incurred by the people covered.

Any changes to coverage for people in the 138% to 200% FPL income range could have implications for the Access Health CT risk pool. As with any insurance risk pool,

individuals enrolled in Access Health CT who are low-risk help to offset the cost of health insurance for higher-risk individuals. Coverage options that significantly change the current Access Health CT risk pool by pulling individuals out of the exchange—such as by expanding eligibility for Medicaid—could affect costs for those still in the exchange, depending on whether those who remain are healthier or sicker. If healthier individuals leave the exchange, the cost of covering remaining enrollees will increase, but if less-healthy individuals leave exchange coverage, exchange costs for those who remain could go down.

Options that increase the affordability of exchange coverage—such as by supplementing the federal subsidy—could also affect enrollment. These options would likely attract new individuals to the marketplace, and the impact on costs depends on whether the new individuals are healthier or less-healthy compared to the current risk pool.

Understanding these interactions is critical to assuring that an affordability solution for those under 200% FPL does not have the unintended consequence of increasing the cost of Access Health CT coverage for those with incomes over 200% of FPL, who make up approximately 80% of Access Health CT enrollees.^{42,43} The direction of the impact is not clear. Research in other states has shown that the risk profile of low-income individuals is mixed.⁴⁴ To fully determine how any option will impact the Access Health CT risk pool and costs, an actuarial risk profile assessment would be necessary.

Other considerations include the federal authority, if any, necessary to implement the option, the potential costs to the state, provider rates, and the extent to which options address uninsurance among immigrants. (*See Appendix A for more detail.*) Immigrants, including lawfully present and undocumented immigrants, account for 7% of the country's population, but 24% of the country's non-elderly uninsured because they face a number of barriers to coverage including eligibility restrictions for Medicaid, CHIP, and exchange coverage.⁴⁵ Affordability options that rely on federal funding must follow federal rules that restrict some lawfully present immigrants' eligibility for coverage during their first five years in the country, making those options less effective in addressing affordability concerns for some immigrants in Connecticut. In addition, recent federal rules related to "public charge" also may be causing some immigrants who are eligible for coverage to decide not to enroll due to concerns about how enrolling might affect their eligibility for a green card.⁴⁶

OPTION 1: MEDICAID “XX” GROUP

Federal law requires states to provide Medicaid to certain populations—such as children and very low-income parents—and allows states to cover other groups on an optional basis. Connecticut’s current coverage is a mix of required coverage and optional groups. For example, it has already opted to cover parents up to 160% of the FPL.

Connecticut could continue along this path by extending Medicaid to additional low-income adults for whom marketplace costs can be unaffordable.

Connecticut has the flexibility to do this under federal Medicaid law, taking advantage of a new optional eligibility group that was established by the ACA and referred to as the “XX” Group because the authority is established by Section 1902(a)(10)(A)(ii)(XX) of the Social Security Act. Key features are as follows:

- States have flexibility to set the upper income level for the group. For example, Connecticut could raise eligibility levels for childless adult levels to the same level as parent coverage in the state (160% FPL), or boost both childless adult and parent coverage up to 200% FPL or some lower level.⁴⁷
- Half of the cost would be covered by the federal government (consistent with most Medicaid groups in Connecticut).
- The state could adopt the new coverage category relatively easily by submitting a Medicaid State Plan Amendment and then using its existing Medicaid eligibility systems to implement the coverage. No waiver is required.
- Because they would be eligible for Medicaid, individuals eligible for the XX Group would no longer be eligible for subsidized coverage through Access Health CT.

CONSIDERATIONS: IMPACT ON STATE RESIDENTS

Individuals newly eligible for Medicaid under the XX Group would experience the most positive impacts as they gain access to a comprehensive array of benefits at little, or even no, cost. By raising the Medicaid eligibility income ceiling, the XX Group also could:

- Simplify health care coverage for low-income families by aligning eligibility for many more parents and their children.
- Prevent coverage losses among those individuals just above poverty who are likely to move back and forth between Medicaid and exchange eligibility as their income fluctuates.

Individual Costs. XX Group coverage would be more affordable for consumers than Access Health CT coverage. Connecticut does not impose premiums or co-payments on any Medicaid populations, but does impose limited premiums and cost-sharing for CHIP beneficiaries.⁴⁸

Benefits. Individuals eligible for Medicaid through the XX Group would have access to the full array of Medicaid benefits. The current Medicaid benefit package is comparable to exchange coverage but also includes coverage of dental care and non-emergency medical transportation.⁴⁹

Exchange Stability & Affordability. Adopting the XX Group would disrupt the Access Health CT risk pool to some degree because individuals who are eligible for the XX Group would not be eligible for exchange coverage. The magnitude of the impact—and its effect on costs for those who remain in the exchange—will depend on the eligibility parameters for the XX Group and their health status. For example, if the state extends Medicaid coverage to all individuals between 138 and 200% FPL, approximately 20% of enrollees in Access Health CT would be diverted to Medicaid coverage.⁵⁰ If the state were to adopt the XX Group only for childless adults between 139% FPL and 160% FPL, there would be less displacement of Access Health CT coverage. There are approximately 6,000 Access Health CT enrollees in this income band, or about 6% of Access Health CT enrollees.⁵¹ Further analysis is necessary to determine what impact any changes would have for the remaining risk pool.

Immigrant Considerations. Consistent with longstanding federal law, many lawfully present immigrants must wait five years before they are eligible for Medicaid coverage.⁵² Adopting the XX Group would not significantly improve coverage for immigrants. For the relatively small segment of lawfully present immigrants who might qualify for the new XX Group, Medicaid coverage under the XX Group would count in a public charge determination, which could deter some immigrants from enrolling.

CONSIDERATIONS: IMPACT ON PROVIDERS

If the state adopts the XX Group, health care providers would be reimbursed using standard Medicaid fee-for-service rates, which are lower than reimbursement rates from commercial insurance plans, including those sold through Access Health CT. Providers that serve both Medicaid and exchange enrollees could experience decreased revenue for some current patients if enrollees move from exchange to Medicaid coverage. However, providers also would realize additional revenue as previously uninsured individuals obtain coverage. Additional modeling is needed to quantify the magnitude of impact.

OPTION 2: SUBSIDIES FOR EXCHANGE COVERAGE

Connecticut could elect to make the existing exchange coverage more affordable by creating its own subsidies for those who buy insurance through Access Health CT.

Because Connecticut operates a state-based exchange using its own technology platform, the state could relatively easily implement this option.

Federal exchange subsidies (i.e., the tax credits and cost-sharing reductions that lower costs for low- and middle-income enrollees) set a floor, not a ceiling, and states can bolster these subsidies with their own funds.⁵³ New Jersey and California recently enacted legislation to implement state-funded premium assistance programs for residents.

- New Jersey recently established a state subsidy program for residents with incomes below 400% FPL funded by an annual assessment on health insurers, to be implemented in 2021.^{54,55}
- California began implementing a sliding scale state-funded premium assistance program for residents with incomes between 138% and 600% of the FPL in 2020.⁵⁶

Key features are as follows:

- Connecticut would have broad latitude to set both the eligibility levels at which subsidies would apply (e.g., for individuals somewhere between 138% and 200% FPL, above 200% FPL, or even for people over 400% FPL who do not qualify for federal subsidies), as well as the amount of subsidy.
- The state could scale its subsidy levels in light of available funding and could adjust the levels annually, though state statutory or regulatory changes may be necessary depending on how the subsidy is authorized.
- Federal approval is not needed to implement exchange subsidies that are funded entirely through state dollars.
- If the state wanted to seek federal financing, either a Section 1115 or 1332 waiver would be required. Federal approval is discretionary and so is not guaranteed. (*Text Box 1 describes Section 1115 waivers that have authorized federal Medicaid funding for subsidies. See Appendix B for more information about both Section 1115 and 1332 options.*)

TEXT BOX 1. HOW MASSACHUSETTS AND VERMONT FUND EXCHANGE SUBSIDIES

Two states use federal financing to increase the affordability of exchange coverage, under Medicaid Section 1115 demonstrations. Both of these states offered subsidized private market coverage for individuals before the ACA was implemented and the waivers effectively continue these policies. These states, which have a long history of working to expand and improve affordability of coverage, have two of the lowest uninsured rates in the country across all state residents and among those with incomes below 200% FPL.⁵⁷

Massachusetts: The state's ConnectorCare Health Plans sold through the exchange offer subsidized coverage on a sliding scale to state residents with incomes up to 300% FPL. In 2020, qualifying residents are eligible for subsidized monthly premiums ranging from \$0 to \$130 depending on their incomes.⁵⁸ The state's MassHealth 1115 demonstration allows the Commonwealth to claim Medicaid matching funds for some of these state-funded premium subsidies.⁵⁹

Vermont: The Vermont Premium Assistance program provides subsidies to state residents with incomes up to 300% FPL. Vermont's 1115 demonstration authorizes the state to claim federal Medicaid matching funds for these premium subsidies.⁶⁰

Both of these waivers were approved under previous federal administrations. The current administration is not likely to approve similar waivers moving forward; a future administration may be more willing to work with states to subsidize coverage.

CONSIDERATIONS: IMPACT ON STATE RESIDENTS

Improving subsidies for low-income individuals can increase enrollment in exchange coverage and reduce the uninsured rate.⁶¹ An analysis of Massachusetts' subsidy program (*Text Box 1*) found that reducing monthly premiums by about \$40 increased enrollment in exchange coverage among eligible individuals by 14% to 24%, with larger impacts seen at lower incomes.

Individual Costs. Premium subsidies would reduce Access Health CT premiums, with the amount of the reduction determined by the state. Connecticut would have the discretion to set the parameters and could establish a sliding scale of subsidies based on income. Evidence suggests that consumers are highly sensitive to premium costs when choosing health care coverage.⁶³ Connecticut could also decide to meet its affordability goals by reducing deductibles or cost-sharing for low-income families.⁶⁴

COMPARING THE COST OF THE MEDICAID XX GROUP AND EXCHANGE SUBSIDIES

While modeling is needed to estimate the costs of adopting the XX Group and the exchange subsidies options, some general principles can inform the analysis.

First, state spending on the XX Group would be matched by the federal government at 50%, without need for a federal waiver.⁶⁶ By comparison, the state would bear the entire cost of exchange subsidies unless it was granted a federal waiver (*see Appendix B*). However, even with the guaranteed federal matching funds for the Medicaid approach, the residual state cost of coverage for XX Group enrollees would be higher than the state cost of the premium subsidy approach (even without a federal waiver).

XX Group. In the fourth quarter of 2019, the average Medicaid per-member per-month cost for childless adults in Connecticut totaled \$618; the average cost of covering a childless adult for a full year would have been approximately \$7,400.⁶⁷ With a 50% federal matching rate, the state could therefore assume an annual cost of \$3,700 per person enrolled in the XX Group, trended forward to account for rising costs.

Exchange Subsidies. After federal subsidies, Access Health CT premiums for individuals with incomes between 139% and 200% FPL who select the benchmark silver plan range from \$56 to \$143 per month, or \$672 to \$1,716 per year. The state could choose to pay some or all of these average premiums.

The costs or projected costs from other states can provide perspective about the scale of possible spending if Connecticut pursued exchange subsidies, although state approaches differ, making precise comparisons difficult:

- Massachusetts, which receives federal funding for a portion of its subsidy program (*see Text Box 1*), spent \$155.6 million on state-funded premium and cost-sharing subsidies in 2019 for 216,249 residents with incomes below 300% FPL, or \$720 on average per resident in this income bracket. Depending on their incomes and plan enrollment, these individuals paid monthly premiums ranging from \$44 to \$323, after subsidies in 2019.⁶⁸
- New Jersey expects to generate \$147 million in funding to support its subsidy and estimates an average monthly subsidy of at least \$47 for an individual and at least \$188 for a family of four.⁶⁹

In Massachusetts, reducing monthly premiums by about \$40 increased enrollment in exchange coverage among eligible individuals by 14% to 24%.

Benefit Package. Exchange subsidies would support the purchase of existing exchange coverage through private insurance plans, so the covered benefits would not change.

Exchange Stability & Affordability. Compared to the XX Group, which would shrink the exchange's risk pool, subsidies would be expected to increase enrollment in the exchange by making Access Health CT coverage more affordable to lower-income adults. Increased subsidies would likely lead individuals who are, on average, healthier and lower-cost than current Access Health CT enrollees to sign up for coverage, which would strengthen the exchange risk pool, reducing premiums for all enrollees, including for those who do not qualify for subsidies. (Individuals with significant health needs are likely to be more inclined to purchase coverage despite affordability concerns, so are more likely to already be in the risk pool.) Additional analysis is necessary to determine the magnitude of any such effects.

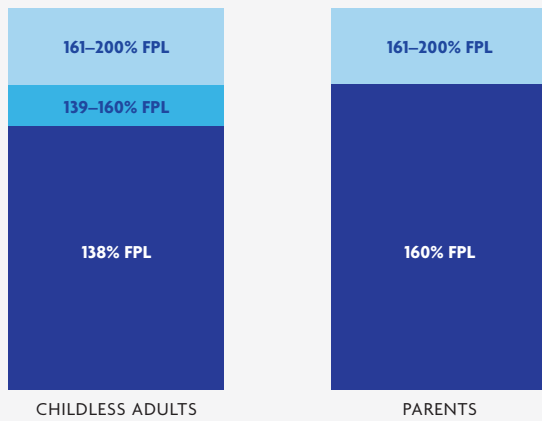
Immigrant Considerations. A state-funded subsidy would not result in changes in eligibility or public charge considerations for immigrants. If the state pursues a Section 1115 Medicaid waiver to cover a portion of the cost of the subsidies, the federal match would not be available for immigrants who are still subject to the five-year bar.⁶⁵

CONSIDERATIONS: IMPACT ON PROVIDERS

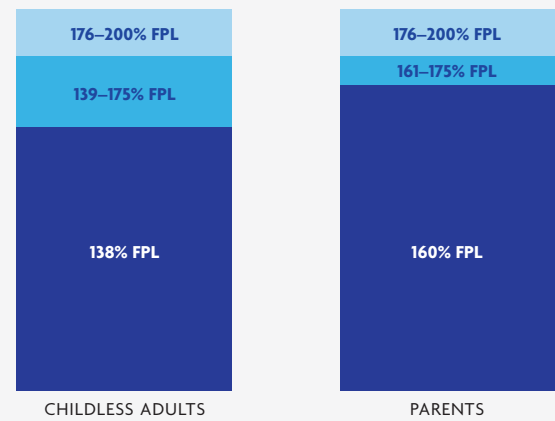
Exchange subsidies would not impact the provider reimbursement rates negotiated by Access Health CT plans, although providers could realize additional revenue if currently uninsured individuals enroll in exchange coverage.

Figure 5. Stacking Optional XX Group and Exchange Subsidies for Residents with Incomes Up to 200% FPL

Scenario 1: Medicaid XX Group Covers Childless Adults Up to 160% FPL and Exchange Subsidies Cover Individuals 161-200% FPL



Scenario 2: Medicaid XX Group Covers Individuals Up to 175% FPL and Exchange Subsidies Cover Individuals 176-200% FPL



■ Current Medicaid Eligibility Levels ■ Optional XX Group Eligibility Levels ■ Exchange Subsidies Eligibility Levels

- California authorized \$295 million for subsidies for the 2020 plan year to assist an estimated 922,000 state residents—\$320 on average per qualifying resident—and calculates the amount of the subsidy to the expected premium range for each household’s income level.^{70,71}

Both the XX Group and exchange subsidy options are scalable and could be adjusted annually, or as needed, to reflect available state funding.

- XX Group.** The state could adjust income eligibility levels for the group, as needed, based on available state funding by submitting a Medicaid State Plan Amendment.⁷² The state could also phase in the coverage under this option, gradually increasing income eligibility based on available state resources.
- Exchange Subsidies.** The state could adjust subsidy amounts based on state budget availability as well, and could provide different amounts of subsidies to people at different incomes. For example, the state could assume the full premium cost for individuals at 139% FPL and only 50% subsidies for people closer to 200% FPL.

The next section discusses how the two options could be used together, which could help the state manage its costs while targeting different solutions to different segments of the uninsured population.

A HYBRID APPROACH: TIERED ADOPTION OF XX GROUP AND EXCHANGE SUBSIDIES

The optional XX Group and state-sponsored exchange premium subsidies for Access Health CT coverage can be used together to design affordable coverage options for low-income residents in Connecticut. The state could expand Medicaid eligibility using the XX Group option for some portion of near-poor adults and provide subsidies for exchange coverage for those with incomes above the XX Group limit. For example:

- The state could simplify Medicaid eligibility and make it uniform for adults—parents and those without minor children—by using the XX Group to bring eligibility for childless adults to 160% FPL. It could then enhance affordability for those above 160% FPL by providing subsidies for exchange coverage for those with incomes up to 200% FPL (see Scenario 1 in Figure 5).
- Alternatively, the state could opt to enroll all adults in Medicaid up to, for example, 175% FPL and then provide additional subsidies for all individuals between 175% and 200% FPL (see Scenario 2 in Figure 5).

ADDITIONAL AFFORDABILITY OPTIONS

Medicaid expansion and exchange subsidies are not the only options for affordability, although they might be the most feasible for Connecticut. The state could also consider two other options, a Medicaid buy-in/public option, or a Basic Health Program.

Public Option/Buy-in. States across the country are considering various “public option” or “buy-in” approaches; one state (Washington) has adopted such an approach. While these terms are often used interchangeably, they can refer to different program-design approaches and may address different goals. A public option generally refers to a state-sponsored plan that mirrors traditional insurance, which might be offered by a third-party administrator or private insurance carrier. In slight contrast, a buy-in describes a coverage option that leverages an existing coverage program, such as Medicaid or the state employee health plan, to make a new product available to consumers who otherwise are not eligible for that program. For the purposes of this issue brief, the terms are used together to describe a model where the state offers either an insurance plan or Medicaid-like coverage option either on or off the exchange to those currently ineligible for Medicaid or Medicare. No waiver is needed if the plan is offered on the exchange and follows all rules for exchange plans. A waiver would, however, be needed if the state wanted to deviate from rules that apply to plans offered on the exchange and/or capture some of the federal savings that result from offering a lower-priced option. For example, an on-exchange buy-in product that has a lower premium than current plans—which may be difficult to design without paying lower provider rates—is likely to result in lower federal subsidies for exchange plans, thus reducing aggregate federal costs. The state could apply for a Section 1332 waiver to access those “pass through” savings. Such savings could then be reinvested to benefit tax-credit-eligible individuals by increasing the subsidies available to them. Connecticut considered a buy-in option in 2019 but did not adopt it.⁷³

The Basic Health Program (BHP). The Basic Health Program was created by the ACA as an alternative to exchange coverage for individuals with income between 138% and 200% FPL.⁷⁴ BHP allows states to improve continuity of care for individuals whose income fluctuates above and below Medicaid levels. BHP benefits must include at least the covered health benefits required under the ACA, and monthly premium and cost-sharing cannot exceed what eligible individuals would have paid for

insurance coverage on the exchange. The federal government makes prospective payments to a state that equal 95% of the tax credits and cost-sharing reductions that eligible BHP enrollees would have received if they enrolled in a health plan offered on the exchange. States receive funding on a per capita basis.

BHP is a state option, not a waiver, so approval is not discretionary, though some negotiation may be required to work through the particulars of the financing. (States must submit a “BHP Blueprint” to the federal government and get federal approval that the blueprint is consistent with federal rules.) BHP, however, must be delivered through managed care plans, which makes it a less viable option for Connecticut since the state does not have a Medicaid managed care delivery system and may be reluctant to set up a new program that relies on managed care.

TEXT BOX 2. DELIVERY SYSTEM REFORM ALSO COULD HELP REDUCE COSTS OF COVERAGE IN CONNECTICUT

Consumers’ health care costs are tied to the overall cost of health care in Connecticut. Therefore, delivery system reform strategies intended to lower health care costs—such as Connecticut’s multi-payer reform proposals—also could impact affordability. In January 2020, Governor Ned Lamont issued an executive order requiring the state to develop to annual health care cost benchmark that would require all health insurers, hospitals, and other health care providers to meet a fixed rate of cost growth. The executive order also directs the state to set targets for increased primary care spending as a percentage of total health care spending; develop quality benchmarks for all health insurers; and monitor accountable care organizations and the take-up of alternative payment models.⁷⁵ Similarly, implementing affordability solutions that increase the number of insured people in the state will create a stronger foundation of coverage, improve population health, and contribute to successful cost control efforts.

COMPARING AFFORDABILITY OPTIONS

Figure 6 (page 12) provides an overview of how the three options described in this brief compare across several key dimensions. (Because of the managed care requirement, the BHP option is not analyzed in this table.)

Figure 6. Overview of Three Primary Affordability Options

	Optional Medicare XX Group	Exchange Subsidies	Public Options/Buy-In
What it Does	Expands Medicaid to higher income levels	Reduces costs for those buying coverage through the exchange	Creates new state-sponsored insurance product
Federal Authority	State option, authorized through a Medicaid state plan amendment	No federal approval needed unless state seeks federal funding, which would require Section 1115 or 1332 waiver approval	Federal certification needed so that premium subsidies are available, potentially in combination with a 1332 waiver, depending on design
Income Level	138% and above, with upper limit determined by the state	138% and above, with upper limit determined by the state	138% and above
Available to Lawfully Present Immigrants Subject to 5-year Bar	No (Eligible lawfully present immigrants would be able to enroll after five years in the country)	Yes (If federally funded, may not be available, depending on design)	Yes
Delivery System	Medicaid (currently fee-for-service)	Access Health CT plans	Managed care or fee-for-service/TPA
Individual Out-of-Pocket Costs	No cost unless state decides to add premiums and/or cost-sharing, which are subject to federal limits	Would lower costs of what those who qualify would otherwise pay for exchange coverage; could be no cost if state chose	Could potentially be designed to result in lower cost than exchange coverage
Impact on Exchange Stability and Affordability	Will pull customers out of the exchange, though the size of the disruption depends on the eligibility parameters of the group Impact on exchange affordability will depend on risk profile of low-income population moving from exchange to Medicaid	Could expand enrollment in the exchange by attracting previously uninsured but eligible individuals Impact on exchange affordability will depend on risk profile of new lives attracted to Access Health CT	Depends on the design of the option and whether it is offered on or off the exchange: <ul style="list-style-type: none"> • If it is a lower-cost option that is offered on the exchange, it could attract previously uninsured but eligible individuals to enroll in exchange coverage • If it is a lower cost option that is offered off the exchange, it could pull individuals from the exchange Impact on exchange affordability will depend on risk profile of new lives attracted from standard exchange insurance plans to new option
State Costs	State finances 50% of the cost of all coverage for this group; total cost depends on the eligibility limits, health status of enrollees, and take-up	State would subsidize coverage that is also heavily subsidized by federal government; state costs depends on the size of the subsidies and whether federal waiver authority is obtained to bring in federal funding	Depends on whether the state decides to subsidize coverage or just offer additional coverage options to consumers
Provider Impact	Reimbursement at Medicaid rates	Reimbursement at exchange rates	TBD based on state policy choices

CONCLUSION

Despite significant gains in coverage, health insurance is unaffordable to many low-income adults in Connecticut. The economic recession caused by COVID-19 will both heighten the need for affordable coverage among Connecticut's population and constrain the state's ability to address the affordability gap. The options reviewed here would help increase the affordability of health care coverage for residents with incomes between 139% and 200% FPL, the group with the greatest need given their low incomes and lack of access to Medicaid. While these options entail some state costs, by providing coverage to a sizeable portion of the state's remaining uninsured population they also would bring longer-term benefits to the state.

The two main approaches reviewed here—building out Medicaid eligibility levels and providing additional subsidies to the lowest-income people enrolling in Access Health CT—each could stand on their own or be pursued in combination, scaled in line with available funding. Either option requires time to support policy development, economic and actuarial modeling, and implementation planning; depending upon the design, federal approval also could be required. A key next step is to more thoroughly model the relative costs of the XX Group and exchange subsidies—considering likely per-person costs and anticipated enrollment—and to analyze how either option could impact Access Health CT costs for people who remain in the exchange. Armed with this knowledge, the state can make informed decisions about how to address health care affordability, balancing the costs of expanded coverage against the benefits of keeping the state's workforce—and their children—healthy and controlling health care costs over time.

Appendix A: Key Considerations When Evaluating Affordability Options

What is the Impact on Consumers?	
Individual Costs	Premiums, deductibles, and copayments directly impact the extent to which low-income residents would likely take up a new option. Options that cost less than current Access Health CT coverage are most likely to attract more individuals to coverage.
Benefit Package	Medicaid and exchange coverage offer robust—but different—benefits. For example, Connecticut’s Medicaid program covers dental benefits for adults and non-emergency medical transportation while exchange plans do not. One consideration in designing an affordability option is whether either benefit package is preferable for the population between 138% and 200% FPL; another consideration is how the choice of benefits impacts costs for consumers and the state.
Exchange Stability & Affordability	A broad, diverse risk pool promotes exchange affordability and the overall stability of the exchange. Affordability options will affect the risk pool in different ways. Options that make coverage on the exchange more affordable are likely to increase enrollment on the exchange and could positively impact its risk pool. Conversely, options that make more people eligible for Medicaid would likely reduce exchange enrollment and could negatively impact its risk pool.
Immigrant Impact	Affordability options that rely on federal funding must follow federal rules that restrict some lawfully present immigrants’ eligibility for coverage during their first five years in the country, making those options less effective in addressing affordability concerns for some immigrants in Connecticut.
What is the Impact on the State?	
State Costs	State investment is necessary to implement any coverage option and policymakers will want to analyze each option to fully understand the cost. Another consideration is whether the state can leverage federal funding to help pay for the option.
Federal Authority	Compared to options that the state can implement without federal approval, affordability options that require federal authority take longer to implement and require the state to invest more time negotiating the approval. Some federal approvals (e.g., Medicaid State Plan Amendments) are more straightforward than those where the federal government has more discretion (e.g., Section 1115 or Section 1332 waivers).
Implementation	The level of administrative effort involved in implementing each option is another consideration. Whether the state can build on its existing infrastructure or must invest in creating new infrastructure will impact costs and administrative resources.
What is the Impact on Providers?	
Reimbursement Rates	Medicaid provider rates tend to be lower than exchange or other commercial insurance rates. Lower provider rates can make coverage more affordable but also reduce the willingness of providers to participate in the insurance network.
Reduction in Uncompensated Care	Affordability options can reduce the number of uninsured patients, leading to a reduction in the volume of uncompensated care for some providers. ⁷⁶ Reducing uncompensated care could benefit providers but it is also possible that some affordability options could drive an increase in Medicaid enrollment, which pays less than other payers do.

Appendix B: Options for Securing Federal Funding for an Exchange Subsidy Program

A purely state-funded subsidy program does not require federal approval. If the state seeks to pursue federal funding for the subsidies, then federal waiver approval—under either Section 1115 or 1332—would be necessary, increasing the complexity of the option. Applying for a federal waiver can be a lengthy process; it requires a detailed application, public notice, and typically months of negotiation with the federal government, without the guarantee of approval.⁷⁷

Using Section 1115 Demonstration Authority to Fund Exchange Subsidies

Connecticut could apply for a Section 1115 demonstration to authorize federal spending on “costs not otherwise matchable” by Medicaid so that the state and the federal government would share in the cost of subsidies for individuals enrolled in Access Health CT coverage. Section 1115 of the Social Security Act gives the Secretary of Health and Human Services authority to approve state-proposed Medicaid demonstration projects so long as they meet the objectives of the Medicaid program, are budget neutral (i.e., cost the federal government no more than it would spend in the absence of the demonstration), and support hypotheses subject to evaluation.

Connecticut’s premise could be that federal support for subsidies could help reduce the level of uninsured within the state, potentially saving federal Medicaid costs if people are less likely to experience health care challenges that keep them from working and becoming eligible for Medicaid at time when their health care needs are more costly.⁷⁸ Two states (Massachusetts and Vermont) have such waivers granted as part of broader demonstrations that include other cost-saving elements. However, the approach these states used has been disfavored by the Trump Administration, suggesting that it is unlikely that Connecticut could secure approval for such a demonstration unless there is a change in administration.

Using Section 1332 Authority to Fund Exchange Subsidies

Another scenario to access federal funding for these subsidies involves a multi-part Section 1332 “State Innovation” waiver. Section 1332 of the ACA permits states to request waivers from the Department of Health and Human Services and the Treasury Department of certain components of the ACA, including benefits and subsidies and exchange standards.⁷⁹ A state waiver application must satisfy four “guardrails” related to coverage, affordability, and federal costs in order to be granted.⁸⁰ Even when a proposal satisfies all four of these guardrails, however, the federal government has discretion about whether or not to approve the waiver.

To access federal funding through a 1332 waiver, the state would need to propose changes to Access Health CT coverage and/or payments that save federal dollars, and then could use those savings to offset all or part of the cost of the subsidies. For example, Connecticut could request Section 1332 authority to secure approval for a reinsurance program to help bring down exchange premiums and then use the federal savings—resulting from lower premium rates that require lower federal subsidies—to support state-based subsidies. In this scenario, state costs would not be “matched” as they would be in Medicaid, but the state’s subsidy costs would be offset by available federal funding. Although a number of states have now received approval for reinsurance waivers, no state has received approval for exchange subsidies as described here. Here, too, a change in the federal administration may result in a different 1332 policy.

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53. This paper assumes that the state-funded subsidies would be used to support the purchase of Access Health CT coverage, but the state could consider allowing individuals to use subsidies to purchase other sources of coverage, including employer-sponsored coverage. It also would be possible for the state to subsidize deductibles, but this is less common and this analysis therefore focuses on premium subsidies. If the state wishes to subsidize deductibles and/or copayments, it could require insurers to cap cost-sharing for qualifying individuals and compensate them for these reductions.
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65. The public charge final rule does not specifically address how Medicaid Section 1115-based benefits are to be considered in a public charge determination, but it is reasonable to assume that because most Medicaid coverage is considered in a public charge analysis (other than, for example, treatment for an emergency condition), Medicaid-financed subsidies to individuals would be considered as a negative factor in a public charge determination. It is possible that a state could design subsidies in a manner that does not invoke the public charge rule; additional analysis would be necessary.
66. By comparison, coverage for the ACA adult Medicaid expansion population (e.g., childless adults up to 138% FPL) is matched at 90%. The 50% matching rate would apply to most administrative costs as well. Costs to upgrade state systems to conduct eligibility and claims processes for the new eligibility group would be matched by the federal government at the applicable higher matching rates (ranging from 75%-90%).
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77. Requirements related to Section 1115 demonstrations are detailed in 42 C.F.R. §§ 431.400-428. Regulations codifying Section 1332 are found at 31 C.F.R. Part 33 and 45 C.F.R. Part 155. Additional guidance about this authority is available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-#regulations-guidance.
78. When evaluating budget neutrality for Section 1115 demonstrations, CMS only considers the impact of costs on Medicaid, not the federal Treasury, so the impact on exchange enrollment would not be directly considered.
79. States cannot waive guaranteed issue and related rating rules (e.g., fair play rules).
80. The four guardrails are: (1) it must provide coverage to at least as many people as the ACA would provide without the waiver; (2) it must provide coverage that is at least as “comprehensive” as coverage offered through the exchange; (3) it must provide coverage that is as affordable for consumers as coverage offered through the exchange; and (4) the waiver must be deficit neutral, meaning that it cannot increase the federal deficit.

ABOUT MANATT HEALTH

This brief was prepared by Cindy Mann, Allison Orris, and Ashley Traube. Manatt Health integrates legal and consulting expertise to better serve the complex needs of clients across the healthcare system. Combining legal excellence, first-hand experience in shaping public policy, sophisticated strategy insight, and deep analytic capabilities, we provide uniquely valuable professional services to the full range of health industry players. Our diverse team of more than 160 attorneys and consultants from Manatt, Phelps & Phillips, LLP and its consulting subsidiary, Manatt Health Strategies, LLC, is passionate about helping our clients advance their business interests, fulfill their missions, and lead health care into the future. For more information, visit <https://www.manatt.com/Health>.

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The Connecticut Health Foundation is the state's largest independent health philanthropy dedicated to improving health outcomes for people of color. Since its creation in 1999, the foundation has awarded more than \$68 million to nonprofit organizations and public entities to expand health equity, reduce health disparities, expand health coverage, and improve the health of all Connecticut residents. For more information, visit www.cthealth.org.

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