CLASP
policy solutions that work for low-income people

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Comments on Maine's Proposed 1115 Demonstration Waiver Amendment Application

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 1115 Demonstration Waiver Amendment Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Maine. In particular, the policies would have a dramatic and negative impact on access to care for a broad range of people including parents, former foster care youth, and people with breast/cervical cancer. This waiver takes a big step backwards in coverage and rolls back important coverage gains. We therefore believe that it is inconsistent with the goals of the Medicaid program.

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.[1] 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" 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. It includes provisions that have not been approved in any other state, and those provisions that have been approved elsewhere for the Medicaid expansion group have never been approved for traditional, non-expansion populations.[2]

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.

Our specific comments follow.

Work Requirements and Time Limits on Medicaid Eligibility

CLASP strongly opposes this unprecedented waiver proposal to limit Medicaid eligibility for adults age 19-64 to 3 months in a 36 month period when they are not working or participating in a work program. This draconian proposal goes far beyond what has been approved by CMS for other states, and goes far beyond even what other states have proposed to do in their Medicaid waiver proposals to date. This limit fails to recognize the reality of chronic disease or serious illness that do not have a time clock and may prevent individuals from participating in work activities. It would make it nearly impossible for people subject to this requirement to receive ongoing care, with severe consequences for their health.

When Maine re-implemented the three-month limit for non-working adults without children in SNAP in October 2014, although much of the state was still eligible for a waiver from the time limit due to high unemployment rates, thousands of people lost benefits. In just a few months after re-implementation of the time limit, nearly 10,000 Maine residents lost access to food assistance according to data from the Maine Department of Human Services. [6] The state's claim that time limits food assistance encourages work or increases employment outcomes is misleading and based on a simple count of recipients entering employment during that period, with no information offered on

how many recipients enter employment when the time limit was not in effect. As the time limit was re-implemented when unemployment rates were falling, many of those included in the employment count would have found work anyway. Moreover, this proposal would affect many more people than the SNAP time limit, which only applies to recipients aged 19-49 without dependent children in the household. This proposal goes far beyond that, applying to ages 19-64 and to parents with children 6 and up.

The waiver proposal suggests "people must receive consistent messaging on the importance of employment to Maine's economy and overall well-being" as a justification for aligning Medicaid eligibility with SNAP's time limit for "able bodied adults without dependents". However, this is proposed without any evidence of a problem that this is intended to solve, and there is no reason to believe that such "messaging" would promote any of the goals of Medicaid. (In addition, these requirements are not actually aligned to the SNAP time limits, which do not apply to parents or people over age 50.)

These time limits 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 proposal to implement time limits on non-work recipients is based on a false assumption that people do not wish to work and need to be incentivized to do so. A recent Kaiser Family Foundation study found that the overwhelming majority of non-working Medicaid recipients were ill or disabled, attending school, caring for other, or seeking work.[7] Many Medicaid beneficiaries work, but for low-wage workers, employer-sponsored insurance is often either not offered or is prohibitively expensive. Even if unemployed Medicaid recipients obtain jobs, they are highly likely to continue to need health coverage through Medicaid.

Time limits would act as a barrier to coverage

The KFF study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI benefits—reported illness or disability as their primary reason for not working.[8] 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 extended periods. While the proposal states that the time limit will not apply to beneficiaries who are diagnosed with a mental illness or who are physically or mentally unable to work, 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% of whom indicated that the condition limited their daily activities. Additionally, nearly 20% of the individuals had applied for SSI or SSDI within the previous 2 years.[9]

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.[10] 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.

This provision may also affect many people who work, but do not consistently meet the 80 hours of work threshold. Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week to week.[11] Many workers are assigned to "call-in shifts", providing no guarantee of work, but preventing them from scheduling other work or activities.[12] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[13] 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.[14]

Access to Medicaid supports work

There is no evidence offered that such time limits would promote work. 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. 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. [15] Without the support of Medicaid, health concerns would threaten employment stability.

Time limits would led to worse health outcomes, higher costs

The proposal limits beneficiaries to three total months of Medicaid during a 36 month period if the beneficiary cannot meet the work requirements. This will have profound implications for the health care outcomes of beneficiaries, and will ultimately lead to increased costs to states. 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.[16] And during months of unemployment, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.[17] A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.[18]

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.[19] Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of $239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.[20]

When the beneficiary re-enrolls in Medicaid – or qualifies for Medicare -- 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.[21] Public programs will end up spending more to bring these beneficiaries back to health.

Even before beneficiaries reach the time limit, this may have adverse effects, as healthy individuals may opt to forgo coverage in order to "bank" their months of eligibility against future need. This means that they are likely to forgo preventative care and screenings. Again this will lead to both worse outcomes and higher costs.

Time limits would add complexity and administrative costs

Tracking these time limits would significantly add complexity and cost to the administration of the Medicaid program. Maine 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 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". 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.

Monthly Premiums

Medicaid has strong affordability protections to ensure that beneficiaries have access to a comprehensive service package and protects beneficiaries from out-of-pocket costs, particularly those due to an illness.[22] CLASP strongly opposes this waiver proposal to require all able-bodied adults with incomes as low as 1% of the FPL to pay a monthly premium. Payment of the first months' premium is required to effectuate coverage—in other words, coverage will not begin until the first premium payment is received. This proposal goes much further—and impacts much lower-income populations—than any other demonstration project approved by CMS.

Studies of the Healthy Indiana waiver, which required Medicaid recipients with incomes between 100 and 138 % of FPL to pay a premium[23] or face disenrollment or lockout,[24] have found that it deters enrollment. About one-third of individuals who applied and were found eligible were not enrolled because they did not pay the premium.[25]

A large body of research shows that even modest premiums keep people from enrolling in coverage.[26] Individuals, particularly during period of unemployment or other financial hardship, may be unable to afford to make the payments. In addition, the structure of the proposed premiums is regressive—the lowest income beneficiaries pay the highest proportion of their income for coverage. While the proposal claims that this structure would encourage work because "members who move to the top of their income band are paying a lower percentage of their income toward their premium", the reality is that the lowest income beneficiaries may need to choose between paying premiums and having the money to pay rent or buy gas to go to work. Low-income consumers have very little disposable income and often must make choices and stretch limited funds across many critical purchases. While Medicaid is designed to protect consumers against costs, this proposal adds another cost to their monthly budget.

Moreover, simply the burden of understanding the premium requirements and submitting payments on a regular basis may be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion of either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.[27] Finally, states or insurance companies may fail to process payments in a timely fashion, leading to benefit denials even for people who make the required payments.[28]

While the stated goal of this provision is to align coverage with private health insurance, the reality is that very few individuals have to write checks on a monthly basis to purchase coverage. The vast majority of people with private insurance receive it through their employers, and have their share of the premiums automatically withheld from their paychecks, without having to take any positive action. Moreover, one-quarter of households with incomes under $15,000 reported being "unbanked,"[29] which may create additional barriers to making regular payments.

What is more, like in Indiana, this proposal introduces a non-payment lock out period of 90 days for unpaid premiums. And a beneficiary can only re-enroll after unpaid premiums are repaid—a significant amount of money for very low-income beneficiaries. As with the time limit, this will reduce the use of preventive services and interfere with ongoing treatment, harming health outcomes and ultimately increasing medical costs.

Copays for Emergency Room (ER) Use

This waiver proposal introduces a $20 copay for non-emergency use of the emergency room on *all* Medicaid enrollees (other than those dually eligible for Medicaid and Medicare). Indiana did receive a waiver for ER co-pays for people who use the emergency room in non-emergency situations, and the results of this waiver have not yet been evaluated. Maine should not replicate—or go further than—Indiana until the results of this implementation have been formally evaluated.

If a co-pay is charged for non-emergency use, it should only be applied for uses of emergency services that are inappropriate based on clearly defined criteria that take into consideration what a reasonable layperson would do, and not simply the determination of whether to admit the patient. There are many situations that are true emergencies, but where inpatient treatment is not needed. The state should also track the geographic patterns in the use of emergency services that are determined to be "inappropriate" and assess whether this data indicates lack of alternative medical services.

Furthermore, the co-pay for even the lowest income beneficiaries is significantly higher than co-pays traditionally allowed under Medicaid. The proposed charges of $20 mean that beneficiaries would face unacceptable choices between needed care or having the money needed for basic needs

Charges for Missed Appointments

The proposed waiver will allow providers to charge beneficiaries for missed visits. Providers may charge beneficiaries according to their standard office policy. The only protection is that the missed appointment fee may not exceed the anticipated reimbursement amount for the service that would have been delivered. Providers could charge any amount to low-income Medicaid beneficiaries, including their standard fees charged to high-income patients.

This policy fails to acknowledge the challenges faced by low-income beneficiaries, including unpredictable shift work, challenges with reliable daycare, lack of reliable transportation or the challenges of public transportation. Under this policy, a Medicaid recipient could be forced to choose between losing their job (when they are unexpectedly required to work additional hours) and paying an unaffordable missed visit charge. In addition, this policy may incentivize use of emergency rooms rather than regular primary care providers, if patients are afraid to schedule appointments that they cannot be certain of making.

Assets Tests

This proposal will impose an asset test of $5,000 to mirror their assets test in SNAP. Maine is one of only 16 states with an assets test in SNAP. Asset tests were removed from Medicaid for the MAGI population as part of the Affordable Care Act. Reinstating asset limits hurts families and state governments. Asset limits run counter to the goals of Medicaid of supporting recipients in work and enabling them to advance economically. Asset limits force families to deplete savings and sell assets to qualify or remain eligible for assistance, sending the message that they should spend rather than save.[30] Raising or eliminating asset limits promotes long-term savings and economic independence rather than dependence on immediate aid. Accumulating even a small amount of savings and assets may reduce the length of time families need public assistance.[31] Additionally, asset limits are fiscally irresponsible and a hassle for state governments—they lead to increased administrative costs and time spent verifying eligibility. Rather than spending time calculating and enforcing asset limits, Maine should focus on helping families overcome barriers to employment and self-sufficiency. [32]

Eliminate Retroactive and Presumptive Eligibility

The proposed waiver would eliminate retroactive eligibility prior to the first day of the month that the application is filed (or the first premium payment is received, as noted above). In addition, the state proposes to eliminate hospital-based presumptive eligibility (except for pregnant women). These policies will present a major burden to providers and emergency rooms, who will shoulder the burden of uncompensated care for beneficiaries who do not get retroactive eligibility. For example, if a patient presents to the emergency room on the 30th of a month and is found eligible for Medicaid on the 2nd of the following month at discharge, the patient's Medicaid coverage will begin the 1st day of the month—and the entire burden of the emergency room visit will be uncompensated care for the

hospital. When combined with the premium requirement, the impact on providers will be even more dramatic – if the patient does not pay the premium in a timely fashion, the provider will not be paid.

The state believes that these policies will incentive beneficiaries to enroll in coverage before a health crisis. However, for a beneficiary who is not working, this waiver request directly contradicts itself. Because of the time limit, a beneficiary has a disincentive to enroll in coverage when these "healthy" months will count against their total Medicaid eligibility. The rational choice in many cases will be to wait until there is an acute health crisis before they enroll.

Thank you for your consideration of these comments.

If you have any questions, please contact Elizabeth Lower-Basch at elowerbasch@clasp.org or (202) 906-8013.

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