NATIONAL HEALTH CARE for the HOMELESS COUNCIL

November 20, 2012

Dear Secretary Sebelius:

I write urging you to issue guidance **requiring states to expand Medicaid to the full extent outlined in the Affordable Care Act** (for states that choose to expand), and not allow partial expansions (e.g., only to 100% FPL, leaving those 101% to 133% to purchase insurance on the state Exchanges). As an organization that represents Health Care for the Homeless grantees (HCHs, a special populations segment of the HRSA-funded Health Center program that serves individuals experiencing homelessness) and other homeless health care providers, we believe the Medicaid expansion is one of the most important aspects of the law. Of the 825,295 patients seen at HCHs in 2011, 62% were uninsured, yet 90% were under 100% FPL. Our goal is not only to improve the health of those without housing, but to prevent and end homelessness itself. The expansion of Medicaid to non-disabled adults without dependent children is not only a critical financial resource for health centers such as HCHs, but also a vital lifeline for those very vulnerable adults we serve.

We are greatly concerned that states will be doing a disservice to an impoverished population and to the very systems they are now creating by threatening to only partially expand Medicaid eligibility to those earning less than or equal to 100% FPL. If states are able to establish eligibility to less than 100% FPL, it leaves one portion of their citizenry ineligible for any health insurance options (through Medicaid or the Exchanges). Expanding to only 100% FPL takes away consumer choice, leaving no other option but the private market plans offered on the Exchange. Please consider the following four points as you craft upcoming guidance to States:

- **Consumers should choose, not governments.** The ACA purposefully allowed an overlap between Medicaid eligibility and the state exchanges for those earning between 100% and 133% FPL, specifically to allow greater consumer choice for a transitional population. The ACA did not intend for governments to make this choice for all consumers, thereby cutting off a key option allowed to them under federal law. HHS can protect consumer choice by ensuring that low-income patients in this income group are able to make their own determinations for their health care home—either in Medicaid or in a private plan purchased on the Exchange.

- **Consistency across all states is important.** There will be enough issues related to individuals "churning" between Medicaid and the Exchanges at the 133% FPL income mark without adding an additional "churn" point as they move across state lines in pursuit of work, health insurance or other life opportunities. Having a consistent eligibility across all states was clearly the ACA's intention, and states should not be introducing further fragmentation, which only adds to the collective state administrative burdens, confusion among beneficiaries, and reduced ability to compare costs and health outcomes across all states. The ACA was intended to simplify and streamline health insurance—

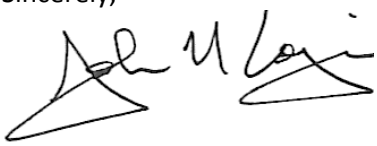
breaking down the very complexities that result from multiple eligibility levels. Allowing all states to set their own, widely varying thresholds works against this goal.

- **Those earning 100-133% FPL are better off under Medicaid.** Lower income individuals generally have greater health care needs and poorer health. The Medicaid program works more effectively for this population specifically because it protects them against the higher out of pocket costs (e.g., premiums, co-pays and deductibles) that will characterize the private plans offered on the Exchange. For an individual, the 100-133% income range translates to $11,170 to $14,856 (roughly $5.40 to $7.00 per hour at a full-time job—not even minimum wage). This level of income is far from adequate to afford stable housing and otherwise provide for independent living. This is still a fragile group and should not be left vulnerable to the additional costs involved with the Exchange (which, even if subsidized, will still amount to 2% of gross income). While all states will vary in their essential health benefit packages, Medicaid has traditionally offered a more comprehensive service structure compared to individual and small group private plans (now to be offered on the Exchange). Individuals and families work hard to rise out of poverty and they deserve not to be undermined by having a crucial safety net program removed at a critical time. Medicaid plans will serve this group better than the Exchanges.

- **Adding the 100-133% FPL population may harm state-based Exchanges.** Because those in the lower income groups generally have poorer health, their care is anticipated to be more expensive. The Congressional Budget Office's July 2012 analysis indicates that costs in the state Exchanges will be 2% higher for this reason. In turn, this jeopardizes the financial stability of the Exchange as a whole (creating a "sick pool"), possibly spreading costs of a sicker population across those at higher income levels, thus creating a disincentive for broader Exchange participation. Hence, in the interests of also protecting the viability of state-based Exchanges, we believe this income group is better served by the Medicaid program.

As Chair of the Interagency Council on Homelessness, you understand and address the connections between poor health and homelessness. We are proud that you have been a champion of the ACA as well as *Opening Doors*—and we hope that you can consider the rationale above when issuing guidance to states. We hope that HHS prohibits states from only partially expanding Medicaid (for those that choose to expand at all). If you or your staff would be interested in talking further about issues related to homelessness and the health needs of this population, please don't hesitate to contact me at jlozier@nhchc.org or at 615-226-2292.

Sincerely,



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