January 29, 2018
The Honorable Eric D. Hargan, Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via Medicaid.gov

Re: Public Comments on New Mexico Human Services Department's Centennial Care 2.0 extension application

Dear Secretary Hargan,

Raising Women's Voices for the Health Care We Need is a national initiative working to ensure that the health care needs of women and our families are addressed in health reform. We have a special mission of engaging women who are not often invited into health policy discussions: women of color, low-income women, immigrant women, young women, women with disabilities, and members of the LGBTQ community. We place a priority on asking women to share their experiences navigating the health care system.

The New Mexico Religious Coalition for Reproductive Choice (RCRC) is part of the national RCRC movement, which values and promotes religious liberty and upholds the human and constitutional rights of all people to exercise their conscience to make their own reproductive health decisions without shame and stigma. RCRC challenges systems of oppression and seeks to remove the multiple barriers that impede individuals, especially those in marginalized communities, in accessing comprehensive reproductive health care with respect and dignity.

We appreciate the opportunity to comment on the New Mexico Human Services Department's (HSD) Centennial Care 2.0 extension application, which currently covers some of the most vulnerable populations in the state, including low-income women and children, as well as tribal members. Overall, we support aspects of the proposal that are likely to expand and improve care for Medicaid beneficiaries, including promoting behavioral health integration, increasing care coordination and flexibility around Indian Health Services (IHS) services, supporting housing services, and increasing funding to maintain an inventory of long-acting reversible contraception for certain providers.

However, we are concerned that several other provisions in the waiver application, including charging premiums, copays and missed appointment fees, gradually phasing out retroactive eligibility, eliminating transitional Medicaid, and changing the eligibility for family planning services and supplies will only lead to women losing coverage and being unable to access care.

While the proposed changes to Medicaid will have a significant, detrimental impact on all low-income individuals, the consequences will be exacerbated for women, whose unique circumstances make them particularly vulnerable. Women live in poverty at higher rates than men do and are much less likely than men to have employer-provided insurance in their own

names.[i] Thus, even women with insurance are at greater risk than men of losing it following changes in their relationship status or in the family coverage offered by their spouse's employer. Unsurprisingly, women are more likely to fall into the Medicaid gap than men, and women of color are particularly vulnerable. In 2013, prior to expansion, a quarter of Black women and a third of Latina women were uninsured.[ii]

At the same time, women are more likely to face non-cost barriers to care. More than one in four low-income women (26%) delayed getting needed health care or skipped it altogether because they couldn't get time off of work, while one in five women with children (19%) did so because they couldn't find child care.[iii] These factors make women more vulnerable to the policy changes proposed. **Overall, we believe the provisions below do not promote the objectives of Medicaid and are likely to particularly harm New Mexico women. We urge the Department of Health and Human Services to reject these aspects of the proposal.**

Requiring premiums, as well as instituting lockout periods, will increase the number of uninsured women and result in barriers to care

HSD seeks to impose premiums starting at 1% of income for expansion adults between 100-138% FPL, with the flexibility to increase this amount to 2% of income in future years of the demonstration. HSD also proposes to eliminate retroactive coverage for this group so that coverage will not take effect until premiums are paid, and to lock these individuals out of coverage for three months if they fail to make up premium payment. We appreciate that HSD decided against imposing premiums on Children's Health Insurance Program (CHIP) enrollees and the Working Disabled population over 100% FPL, as a result of comments received previously. However, we are still concerned that imposing premiums on expansion adults will cause women to lose coverage and access to care. We therefore urge HHS to reject these proposals.

Several decades and bodies of research confirm that imposing premiums on low-income individuals causes them to lose coverage, and once uninsured, these individuals face significant barriers to care and larger unmet health needs than those with coverage. For example, a recent report from the Kaiser Family Foundation looked at research from 65 papers published between 2000 and March 2017 on the effects of premiums on Medicaid and CHIP enrollees, and found that premiums are a barrier to obtaining Medicaid and CHIP coverage.[iv] Evidence from several states also confirms the conclusion that imposing premiums causes coverage losses. For example, in Oregon, nearly half of adults disenrolled from Medicaid after premiums increased to $20.[v] Similarly, a recent study of the Healthy Indiana Plan, which requires adults to pay between $1 and $100 in monthly premiums to enroll in a more comprehensive plan, found that 55% of eligible individuals either did not make their initial payment or missed a payment.[vi] Lastly, in Florida, a $5 premium increase for CHIP enrollees between 101-150% FPL resulted in 61% of children being disenrolled.

The impact of these premium increases are felt even more strongly by women—who earn less, have fewer financial resources, and are more likely to be taking care of family members. Not surprisingly, then, significantly more women than men are forced to forgo care when costs increase.[vii] And women who fall behind in their payments are likely to find themselves permanently locked out of care.

We're also concerned that disenrolling women who fall behind on premium payments for three months will take away their access to needed care while sick, which could result in increased hospitalizations and emergency room utilization. Therefore, the premium and lockout provisions will not only increase the number of uninsured women, preventing them from accessing much needed care, but also worsen health outcomes.

Recent research also shows that state savings from collecting premiums are limited. Studies find that potential increases in revenue from premiums are often offset by care costs and administrative expenses.[viii] For example, a recent study looking at Arkansas' Independence Accounts found that they were not cost effective to implement. The state collected $426,457 from eligible enrollees, but spent $595,135 in co-payment collections. In addition to spending more than it collected, the state spent $9 million to contract with a vendor to manage the accounts.[ix] Because of the coverage losses likely to result from premiums, the uninsured rate and uncompensated care costs in New Mexico will likely skyrocket, causing more individuals to seek care at the emergency room (ER) and straining safety net providers and the state budget in the process.

Instituting copays will also result in barriers to care, and missed appointment fees will cause financial hardship that will worsen health

HSD seeks to impose copays for non-emergent uses of the ER and use of a non-preferred drug when a preferred and equivalent drug is available (with the exceptions of psychotropic drugs, contraceptive drugs and devices, any non-preferred drug deemed medically necessary or proven to be more effective or cause less adverse reactions than a preferred drug) on almost all Centennial Care enrollees. Additionally, HSD seeks to request authority to allow providers to charge a $5 fee on patients who miss three or more appointments.

Imposing copays for using the health care system in these two ways unfairly requires Centennial Care enrollees to have the same knowledge as medical providers regarding whether symptoms they are experiencing qualify as an "emergent" condition. Moreover, studies on the effects of imposing cost-sharing requirements on low-income populations have shown that imposing higher costs leads to reduced use of care, including necessary services.[x] [xi] In fact, an analysis of the famous RAND health insurance experiment has shown that while instituting cost-sharing requirements helped reduce government health care expenditures, the reduction was based on individuals deciding not to receive services or treatment, rather than making "savvier" health care choices.[xii] We are concerned that imposing copays will cause women to initially forego care, which will likely lead to costlier care in the future.

Imposing nominal fees for missed appointments in no way furthers the goal of the Medicaid program, which is to provide health care to individuals "whose income and resources are insufficient to meet the costs of necessary medical services." HSD even admits in its application that the missed appointment fees do not further any of the waiver's intended goals, but rather are simply to address recent provider complaints regarding expansion adults missing appointments. There are plenty of reasons why an individual may have to miss a scheduled appointment, including lack of access to reliable transportation, fluctuating work hours or unanticipated employment or childcare needs. And these factors are more likely to affect women than men. Rather than penalize women for missing appointments for reasons that may have been outside of their control, HSD should instead focus on only incentivizing and rewarding

individuals for engaging in certain behaviors or using certain health care services and foregoing a punitive component, as it's already planning to do with its Centennial Rewards program.

Waiving retroactive eligibility will put new Centennial Care beneficiaries at risk of medical debt

HSD seeks to reduce Medicaid's 90-day retroactive eligibility period to a one-month period in 2019 before completely eliminating the policy in 2020, which will be harmful to women and families. Retroactive eligibility is an important protection against medical debt for low-income women who need access to medical care before enrolling in Medicaid, as well as protection for providers against the risk of bad medical debt. 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.[xiii] Women are already uniquely affected by medical debt and are more likely than men to report having such problems.[xiv] In 2016, 42 percent of women, or 40 million, reported having a medical bill problem in the past year or medical debt.[xv]

We firmly believe that retroactive eligibility should not be waived for Centennial Care enrollees and violates the waiver's intended goal of preserving the state's limited financial resources for the most needy populations. None of the Department's goals align with the goals of the Medicaid program and instead, will likely only serve to hinder the program's intended goal of providing medically necessary care to low-income individuals.

Transitional Medicaid cannot be waived under federal law

We urge HHS to reject HSD's proposed elimination of the Transitional Medicaid program because this program cannot be waived under federal law. Rather, federal Medicaid law contains an independent requirement that clearly states each state must provide transitional Medicaid "[not]withstanding any other provisions of this subchapter."[xvi] Furthermore, the statute says that even if a state is granted a Section 1115 waiver, the "Secretary shall require the state to meet the requirements of this section in the same manner as the state would be required to meet such requirement if the state had in effect a plan approved under this subchapter."[xvii] Therefore, all states must continue to provide Transitional Medicaid Assistance as though they were operating under a state plan. Finally, the HHS Secretary is prohibited from exercising his or her authority to waive any part of 42 USC 1396r-6.

Changing the eligibility for family planning services and supplies will mean fewer women have access to critical reproductive health services.

While we support New Mexico's request for additional administrative funding to maintain an inventory of long-acting reversible contraception for certain providers, we are concerned about other aspects of the waiver that will negatively affect women's access to family planning services and supplies. Currently, individuals who apply for Medicaid, but do not meet the financial eligibility standards to qualify for full coverage, are eligible for services under the state Medicaid Family Planning program. The proposal seeks to change this by limiting family planning services and supplies to those under 50 who have no other health insurance coverage, with few exceptions. This proposed change will reduce the number of women and men able to access critical family planning services and supplies, such as contraception and screenings for STIs, which will increase the rates of unintended pregnancies in New Mexico, and worsen health outcomes for women and their children.[xviii] We believe the age restrictions proposed by HSD are problematic, as there are women over 50 who may still need or want access to contraceptives, as well as menopausal women who need or want access to contraceptives for hormone

replacement therapy. HSD has not adequately addressed or responded to the comments they received previously expressing concern that this change would cause individuals to lose access to care.

In conclusion, we urge you to reject provisions whose impact would be particularly harmful to New Mexico's women and the gains they have made under the current expansion.

Sincerely,

Raising Women's Voices for the Health Care We Need
New Mexico Religious Coalition for Reproductive Choice

---

[i] "Women's Health Insurance Coverage," Kaiser Family Foundation, February 2, 2016, http://kff.org/womens-health-policy/fact-sheet/womens-health-insurance-coverage-fact-sheet/

[ii] Eichner A, Gallagher Robbins K, "National Snapshot: Poverty Among Women & Families, 2014," National Women's Law Center, September 2015, http://nwlc.org/wp-content/uploads/2015/08/povertysnapshot2014.pdf

[iii] Salganicoff A, Ranji U, Beamesderfer A, Kurani N, "Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey," Kaiser Family Foundation, May 2014, https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

[iv] Artiga S, Ubri, P, Zur, J, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 1, 2017. http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[v] Ku L and Wachino V, *The Effect of Increased Cost-Sharing in Medicaid*, Center on Budget and Policy Priorities, July 2005, https://www.cbpp.org/research/the-effect-of-increased-cost-sharing-in-medicaid

[vi] The Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, Prepared for Indiana Family and Social Services Administration (FSSA), March 2017.

[vii] Salganicoff A, Ranji U, Beamesderfer A, Kurani N, "Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey," Kaiser Family Foundation, May 2014, https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-the-affordable-care-act.pdf

[viii] Artiga S, Ubri, P, Zur, J, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 1, 2017. http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[ix] Thompson J, Goudie A, Self J, Shah A, Tilford J, "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population, Academy Health, June 2017, https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272

[x] Artiga S, Ubri, P, Zur, J, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 1, 2017. http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[xi] Eaddy M, Cook C, O'Day K, Burch S, Cantrell R, "How Patient Cost-Sharing Trends Affect Adherence and Outcomes," Pharmacy and Therapeutics, January 2012, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3278192/

[xii] Chernew M, Newhouse J, "What Does the RAND Health Insurance Experiment Tell us About the Impact of Patient Cost Sharing on Health Outcomes?," The American Journal of Managed Care, July 15, 2008, http://www.ajmc.com/journals/issue/2008/2008-07-vol14-n7/Jul08-3414p412-414/

[xiii] Wachino V, Letter to Tyler Ann McGuffee, July 29, 2016, 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

[xiv] Hamel L, Norton M, Pollitz K, Levitt L, Claxton G, Brodie M, "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey," Kaiser Family Foundation, January 5, 2016, https://www.kff.org/report-section/the-burden-of-medical-debt-section-1-who-has-medical-bill-problems-and-what-are-the-contributing-factors/

[xv] "How the Affordable He Care Act Has Helped Women Gain Insurance and Improved Their Ability to Get Health Care," The Commonwealth Fund, http://www.commonwealthfund.org/publications/issue-briefs/2017/aug/aca-helped-women-gain-insurance-and-access

[xvi] 42 USC 1396-r6

[xvii] 42 USC 1396r-6(c)(1)

[xviii] Kavanaugh M, Anderson R, "Contraception and Beyond: The Health Benefits of Services Provided at Family Planning Centers," Guttmacher Institute, July 2013, https://www.guttmacher.org/sites/default/files/report_pdf/health-benefits.pdf