CLASP

Policy solutions that work for low-income people

January 4, 2019

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

Re: Virginia's COMPASS 1115 Demonstration Extension Application

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. CLASP submits the following comments in response to Virginia's COMPASS 1115 Demonstration Extension Application and raises serious concerns about the effects of the amendment, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Virginia.

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 proposal 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 (WSS) 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.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. In fact, many Medicaid enrollees 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 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.

This waiver proposal's attempt to transform Medicaid and reverse its core function will result in parents losing needed coverage, poor health outcomes, and higher administrative costs. There is 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] Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries. This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and should be withdrawn. It is also inconsistent with improving health and increasing employment.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements

CLASP does not support Virginia's proposal to take away health coverage from parents who do not meet new work requirements. Our comments focus on the harmful impact the proposed Training, Education, Employment, and Opportunity Program (TEEOP) will have on Virginians and the state. Virginia is proposing to implement a work requirement for beneficiaries who are between the ages of 19-64 with incomes up to 138 percent of the federal poverty level, unless they qualify for an exemption. In total, Virginia estimates that approximately 120,000 enrollees would not qualify for an exemption and, therefore, be subject to the work requirement.

Those who are subject to the work requirement will have to work or participate in other qualifying activities for a specific amount of time per month depending on their duration of enrollment. For the three months after enrollment, Medicaid beneficiaries would be required to work or participate in qualifying activities for a minimum of 20 hours per month. The required hours will increase over time until 12 months after enrollment when the beneficiary would be required to work or participate in qualifying activities for a minimum of 80 hours per month. The difference in required hours over time is complicated and will be difficult to communicate to Medicaid enrollees. If Medicaid beneficiaries do not understand what they are required to do to keep insurance, they will not be able to comply, putting their health coverage at risk. Further, the penalty for not complying with the work requirement for three consecutive or non-consecutive months within a 12-month period is disenrollment from Medicaid for at least one month or until the requirements are met.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Virginia to reconsider their approach to TEEOP. 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. 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 preventive and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Promote Employment

Lessons learned from TANF, SNAP, and other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.[3] A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to

climb their career ladder, and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.[4] Medicaid expansion enrollees from Ohio[5] and Michigan[6] reported that having Medicaid made it easier to look for employment and stay employed. Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

Taking away health coverage from Medicaid enrollees who do not meet new work requirements would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement every month is a considerable undertaking that will be costly and possibly require new technology expenses to update IT systems.

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 must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements.

As a result of Virginia's new administrative complexity and red tape, ***eligible*** people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome. Recent evidence from Arkansas' first five months of implementing work requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 3,800 beneficiaries lost coverage on November 1st, likely becoming uninsured because they didn't report their work or work-related activities.[7] In September, over 4,300 beneficiaries lost coverage and, in October, over 4,100 lost coverage.[8] In total, more than 12,200 Arkansas Medicaid beneficiaries have lost coverage since the state implemented its work requirements. These individuals represent about 18 percent of the state's first cohort of Medicaid beneficiaries subject to the work requirement.[9] 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.[10]

The complexity of the processes and the ensuing churn will also impose administrative costs on social services offices and health care providers. Many people will likely call or visit their local DSS offices, health care providers, and nonprofit organizations with questions or needing help with their paperwork. People who lose benefits will later reapply, which consumes more staff time. People losing coverage will have to cancel and reschedule medical appointments.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take away health coverage from Medicaid enrollees who do not work a set number of hours per month do not reflect the realities of today's low-wage jobs. For example, 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. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum numbers of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[11] This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Disenrollment Would Lead to Worse Health Outcomes, Higher Costs

After Medicaid enrollees lose employment status, notices will be sent to enrollees and they have 30 days from the date of notice to comply with the work requirement. If they are not able to comply within 30 days of the date of notice, Medicaid eligibility will be terminated for a minimum of one month until the individual meets work requirement criteria.

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.[12] Although the proposal allows for people who have been disenrolled to qualify for a hardship exemption if they are hospitalized or if certified by a provider, many individuals will not be able to be seen by a provider if uninsured, except in an emergency. This will only lead to poorer health outcomes and ultimately more costs for Medicaid as well as higher uncompensated costs for providers.

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.[13] 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.[14]

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.[15] 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.[16]

When the beneficiary re-enrolls in Medicaid, 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.[17] Public programs 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 Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose coverage because of the work requirement. Although Virginia proposes to exempt individuals who have a disability or are medically frail, including individuals with disabling mental disorders and chronic substance use disorders (SUD), in reality many people who are not able to work due to physical or mental illness or disability are likely to not receive an exemption due to the complexity of paperwork. A Kaiser Family Foundation 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. In Virginia, this rate is 46 percent.[18]

In particular, despite being exempt, the proposed work requirements would harm people with mental illnesses and SUDs, worsening their ability to seek treatment and maintain employment. Mental illnesses and SUDs affect one-third of working-age individuals eligible for Medicaid, and a large proportion of these individuals have co-occurring disorders and/or poor physical health. Additionally, about 36% of those eligible for Medicaid who have a mental illness currently do not work.[19] Without proper access to care through Medicaid, including prevention, screening, and treatment for mental health and substance use, these individuals will be lost to the system. Furthermore, underlying costs to the system may be much greater later on, as mental health and substance use issues advance and need more costly treatment and intervention.

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[20] In states that have expanded Medicaid, 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.[21] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed in Virginia's proposal will ultimately create a disincentive for employment among persons with disabilities.

Further, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[22] and nearly 20 percent had filed for Disability/SSI within the previous 2 years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement, including proving they are exempt. The end result is that many people with physical and mental disabilities will in fact be subject to the work requirement and be at risk of losing health coverage.

Proposal to Implement Monthly Premiums

Medicaid has strong affordability protections to ensure that beneficiaries have access to a comprehensive service package and are protected from out-of-pocket costs, particularly those due to an illness.[23] CLASP strongly opposes this waiver proposal to require individuals with income between 100 to 138 of the federal poverty line to pay a monthly premium or risk losing coverage.

Studies of the Healthy Indiana waiver, which required Medicaid recipients with incomes between 100 and 138 percent of FPL to pay a premium[24] or face disenrollment or lockout,[25] 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.[26]

A large body of research shows that even modest premiums keep people from enrolling in coverage.[27] Individuals, particularly during a period of unemployment or other financial hardship, may be unable to make the payments. 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 individual's 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. 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.[28] 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.[29]

While the stated goal of this provision is Medicaid enrollees for the financial requirements of employer-sponsored insurance or other private health insurance coverage, 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,"[30] which may create additional barriers to making regular payments.

Although the proposal will allow recipients to earn back a portion of these premiums, the rules are sufficiently complicated that few recipients are likely to do so.

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]

Supporting Individuals with Serious Mental Illnesses (SMIs)

CLASP is in strong support of the language focusing on providing housing support to Medicaid eligible individuals experiencing various types of mental illnesses. Support in housing addresses one of the main social determinants of health, which CLASP believes is necessary in order to maintain and treat SMIs, and prevent further complications down the road. It is good public health, and is a strong step in the right direction.

State Public Comment Period Established Overwhelming Record of Opposition to Virginia's Proposal

Virginia notes that of 1,832 comments submitted during the state comment period only four commenters expressed support for parts or all the work requirements provisions. More than 99% of commenters opposed the proposed work requirement and premiums and raised concerns about how vulnerable populations like those with chronic health conditions would be able to comply with the new requirements. They worried that people who lose their coverage will experience gaps in care and loss of access to needed medications. And they explained how premiums will pose a financial hardship to people with low-incomes who are already struggling to make ends meet. Despite the overwhelming opposition to the waiver and the specific issues raised in the comments, the state submitted a proposal to HHS with few substantive changes.

Conclusion

For all the reasons laid out above, CMS should reject Virginia's approach to encouraging work. If Virginia is serious about encouraging work, helping people move into jobs that allow for self-sufficiency, the state would be committed to ensuring that all adults have access to health insurance in order to ensure they are healthy enough to work. While Virginia is taking a step in the right direction by expanding Medicaid as intended by the ACA, the state takes a step backward by placing additional barriers between the state's most vulnerable families and their health care.

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 considering CLASP's comments. Contact Suzanne Wikle (**swikle@clasp.org**) and Renato Rocha (**rrocha@clasp.org**) with any questions.

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