CLASP
policy solutions that work for low-income people

August 2, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Kentucky HEALTH 1115 Demonstration Modification Request

Dear Administrator Verma,

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 deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits.

These comments also 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 July 3, 2017 modification request on the 1115 Demonstration Waiver Amendment. We have serious concerns about the effects of the underlying waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Kentucky. This modification takes an even bigger step backwards in coverage; the state's own enrollment projections estimate that more than 95,000 people will be uninsured after this waiver with the modifications is implemented.

The modification request and the underlying waiver do not reflect the reality of low-wage work. Throughout the modification request, there is an underlying implication that the only barrier to employer based insurance is finding a job. This is simply inaccurate. Only 12 percent of workers earning the lowest wages had employer-provided health insurance in 2016.[1] Even at higher wages, part-time workers have less access to health coverage—just 22 percent of part-timers have access to health insurance coverage compared to 73 percent of full-timers.[2] The reality is that many people enrolled in Medicaid are working but are not offered employer health insurance.

The modification request and underlying waiver significantly increase administrative burdens and red tape for enrollees. Simply put, this modification request significantly increases red tape for applicants and enrollees, while also greatly expanding administrative burdens by making the program so complex. Medicaid has a well-established low administrative overhead cost relative to private insurance, but the proposals outlined in Kentucky HEALTH will create larger government and be extremely costly for the state to implement. Components of this modification request, and the underlying waiver, in practice only create additional bureaucratic burdens for people who are working and struggling to meet their basic needs.

The modification request does not cause Medicaid to mirror commercial insurance, as it purports to do. Throughout the document, it is stated that Kentucky HEALTH is designed to mirror commercial or employer insurance. However, the requirements placed on Kentucky HEALTH enrollees far outweigh those placed on someone with typical employer health coverage. For example, I do not have to report household income changes to my employer because a fluctuation in my household income does not affect my monthly premium costs. For major life changes that do impact my employer coverage (such as the birth of a child), I have 30 days to report that change – three times as long as the time period given to Kentucky HEALTH enrollees to report changes. Furthermore, very few individuals have to write checks on a monthly basis to purchase coverage. The vast majority of people with commercial insurance receive it through their employers, and their monthly premium is automatically deducted from their paycheck, without them having to take any positive action. The bottom line is that the comparison to employer insurance is a false and misleading analogy. Rather than "prepare" or "teach" people how employer insurance works, it will only have the effect of increasing the burden on Kentucky HEALTH enrollees.

The policies in the modification request do not support the goals outlined in the request. In the public notice document soliciting comments on the modification request, the first goal listed is to "Improve participants' health and help them be responsible for their health". The policies and procedures laid out in this modification request do not support this goal. By the state's own estimate, 95,000 people will lose their health insurance if these waiver modifications are implemented. 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."[3] Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries. As explained below, access to health insurance makes it possible for people to address health issues that prevent them from working or going to school.

The modification request does not include minor changes, but rather very substantial changes. While CLASP appreciates the opportunity to provide comments on the modification request, we respectfully disagree with the statement that all proposals in the modification request are minor. The requested changes are quite substantial and stand to have significant negative effects on the health of Kentuckians, as outlined below.

Work Requirement/Community Engagement Requirement

The amendment will implement a 20 hour per week (80 hours per month) work requirement for nonexempt individuals. This replaces the underlying application's provision that gradually phased in a work requirement. New beneficiaries will get a three-month notice period after enrollment so that they can learn about the program and its requirement, and to tend to any urgent health care needs. But after the

third month of enrollment, the individual will be required to complete 20 hours a week of qualifying activities or be disenrolled from Kentucky HEALTH until they complete the work requirement for a full month. For Kentucky HEALTH enrollees who transition from the existing Medicaid program, the work requirement will take effect immediately

While the amendment purports to align this proposed work requirement with the time limit in the SNAP program, the exemptions outlined for Medicaid enrollees do not align with the exemptions in SNAP. For example, the SNAP time limit does not apply to individuals over age 49, and resets after 36 months. Having dissimilar exemptions between two programs with significant overlap in income eligibility will cause immense confusion among enrollees and among state personnel who are administering the programs and tracking enrollees' compliance with the work requirement.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges CMS to reject the underlying proposal and this modification. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventative and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

The lack of a notice period for existing enrollees is particularly extreme and concerning. There is no detail about what the education and notice component is or how the state will ensure that everyone knows their rights and responsibilities. Expecting current enrollees who transition to Kentucky HEALTH to meet the work requirements in the first month of Kentucky HEALTH does not support work, but only serves to immediately disenroll people from Medicaid. Implementation of any new administrative and bureaucratic rule always takes several months, at the least, to implement. Therefore, it is completely unrealistic to expect that both enrollees and the state can immediately implement accurate reporting and tracking of the work requirement hours. The consequence of confusion among enrollees and new bureaucratic procedures will be the loss of insurance for Kentuckians who likely meet all the work requirements.

It is unclear from the waiver amendment and the original waiver if the state will provide applicants and enrollees with classes or activities that will enable them to meet the work requirement, or if people will be cut off if they cannot find an open slot. It is unrealistic to expect that Kentucky's adult education or workforce systems will have the capacity to serve the tens of thousands of Medicaid recipients who would be subject to this requirement.

Access to Medicaid supports work

There is no evidence offered that disenrollment and lock-out periods promote work. The original waiver request cites a Maine study of SNAP recipients subject to the time limit and claims that it led to increased earnings. However, this study includes no comparison group and therefore provides no evidence of a causal relationship. It attributes rising work rates and earnings to the return of the time limit even though many of the changes would have happened without it.[4]

In fact, because providing access to coverage is an important way to support work, this proposal would likely reduce employment outcomes. A recent report from Ohio found that providing access to affordable health care through Medicaid helps enrollees to seek and maintain employment.[5] More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three-quarters of unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment. Data from Michigan reinforces this finding, with 55 percent of unemployed Medicaid enrollees reporting that health care through Medicaid makes it easier to search for employment.[6] This simply makes sense – people must be healthy in order to seek, obtain, and maintain employment. Without the support of Medicaid, health concerns would threaten employment stability.

Individuals with disabilities would be affected

Even though the waiver states that those who are determined to be medically frail would be exempt, individuals with disabilities are likely to be adversely affected. A Kaiser Family Foundation (KFF) study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working.[7] People with chronic conditions that impact their ability to work but do not qualify them for disability benefits will be at high risk of losing access to care. Chronic conditions are, by definition, not time-limited and often impact individuals for an extended period. The evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits.

The evidence from SNAP is most relevant, as this provision is clearly modeled after the SNAP time limit for so called "able bodied adults without dependents." For example, one study from Franklin County, OH, found that one-third of the individuals referred to a SNAP employment program in order to keep their benefits reported a physical or mental limitation, 25 percent of which indicated that the condition limited their daily activities. Additionally, nearly 20 percent of the individuals had filed for SSI or SSDI within the previous 2 years.[8]

Similarly, repeated studies of TANF programs have found that clients with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirements.[9] Such clients may not understand what is required of them or may find it difficult to complete paperwork or travel to appointments to be assessed for exemptions. Access to employment services on a voluntary basis can certainly be beneficial for some, but work requirements and time limits most often serve as a mechanism to take away crucial support for low-income individuals.

Workers with variable hours of employment would be affected

This provision may also affect many people who work, but do not consistently meet the 80 hours of work per month threshold. Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week to week.[10] Many workers are assigned to "call-in shifts", providing no guarantee of work, but preventing them from scheduling other work or activities.[11] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[12] both industries well known for their variable and seasonal hours of

employment. Individuals with variable hours of employment may also lose coverage if they fail to keep up with the requirement to document their hours of employment.[13]

Disenrollment and lock out would lead to worse health outcomes, higher costs

When a beneficiary fails to meet the work requirement, they will be disenrolled from Medicaid coverage until they are able to complete one-month of work requirements—only then may they reenroll. This is not an incentive to seek work. Rather, this will have profound negative implications for the health care outcomes of beneficiaries, and will ultimately lead to increased costs to Kentucky. Once terminated from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.[14.] And during the lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

When the beneficiary re-enrolls in Medicaid after the lock-out period, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[15] Medicaid will end up spending more to bring these beneficiaries back to health.

Work requirements add complexity and administrative costs

In the waiver modification, Kentucky acknowledges that tracking work hours is burdensome and tries to eliminate the burden by requiring a static number of hours. But even tracking these time limits would significantly add complexity and cost to the administration of the Medicaid program. Kentucky would need to develop a whole new system to track months towards the time limit, send notices to clients, and determine whether a beneficiary qualified for an exemption in that month. One of the key lessons of the Work Support Strategies initiative is that every time that a client needs to bring in a verification or report a change it adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that have to process additional applications. The WSS states found that that reducing administrative redundancies and barriers used workers' time more efficiently and also helped with federal timeliness requirements.

An administrator in Idaho reported that unnecessary reevaluations resulted in wasting caseworkers' time and confusion for families. A Colorado WSS team member reflecting on their former processes noted "it was crazy-making for us… it was a constant workload for all of us."[16] Adding new complicated requirements to Medicaid eligibility, including determining exemptions and tracking the hours of work, which often vary from month to month, would be a major step in the wrong direction.

Disenrollment for Failure to Report a Change in Circumstance

The underlying application includes a provision requesting to be able to terminate coverage for members who don't fully complete their redetermination paperwork. This amendment adds a six-month lock out for failure to report a change in an individual's circumstance, including a change in income. Most alarmingly,

the state proposes to characterize a failure to report a change in circumstance as an intentionally fraudulent action and will disenroll an individual for a six-month lock out period.

The practical components of this proposed policy are difficult to comprehend and will be more difficult for the state to implement and for enrollees to understand. Due to the overwhelming complexity of the design of Kentucky HEALTH, enrollees will be required to provide documentation for any additional income that bumps them into the next premium payment level. Therefore, if someone picks up an extra shift or two, or is paid overtime they may be required to report this change. Not only is this an extremely burdensome policy, it is also extremely complex and requires people to know at what income threshold their premium would increase or decrease. It is reasonable to assume that someone may actually turn down extra hours at work simply to avoid this complex policy and risk their health insurance coverage. As discussed above, this policy does not reflect the reality of low wage work when employees are often at the mercy of last-minute scheduling by their employers. Here are three examples that illustrate how burdensome, complex, and ill received this reporting requirement is:

- **Change in Premium** – A beneficiary working 20 hours per week at $11 per hour has income below the poverty line and pays an $8 monthly premium. If she picks up an extra shift in any month, her income would be over 100 percent of the poverty line, changing her monthly premium to $15. She would have to know that the extra shift increases her premium and report the change. If she failed to do so, she could be disqualified for six months under Kentucky's proposal.

- **Employer-Sponsored Insurance (ESI)** – A beneficiary who works 20 hours per week at minimum wage picks up some additional shifts. Because he is now working 30 hours per week, he has access to ESI. Even though he is still eligible and owes the same amount of premium, he could be disqualified for not reporting that he has access to ESI, even if his employer has not notified him of the opportunity.

- **Community Engagement** – A beneficiary volunteers at her children's school 20 hours per week to meet the community engagement requirement. However, the school is closed during winter break. Depending on how Kentucky implements the engagement requirement, she could be disqualified for failing to report the change or disqualified for failing to meet the community engagement requirement during the closure.

We are extremely concerned by the proposal that implements a disenrollment and 6-month lock-out period for beneficiaries who fail to report a change in life circumstance, like a change in income, within 10 days of the change. This proposal flies in the face of the goals of this waiver—if a beneficiary gets a higher-paying job, their focus should *and must* be on preparing to succeed in their new employment. Insurance should be there to support their health and well-being so that they are healthy to work. Instead, this proposal says that the top priority of an individual should be to fill out paperwork or risk losing health insurance. Similarly, if an individual has their hours permanently cut—a reality faced by many low-income workers—the individual should be focused on finding new employment rather than filling out paperwork to report a drop in income. Or if an individual experiences a health crisis that forces them to reduce hours of work, they may not remember to submit the paperwork.

There is no precedent for this and no justification. It is outside the scope of what is allowable under section 1115, which authorizes demonstration projects that promote the objectives of Medicaid. Kentucky

doesn't even purport to justify its proposal on this basis but only as a way to help the state administer its proposal.

Furthermore, it is incredibly ironic and hypocritical that the state is changing the work requirement (eliminating the phase in) due to the complexity of administering the requirement, but at the same time is drastically increasing the administrative burden on enrollees and applicants. Moreover, the state is actually increasing its own administrative burden. State workers would have to not only deal with increased reports of changes, verify the reports and decide whether they affect eligibility or premium payments, they would also have to monitor whether people are reporting, decide whether any of the limited good cause exceptions in the proposal apply, and adjudicate appeals when beneficiaries dispute the sanctions. As mentioned earlier in these comments, the stated reason of mirroring employer insurance as a rationale for these reporting requirements is completely ill conceived. The level of reporting required by Kentucky HEALTH far exceeds any level of reporting required by employer insurance.

Data from Indiana demonstrates the impact on enrollment on the complex nature of this program design. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.[17] These beneficiaries are highly likely to be locked out of coverage, with severe consequences for their health. CLASP has serious concerns about the notification process and how enrollees will know about this rule. The amendment outlines the process by which individuals would be notified of the requirement to report a change in circumstance, but the reporting window is a mere 10 days from the change in circumstance. While this policy is likely to be confusing and overly burdensome to everyone, it raises particular concerns for people with limited literacy and for whom English is not their first language.

The state's plan to allow re-enrollment upon completion of a financial or health literacy course is both condescending to enrollees and a prime example of wasteful government spending. Implying that people are unable to manage their financial resources or health is ironic, given that many poor people manage a much more complicated financial scenario than those who are not poor. Making people jump through more hoops to re-enroll, after having been disenrolled due to other red tape and bureaucratic hoops, is wasteful. Limited state budgets would be better served by providing care than establishing reporting mechanisms and new classes.

Thank you for your consideration of these comments. If you have any questions, please contact Suzanne Wikle at swikle@clasp.org or (202) 906-8027.

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