

CLASP

Policy solutions that work for low-income people

June 28, 2019

Utah Department of Health
P.O. Box 141010
Salt Lake City, UT 84114

Re: Utah Section 1115 Demonstration Application: Per Capita Cap

Dear Deputy Director Nate Checketts:

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 Utah's Section 1115 Demonstration Application, Per Capita Cap and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Utah.

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 some 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.

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. In fact, only 16 percent of poor adults receive health insurance through their jobs¹ and, according to a recent survey by the Bureau of Labor Statistics, low-wage workers pay more for employer-provided medical care benefits than higher-wage workers.² 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" of the Medicaid Act.³ A waiver that does not promote the provision of health care would not be permissible.

This proposal's attempt to transform Medicaid - both in eligibility criteria and funding structure - will result in individuals 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."⁴ 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.

Utah's request to receive continued approval to take health coverage away from individuals who do not meet new work reporting requirements

CLASP does not support Utah's request to take away health coverage from individuals in the Adult Expansion Population who do not meet work reporting requirements. Our comments that follow focus on the harmful impact the work reporting requirement will have on low-income Utahns and the state.

CLASP strongly opposes work reporting requirements for Medicaid beneficiaries. Work reporting requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they act as a barrier to accessing 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 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 Reporting Requirements Do Not Promote Employment

Creating a work reporting requirement for Medicaid is misguided and short-sighted. Lessons learned from other programs demonstrate that work reporting 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.⁵ A new article published in the New England Journal of Medicine about Arkansas's work reporting requirement found no significant change in employment among those subject to the requirement, while insurance coverage declined.⁶

Utah's proposal of work registration, job search training and completing a set number of job applications has been tried in other programs, notably TANF and SNAP. This low-touch approach to employment practices has not shown to result in long-term employment outcomes. 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 – all without jeopardizing people's health insurance.

Another consequence of a work reporting 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.⁷ Medicaid expansion enrollees from Ohio⁸ and Michigan⁹ reported that having Medicaid made it easier to look for employment and stay employed. Further, recent analysis by the New York Times finds that young single mothers' participation in the labor force increased four percentage points more in states that expanded Medicaid in 2014 compared to those that didn't, providing evidence that if people don't lose their health insurance when they go to work, they are more likely to work.¹⁰ Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work reporting requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Reporting Requirements Do Not Lead to Employer-Sponsored Insurance

The waiver request assumes that if participants become employed, they will be able to transition to affordable employer-sponsored insurance (ESI). Unfortunately, this is simply not the reality of many jobs in America. Only 49 percent of people in this country receive health insurance through their jobs—and only 16 percent of poor adults do so.¹¹ The reality is that many low-wage jobs, particularly in industries like retail and restaurant work, do not offer ESI, and when they do, it is not affordable.¹² In fact, in 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under their employer offered insurance.¹³ People working multiple part-time jobs or in the gig economy are particularly unlikely to have access to ESI.

A recent study by the Urban Institute provides additional evidence in New Hampshire – a state that was recently approved to move forward with their work reporting requirement. The paper found that New Hampshire residents who could lose Medicaid under work reporting requirements will likely face limited and costly employer-sponsored insurance options. In particular, researchers found that less than one in ten part-time private-sector employees in New Hampshire were eligible for employer-sponsored coverage and just over half of full-time employees at firms with fewer than 50 employees were eligible for employer-sponsored coverage in 2017. Additionally, annual employee contributions for a single-coverage plan would represent 12.5 percent of annual income for a minimum-wage, full-time worker and 25.0 percent of annual income for a minimum-wage, part-time worker— more than ten times the percentage premium limit in the Marketplace for individuals earning 100 percent of the federal poverty level.¹⁴

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

Taking away health coverage from Medicaid enrollees who do not meet new work reporting requirements would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Keeping track of who is and is not subject to the work requirement and who has complied 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 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 Utah'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' implementation of work reporting requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 18,000 beneficiaries lost coverage before the program was suspended by a federal judge, likely becoming uninsured because they didn't report their work or work-related activities.¹⁵ 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.¹⁶ The recent study looking at the Arkansas program found that "work requirements have substantially exacerbated administrative hurdles to maintaining coverage". The study found a reduction in Medicaid of 12 percent, even though more than 95 percent of those who were subject to the policy already met the requirement or should have been exempt.¹⁷

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

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 Utah, this rate increases to 39 percent.¹⁸ Many of these people are likely to lose coverage because of the work requirement. Although Utah says it will exempt people who meet certain disability requirements, evidence from both Medicaid work requirements in other states and similar requirements in other programs shows that many people who are not able to work due to disability or disease are likely to **not** receive an exemption due to the complexity of paperwork.

Research from the Kaiser Family Foundation shows that people with disabilities were particularly vulnerable to losing coverage under the Arkansas work reporting requirements, despite remaining eligible.¹⁹ Similarly, an Ohio study found that one-third of the people referred to a SNAP employment program in order to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,²⁰ and nearly 20 percent had filed for Disability/SSI within the previous two years. Those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work reporting requirement. The result is that many people with disabilities will, in fact, be subject to the work reporting requirement and be at risk of losing health coverage.

Transition age youth and young adults will be harmed by proposal

Young adults in Utah experience the highest poverty rates of any demographic group in the state. In 2016, 13.1% of males age 18-24 and 12.5% of females age 18-24 in Utah lived in poverty,²¹ compared to a poverty rate of 9.7% for the state as a whole.²² In 2017, 13.3% of males ages 19-26 and 10.6% of females age 19-26 were uninsured.²³ Medicaid expansion opens an opportunity to close the coverage gap for young adults in Utah. Several of the proposed waiver components, however, risk significant harm to this populations and diminished, rather than improved health outcomes.

Utah's request to receive continued approval to waive coverage for Early Periodic Screening, Diagnostic, and Treatment (EPSDT) services for young adults ages 19 and 20 is harmful to young adults during a key period of transition. The EPSDT benefit provides comprehensive and preventative health care to children and youth covered by Medicaid up to age 21. EPSDT is key to ensuring that children and youth receive appropriate preventative, dental, mental health, developmental, and specialty services.²⁴ Preventative services are critical, particularly for young people as they transition from adolescence to young adulthood. Failure to provide this benefit to 19 and 20-year-olds risks pushing young adults into more expensive emergency room care. Failure to provide this benefit also represents a missed opportunity to identify health and mental health problems that frequently onset during late adolescence or early adulthood. By failing to identify these challenges early, young adults are likely to require much more costly care in their mid-twenties when these health problems have reached a crisis point.²⁵ The overwhelming body of evidence indicates that failing to cover preventative services results in increased costs and poorer health outcomes.²⁶

The proposal also risks exacerbating existing challenges that the state experiences retaining youth who receive mental health services as adolescents in those services as they transition to adulthood. In 2016, 17-year-olds in Utah were much less likely to continue services into their 18th year than 15-year-olds were to continue services into their 16th year or 20-year-olds into their 21st year. Only one third of 17-year-olds maintained services across this transition, compared to about half of 15-year-olds and 20-year-olds.²⁷ This data suggests that mental health services are disproportionately disrupted when children move into the adult mental health system; insurance barriers are almost certainly a factor in this disruption. The substantial paperwork barriers created by the waiver proposal will likely increase the challenges associated with maintaining needed services across this transition.

Young adults are in a unique developmental period that requires negotiating challenges and establishing independence across a range of life domains;²⁸ the paperwork requirements included in Utah's proposal are likely to pose particular challenges to vulnerable young adults during this period. Young adults ages 18 to 24 are just beginning to establish themselves in work and careers. Low-income youth and young adults are much more likely to be working part-time, low wage jobs that do not offer employer sponsored health insurance, or that offer insurance that is unaffordable to young people who are working to establish themselves in an independent household.²⁹ Emerging adults in many cases are also just learning for the first time how to navigate the health system on their own;³⁰ "gatekeeping" in the form of paperwork requirements is experienced as a major barrier to accessing needed services. Developmentally, young adults have a lower frustration tolerance and still developing executive function capacity and are more likely to give up when confronted with barriers and obstacles.

Adolescents in Utah experience higher rates of depressive symptoms (24% of boys, 43% of girls) than the national average, and has one of the highest suicide rates in the nation.³¹ Utah is ranked 7th in the nation in Opioid overdose deaths and has the highest rate of mental illness in the country.³² In this context, Utah cannot afford to miss opportunities to improve these outcomes, and certainly cannot afford to implement policies that risk worsening them. Utah's waiver proposal risks further undermining the health and mental health of vulnerable young adults in the state by imposing paperwork requirements that are not developmentally appropriate and do not acknowledge the existing challenges associated with the transition to adulthood.

Children will be harmed by proposal

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.³³ 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.³⁴ Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.³⁵ 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. These findings were reinforced in a study, which found that when parents were enrolled in Medicaid their children were more likely to have annual well-child visits.³⁶

Further, research shows that when parents have health insurance their children are more likely to have health insurance.³⁷ Utah's proposal to disenroll Medicaid enrollees from health coverage for not meeting a work requirement will reduce the number of parents with health insurance, which the evidence suggests will lead to children becoming uninsured. Utah's proposal would only exempt parents caring for a dependent child under age 6, putting at risk the health care of all parents and their children seven years of age and older.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Reporting Requirements Will Have a Disparate Impact on Communities of Color

We strongly oppose the proposal due to its disproportionate impact on communities of color. People of color are more likely to live in neighborhoods with poor access to jobs: In recent years, majority-minority neighborhoods have experienced particularly pronounced declines in job proximity. Proximity to jobs can affect the employment outcomes of residents and studies show that people who live closer to jobs are more likely to work.³⁸ They also face shorter job searches and fewer spells of joblessness.³⁹ As residents from households with low-incomes and communities of color shifted toward suburbs in the 2000s, their proximity to jobs decreased. Between 2000 and 2012, the number of jobs near the typical Hispanic and Black resident in major metropolitan areas declined much more steeply than for white residents.⁴⁰ Utah's requirement that people subject to the work reporting

requirement apply for employment with at least 48 potential employers is likely to be more difficult for persons of color to comply with.

Further, work reporting requirements are part of a long history of racially-motivated critiques of programs supporting basic needs. False race-based narratives have long surrounded people experiencing poverty, with direct harms to people of color. For decades these narratives have played a role in discussions around public assistance benefits and have been employed to garner support from working-class whites.⁴¹ Below are a few examples of the relationship between poverty, racial bias, and access to basic needs programs.

- When the “Mother’s Pension” program was first implemented in the early 1900s, it primarily served white women and allowed mothers to meet their basic needs without working outside of the home. Only when more African American women began to participate were work reporting requirements implemented.⁴²
- Between 1915 and 1970, over 6 million African Americans fled the south in the hope of a better life. As more African Americans flowed north, northern states began to adopt some of the work reporting requirements already prevalent in assistance programs in the South.⁴³
- As civil rights struggles intensified, the media’s portrayal of poverty became increasingly racialized. In 1964, only 27 percent of the photos accompanying stories about poverty in three of the country’s top weekly news magazines featured Black subjects; by 1967, 72 percent of photos accompanying stories about poverty featured Black Americans.⁴⁴
- Many of Ronald Reagan’s presidential campaign speech anecdotes centered around a Black woman from Chicago who had defrauded the government. These speeches further embedded the idea of the Black “welfare queen” as a staple of dog whistle politics, suggesting that people of color are unwilling to work.⁴⁵
- In 2018, prominent sociologists released a study looking at racial attitudes on welfare. They noted that white opposition to public assistance programs has increased since 2008 — the year that Barack Obama was elected. The researchers also found that showing white Americans data suggesting that white privilege is diminishing led them to express more opposition to spending on basic needs programs. They concluded that the “relationship between racial resentment and welfare opposition remains robust.”⁴⁶

Enrollment Limits

CLASP strongly opposes Utah’s request to continue the opportunity to cap enrollment when state appropriations are inadequate, as approved in March 2019 through the State’s 1115 PCN Demonstration Waiver amendment. This provision effectively allows Utah to cap enrollment in an entitlement program at the state’s discretion – an unprecedented and dangerous policy.

Since its creation, Medicaid has been available to anyone who meets eligibility criteria. Changing course on this policy is a blatant disregard of Medicaid law and stands to negatively impact the health of low-income Utahns who meet all eligibility criteria but may be prevented from enrolling in Medicaid.

If Utah implements an enrollment cap, *people who are eligible for Medicaid but unable to enroll* will suffer negative health consequences. Whether Utahns are in need of medication to manage chronic conditions, need mental health services to maintain employment, or find themselves unable to work due to a diagnosis of cancer or other debilitating disease, the state will choose to turn them away from health coverage.

The threat of an enrollment cap is an extreme disincentive for an enrollee to increase their earnings and creates a steep “cliff effect.” An individual who takes a job and therefore earns too much to qualify for Medicaid will have no guarantee of being able to restore coverage if the job ends. Capping enrollment takes away the security of the safety-net, causing those who are enrolled to prioritize remaining enrolled over increasing their income, particularly if they know a job may not be permanent. The fear that enrollment will be capped, leaving someone unable to re-enter the program should they experience another financial downturn, is itself a disincentive to increase earnings.

The state notes in their waiver language that they do not anticipate implementing an enrollment cap. However, the mere possibility of an enrollment cap is likely to spread misinformation about Medicaid eligibility and deter eligible persons from applying. This is only the beginning of the potential confusion caused by such policy. Should an enrollment cap be implemented, there's no clear information about under what criteria the cap would be lifted or how eligible persons would be made aware of enrollment being re-opened.

Per Capita Cap

The per capita cap outlined in this waiver request puts Utah in unnecessary financial risk and jeopardizes the health of Utahns. CLASP strongly opposes Utah's request for a per capita cap.

Placing an annual cap or limit on the amount of federal funds the state can spend for each Medicaid enrollee will not in itself reduce Medicaid spending. Rather, a reduction in Medicaid spending will happen due to cuts (i.e. to provider rates) necessitated by a state-requested limitation on federal funding. By voluntarily asking for a limited amount of federal funding, Utah is setting the stage for greater demands on state resources.

This financial shift to state funds created by a per capita cap is especially troublesome when coupled with the above mentioned enrollment cap. With CMS's approval to implement an enrollment cap, pressures on Utah's state budget created by limited Federal funding will incentivize Utah to implement an enrollment cap. The ultimate outcome will be fewer *eligible* people insured due to Utah's self-imposed limit on federal Medicaid dollars.

Congressional efforts to impose a per capita cap in Medicaid failed in 2017, indicating that a state's request for such a waiver would be incompatible with Medicaid. Furthermore, analysis of the 2017 Congressional proposals reinforced the position that a per capita cap will result in coverage and benefit losses. According to the Kaiser Family Foundation, "Facing federal reductions, states would likely turn to Medicaid program cuts to eligibility, benefits, and reimbursement to providers. These cuts would put populations and providers that disproportionately rely on Medicaid at risk including poor children, the elderly and individuals with disabilities, nursing home and community-based long-term care providers and safety-net hospitals and clinics."⁴⁷

The state appears to recognize the financial risk involved with a per capita cap by proposing firewalls, such as high unemployment rates and public health emergencies. The state is also requesting Utah's typical federal financial participation rate for any expenses incurred above the per capita cap amount. These requested safeguards raise the question of whether Utah's request for the per capita cap is offered as an incentive for CMS to approve the other items in the waiver.

Rather than pursuing a complicated per capita cap formula with several caveats to attempt to protect the state's financial interest, a wiser approach would be to follow the intent of the Affordable Care Act (ACA) and will of the Utah voters that approved the ballot initiative expanding Medicaid by increasing Medicaid eligibility to 138 percent of poverty and thereby receive a federal match rate of 90 percent for the expansion population.

Partial Medicaid expansion to 100 percent FPL

Utah's current plan to expand Medicaid eligibility to 95 percent of the poverty level with a five percent disregard (effectively an eligibility level of 100% FPL) is detrimental to the health of Utahns between 100 and 138 FPL that should be included in the expansion population, and also costlier for the state.

Utahns in the expansion group defined by the Affordable Care Act (ACA) as up to 138 percent of poverty but not included in Utah's current expansion face higher costs and potentially fewer benefits if purchasing health insurance through the Marketplace instead of being insured through Medicaid⁴⁸. Requesting the enhanced federal

match for the expansion population – but not for the *entire* expansion population – does nothing to alleviate the cost burdens of those between 100 and 138 percent of poverty.

Failing to implement a full expansion of Medicaid to 138 percent of poverty means 50,000 fewer Utahns are eligible for Medicaid. While this population is able to purchase health insurance through the Marketplace, persons with this level of income are less likely to enroll in Marketplace coverage due to out of pocket costs associated with Marketplace plans.⁴⁹ As a result, the partial expansion will leave thousands of Utahns without access to affordable health insurance.

Intentional Program Violations and Lock Out Period

CLASP has serious concerns about the state’s request to identify Intentional Program Violations (IPVs) and implement a six-month lock out period if it is determined that someone committed an IPV.

Utah presents no evidence to suggest that Medicaid enrollees are committing IPVs. It’s troubling that the basis for determining an IPV appears to be highly subjective and up to the discretion of eligibility workers. The subjectivity of these decisions are likely to be influenced by implicit biases, resulting in certain populations – likely people of color and other marginalized groups – being more apt to be found to commit an IPV.

CLASP strongly opposes the six-month lock out period for those who are found to have committed an IPV. 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.⁵⁰ Further, during the six month 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. This will only lead to poorer health outcomes and 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.⁵¹ 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.⁵²

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.⁵³ 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.⁵⁴

The proposed lock out period is extra problematic and concerning when coupled with the state’s enrollment cap. If someone were subject to a lock out period during a period when Medicaid enrollment was capped and enrollment suspended, once the person’s lock out period ends they may be effectively subject to a continued lock out period due to the enrollment cap. The compounding effects of these problematic policy proposals will do nothing to further health outcomes and will instead cause Utahns to be sicker and forgo needed care.

12-month continuous eligibility

CLASP supports Utah's request in the waiver to implement 12-month continuous eligibility for the adult expansion population. Continuous eligibility will allow for consistent treatment of chronic conditions and lead to a reduction in churn. This provision will directly benefit the health of Utahns in the adult expansion population. Unfortunately, the benefits of 12-month continuous eligibility are likely to be limited when eligible people lose Medicaid coverage due to onerous work reporting requirements or a finding they have committed an intentional program violation and are subject to the proposed lock out period.

Presumptive Eligibility

CLASP opposes Utah's request to exclude the expansion population from hospital based presumptive eligibility. Not using presumptive eligibility puts the expansion population at risk of receiving hospital bills that place significant financial strain on their lives and may lead to bankruptcy. This policy also puts hospitals at greater risk of uncompensated care. It is in all parties' financial interest to include the expansion population in hospital based presumptive eligibility and we encourage Utah to reconsider this point.

Thank you for considering CLASP's comments. Contact Suzanne Wikle (swikle@clasp.org) or Renato Rocha (rrocha@clasp.org) with any questions.

All sources accessed June 2019.

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