August 17, 2018

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

Re: Kentucky HEALTH 1115 Demonstration Waiver (second comment period)

Dear Secretary Azar,

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 Kentucky HEALTH proposal. We have serious concerns about the effects of the underlying waiver and subsequent modification on the coverage and health outcomes of low-income Medicaid beneficiaries in Kentucky. This propoal takes a step backwards in coverage; the state's own enrollment projections estimate that more than 95,000 people will be uninsured if this proposal is implemented.

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 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" of the Medicaid Act.[1] A waiver that does not promote the provision of affordable health care would not be permissible.

Proposal will Not Support the Goals Outlined by the State

The waiver will reduce Medicaid coverage, subsequently harm low income Kentuckians

Kentucky's own estimate is that 95,000 Kentuckians will lose coverage should this waiver be implemented. A national study found that a work requirement would cause coverage losses ranging from 1.4 million to 4 million largely because of the red tape burdens associated with implementing work requirements.[2]

The Urban Institute report provides information about Kentucky Medicaid recipients who are not working and will not qualify for an exemption, and therefore will lose coverage if Kentucky's waiver is implemented. The report finds that this population faces significant barriers to employment – barriers that are incredibly unlikely to be overcome by a punitive work requirement policy. Nearly three-quarters (74 percent) of this population do not have access to a vehicle or the internet in their household, have not completed high school, or have a serious health limitation or live with someone who does.[3] Simply taking away health coverage from a population with these barriers to employment will not suddenly cause someone to be employed, let alone employed in a job with affordable employer health coverage. Rather, the only result will be a loss of health insurance for this population.

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. As stated, the state estimates that 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."[4] 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 waiver does not reflect the reality of low-wage work

Throughout the waiver application, there is an underlying assumption 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.[5] 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.[6] The reality is that many people enrolled in Medicaid are working but are not offered employer health insurance.

A June 2018 report finds that 51 percent of working adult Medicaid beneficiaries work full-time (at least 35 hours per week) for at least 50 weeks of the year.[7] Even with this level of work, this population's income is still low enough to qualify for Medicaid.[8] The inconvenient truth is that far too often full-time work still leaves people with incredibly low incomes and no access to employer benefits such as employer sponsored insurance. Only one-third of Medicaid workers have an offer of employer-sponsored insurance from their employer, although that insurance may not meet affordability requirements of the Affordable Care Act (ACA).[9]

Further, a recent study from the Urban Institute found that Kentucky's proposal to take away health care from individuals who do not work a set number of hours does not align with the reality of some working enrollees' lives. Urban found that an estimated 13 percent of nondisabled, nonelderly working Medicaid

enrollees who do not appear to qualify for a student or caregiver exemption in Kentucky's Medicaid program could be at risk of losing Medicaid coverage at some point in the year under the work requirements because, despite working a set number of hours, they may not work consistently enough throughout the year to comply with the waiver.[10] For those who are unable to meet the work requirement and not eligible to receive subsidized coverage through the ACA Marketplace, some working Medicaid enrollees may seek out employer-sponsored insurance. However, Urban estimates that only 13 percent of part-time private-sector employees in Kentucky were eligible for employer-sponsored coverage, compared to 81 percent of their full-time counterparts.[11] Even if the working individual had access to employer-sponsored coverage, affordability is another barrier to coverage in Kentucky. The same Urban study found that annual premium contributions for employer-sponsored coverage in Kentucky were approximately 11 percent of a person's income, on average, if the person worked full-time and earned the minimum wage.[12]

The waiver application 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.

Proposal to Take Health Coverage Away from Individuals Who Do not Meet New Work Requirements

CLASP does not support Kentucky's proposal to take away health coverage from individuals who do not meet new work requirements. The waiver request 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 urges CMS to reject the underlying proposal and the 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.

Disenrollment and lock-out periods do not promote work; 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.[13]

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.[14] 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.[15] 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 and disincentivized from working

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 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working.[16] In Kentucky, this

rate increases to 51 percent. 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.[17]

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.[18] 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.

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[19] In states that have expanded Medicaid, such as Kentucky, persons with disabilities no longer have to qualify for SSI in order to be eligible for Medicaid. This change in policy allows persons with disabilities to access health care without having to meet the criteria for SSI eligibility, including an asset test. Other research that shows a drop in SSI applications in states that have expanded Medicaid supports the theory that access to Medicaid is an incentive for employment.[20] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed in Kentucky's proposal will ultimately create a disincentive for employment among persons with disabilities.

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.[21] Many workers are assigned to "call-in shifts", providing no guarantee of work, but preventing them from scheduling other work or activities.[22] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[23] 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.[24]

As previously stated, recent data shows that an estimated 13 percent of nondisabled, nonelderly working Medicaid enrollees who do not appear to qualify for a student or caregiver exemption in Kentucky will cumulatively work enough hours in a year to meet the work requirement, but are still at risk of losing coverage because their annual work hours are not evenly spread out among all 12 months.[25]

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.[26.] 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.[27] Medicaid will end up spending more to bring these beneficiaries back to health.

Proposals to take health coverage away from individuals who do not meet new work requirements add complexity and administrative costs

Simply put, this waiver application significantly increases red tape for applicants and enrollees, while also greatly expanding administrative burdens by making the program 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.

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.

The national Kaiser report with findings that between 1.4 and 4 million people will lose coverage due to work requirements also finds that the majority of coverage loses are due to paperwork issues and barriers rather than ineligibility for Medicaid. The report finds that even in the low-end estimate of 1.4 million people losing coverage, 62 percent of those losing coverage would be working or exempt, and therefore lose coverage due to red tape and paperwork rather than a change in their eligibility status.[28]

Further, 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. 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.

Lastly, recent evidence from Arkansas' first and second month of implementing work requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead

to disenrollment. Over 6,500 Medicaid beneficiaries have one month of non-compliance and over 5,400 beneficiaries have two months of non-compliance of the new requirement. These Medicaid enrollees will lose coverage if they have three months of non-compliance. As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.[29]

Disenrollment for Failure to Report a Change in Circumstance

The waiver 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.[30] 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.

Recent Reports that Claim to Provide Supporting Evidence for Taking Away Health Insurance from People Who Don't Meet Work Requirements are Deeply Misleading

The White House Council on Economic Advisors (CEA) and the conservative Foundation for Government Accountability recently released reports that provide a deeply misleading view of Medicaid and work requirements. Several analyses paint a picture of low-wage work that contradicts claims in the CEA report. These reports find that many people who need assistance from programs like Medicaid are working, but characteristics of low-wage jobs mean this population faces job volatility, higher unemployment and less stability in employment.[31]

The CEA report does not even address health insurance coverage and never mentions the well-known data showing that most Medicaid beneficiaries who can work do work. Further, when examining the share of Medicaid beneficiaries that work the CEA report chose to focus on one month (December 2013), which gives a much lower rate of employment than another report from the Kaiser Family Foundation that uses the same data set but looks at employment over the course of a year. It's also important to note that the Medicaid data cited in the report pre-dates the Medicaid expansion, which dramatically affects the composition of the caseload.

Additionally, the CEA and FGA reports consider all Medicaid beneficiaries who do not receive disability benefits as "able-bodied," ignoring data and research that show that substantial numbers of Medicaid beneficiaries who do not receive disability benefits face significant personal or family challenges that limit the amount or kind of work they can do. In reality, barriers to work are significant and common. Five million Medicaid beneficiaries have disabilities but do not receive disability benefits, meaning that they could be subject to work requirements under the Administration's guidance.[32] Moreover, large majorities of non-working Medicaid beneficiaries report that they are unable to work due to disability or illness, caregiving responsibilities, or because they are in school.[33]

Lastly and most notably, the CEA and FGA reports do not offer any actual evidence to support the claim that taking away health care or other basic supports from people who fail to work a minimum number of hours will cause them to work more. In fact, the report ignores the ample evidence, as cited earlier in these comments, that work supports such as Medicaid make it easier for people to work. While the FGA report alludes to "success" with work requirements in other programs, their analyses have been called out as flawed and misleading.[34]

Conclusion

Our comments include citations to supporting research and documents for the benefit of the Centers for Medicare and Medicaid Services (CMS) in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks and as attachments, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposal.

Thank you for your consideration of these comments. If you have any questions, please contact Suzanne Wikle at **swikle@clasp.org**.

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