February 1, 2018

Chairman Representative Frank Kotowski
House Committee on Health, Human Services, and Elderly Affairs
Legislative Office Building Room 205
33 N. State Street
Concord, NH 03301

RE: HB 1813-FN relative to the law regarding Medicaid expansion

Dear Representative Kotowski and members of the House Health, Human Services, and Elderly Affairs Committee:

Thank you for the opportunity to submit testimony on HB 1813, which amends the New Hampshire Health Protection Program to: 1) reduce eligibility from 138% to 100% of the federal poverty level (FPL); 2) eliminate retroactive eligibility; and 3) require the New Hampshire Department of Health and Human Services (DHHS) to implement enhanced eligibility screenings for the purpose of identifying ineligible people and to recover payments made for their Medicaid health care coverage.[1] Bi-State Primary Care Association appreciates the sponsor's desire to ensure that any taxpayer dollars used to pay for Medicaid enrollees' health coverage is spent correctly and recaptured when inadvertently spent. However, we respectfully request the Committee recommend HB 1813 inexpedient to legislate because we believe that this bill will negatively affect low income Granite Staters, their communities, and the providers who serve them.

Bi-State is a non-profit organization that advocates for access to primary and preventive care for all New Hampshire residents with a special emphasis on the medically underserved. We also represent New Hampshire's 16 community health centers, which are located in medically underserved areas throughout our state. Community health centers are non-profit organizations providing integrated oral health, substance use disorder treatment, behavioral health, and primary care services to more than 113,000 patients, most of whom live below 200% of the FPL or $24,280 annually for an individual.[2]

As introduced, HB 1813 requires DHHS to seek a waiver to reduce the income eligibility criteria from 138% to 100% of the FPL. During the implementation of the Affordable Care Act, several states sought to limit their Medicaid expansion programs to cover only those childless individuals earning up to 100% of the FPL. In response, the Centers for Medicare and Medicaid Services (CMS) indicated that states could not partially expand Medicaid and still receive the full enhanced federal match, as the statute did not contemplate a partial expansion but rather statutorily defined the new adult group as those with incomes at or below 133% FPL (138% with the 5% disregard).[3] That being said, CMS may approve a waiver if a state can demonstrate that the proposed changes will further the purpose of the Medicaid program.[4] It is unclear as to whether CMS will entertain a new waiver to reduce eligibility or whether, if approved, the federal match will decrease. We do not believe that eliminating health insurance coverage for people earning less than $16,040 furthers the purpose of the Medicaid program.

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[1] For a single individual, 100% of the FPL is approximately $12,140 per year. https://aspe.hhs.gov/poverty-guidelines
[2] Health Resources and Services Administration, Uniform Data System, NH Rollup (2016); BSPCA Survey of Membership (2016).
[3] CMS "Frequently Asked Question on Exchanges, Market Reforms, and Medicaid" December 10, 2012, page 12. https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf; §1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119.
[4] CMS "Frequently Asked Question on Exchanges, Market Reforms, and Medicaid" December 10, 2012, page 12. https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf; *See* https://aspe.hhs.gov/poverty-guidelines

The reduction of eligibility as proposed by HB 1813 will cause 23.5% of those currently enrolled in the NHHPP to lose their health care coverage.[5] The plans on the Marketplace are often unaffordable for individuals earning between $12,100 and $16,100. Bronze plans, the least expensive plan available, are ineligible for cost sharing reductions, making simple doctors visits inaccessible. For example, the premium for an Anthem Blue Cross and Blue Shield Anthem Bronze Pathway plan costs as little as $1.48 per month. However, the enrollee with Type 2 diabetes could potentially spend half of their yearly income on physician visits, prescription medicines, and hospital visits because the deductible is $6,350 and the out-of-pocket maximum is $7,350. The enrollee is also responsible for co-insurance, which means that until the out-of-pocket maximum is met, the enrollee must pay a percentage of the care received after meeting the deductible. The financial impact to the more than 10,000 affected individuals and their health care providers is very real.

Over half of the community health centers' patients earn less than 150% of the federal poverty level, and a reduction in the eligibility for the NHHPP will result in an increase in the health centers' uncompensated care. Community health centers must offer care to patients regardless of their ability to pay and must provide patients living at or below 200% of the FPL a sliding fee discount for services provided.[6] Our health centers continue to report to us that it is common for patients living at or below 200% of the FPL to be unable to afford Marketplace plans with high deductibles and limited cost sharing. House bill 1813 will decrease access to affordable health care coverage.

Further, the provision to end retroactivity will also financially impact CHCs and other health care providers, who in good faith provide necessary medical treatment to those who may be Medicaid eligible at the time of service. Medicaid allows for a three month retroactive payment to the date of the enrollee's application. Removing retroactive coverage will result in an increase in uncompensated care costs for those providers who continued to provide treatment under the assumption the patient was covered by Medicaid.

Finally, HB 1813 seeks to recapture payments made under NHHPP for those later found to be income ineligible. We have concerns about the quality of the data and whether inaccurate data may inadvertently result in eligible individuals being removed from the program, further increasing CHCs' uncompensated care costs. It is unclear whether the bill seeks to recapture payments made to the insurers or providers. Please note that payments are made *on the behalf of* patients and not *to* patients as the bill's language seems to indicate. If the goal is to recapture payments from the providers, an administrative burden will be placed on the health centers and other physician practices needing to reimburse the state.

For the reasons outlined in this letter, we respectfully request that the Committee recommend the bill inexpedient to legislate. Please do not hesitate to contact me if you have any questions or would like more information.

Sincerely,

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[5] *See* the fiscal note to HB 1813 (2018).
[6] 42 U.S.C. 254b, §330 (2018).