National
Family Planning
& Reproductive Health Association

September 15, 2017

Seema Verma, MPH
Administrator, Centers for Medicare and Medicaid Services
200 Independence Avenue, SW
Washington, DC 20201

Re: Maine's § 1115 Demonstration Application

Dear Administrator Verma:

The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to provide comments on the MaineCare demonstration application. For the reasons outlined below, we urge the Department of Health and Human Services (HHS) to reject the application as proposed.

NFPRHA is a national membership organization representing the nation's publicly funded family planning providers – nurse practitioners, nurses, administrators, and other key health care professionals. NFPRHA's members operate or fund a network of more than 3,500 health centers and service sites that provide high-quality family planning and other preventive health services to millions of low-income, uninsured, or underinsured individuals in 50 states and the District of Columbia. Services are provided through state, county, and local health departments as well as hospitals, family planning councils, Planned Parenthoods, federally qualified health centers and other private non-profit organizations.

NFPRHA recommends that HHS not approve the MaineCare application. The application contains a number of troubling provisions that would be harmful to low-income people who need Medicaid coverage to obtain critical health care services, including family planning and sexual health services. For this and other reasons, the application does not meet the requirements for approval under § 1115.

HHS Authority and § 1115

To be approved pursuant to § 1115, Maine's application must:

- propose an "experiment, pilot, or demonstration";
- waive compliance only with requirements in 42 USC § 1396a;
- be likely to promote the objectives of the Medicaid Act; and
- be approved only "to the extent and for the period necessary" to carry out the experiment.[1]

[1] 42 USC § 1315(a).

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are too poor 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.[2] As explained below, Maine's proposals to impose work requirements, charge individuals a premium and impose a lock-out period for failure to pay, charge emergency room copayments, eliminate retroactive eligibility, reinstate the asset test, and eliminate presumptive eligibility cannot be approved because, separately and together, they are inconsistent with the provisions of § 1115.

Work Requirements and Lock-Out Penalty

Maine proposes requiring "able-bodied" adults ages 19-64 to engage in at least 20 hours of work or other approved activities each week. Failure to engage in these activities for three months during a 36-month period will result in termination of MaineCare. Individuals will only be able to regain eligibility by waiting until the end of the 36-month period or by engaging in approved work or other activities. The Secretary must deny this proposal, as it is contrary to the objectives of Medicaid and offers no legitimate experimental purpose.

The work requirements are not likely to promote Medicaid's objectives. Conditioning Medicaid eligibility on completion of a work requirement is contradictory to the program's objectives because it blocks access to care and services that help individuals attain and retain independence or self-care that enable them to work.[3] Research confirms that Medicaid coverage allows individuals to obtain and maintain employment. For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[4] In addition, considerable scientific evidence, including surveys of women themselves, demonstrates that access to family planning services helps women to complete their education, find and hold

---

[2] 42 USC § 1396a-1.

[3] By contrast, as far back as the 1970s, states obtained Section 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, http://aspe.hhs.gov.hsp/isp/waiver2/waivers.htm.

[4] Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf. Additional evidence disproves Maine's apparent assumption that Medicaid serves as a deterrent to work. Medicaid enrollment fluctuates with the economy - enrollment increases during economic recessions and the resultant losses in jobs and employer-sponsored insurance. Kaiser Family Foundation, *The Role of Medicaid in State Economies: A Look at the Research*, January 2009, at 2 *available at https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7075_02.pdf*.

steady employment, and care for themselves and their families.[5] By preventing Maine residents from receiving family planning services through Medicaid, the work requirements will undermine the ability of low-income women to improve their economic circumstances.

Moreover, a recent study by the Kaiser Family Foundation confirmed that the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[6] Thirty-five percent of adult Medicaid enrollees who were not receiving disability benefits and did not have a job reported illness or disability as their primary reason for not working.[7] While the application indicates that the work requirements will not apply to individuals who are receiving disability benefits or who are physically or mentally unable to work, evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be—often due to verification requirements—and are more likely than other individuals to lose benefits.[8]

Extensive research has revealed that a mandatory work requirement does not effectively increase self-sufficiency. Studies of cash assistance programs have already established that a work requirement does little to increase stable, long-term employment and does not decrease poverty.[9] In fact, implementation of the work requirement in the Temporary Assistance for Needy Families (TANF) program led to more individuals—particularly single mothers—living in extreme poverty, as they were unable to get a job and lost their eligibility for benefits.

A far better, evidence-based approach would be to connect MaineCare enrollees to properly resourced voluntary employment programs, an activity that does not need waiver approval from

---

[5] Sonfield A, What women already know: documenting the social and economic benefits of family planning, *Guttmacher Policy Review*, 2013, 16(1):8-12, https://www.guttmacher.org/gpr/2013/03/what-women-already-know-documenting-social-and-economic-benefits-family-planning.

[6] Rachel Garfield, Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work (finding that almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves).

[7] *Id.*

[8] *See, e.g.*, Andrew J. Cherlin et. al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 Soc. Serv. Rev. 387, 398 (finding that individuals in "poor" or "fair" health were more likely to lose TANF benefits than those in "good," "very good," or "excellent health"); Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities,* 4, 14 (2014); Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf (finding that one-third of individuals referred to a SNAP employment and training program in reported a physical or mental limitation, and 25% of these individuals indicated the condition limited their daily activities).

[9] LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Management 231, 234 (2016).

CMS. Studies show that these voluntary employment programs increase employment and income among low-income individuals.[10]

Premiums and Lock-Out Penalty

Beginning at 51% of the federal poverty level (FPL), Maine seeks to impose premiums on able-bodied individuals between the ages of 19-64, including parents, children ages 19 and 20, adults seeking family planning services, and former foster care children. Under the proposal, non-payment of the premiums bars coverage for 90 days, or until the amount is paid, whichever comes first. The proposal exceeds statutory limits on § 1115 waivers, does not promote the objectives of the Medicaid Act, and is not experimental.

As stated above, § 1115 only permits the Secretary to waive compliance with the requirements of 42 USC § 1396a. But the provisions on premiums are contained in independent, free-standing requirements set forth at 42 USC §§ 1396o, 1396o-1. While these provisions provide states with a great deal of flexibility to impose premiums and cost sharing, they prohibit imposing premiums on individuals with incomes below 150% FPL, and as a result, also prohibit the lock-out penalty for failure to pay. The Secretary should deny this request because he does not have the authority to grant it under § 1115.

The premiums are also not experimental and not likely to advance the objectives of the Medicaid Act. An ample body of research already clearly demonstrates that the imposition of premiums on very low-income populations only reduces access to coverage.[11] This longstanding research consistently reaches the same conclusion: premiums lead low-income individuals to lose health care coverage, and they increase expenditures when sick but uninsured individuals delay care until they need emergency, urgent, and/or acute care.[12] The lock-out penalty for failure to pay makes Maine's proposal even more problematic; it will

---

[10] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

[11] "Research examining the impact of premiums in public programs has found that participation falls off sharply as the premium amount increases" *Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations* by Julie Hudman and Molly O'Malley, The Kaiser Commission on Medicaid and the Uninsured , March 2003, available at http://www.academia.edu/6759690/Health_Insurance_Premiums_and_Cost-Sharing_Findings_from_the_Research_on_Low-Income_Populations; and "Research has shown that as premiums rise, fewer low-income people participate in health insurance voluntarily." *ENSURING AFFORDABLE HEALTH COVERAGE AND HEALTH CARE SERVICES IN AN INSURANCE EXCHANGE* by Judith Solomon available at http://www.cbpp.org/sites/default/files/atoms/files/5-21-09health2.pdf.

[12] *See*, *e.g.*, Samantha Artiga et al., KAISER FAM. FOUND., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (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/; David Machledt & Jane Perkins, NAT. HEALTH LAW PROGRAM, *Medicaid Premiums & Cost Sharing and Premiums* (March 2014), http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing.

further increase the number of uninsured individuals, counteracting any effort to promote continuity of care and harming the provider infrastructure in Maine (as providers will continue to treat uninsured patients).

Finally, we are deeply concerned that the proposed waiver would require adults enrolled in family planning-only coverage to pay premiums. Federal law recognizes the intimate nature of family planning services and the need to provide unimpeded access to family planning care, requiring states to cover family planning services and supplies,[13] providing states the option to offer family planning-only coverage (as Maine has chosen to do),[14] and stipulating that family planning services and supplies must be free from cost-sharing requirements.[15] Applying the premium requirement to individuals who receive only family planning services is particularly misguided in part because the premium charge (as much as $360 a year) would likely be greater than what the state actually spends on Medicaid services for these enrollees or the amount an individual would pay out of pocket for many contraceptive options. Therefore, a premium requirement would dissuade people from enrolling in family planning-only coverage, leading them to rely on more limited over-the-counter options or on subsidized care from safety-net providers, who have very limited grant funding.

For all of these reasons, HHS should deny the state's proposal to impose premiums on MaineCare enrollees, including adults enrolled in the state's family planning expansion.

Eligibility Changes

Maine proposes to make several changes to the eligibility process, each of which will impose barriers to care and result in disenrollment from the program. Accordingly, these proposals do not promote the objectives of the Medicaid Act, and further, serve no experimental purpose.

Elimination of Retroactive Eligibility

The proposed waiver seeks elimination of retroactive eligibility under 42 USC § 1396a(a)(34), which requires retroactive coverage for the three months prior to the month of application, provided that the individual otherwise meets the eligibility requirements during the months and has incurred medical expenses. The purpose of the change is to make MaineCare "consistent with private insurance coverage," designed to have providers determine insurance status at the time of delivering the service and not later, and to encourage people to enroll in coverage to receive preventive services.

These goals are not consistent with the objectives of the Medicaid Act and misunderstand the difference between MaineCare and private insurance. MaineCare

[13] 42 USC §§ 1396a(a)(10)(A), 1396d(a)(4)(C).

[14] *Id.* §§ 1396a(a)(10)(A)(ii)(XXI), 1396a(ii).

[15] 42 USC §§ 1396o(a)(2)(D), 1396o(b)(2)(D), 1396o-1(b)(3)(B)(vii); 42 CFR § 447.53(b)(5).

eligibility is determined monthly, and in each month the person must both be in a coverable group and meet the financial requirements for that group. Thus, a person who is a non-disabled, non-pregnant adult without children is not eligible until, for example, they become a parent, disabled, or pregnant. If any of these events occur, for example, towards the end of the month, the failure to file an application before the end of that month will result in no coverage under this policy. Thus, it is sheer chance, and not some notion of lack of personal responsibility, that very often controls whether it is appropriate to submit an application.

Eliminating retroactive coverage will have predictable and harmful results. First, more low-income people will have medical debt that they are unable to pay, which could force them to declare bankruptcy. Second, more providers, especially safety net hospitals, will face financial losses. Without the ability to retroactively claim for care provided to Medicaid-eligible individuals, providers will see an increase in uncompensated care, making it challenging for them to keep their doors open to serve the most vulnerable Maine residents. Finally, more individuals will be denied appropriate treatment when providers refuse to treat them because they know they will not be paid retroactively by Medicaid or by the individuals. Timely access to care is particularly important in the context of family planning and sexual health care, as such health services are often time-sensitive; only a few days without contraception can result in an unintended pregnancy, and sexually transmitted infections that go untested and untreated can spread throughout communities. By eliminating retroactive eligibility, Maine will delay access to these critical family planning and sexual health services, at great cost to both individuals and the overall health system.

Reinstating the Asset Test

Until several years ago, asset tests were a standard eligibility requirement for all eligibility categories, including those affected by this waiver (parents, children, and pregnant women), although, prior to that Maine, like most other states, had dropped its asset test for children. However, the Affordable Care Act (ACA) removed asset tests as an eligibility requirement for specified eligibility groups. Moreover, Congress expressly limited the Secretary's authority to grant waivers like the one Maine proposes.[16] Thus, the Secretary has no authority to grant this portion of Maine's waiver.

In addition, it is difficult to understand what experimental value this proposal could have. After decades of asset tests and research examining them, Maine has not described what new information will be learned. It is now well understood that asset tests are cumbersome to administer and complicated for applicants and recipients. In fact, prior to the changes in the Affordable Care Act (ACA), § 1115 waivers were utilized

[16] 42 USC Section 1396a(e)(14)(C) and (F).

to demonstrate the impact of *eliminating* asset tests, and those demonstrations did yield valuable information.[17] After considering the decades-long effect of asset tests, Congress eliminated asset tests for parents, children and pregnant women, among others, applying this policy to both state plan and waiver programs, and limited the States' and the Secretary's authority to revert to the old policy.

Therefore, the proposed waiver to reinstitute an asset test not only violates federal law, but it has no merit as an experiment because it provides no opportunity to examine untested policy measures. In addition, it will not improve health outcomes.

Importance of Medicaid for Family Planning and Sexual Health

In addition, imposing barriers to coverage and care—as Maine's waiver proposal would do through work requirements, premiums, lock-out periods, eligibility limitations and more—would be extremely harmful to family planning and sexual health. That is because Medicaid is the central US program for ensuring that low-income people have coverage for and access to family planning, pregnancy-related care, STI testing and treatment, and other preventive health services.[18]

First, Medicaid is an essential source of health coverage for women of reproductive age, covering 20% of US women ages 15-44 in 2015 and 21% in Maine.[19] It is particularly important for poor women, covering 48% of US reproductive-age women with incomes below the federal poverty line.

Second, Medicaid is central to the US family planning effort. Federal Medicaid law and regulations include strong protections for coverage of family planning services and supplies, without cost-sharing and free of coercion. And about half of states, including Maine, have expanded eligibility for family planning services to individuals otherwise ineligible for Medicaid. As a result, Medicaid accounts for 75% of all public dollars spent on family planning in the United States.[20] That overall US family planning effort helped women and couples avoid 1.9

---

[17] Vernon K. Smith, Eileen Ellis and Christina Chang, "Eliminating the Medicaid Asset Test for Families: A Review of State Experiences," Kaiser Commission on Medicaid and the Uninsured, April 2001, *https://kaiserfamilyfoundation.files.wordpress.com/2001/04/2239-eliminating-the-medicaid-asset-test.pdf.*

[18] Sonfield A, Why protecting Medicaid means protecting sexual and reproductive health, *Guttmacher Policy Review,* 2017, 20:39-43, https://www.guttmacher.org/gpr/2017/03/why-protecting-medicaid-means-protecting-sexual-and-reproductive-health.

[19] Guttmacher Institute, Uninsured rate among women of reproductive age has fallen more than one-third under the Affordable Care Act, *News in Context,* Nov. 17, 2016, https://www.guttmacher.org/article/2016/11/uninsured-rate-among-women-reproductive-age-has-fallen-more-one-third-under.

[20] Hasstedt K, Sonfield A and Gold RB, Public Funding for Family Planning and Abortion Services, FY 1980-2015, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/public-funding-family-planning-abortion-services-fy-1980-2015.

million unintended pregnancies in 2015, and the abortions, unplanned births, and miscarriages that would otherwise follow.[21]

Third, Medicaid is also crucial for pregnancy-related care. Again, federal Medicaid law includes long-standing protections for coverage of maternity care, including prenatal care, labor and delivery, and postpartum care. And states provide Medicaid coverage for pregnancy-related care for many women who are otherwise be ineligible: up to 214% of poverty in Maine.[22] With this extensive coverage, Medicaid covers roughly half of all US births, including 53% in Maine, for women who would find it difficult if not impossible to pay out of pocket for pregnancy-related care and infant care.[23]

Finally, Medicaid helps patients address HIV and other STIs, breast and cervical cancer, intimate partner violence, and other sexual health-related issues. That includes vaccinations (such as for the human papillomavirus), screening and testing services (such as Pap tests and STI tests), treatments services (ranging from antibiotics for chlamydia to radiation therapy for cancer), and counseling and referral (including for non-medical support services).

All of these services are necessary for the health and well-being of Medicaid enrollees over the course of their whole lives. For example, the typical US woman spends roughly three years pregnant, postpartum, or attempting to become pregnant (and therefore in need of pregnancy-related care) and about three decades trying to avoid pregnancy (and therefore in need of contraceptive care).[24] In addition, all sexually active people may be at risk of HIV and other STIs, and continue to be at risk of reproductive health-related cancers for decades. Imposing barriers to these critical health services would inevitably lead to harm.

***

[21] Frost JJ, et al., Publicly Funded Contraceptive Services at U.S. Clinics, 2015, New York: Guttmacher Institute, 2017, https://www.guttmacher.org/report/publicly-funded-contraceptive-services-us-clinics-2015.

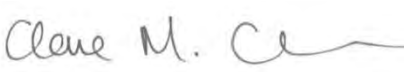
[22] Kaiser Family Foundation, Medicaid and CHIP income eligibility limits for pregnant women as a percent of the federal poverty level, 2017, State Health Facts, http://kff.org/state-category/medicaid-chip/medicaidchip-eligibility-limits/.

[23] Sonfield A and Kost K, Public Costs from Unintended Pregnancies and the Role of Public Insurance Programs in Paying for Pregnancy-Related Care: National and State Estimates for 2010, New York: Guttmacher Institute, 2015, https://www.guttmacher.org/report/public-costs-unintended-pregnancies-and-role-public-insuranceprograms-paying-pregnancy.

[24] Sonfield A, Hasstedt K and Gold RB, Moving Forward: Family Planning in the Era of Health Reform, New York: Guttmacher Institute, 2014, https://www.guttmacher.org/report/moving-forward-family-planning-era-health-reform.

NFPRHA appreciates the opportunity to comment on Maine's proposed § 1115 project. If you require additional information about the issues raised in this letter, please contact Robin Summers at rsummers@nfprha.org or 202-552-0150.

Sincerely,



Clare Coleman
President & CEO