State of Connecticut
Department of Social Services

COVERED CONNECTICUT (COVERED CT) DEMONSTRATION PROGRAM

Demonstration Waiver Application
Pursuant to Section 1115 of the Social Security Act

To be submitted to the U.S. Centers for Medicare and Medicaid Services (CMS)

Draft for Public Comment
Updated February 3, 2022

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I. SUMMARY

Sections 15 through 19, inclusive, of Public Act 21-2 (Act) of the June 2021 Special Session of the Connecticut General Assembly, established the Covered Connecticut (Covered CT) program to close the health insurance affordability gap for low-income individuals who earn too much to qualify for Medicaid but not enough to afford coverage through the state's health insurance marketplace, Access Health CT. The law further directs the Connecticut Department of Social Services (DSS) to submit this demonstration waiver application pursuant to section 1115 of the Social Security Act (Demonstration) to the U.S. Centers for Medicare and Medicaid Services (CMS) to provide federal matching funds for the program.

Legislative debate in the Connecticut General Assembly leading to passage of the Act centered on two policy options for improving the affordability of healthcare coverage: an expansion of Medicaid eligibility or State subsidies for health insurance coverage available through Access Health CT. Lawmakers' rationale for choosing the State subsidy approach was that by leveraging both federal subsidies for marketplace coverage and federal funding for the Medicaid program, the State could, with the same amount of state funds, provide affordable health insurance coverage to more people than by expanding Medicaid.

The Demonstration proposed in this application will be available to parents and caretaker relatives, and their tax dependents under age 26, and non-pregnant childless adults ages 19 to 64 who have income that is above the Medicaid limit but does not exceed 175% of the federal poverty level (FPL) and enroll in a silver-level qualified health plan (QHP) available through Access Health CT using federal premium subsidies and cost-sharing reductions.

Demonstration enrollees will receive free QHP coverage available through Access Health CT. The State will directly reimburse the plan for the monthly premium and the cost-sharing amounts that the enrollee would normally need to pay with the plan, such as out-of-pocket costs for deductibles, copays, and coinsurance. Enrollees will also receive free dental care and non-emergency medical transportation (NEMT) services, comparable to the benefits under Connecticut Medicaid and provided through the Medicaid delivery and payment system, HUSKY Health. No cost-sharing requirements will apply to benefits provided under the Demonstration.

The hypotheses to be tested by the Demonstration are that providing free QHP coverage and dental care and NEMT services comparable to the benefits under Connecticut Medicaid will: (1) improve the affordability of health insurance coverage; (2) promote health insurance coverage; (3) ensure stable coverage; (4) reduce the statewide uninsured rate; (5) improve oral health; and (6) enable access to medical appointments.

DSS requests a five-year waiver term, from July 1, 2022 through June 30, 2027. As detailed below, during this period, Demonstration enrollment is projected to total 39,000, and Demonstration expenditures are projected to total $363,396,545. This expenditure projection assumes that the enhanced QHP premium subsidies available through section 9661 of the American Rescue Plan Act of 2021 (ARP), Public Law 117-2, will continue throughout the five-year Demonstration period. Should the enhanced ARP subsidies end on December 31, 2022, as currently authorized by federal law, or on any date prior to the expiration of the Demonstration, the State would need to revisit the Demonstration financing and possibly make programmatic changes, such as, but not in any particular order: increase State funding, reduce eligibility or benefits, cap enrollment, or terminate the Demonstration.

As detailed below, DSS is requesting expenditure authority for the individuals enrolled under the Demonstration. It has not identified the need for any waivers of section 1902.

II. BACKGROUND

This section details this challenge of affordable coverage for low-income individuals in Connecticut and the leading policy options considered by state policy makers. Much of the content is drawn from the November 2020 Policy Brief entitled "Closing the Health Insurance Affordability Gap: Two Options for Connecticut." ***Note*:** In this section of the Demonstration application, except as otherwise specifically indicated, all FPL, premium cost, premium subsidy, and cost-sharing reduction figures are as of that date, reflecting the premium subsidies and cost-sharing reductions provided by the Affordable Care Act (ACA) but not the enhanced premium subsidies provided by the ARP.

The Challenge: Affordable Coverage for the Near-Poor

Connecticut has a strong history of working to make healthcare 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 individuals and families. In 2018, individuals with incomes between 100% and 200% FPL made up 13% of Connecticut's population, but 26% of the state's uninsured residents; approximately 48,000 people in this income range were uninsured.[1]

Among this income group, those earning just above the Medicaid eligibility levels are hardest hit by affordability challenges and are the focus of the Covered CT program. A single individual in this group earns approximately between $17,600 and $25,000 annually, or about $12 an hour at a full-time job; note that effective August 1, 2021, the state's minimum wage increased to $13 per hour and under current state law, it will increase to $14 per hour effective July 1, 2022.[2] Even with the newly increased state minimum wage, at that wage level, expenses related to housing, utilities, food, and transportation leave little room to pay a monthly healthcare premium.
The high level of uninsured low-income people is generally not the result of a lack of coverage options, but rather a lack of affordable coverage choices. Individuals who are not eligible for Medicaid can buy coverage from a QHP available through Access Health CT. That coverage is subsidized by the federal government, but still costly for low-income residents who are just above Medicaid eligibility levels.

[1] Kaiser Family Foundation. (Year 2018). Distribution of the Nonelderly Uninsured by Federal Poverty Level (FPL). Retrieved from: https://www.kff.org/uninsured/state-indicator/distribution-by-fpl-2/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22connecticut%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[2] Connecticut Health Foundation. (November 2020). Closing the Health Insurance Adorability Gap: Two Options for Connecticut. Retrieved from: https://www.cthealth.org/wp-content/uploads/2020/11/CT-Health-Closing-the-Affordability-Gap.pdf

Research shows that monthly premiums can deter low-income individuals straining to meet their basic needs from enrolling in healthcare coverage. These findings are particularly relevant to Connecticut, which is one of the costliest states 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.[3] 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 healthcare and other items.

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 commercial plans available through Access Health CT.

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.[4,5] Approximately 48,000 of Connecticut's uninsured residents in 2018 had incomes between 100% and 200% FPL,[6] accounting for a quarter of the state's uninsured population even though this income range makes up just 13% of the state's population.[7] Some of these uninsured individuals are eligible for Medicaid based on the state's current eligibility requirements (i.e., childless individuals with income under 138% FPL and parents and caretaker relatives earning less than 160% FPL).[8] People earning above those levels are likely to be eligible for subsidized coverage through a QHP available through Access Health CT.

The number of uninsured individuals in Connecticut with incomes between 100% and 199% 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 non-Medicaid eligible individuals.[9] For individuals between

[3] Cohn, S. (July 10, 2018). 10 Most Expensive Places to Live in America. CNBC. Retrieved from: https://www.cnbc.com/2018/06/28/these-are-americas-most-expensive-states-to-live-in-for-2018.html
[4] Access Health CT. (February 20, 2020). 2020 Open Enrollment Summary.
[5] State Health Access Data Assistance Center. (October 17, 2019). SHADAC Uninsurance Rates for Connecticut in 2017 and 2018. Retrieved from: https://www.shadac.org/sites/default/files/publications/1_year_ACS_2018/aff_s2701_CT_2017_2018.pdf
[6] Ibid.
[7] In this section, data on the uninsured and the shifts in Connecticut's coverage landscape include all non-elderly state residents (i.e., state residents who are 64 years old or younger).
[8] ***Note***: Throughout this document, the applicable Medicaid eligibility FPL limits, including references to 138%, 160%, and 201%, each incorporates the 5% income disregard.
[9] Kaiser Family Foundation. (2016). Uninsured Rates for the Nonelderly by Federal Poverty Level (FPL). Retrieved from: https://www.kff.org/uninsured/state-indicator/nonelderly-uninsured-rate-federal-poverty-level-fpl/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

139% and 250% 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% FPL, employer coverage declined by approximately 6,700 and enrollment in individual market coverage (both on and off Access Health CT) dropped by approximately 7,400. During this same period (2016–2018), the share of individuals between 139% and 250% 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 likely to rise. Since the start of the COVID-19 pandemic, more than 400,000 state residents have filed for unemployment.[10] 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 an additional 36,000 to 77,000 state residents may become uninsured as a result of the COVID-related economic downturn.[11] Those with the least ability to afford new coverage will be the people with incomes below 200% FPL but above the Medicaid thresholds. The end of the COVID-19 public health emergency (PHE) and the continuous enrollment requirements of the Families First Coronavirus Response Act (FFCRA) will be particularly impactful for this population.

Medicaid Coverage in Connecticut

Most of the lowest-income state residents are eligible for coverage through HUSKY Health, 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 961,000 people, or about one out of four state residents.[12] Before the ACA, federal Medicaid rules allowed states considerable flexibility to cover parents and caretaker relatives but not childless adults. The ACA created a new eligibility pathway and enhanced federal matching funds for states to expand

[10] CT Data Collaborative. (May 24, 2020). Unemployment in Connecticut During COVID-19 Crisis. Retrieved from: https://www.ctdata.org/covid19-unemployment
[11] Banthin J, Simpson M, Buettgens, M, et al. (July 2020) Changes in Health Insurance Coverage Due to the COVID-19. Retrieved from: https://www.urban.org/sites/default/files/publication/102552/changes-in-health-insurance-coverage-due-to-the-covid-19-recession_4.pdf Health Management Associates (April 3, 2020). COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. Retrieved from: https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf
[12] Centers for Medicare and Medicaid Services (Last Updated December 21, 2021). June 2021 Medicaid & CHIP Enrollment. Retrieved from: https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

coverage to all adults (subject to immigration requirements) up to 138% FPL (currently $1,467 monthly for an individual). Connecticut had already expanded coverage for parents and caretaker relatives before the ACA and it was the first state to implement the ACA early option for coverage of childless adults in 2010. The ACA also created a pathway to regular federal matching funds for states to expand coverage to childless adults with income above 138% FPL.

Over the years, Connecticut made several changes to its Medicaid parent and caretaker relatives eligibility levels. Before the ACA, parents and caretaker relatives 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 and caretaker relatives above that income level could buy subsidized coverage through Access Health CT.[13] Since then, lawmakers have raised the Medicaid eligibility limit for parents and caretaker relatives to 160% FPL. For adults in a family of four, that equates to a Medicaid income limit of $3,493 per month. State data shows that of those who lost Medicaid coverage as a result of the change, while many returned to Medicaid (approximately 40%), only a small fraction enrolled in Access Health CT coverage (approximately 12%) and nearly half appeared to have become uninsured, as they were not enrolled in either Medicaid or QHP coverage available through Access Health CT.[14]

QHP Coverage Available through Access Health CT in Connecticut

Access Health CT is Connecticut's official health insurance marketplace for QHPs. State residents can qualify for federal financial assistance to buy insurance through Access Health CT if they do not qualify for Medicaid, Medicare, or other government programs and do not have access to affordable insurance through a job.[15] 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). In addition to the tax credits, people with incomes below 250% FPL are eligible to buy QHP coverage with lower cost-sharing or cost-sharing reductions. 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. As of June 2020, enrollment had grown by 37,000 at the early part of the COVID-19 pandemic.

[13] Levin Becker, A. 39 Percent of Parents Affected by HUSKY Cut Still in Program (December 9, 2016). The CT Mirror. Retrieved from: https://ctmirror.org/2016/12/09/39-percent-of-parents-affected-by-husky-cut-still-in-program/

[14] DSS Data. Also note that for the six-month period from January 1, 2018 through June 30, 2018, state lawmakers reduced eligibility for that group to 138% FPL, which was restored back to 155% FPL effective July 1, 2018.

[15] Those who are eligible for employer-sponsored insurance can also be eligible for subsidies through the exchange if their employer coverage would cost more than 9.78% of their income. Kaiser Family Foundation. (January 16, 2020). Explaining Health Care Reform: Questions About Health Insurance Subsidies. Retrieved from: https://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/

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.[16] 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 Health CT qualify for tax credits that cover 80% or more of the cost of their premium.[17] People with incomes under 250% FPL also qualify for cost-sharing subsidies if they choose a benchmark silver level plan through Access Health CT. (The benchmark silver plan refers to the second-lowest cost silver plan available by Access Health CT; individuals who are eligible forgo the federal cost-sharing subsidies if they do not enroll in silver coverage.)

For individuals buying coverage through Access Health CT who have incomes between 139% and 200% FPL, the average monthly premium for a benchmark silver plan ranges from $56 to $143, respectively.[18]

Out-of-pocket costs also vary based on 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.[19]
- 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.[20]

[16] Among the other factors that contribute to the cost of Access Health CT coverage are the scope of covered benefits, reimbursement levels for participating providers, and the overall health of the risk pool (i.e., groups of people purchasing health insurance together). A key factor that influences consumers' out-of-pocket costs is the actuarial value of the plan, which refers to the percentage of benefit costs for covered benefits paid by the insurance plan. As described above, exchange plans are categorized by a "metal level" based on how the consumer and insurer split the costs of care; actuarial value of plans increase across the metal tiers from bronze to platinum plans.
[17] Access Health CT. (February 20, 2020). 2020 Open Enrollment Summary.
[18] Ibid.
[19] Simulations taken from compare plans tool on Access Health CT. Retrieved from: https://www.accesshealthct.com/AHCT/official/famInfo/loadFamilyInfo.
[20] Similar information is available for two-parent families. Parents with incomes at 165% FPL (which is just above Connecticut's current Medicaid eligibility level for parents) who enroll in the benchmark plan pay average annual monthly premiums, after federal subsidies, of $184 and $1,300 in annual deductibles. Their annual out-of-pocket spending is capped at $5,000. At 200% FPL, two parents pay an average monthly premium of $295 for the benchmark plan, an annual deductible of $7,900, and have out-of-pocket payments capped at $13,000.

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 healthcare. Given the share of income for healthcare costs through Access Health CT, and how difficult it is for someone in this income range to stretch their budget to meet basic needs other than healthcare, it is not surprising that many in this income range go without coverage.

The cost of living in Connecticut is particularly high. 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.[21]

The consequences of being uninsured are significant, with coverage gaps being a key driver of health disparities. The ACA requires the Secretary of the Department of Health and Human Services to establish data collection standards for race, ethnicity, sex, primary language, and disability status. Data collected show clear disparities in rates of health insurance coverage among Black and Latinx populations.[22] The use of fewer preventive services results in poorer health outcomes, higher mortality and disability rates, lower annual earnings because of sickness and disease, and advanced stages of illness. The uninsured tend to be disproportionately poor, young, and from racial and/or ethnic minority groups.[23] Improving the affordability of health insurance coverage for low-income adults who are disproportionately people of color – promoting healthcare coverage, reducing the uninsured rate, and ensuring stable coverage – will advance health equity by preventing gaps in coverage that often lead to delayed and more expensive care and poor health outcomes.

[21] Pearce, D. (October 2019). The Self-Sufficiency Standard for Connecticut 2019. Connecticut Office of Health Strategy and Connecticut Office of the State Comptroller.
[22] Pew Charitable Trusts, "How Income Volatility Interacts With American Families' Financial Security," March 9, 2017, https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2017/03/how-income-volatility-interacts-with-american-families-financial-security.
[23] Riley W. J. (2012). Health disparities: gaps in access, quality and affordability of medical care. Transactions of the American Clinical and Climatological Association, 123, 167–174.

Affordability Options to Promote Coverage

In the 2021 regular session and the June 2021 Special Session of the Connecticut General Assembly, State lawmakers considered two options for closing the health insurance affordability gap for low-income individuals: expanding Medicaid eligibility for adults or providing a State subsidy for plans available through Access Health CT.

Option 1: Medicaid Eligibility Expansion

Connecticut could expand eligibility to 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. This authority allows states to set the upper income level for the group. For example, Connecticut could raise eligibility levels for childless adults from 138% FPL to 175% FPL. 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 by submitting a Medicaid State Plan Amendment and then using its existing Medicaid eligibility systems to implement the coverage and provide the current State Plan benefits at State Plan reimbursement rates. No waiver would be required for this option.

Option 2: State Subsidies for QHPs Available through Access Health CT

Alternatively, Connecticut could elect to make the existing Access Health CT coverage more affordable by creating its own subsidies for those who buy insurance through Access Health CT. Because Connecticut operates a state-based marketplace using its own technology platform, the State could implement this option relatively easily. Federal marketplace subsidies (i.e., the tax credits and cost-sharing reductions that lower costs for low- and middle-income populations) set a floor, not a ceiling, and states can bolster these subsidies with their own funds. Connecticut would have broad latitude to set both the eligibility levels at which subsidies would apply, as well as the amount of subsidy. Federal approval is not needed to implement State subsidies that are funded entirely through state dollars. If a state wanted to seek federal financial participation (FFP) for State subsidies, a section 1115 demonstration waiver would be required.

Improving subsidies for low-income individuals can increase enrollment in Access Health CT coverage and reduce the uninsured rate. Evidence suggests that consumers are highly

sensitive to premium costs when choosing healthcare coverage.[24] An analysis of Massachusetts' subsidy program found that reducing monthly premiums by about $40 increased enrollment in marketplace coverage among eligible individuals by 14% to 24%, with larger impacts seen at lower incomes.[25] Connecticut would have the discretion to set the parameters of such a program by providing subsidies to reduce to $0 the monthly premium and the cost-sharing amounts that the enrollee would normally have to pay with the plan (e.g., deductibles, copays, coinsurance, and maximum out-of-pocket costs).

Connecticut's Approach

State lawmakers ultimately chose the State subsidies for QHP coverage approach paired with a section 1115 waiver. Their rationale was that by leveraging both federal subsidies for QHP coverage available through Access Health CT and federal funding for the Medicaid program, the State could, with the same amount of state funds, provide affordable health insurance coverage to more people than by expanding Medicaid.

[24] Holahan, J., Blumberg, L. J., & Wengle, E. (March 2016). Marketplace Plan Choice: How Important Is Price? An Analysis of Experiences in Five States. The Urban Institute. Retrieved from: https://www.researchgate.net/publication/301685561_Marketplace_Plan_Choice_How_Important_is_Price_An_Analysis_of_Experiences_in_Five_States

[25] MassHealth Medicaid Section 1115 Demonstration Special Terms & Conditions, (June 26, 2019). Department of Health and Human Services, Centers for Medicare and Medicaid Services.

III. DEMONSTRATION ELIGIBILITY

Eligibility Criteria

Eligible for the Demonstration are two populations: (1) parents and caretaker relatives (parents and caretaker relatives) and (2) childless adults. Eligibility criteria for these populations are as follows:

1) **Parents and Caretaker Relatives**, and their tax dependents under 26 years of age, who:
    i) are ineligible for Medicaid because their income exceeds the Medicaid income limits but does not exceed 175% FPL, and
    ii) enroll in a silver-level QHP available through Access Health CT using federal premium subsidies and cost-sharing reductions.

2) **Childless Adults** who:
    i) are ages 19 to 64,
    ii) are not pregnant,
    iii) are ineligible for Medicaid because their income exceeds the Medicaid income limits but does not exceed 175% FPL, and
    iv) enroll in a silver-level QHP available through Access Health CT using federal premium subsidies and cost-sharing reductions.

Eligibility Standards and Methodologies

The Demonstration will not affect or modify the State's current Medicaid program and Children's Health Insurance Program (CHIP). It will not change Medicaid or CHIP State Plan eligibility standards or methodologies.

Eligibility for the Demonstration will be determined through the existing application and redetermination processes and the eligibility and enrollment system shared by Access Health CT and DSS for the Medicaid, CHIP and marketplace programs. The system will apply Demonstration eligibility criteria in conjunction with the eligibility criteria for Medicaid, CHIP and marketplace programs.

Projected enrollment

The Demonstration is projected to enroll approximately 39,000 individuals by the final year of the waiver, including a total of 13,000 parents and caretaker relatives and 26,000 childless adults.

Population	Demo Year 1	Demo Year 2	Demo Year 3	Demo Year 4	Demo Year 5
Parents and Caretaker Relatives	2,818	8,991	13,157	13,223	13,289
Childless Adults	15,903	24,302	25,568	25,696	25,824
Total	18,721	33,293	38,725	38,919	39,113

The Demonstration will provide an enhanced safety net for individuals who lose Medicaid eligibility at the end of the continuous eligibility requirements of the FFCRA and the COVID-19 PHE. As adults who are currently enrolled in HUSKY A and HUSKY D are asked to reestablish Medicaid eligibility at the end of the PHE, they will also be advised of the availability of the Demonstration as a potential source of coverage if they have increased income.

As the Demonstration go-live date approaches, the State will launch an outreach campaign to promote enrollment in the program. It will use administrative data from the eligibility and enrollment system shared by Medicaid and Access Health CT to identify potentially eligible individuals for targeted outreach, including adults who are not enrolled in Medicaid but whose children are enrolled in Medicaid or CHIP.

At go-live, individuals enrolled in a silver-level QHP will have their premium and cost sharing amounts reduced to zero and eligible individuals enrolled in a bronze-level plan will be offered the opportunity to move to a free silver-level plan.

More broadly, the state will launch a communications campaign to educate the general public on the availability of the program. It will leverage existing channels, such as member notices, mail, email, online member accounts, websites, social media, press releases, and provider bulletins. Additional methods, such as text messaging, robocalls, radio and television advertising, are being explored. To the extent that the Demonstration goes live during the PHE winddown period, communications about reapplying for Medicaid will also include information about the availability of the Demonstration program.

Demonstration enrollment projections assume expiration of the PHE as of April 16, 2022, and the resumption of pending redeterminations at the beginning of the month after the PHE ends. Also anticipated is the completion of pending Medicaid and CHIP redeterminations within a 12-month timeframe, on a monthly basis that allows the state to reestablish a renewal workload that is sustainable in future years.

Take-up rates are expected to differ for the parents and caretaker relatives group and the childless adult group because of the availability of Transitional Medical Assistance (TMA). Parents and caretaker relatives whose income has increased will receive one year of TMA; however, TMA is not available to childless adults. Childless adults who lose Medicaid eligibility because their income has increased may be determined eligible for the Demonstration at renewal.
It is anticipated that a period of TMA eligibility will result in enrollment of parents and caretaker relatives at a lower rate in the early years of the Demonstration than in subsequent years. Accordingly, childless adults are expected to account for a larger share of Demonstration enrollees in the year following the end of the PHE. In the outyears of the Demonstration, enrollment of the two groups is expected to normalize, with the proportion of parents and caretaker relatives and childless adults more closely aligning with the distribution of these populations in the state.

Finally, Demonstration enrollment projections take into consideration a key difference between the eligibility and enrollment process for Medicaid or CHIP and the eligibility and enrollment process for QHP coverage available through Access Health CT. In general, individuals who are determined eligible for Medicaid or CHIP are automatically enrolled in the program. By contrast, individuals who are determined eligible for QHP coverage must proactively enroll in a QHP. These differences apply equally to the Demonstration. Demonstration enrollees whose income has decreased, making them eligible for Medicaid or CHIP, will be automatically disenrolled from the Demonstration and enrolled in Medicaid or CHIP. Individuals who are determined eligible for the Demonstration, whether or not enrolled in Medicaid or CHIP at the time of the decision, must proactively enroll in a QHP. This mandatory action step is anticipated to result in fewer people enrolling in the Demonstration than are determined eligible.

IV. DEMONSTRATION BENEFITS, DELIVERY SYSTEM, PAYMENT RATES AND COST SHARING REQUIREMENTS

The Demonstration will not affect or modify the State's current Medicaid program and CHIP. It will not change State Plan benefits, cost sharing requirements, delivery system, or payment rates.

Benefits, Delivery System and Payment Rates

Demonstration benefits for both the parent and caretaker relatives and the childless adult populations will include:

1) **Premium and cost-sharing subsidies** sufficient to provide free coverage under a silver level QHP available through Access Health CT with federal premium subsidies and cost sharing reductions.

   The State will directly reimburse plans for the monthly premium and the cost-sharing amounts that the enrollee would normally need to pay with the plan, such as out-of-pocket costs for deductibles, copays, and coinsurance. Benefits provided by a plan will be delivered by plan providers and paid at plan reimbursement rates.

2) **Dental care** comparable to the benefits under Connecticut Medicaid, except where dental care is provided by a QHP to dependents under age 26. State law requires QHPs available through Access Health CT to cover dental care for dependents under age 26.
   For all others, the Demonstration dental care benefit will align in amount, duration, and scope with the comparable benefit available through HUSKY Health, be delivered through the HUSKY Health dental fee-for-service delivery system and be paid at State Plan payment rates.

3) **NEMT services** comparable to the benefits under Connecticut Medicaid.
   The Demonstration NEMT benefit will align in amount, duration, and scope with the comparable benefit available through HUSKY Health, be delivered through the HUSKY Health NEMT broker, and be paid at State Plan payment rates.

Cost-Sharing Requirements

Cost-sharing requirements do not apply to Demonstration benefits.

V. FINANCING AND BUDGET NEUTRALITY

Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, assisted the State of Connecticut (State) Department of Social Services, Connecticut's single State Medicaid Agency, in developing budget neutrality estimates to include in their 1115 waiver application for the Covered CT Demonstration program, with a requested start date of July 1, 2022.

This document provides a summary to the State of the 1115 budget neutrality modeling methodology, including a summary of historical data and modeling assumptions to develop projected expenditures over the five-year 1115 Demonstration period.

Covered CT is a budget-neutral alternative to expanding Medicaid eligibility through State Plan authority to ensure affordable healthcare coverage for eligible, low-income individuals. To set a higher upper income level for parents and other caretaker relatives group, State Plan authority is found in section 1931(b) of the Social Security Act. To establish Medicaid eligibility for childless adults with income above 138% FPL, State Plan authority is found in section 1902(a)(10)(A)(ii)(XX) of the ACA. Both authorities allow states to submit a State Plan amendment to claim federal matching funds for the cost of the eligibility expansion at a state's regular federal medical assistance percentage rate. Under State Plan authority, both groups would be entitled to full Medicaid coverage.

Per member per month (PMPM) costs associated with the hypothetical expansion of Medicaid eligibility through State Plan authority comprise the Without Waiver (WOW) projections. PMPM costs associated with the Covered CT program, including eligible individuals' share of the cost of QHP coverage available through Access Health CT, and dental care and NEMT services comparable to the benefits under Connecticut Medicaid and provided through HUSKY Health comprise the With Waiver (WW) projections.

Base Data

To develop the projections for budget neutrality, Mercer evaluated data available through Medicaid and Access Health CT. Mercer discussed the available data sources with the State and determined that state-specific data was available for developing WW and WOW projections.
In accordance with CMS guidance for section 1115 demonstration waivers, the State is demonstrating budget neutrality to the federal government using the PMPM expenditures for the Medicaid eligibility group (MEG). The State and Mercer are developing budget neutrality projections under a single Covered CT MEG for all ages combined. Low-income individuals eligible for Covered CT are presumed to be childless adults with incomes greater than the Medicaid

limit but not exceeding 175% of the FPL and parents and caretaker relatives with incomes greater than the Medicaid limit but not exceeding 175% of the FPL.

To develop WOW costs, Mercer utilized available fee-for-service claims experience for Medicaid-enrolled adults under HUSKY A (Temporary Assistance for Needy Families-related, generally children and caretaker adult coverage groups) and HUSKY D (adult expansion population coverage groups) as a proxy to develop per capita costs reflecting hypothetical Medicaid coverage for the proposed MEG.

To develop the WW costs, the State provided Mercer with available program data for average gross premiums, average net premiums after the application of all available tax credits and state subsidies, and expected experience for maximum and average out-of-pocket expenditures, including copays and deductibles, to develop per capita costs representing eligible individuals' share of the cost of health insurance coverage available through Access Health CT.

The net premium component assumes that funding for state subsidies available through ARP will continue during the Demonstration period. Should the ARP subsidies terminate on December 31, 2022, as currently authorized by federal law, or any other date prior to the expiration of the Demonstration, the State would need to revisit the Demonstration financing and possibly make programmatic changes, such as, but not in any particular order: increase State funding, reduce eligibility or benefits, cap enrollment, or terminate the Demonstration. In order to account for the dental and NEMT services, Mercer relied on dental claims experience for Medicaid-enrolled adults and Medicaid-contracted costs for NEMT services. These components were combined to develop per capita costs.

Results

Across the five-year waiver period, the aggregate State WOW cost is projected to total approximately $1.4 billion; the aggregate WW cost is projected to be $363,396,545, demonstrating budget neutrality based on the hypothetical expenditures across the five-year waiver period.

With Waiver Projections					
	Demo Year 1	Demo Year 2	Demo Year 3	Demo Year 4	Demo Year 5
Per Capita Costs for Covered CT (PMPM)	$160.26	$168.27	$176.68	$185.51	$194.79
Projected Covered CT Member Months	224,652	399,516	464,700	467,024	469,359
Total Cost	$36,002,730	$67,226,557	$82,103,196	$86,637,622	$91,426,440

Note: Totals may differ due to rounding. Total Cost is calculated as PMPM multiplied by member months.

Disclosures

In preparing these projection estimates, Mercer relied on readily available State-specific information and guidance from the State. Mercer reviewed the data and information for internal consistency and reasonableness, but did not audit them. The suppliers of data are solely responsible for its validity and completeness.

All estimates are based upon the information and data available at a point in time and are subject to unforeseen and random events, and actual experience will vary from estimates.
This document is intended to support the State's 1115 waiver application and related public notice requirements. Mercer expressly disclaims responsibility, liability, or both for any reliance on this communication by third parties or the consequences of any unauthorized use. To the best of Mercer's knowledge, there are no conflicts of interest in performing this work.

VI. PROPOSED WAIVERS AND EXPENDITURE AUTHORITIES

Connecticut is requesting expenditure authority pursuant to section 1115(a)(2) of the Social Security Act for expenditures for Covered CT Access Health CT subsidies (including premium and cost-sharing subsidies), Demonstration dental services and Demonstration NEMT services provided to:

1) Parents and caretaker relatives, and their tax dependents under 26 years of age, who:
    i) are ineligible for Medicaid because their income exceeds the Medicaid income limits but does not exceed 175% of the FPL, and
    ii) enroll in a silver-level QHP available through Access Health CT using federal premium subsidies and cost-sharing reductions.

2) Non-pregnant low-income adults who:
    i) are ages 19 to 64,
    ii) are ineligible for Medicaid because their income exceeds the Medicaid income limits but does not exceed 175% of the FPL, and
    iii) enroll in a silver-level QHP available through Access Health CT using federal premium subsidies and cost-sharing reductions.

DSS has not identified the need for any waivers of section 1902 of the Social Security Act.

VII. DEMONSTRATION HYPOTHESES AND EVALUATION

The table below presents an overview of the preliminary plan to evaluate the Demonstration. It is subject to change and will be further defined as the program is implemented. The sample measures are not final and do not represent an exhaustive list of measures that could be used to test each hypothesis.

Hypothesis	Sample Measures	Data Sources
1) Improve the affordability of health insurance coverage		
The availability of free health insurance coverage for Demonstration-eligible individuals will reduce the percentage of low-income people with high medical cost burden, and reduce race/ ethnicity-based disparities	• Percent of people with a high medical cost burden, stratified by income • Percent of people with a high medical cost burden, stratified by income and race/ethnicity	Census Bureau, Current Population Survey's Annual Social and Economic Supplements (CPS)
2) Promote health insurance coverage		
The availability of free health insurance coverage for Demonstration-eligible individuals will increase the number of people who enroll in QHP coverage available through Access Health CT	• Number of low-income people who enroll in QHP coverage available through Access Health CT	Data from the state eligibility and enrollment system shared by Medicaid, CHIP and Access Health CT
3) Ensure stable coverage		
The availability of free health insurance coverage for Demonstration-eligible individuals will increase the number of people who maintain healthcare coverage when their Medicaid coverage ends	• Number of people who lose Medicaid coverage and enroll in the Demonstration without a break in coverage	The state eligibility and enrollment system shared by Medicaid, CHIP and Access Health CT

4) Reduce the statewide uninsured rate		
The availability of free health insurance coverage for Demonstration-eligible individuals will reduce the rate of working-age adults without health insurance coverage, and reduce race/ ethnicity-based disparities	• Percentage of working-age adults without health insurance coverage, stratified by income • Percentage of working-age adults without health insurance coverage stratified by income and race/ethnicity	Census Bureau, American Community Survey
5) Improve oral health		
Providing free dental care to Demonstration-eligible individuals will reduce emergency department utilization for dental conditions which can be prevented by timely and effective outpatient care	• Number of emergency department visits for ambulatory care sensitive dental conditions per 100,000 member months for adults enrolled in the Demonstration	Dental Quality Alliance (DQA) adult measures calculated using administrative claims-based data for the HUSKY Health dental program, Connecticut Dental Health Partnership
6) Enable access to medical appointments		
Providing free non-emergent medical transportation to Demonstration-eligible individuals will reduce transportation-related barriers to accessing healthcare	• NEMT ride-days per Demonstration enrollee	Administrative claims-based data from the NEMT broker for HUSKY Health

VIII. PUBLIC NOTICE

Public Notice and Comment

Pursuant to 42 C.F.R. § 431.408(a)(2)(ii), DSS intends to publish an abbreviated public notice in the Connecticut Law Journal, which is the state's administrative record, on February 8, 2022. Pursuant to 42 C.F.R. § 431.408(a)(1) and (a)(2)(i), DSS intends to post the full public notice on the DSS website for a public comment period that will begin on February 8, 2022 and end on March 11, 2022, which is more than 30 days. The abbreviated and full versions of the public notice referenced above each contains all information required by 42 C.F.R. § 431.408. The full public notice and the draft waiver application are posted on the following dedicated demonstration webpage within the DSS website: https://portal.ct.gov/DSS/Health-And-Home-Care/Covered-Connecticut-Demonstration-Program and also posted a link to that dedicated webpage on the DSS main page under the "News and Press" section, anticipated to be entitled "Covered Connecticut Section 1115 Demonstration Waiver – Public Comment & Public Hearings." DSS intends to keep that content posted throughout the state's public comment and review period.

The State intends to utilize additional mechanisms to notify interested parties of the Demonstration, including distributing a link to the public notice on the email list for the state's legislatively established Medical Assistance Program Oversight Council (MAPOC).
DSS will hold two electronic public hearings, both of which will have electronic and telephone access. Due to public health protocols related to the Coronavirus Disease 2019 (COVID-19) public health emergency, these public hearings will be held electronically and will be open to anyone who wishes to participate. The first public hearing will be hosted by MAPOC on February 10, 2022, which is a legislative process that would afford an interested party the opportunity to learn about the Demonstration and to comment on its contents. The second public hearing will be hosted by DSS on February 16, 2022 and will provide interested parties the opportunity to learn about the contents of the Demonstration and to comment on its contents.

Tribal Consultation

There are two federally-recognized Indian tribes in Connecticut, the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. In accordance with the State's approved tribal consultation process in the Medicaid State Plan, the State will send an email to tribal representatives of each tribe with a summary of the Demonstration, plus a copy of the public notice and waiver application (as well as a link to the DSS Demonstration webpage referenced above). This Demonstration does not have a unique or particular impact, nor a direct effect on tribal members, tribes, or tribal health programs or organizations.

IX. DEMONSTRATION ADMINISTRATION

Please provide the contact information for the state's point of contact for the Demonstration application.

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