CLASP

Policy solutions that work for low-income people

December 1, 2017

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

Re: Proposal to amend New Hampshire's Proposed 1115 Demonstration Waiver Amendment Application

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 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 New Hampshire. In particular, the policies would have a dramatic and negative impact on access to care for a broad range of people. 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. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives"[1] of the Medicaid Act.

A waiver that does not promote the provision of health care would not be permissible. This waiver proposals' attempt to transform Medicaid and reverse its core function will result in many adults losing needed coverage, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health, and should be rejected. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

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

Our specific comments follow.

The amendment will implement a work requirement that phases in for nonexempt individuals if the individual is engaging in at least 20 hours per week upon application of benefits, 25 hours per week after receiving 12 months of benefits in a lifetime and 30 hours per week after receiving 24 months of benefits over a lifetime.

CLASP strongly opposes work requirements for Medicaid. Work requirements—and disenrollment for failure to comply—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.

Individuals with disabilities and illnesses would be affected

Even though the waiver states that those who unable to participate due to illness or incapacity 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.[6] 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. In particular, this proposal requires all exemptions to be certified by a medical professional—but the work requirements are imposed as soon as the individual begins receiving benefits. It is likely that people will be stuck in a "catch-22" situation where they can't prove that they can't work because they can't get insurance because they aren't working.

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. 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.[7]

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.[8] 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 most often serve as a mechanism to take away crucial support for low-income individuals.

Work requirements do not reflect the realities of our economy

This provision may also affect many people who work, but do not consistently meet the minimum hours of work per week threshold. Work requirements do not reflect the realities of today's low-wage jobs. Low-wage work in America does not fit into the "9 to 5" conception that many politicians and state administrators have of work. About half of low-wage hourly workers have schedules outside the traditional Monday-Friday, 9-5 routine and are patching together two or more part-time jobs to support their families.[9] Frequently, they aren't getting traditional employment benefits (such as health insurance) that middle- and upper-income Americans receive with their jobs. Recent data show that 5 million workers reported working part-time, despite wanting full-time jobs. Involuntary part-time work is a symptom of the low-wage labor market that makes it difficult for people to gain economic security.[10]

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] Seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off the program during that time of year.

Disenrollment would lead to worse health outcomes, higher costs

Work requirements 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 because of failure to meet the work requirements, beneficiaries will likely become uninsured.

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.[15] 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.[16]

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.[17] 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.[18]

When the beneficiary re-enrolls in Medicaid, they will be sicker and have higher health care needs. Public programs will end up spending more to bring these beneficiaries back to health.

In addition, the proposed policy of increasing the work requirement based on the duration of participation has negative effects. This policy incentives people to enroll in Medicaid only when they are sick, rather than using their limited months during times when they are well. This will have negative consequences for enrollees and for the program. People will not receive preventative care, early treatment for new illnesses, or consistent treatment of chronic diseases, which will make them less healthy and drive up costs.

Access to Medicaid supports work

CLASP strongly opposes implementing a work requirement for Medicaid. The proposal to implement a work requirement is based on a false assumption that people are not working, do not wish to work, or need to be incentivized to do so. In fact, nearly 8 in 10 Medicaid enrollees live in working families, and the majority are working themselves.[19] A recent Kaiser Family Foundation (KFF) study found that the overwhelming majority of non-working Medicaid recipients were ill or disabled, attending school, caring for others, or seeking work. [20] Likewise, a 2016 report from the American Enterprise Institute found similar results – non-parents are most likely to not be working due to disability or illness.[21]

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.[22] 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.[23] 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.

Limiting Parents' Coverage Hurts Children

Limiting parents' coverage will have negative implications for their children's coverage and health. Research repeatedly demonstrates that children are more likely to have health insurance when their parents have health insurance. New research shows that when parents have insurance their children are more likely to receive annual check-ups and well child visits.[24] Limiting parents coverage will have a trickle-down effect on children's coverage – children will become uninsured and will be less likely to receive annual check-ups and well-child visits.

Work requirements add complexity and administrative costs

Tracking work hours is burdensome and would add complexity and cost to the administration of the Medicaid program. 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."[25] This proposal is particularly complicated, with the hours of participation varying depending on how long a person has been receiving Medicaid. 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.

In summary, the waiver amendment undermines the goal of Medicaid. The proposed work requirement will have the effect of reducing enrollment and increasing barriers to care while, at the same time, greatly increasing state administrative bureaucracy.

In addition, we would like to raise concerns about New Hampshire's cavalier attitude toward the public comment process. Many of the critical aspects of a work requirement programs, including both criteria and processes for exemptions have not been made available for public comment and are described as "operational details." The state has made no attempt to estimate how many people would be affected, or the administrative costs. Moreover, the state does not respond to any of the significant concerns that are raised in the comments, and simply states that "the Department appreciates this concern" or "this feedback." Allowing this waiver request to go forward would make a mockery of the requirement that states take into consideration the feedback provided in the public review process.

Thank you for your consideration of these comments.

If you have any questions, please contact Suzanne Wikle at **swikle@clasp.org** or (202) 906-8000.

End Notes

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