CLASP
Policy solutions that work for low-income people

January 30, 2018

The Honorable Alex Azar
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: New Mexico's proposal for Centennial Care 2.0

Dear Secretary Azar,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the Centennial Care 2.0 1115 Waiver and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in New Mexico.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives"[1] of the Medicaid Act. A waiver that does not promote the provision of health care would not be permissible. This waiver proposals' attempt to transform Medicaid and reverse its core function will result in many adults losing needed coverage, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be

rejected. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

It is important to recognize that limiting parents' access to health care will have significant negative effects on their children as well. Children do better when their parents and other caregivers are healthy, both emotionally and physically.[3] Adults' access to health care supports effective parenting, while untreated physical and mental health needs can get in the way. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.[4] Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[5] Additionally, health insurance coverage is key to the entire family's financial stability, particularly because coverage lifts the burdens of unexpected health problems and related costs. These findings were reinforced in a new study, which found that when parents were enrolled in Medicaid their children were more likely to have annual well-child visits.[6]

Our specific comments are below.

Premiums and Lock Out Periods are Barriers to Care

New Mexico's proposal would require individuals with incomes between 100 and 138 percent of the poverty line to pay $10 in monthly premiums in 2019, increasing to $20 per month in 2020. Individuals must pay their monthly premium to effectuate coverage, and if they aren't able to pay or aren't aware of the requirement, they would be locked out of coverage for 90 days. Individuals could only regain coverage after completion of the 90-day lockout and upon payment of any unpaid premiums.

No state has ever been allowed to require beneficiaries to pay unpaid premiums after a lockout period as a condition of regaining coverage and allowing a state to do so would not meet the objectives of the Medicaid program. Such a policy would likely cause people who are disenrolled for unpaid premiums to remain uninsured indefinitely because of the high cost of reenrollment. For example, if the state imposes a $20 monthly premium, and an individual misses three months of premium payments, they would need $80 to reenroll ($60 for past premiums and $20 for the first month of coverage).

A large body of research shows that even modest premiums keep people from enrolling in coverage.[7] A recent literature review by the Kaiser Family Foundation examined 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income people enrolled in Medicaid and CHIP. The authors concluded that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty. The research shows that while some individuals losing Medicaid or CHIP coverage move to other coverage, many become uninsured. Those with lower incomes are most likely to become uninsured. Once uninsured, people face increased barriers to accessing care, greater unmet health needs and increased financial burdens.[8]

In Oregon, for example, nearly half of adults disenrolled from Medicaid after premiums increased to a maximum of $20. Many former enrollees became uninsured and faced barriers to obtaining care.[9] Similarly, a recent study of the Healthy Indiana Plan, which requires adults to pay between $1 and $27 in monthly premiums to enroll in a more comprehensive plan, found that 55 percent of eligible individuals either did not make their initial payment or missed a payment.[10]

Moreover, recent research shows that state savings from premiums are limited. Studies find that potential increases in revenue from premiums are offset by the use of more expensive services, such as emergency room care, and costs in other areas—such as resources for uninsured individuals, and administrative expenses.[11] For example, a recent study looking at Arkansas' Independence Accounts found that they were not cost effective to implement because the administrative costs were so high. The state collected $426,457

from eligible enrollees but spent $595,135 in co-payment protections.[12] In addition to spending more than it collected, the state spent $9 million to contract with a vendor to manage the accounts.[13]

The research is clear that premiums decrease participation in Medicaid and increase uninsurance and hardship. States should no longer be permitted to use 1115 waiver demonstrations to test the effect of premiums in Medicaid.

Copayments and Missed Appointment Fees Would Deter Needed Care

The proposal also requests authority to charge a $10 copayment for non-preferred prescription drugs and a $25 copayment for emergency department (ED) use that the state claims is "non-emergent." New Mexico states its hypothesis for these copayments as, "Copayments for certain service will drive more appropriate use of services, such as reducing non-emergent use of the emergency department." However, this hypothesis is inconsistent with a significant body of research showing that copayments are a barrier to obtaining appropriate care. Moreover, under section 1916(f) of the Social Security Act (the Act), a state that wants to impose cost-sharing that exceeds statutory limits must meet specific criteria:

1. The state's proposal will test a previously untested use of copayments;
2. The waiver period cannot exceed two years;
3. The benefits to the enrollees are reasonably equivalent to the risks;
4. The proposal is based on a reasonable hypothesis to be tested in a methodologically sound manner; and
5. Beneficiary participation in the proposal is voluntary.

New Mexico's proposal does not meet these criteria; in fact, the state doesn't even acknowledge these statutory criteria. Moreover, the state proposes to use a broad standard of non-emergency care that could keep people from getting the emergency care they need. Not only could this broad standard of non-emergency care harm beneficiaries, but the copayment itself could prevent people from seeking care. The review of the literature on premiums and cost-sharing discussed above found that even small levels of cost sharing, in the range of $1 to $5, are associated with reduced use of care, including necessary services. The review cites numerous studies that have found that cost sharing has negative effects on individuals' abilities to access needed care and health outcomes and increases financial burdens for families.[14]

The state is also requesting authority to forgo tracking out-of-pocket spending that is needed to ensure that premiums and co-pays imposed on beneficiaries don't exceed Medicaid's five percent aggregate out-of-pocket spending maximum. New Mexico states that such tracking is no longer necessary since premiums are set at 2 percent of income and that the only copayments beneficiaries are subject to would "only be imposed based on the choice of the beneficiary to access such services." The state would need a waiver under section 1916(f) of the Act to implement such a proposal, but New Mexico did not include information on how it meets the statutory criteria for such a waiver in its proposal. Moreover, such a policy could harm the financial security of Medicaid beneficiaries, and is inconsistent with the purpose of an out-of-pocket spending maximum, which is intended to protect individuals from financial harm. Finally, obtaining health care isn't a choice; beneficiaries shouldn't be penalized for getting the care they need by having to pay more than they should under Medicaid rules.

Finally, New Mexico is seeking authority to impose a $5 missed appointment fee after a beneficiary has missed three scheduled appointments in a given calendar year without prior notification by the beneficiary to the provider. This proposal does not take into account any hardship a beneficiary may experience in

seeking medical care, such as lack of transportation, ability to notify the provider in a timely manner, mental health challenges etc., and would therefore create unacceptable barriers to care.

Retroactive Eligibility and Transitional Medical Assistance are Crucial for Beneficiaries and Providers

New Mexico's proposal would end Medicaid payments for medical costs that beneficiaries incurred up to three months before enrolling in Medicaid if they were eligible for Medicaid during that period. The state is proposing to phase-in this policy by reducing the period of retroactive eligibility from 3 months to one month in 2019, and eliminating it altogether starting in 2020.

First, New Mexico's proposal isn't specific as to which eligibility groups would be subject to the retroactive coverage waiver. The proposal states that *most* (non-SSI) Centennial Care members would be subject to the waiver. Retroactive coverage is an important Medicaid protection because it prevents medical debt and even bankruptcy and provides financial security to vulnerable beneficiaries, especially seniors and adults with disabilities who need long-term services and supports and may not be familiar with Medicaid or its eligibility rules.

While the New Mexico indicates in its proposal that about 10,000 beneficiaries requested retroactive coverage in 2016, the financial protection for these individuals could have been significant. For example, data from Indiana showed that, on average, individuals with medical bills incurred prior to enrollment owed $1,561 to providers, which Medicaid would pay.[15] Ending retroactive coverage would pose significant financial harm to both Medicaid beneficiaries and safety net providers.

In addition to protecting vulnerable individuals, retroactive coverage helps ensure the financial stability of safety net providers by paying for medical services that would otherwise have been uncompensated. Retroactive coverage provides reimbursement to hospitals and other safety net providers for care they have provided during the three-month period, helping them meet their daily operating costs and maintain quality of care.

New Mexico is also seeking authority to end another important Medicaid protection — Transitional Medical Assistance (TMA). Under TMA, parents and caretaker relatives who lose Medicaid coverage due to increases in income remain in Medicaid for up to an additional 12 months. To our knowledge, no state has ever received such a waiver. Eliminating TMA would have a negative effect on the health and well-being of adults and their children's. Studies show that children are more likely to have health insurance if their parents are covered.[16] Losing coverage would mean children and their parents would go without needed medical care or that they would incur significant medical debt when they did seek care. For example, studies have shown that expanding Medicaid coverage results in fewer debts being sent to third-party collection agencies.[17]

Thank you for consideration of these comments. If you have any questions, please contact Suzanne Wikle at **swikle@clasp.org**.

[1] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, **http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRlBFWnHIU**.

[2] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., Health Insurance Coverage and Health — What the Recent Evidence Tells Us, New England Journal of Medicine, July 21, 2017. **http://www.nejm.org/doi/full/10.1056/NEJMsb1706645.**

[3] Jack Shonkoff, Andrew Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," Pediatrics, December 2011, **http://pediatrics.aappublications.org/content/early/2011/12/21/peds.2011-2663**.

[4] Stephanie Schmit and Christina Walker, "Seizing New Policy Opportunities to Help Low-Income Mothers with Depression," CLASP, 2016, **http://www.clasp.org/resources-and-publications/publication-1/Opportunities-to-Help-Low-Income-Mothers-with-Depression-2.pdf**.

[5] National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation, "Maternal Depression Can Undermine the Development of Young Children," Center on the Developing Child, Harvard University, Working Paper 8, 2009, **http://developingchild.harvard.edu/resources/maternal-depression-can-undermine-thedevelopment-of-young-children**.

[6] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," Pediatrics. 2017;140(6):e20170953, **http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf**.

[7] David Machledt, "What Makes Medicaid, Medicaid? Affordability." National Health Law Program. March 2017. **http://www.healthlaw.org/issues/medicaid/what-makes-medicaid-medicaid-affordability#.WQn1BlPytPM.**

[8] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, **http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.**

[9] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, **http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/**.

[10] *Ibid.,* see also The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA)," March 2017. Premiums in Healthy Indiana are generally set at 2 percent of household income or $1 a month for people with incomes below 5 percent of the poverty line.

[11] *Op cit.,* Artiga, Ubri, and Zur 2017.

[12] By making monthly contributions to their accounts, enrollees were "protected," or not required to pay co-payments for services rendered in the subsequent. The $595,135 represents state spending to offset the enrollee's co-payment Obligation.

[13] Joseph Thompson, et al., "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population," Arkanasa Center for Health Improvement, June 27, 2017, **https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272**.

[14] Op cit., Artiga, Ubri, and Zur 2017.

[15] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at **https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf**.

[16] Georgetown Center for Children and Families, "Healthy Parents and Caregivers are Essential to Children's Healthy Development," December 2016, **http://ccf.georgetown.edu/wp-content/uploads/2016/12/Parents-and-Caregivers-12-12.pdf**.

[17] Matt Broaddus, "Medicaid Improves Financial Well-Being, Research Finds," Center on Budget and Policy Priorities, April 28, 2016, **http://www.cbpp.org/blog/medicaid-improves-financial-well-being-research-finds.**