CLASP
policy solutions that work for low-income people

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Program Development and Quality Assurance
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Little Rock, Arkansas 72203-1437

Re: Proposal to amend the Arkansas Works 1115 Demonstration waiver

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the 1115 Demonstration Waiver Amendment Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Arkansas. This waiver takes a big step backwards in coverage and rolls back important coverage gains. What's more, while the state claims that it seeks to support low-income people in their work and education goals, this waiver proposal makes achieving these goals significantly more difficult.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer sponsored health care is not offered, or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

Our specific comments follow.

Reduction in Eligibility

This proposal reduces Medicaid eligibility for adults—including for medically frail adults. The limit for eligibility is dropped from 133% of the federal poverty level (FPL) to 100% of the FPL. This means that all adults between 101-133% of FPL will lose their access to Medicaid. No explanation is offered for how this will promote the goals of Medicaid; rather, this is simply a shift of costs to the federal government. CLASP strongly opposes this provision, and any reduction in eligibility that will result in more people becoming uninsured or having interruptions in their continuity of care.

This eligibility reduction will result in an increase in the number of low-income individuals who churn between Medicaid, the marketplace and being uninsured. This will have negative health consequences, as changes in coverage often require changes in health care providers, and can lead to interruptions in treatment. In one recent study, even among those who churned with no gap in coverage, 29 percent reported a decrease in their overall quality of care as a result of the transition.[1] This is particularly harmful for those with significant health conditions.

Changes in employment, income and family structure all impact churn. Low-income individuals are more at risk of churning from one type of coverage to another[2] because low-wage work is increasingly variable in hours and/or seasonal.[3] The Affordable Care Act deliberately created an overlap between the eligibility levels for Medicaid and the premium subsidy tax credits in order to reduce the need for consumers to frequently switch between coverage under Medicaid and the Marketplace

As discussed below, the likelihood of people churning on and off coverage is increased by the burdensome administrative requirements included in this proposal. Even people who continue to be eligible will fall through the cracks as the paperwork burden increases.

Work Requirements and Lockout Periods on Medicaid Eligibility

CLASP strongly opposes the work requirements and lock out periods proposed in this waiver amendment that would apply to all adults age 19-49 on ArkansasWorks. This is proposed without any evidence of a problem that this is intended to solve; rather, this proposal is based on a false assumption that people do not wish to work and need to be incentivized to do so. (There is also no basis offered for the arbitrary age limits proposed for this policy.)

We strongly oppose the lock-out periods from Medicaid for recipients who fail to meet the work requirement for three months—consecutive or non-consecutive. These lock-out periods 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 extremely complex documentation requirements mean that many people who should be exempt --or who are actually working or participating in a qualifying activity -- will be cut off and will have no way to regain health insurance until the following year.

In addition, while the purported goal of this provision is to promote work, the reality is that the proposal makes no commitment to providing work activities to participants. In fact, denying

access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventative and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

The proposal to implement time limits on non-working recipients is based on a false assumption that people do not wish to work and need to be incentivized to do so. A recent Kaiser Family Foundation study found that the overwhelming majority of non-working Medicaid recipients were ill or disabled, attending school, caring for other, or seeking work.[4] Many Medicaid beneficiaries work, but for low- wage workers, employer-sponsored insurance is often either not offered or is prohibitively expensive. Even if unemployed Medicaid recipients obtain jobs, they are highly likely to continue to need health coverage through Medicaid.

A recent Kaiser Family Foundation (KFF) study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI benefits—reported illness or disability as their primary reason for not working.[5] People with chronic conditions that impact their ability to work but do not qualify them for disability benefits will be at high risk of losing access to care. Chronic conditions are, by definition, not time-limited and often impact individuals for extended periods. While the proposal states that the work requirement will not apply to beneficiaries who are physically or mentally unable to work, the evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits.

For example, even though individuals who were unable to work should have been exempted, one study from Franklin County, OH, found that one third of the individuals referred to a SNAP employment program in order to keep their benefits reported a physical or mental limitation, 25% of whom indicated that the condition limited their daily activities. Additionally, nearly 20% of the individuals had applied for SSI or SSDI within the previous 2 years.[6]

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.[7] 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. Precisely those who need health care the most will struggle to meet the requirement that exemptions for short-term incapacities and for caregivers be renewed every two months. Simply the burden of understanding the requirements and documenting their exemption is likely to be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.[8] These beneficiaries are highly likely to be locked out of coverage, with severe consequences for their health.

This provision may also affect many people who work, but do not consistently meet the 80 hours of work threshold. Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week to week.[9] Many workers are assigned to “call-in shifts”, providing no guarantee of work, but preventing them from scheduling other work or activities.[10]

The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[11] both industries well known for their variable and seasonal hours of employment. Individuals with variable hours of employment may also lose coverage and be locked out if they fail to keep up with the requirement to document their hours of employment.[12] While workers receiving unemployment benefits are not subject to the work requirements, less than 30 percent of unemployed workers in Arkansas receive unemployment insurance.[13]

Access to Medicaid supports work

There is no evidence offered that the threat of Medicaid lock-outs would promote work. Arkansas makes no commitment to provide employment services to beneficiaries subject to the work requirement. In the most recent year for which data are available, less than 2,000 people in the entire state participated in Department of Workforce Services training programs.[14] Providers of welfare-to-work services often report that sanctions or penalties that continue for a fixed period of time make it *harder* to reengage participants, because they cannot lift the sanction by coming into compliance. Many beneficiaries will not understand the new rules until they have already been locked out of coverage.

In fact, because providing access to coverage is an important way to support work, this proposal would likely reduce employment outcomes. A recent report from Ohio found that providing access to affordable health care through Medicaid helps enrollees to seek and maintain employment. More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three-quarters of unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment.[15] Without the support of Medicaid, health concerns would threaten employment stability.

Time limits would led to worse health outcomes, higher costs

During the lock-out period, beneficiaries will likely be uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. For a beneficiary who gets "locked-out" in the first quarter of the year, they may be uninsured for as long as 9 months, during which time they will go without needed care. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.[16] And during 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.

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

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

When beneficiaries re-enroll 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.[21] Public programs will end up spending more to bring these beneficiaries back to health.

Monthly determinations and lock-out periods add complexity and administrative costs
Tracking exemptions and participation for every beneficiary would significantly add complexity and cost to the administration of the Medicaid program. Arkansas would need to develop a whole new system to track months, send notices to clients, and determine whether a beneficiary qualified for an exemption that month.

One of the key lessons of the Work Support Strategies initiative is that every time that a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that have to process additional applications. The WSS states found that that reducing administrative redundancies and barriers used workers' time more efficiently and also helped with federal timeliness requirements.

An administrator in Idaho reported that unnecessary reevaluations resulted in wasting caseworkers' time and confusion for families. A Colorado WSS team member reflecting on their former processes noted "it was crazy-making for us... it was a constant workload for all of us". Adding new complicated requirements to Medicaid eligibility, including determining exemptions and tracking the hours of work, which often vary from month to month, would be a major step in the wrong direction.

Eliminate Retroactive Eligibility
The proposed waiver would eliminate retroactive eligibility prior to the first day of the month that the application is. This will present a major burden to providers and emergency rooms, who will shoulder the burden of uncompensated care for beneficiaries who do not get retroactive eligibility. For example, if a patient presents to the emergency room on the 30th of a month and is found eligible for Medicaid on the 2nd of the following month at discharge, the patient's Medicaid coverage will begin the 1st day of the month—and the entire burden of the emergency room visit will be uncompensated care for the hospital.

Thank you for your consideration of these comments.

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

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