CLASP

Policy solutions that work for low-income people

October 26, 2018

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

Re: Michigan's Section 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 Michigan's Demonstration Extension Application Amendment and raises serious concerns about the effects of the amendment, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Michigan.

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 and is not a government "interference," as suggested by Michigan. 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.

Among the state's professed goals for the proposal is to increase access to health care and reduced uncompensated care. However, this proposal's attempt to transform Medicaid and reverse its core function will result in Medicaid enrollees losing needed coverage, poor health outcomes, and higher 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 amendment is therefore inconsistent with the Medicaid purpose of providing medical assistance and should be rejected. It is also inconsistent with improving health and increasing employment.

Michigan's Medicaid Expansion Has Been Extremely Successful

Michigan expanded Medicaid coverage in April 2014 through a section 1115 waiver which it called the "Healthy Michigan Plan" (HMP). Today, over 650,000 Michiganders with incomes below 138 percent of the poverty line who were previously uninsured or underinsured have coverage. Mirroring the experience of other expansion states, Healthy Michigan has helped lower Michigan's uninsured rate, while improving access to care and the physical and financial health of Medicaid beneficiaries.[3] Specifically, Healthy Michigan has:

- *Cut the state's uninsured rate in half.* Michigan's uninsured rate has decreased by 50 percent overall, and by at least 40 percent in all but one of the state's counties since 2014.[4]
- *Made working and searching for a job easier.* In a survey of beneficiaries, over half of non-working adults reported that Medicaid makes it easier to look for work, while nearly 70 percent of working adults said Medicaid made it easier to work or made them better at their jobs.[5] One study found that more than half of Michigan's working expansion beneficiaries had a serious physical health condition such as heart disease, asthma, or diabetes, and 25 percent had a mental health condition, often depression.[6]
- *Improved access to care.* Physicians surveyed by Healthy Michigan evaluators reported that Medicaid expansion has improved access to care, detection of serious health conditions, and management of chronic health conditions, particularly among beneficiaries who were previously uninsured.[7] The increase in the number of Medicaid beneficiaries did not result in less access to care.
- *Improved physical health.* Nearly 48 percent of enrollees surveyed reported improvements in their physical health since enrolling in the program.[8] Researchers comparing Michigan and Virginia, which hadn't expanded Medicaid, found Michigan hospitals had fewer uninsured cardiac surgery patients and improved estimates of the risk of morbidity and mortality and morbidity rates.[9]
- *Improved financial health.* After enrolling in Healthy Michigan, beneficiaries had less debt sent to collectors, less debt that is past due, and were less likely to spend over their credit card limits, according to a recent study of Healthy Michigan administrative data matched to consumer credit reports. The study also found a significant reduction in the number of public records related to financial challenges, such as evictions, bankruptcies, and wage garnishments.[10] This is consistent with findings from the beneficiary survey which shows that 86 percent of beneficiaries reported that "problems paying their medical bills got better" after enrolling in the program.

Proposal to increase cost-sharing and participation requirements for individuals enrolled for 48 cumulative months

CLASP does not support Michigan's proposal to require a monthly premium equal to 5% of income and eliminate eligiblity for cost-sharing reductions for persons enrolled for 48 cumulative months. No rational is provided for the changes in eligiblity and cost-sharing to persons with 48 months of cumulative coverage. This proposed policy is essentially a punishment for maintaining employment with income between 100 and 138 percent of poverty but not increasing your earnings.

The reality of low-wage work is that many people work for poverty-level wages and do not substantially increase their earnings from year to year. In one study that followed a group of women who received welfare in an urban county in Michigan, the share of respondents who were working in "good jobs" (defined by a combination of wages, hours, and health benefits) increased from 8.3% in 1997 to just 29% in 2001. This is in spite of a historically strong labor market that resulted in labor force participation rates for single mothers that have not been seen since. As would be expected, the probability of holding a good job is higher for former recipients who worked steadily. However, even exceptionally regular employment did not guarantee progression to a good job; of the small fraction of respondents who had worked in every month of the past five years, only 55% were employed in good jobs in 2001.[11]

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

CLASP does not support Michigan's proposal to take away health coverage from individuals who do not meet new work requirements. Our following comments focus on the harmful impact the proposed work requirements will have on Michiganders and the state. Michigan is proposing to implement a work requirement for beneficiaries who are between the ages of 19-62, unless they qualify for an exemption.

Those who are subject to the work requirement will have to work or participate in other qualifying activities for 80 hours per month to stay enrolled in Medicaid. Medicaid enrollees will also be required to demonstrate that they are compliant with the work requirements through monthly verification. The penalty for not complying with the work requirement is disenrollment from Medicaid.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Michigan to reconsider their approach to workforce development. 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.[12] 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.[13] As reported by the University of Michigan, Medicaid expansion helped low-income Michigan residents look for employment and stay employed. In particular, the study highlights that most (55 percent) of those who were out of work said that coverage made them better able to look for a job and, among those who had jobs, 69 percent said they did better at work once they got covered.[14] 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. Michigan's proposal would require Medicaid enrollees subject to new work requirements to demonstrate that they are meeting the requirements through monthly verification. Not only will this create considerable paperwork for Medicaid enrollees, but also significantly increase administrative costs. 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.

Lessons from the WSS initiative is that the result of Michigan's new administrative complexity and red tape is that ***eligible*** people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome. Lastly,
recent evidence from Arkansas' first four 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 4,100 beneficiaries lost coverage on October 1st, likely becoming uninsured because they didn't report their work or work-related activities.[15] In September, over 4,300 beneficiaries lost coverage. These individuals represent about 17 percent of the state's first cohort of Medicaid beneficiaries subject to the work requirement.[16] In total, more than 8,400 Arkansas Medicaid beneficiaries have lost coverage since the state implemented its work requirements. 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.[17]

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 ours 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.[18] 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.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements are Likely to Increase Churn

Michigan's proposal to take away health coverage from Medicaid enrollees who do not meet new work requirements is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid as their hours increase or the seasons change. People may be most likely to seek to re-enroll once they need healthcare and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

Disenrollment and lock out would lead to worse health outcomes, higher costs

After three months of non-compliance within a 12-month reporting period, Medicaid enrollees subject to new work requirements will be disenrolled from Medicaid. If they are not able to comply within 30 days following disenrollment, they will continue to be without coverage until they meet new work requirements. If a beneficiary is found to have misrepresented his or her compliance, the Medicaid enrollee would be locked out of coverage for a one-year period.
The lock-out period serves no purpose other than to be punitive and does not encourage work. The broadness of this lanugage raises concern that beneficiaires who mistakenly and unintentionally provide inaccurate information may be locked out of having health insurance for a year. Given the unavoidable complexity that must exist to navigate the bureaucracy and red tape created by Michigan's proposal, it is not unreasonable that beneficiaries may make errors on their paperwork.

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.[19] Further, 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. 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.[20]

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.[21]

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.[22] 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.[23]

When the beneficiary re-enrolls in Medicaid—or qualifies for Medicare—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.[24] Public programs will end up spending more to bring these beneficiaries back to health.

Children will also be harmed by the 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.[25] 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.[26] Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[27] 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 new study, which found that when parents were enrolled in Medicaid their children were more likely to have annual well-child visits.[28]

Further, research shows that when parents have health insurance their children are more likely to have health insurance.[29] Michigan'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. Michigan's plan would only exempt one parent of a child under 6 years of age, putting at risk the health care of all parents and their children 6 years of age and older.

Support services will be inadequate

Child care is a significant barrier to employment for low-income parents. Many low-income jobs have variable hours from week to week and evening and weekend hours, creating additional challenges to finding affordable and safe child care. Under Michigan's proposal, parents whose children are older than 5 years are subject to the work requirements. Finding affordable and safe child care for children is difficult and a barrier to employment. Requiring employment to maintain health care, but not providing adequate support services such as child care, sets a family up for a no-win situation. Even with the recent increase in federal child care funding, Michigan does not have enough funding to ensure all eligible

families can access child care assistance.[30]

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 Michigan proposes to exempt individuals who currently receive temporary or permanent long-term disability benefits from a private insurer or the government or designated as unfit to work or medically frail, in reality many people who are not able to work due to disability or unfitness 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 Michigan, this rate increases to 39 percent. [31]

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[32] In states that have expanded Medicaid, such as Michigan, 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.[33] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed in Michigan'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,[34] 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 disabilities will in fact be subject to the work requirement and be at risk of losing health coverage.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm Returning Citizens

Having a criminal record can make it extremely difficult to find a job and meet work requirements. Research shows that roughly half of returning citizens are still unemployed one year after release.[35] These individuals face many legal and social impediments to finding and retaining employment which can build stability and reduce the risk of recidivism. Taking away health coverage for not working a set number of hours per month only exacerbates this challenge. People with criminal records face many more legal barriers to employment such as occupational licensing bans that preclude them from obtaining even low skilled and entry level positions. Even an arrest record can be a long-term barrier to finding and keeping employment since many businesses conduct background checks; a recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[36]

Michigan's proposal would subject returning citizens after only six months of release to work a set number of hours per month. Many people with criminal records need more time, training, and hands-on assistance to find adequate employment. Access to benefits, such as Medicaid can mean the difference between an individual successfully reintegrating into society, or recidivating.

Former foster youth are likely to lose coverage

The Affordable Care Act (ACA) included a provision to help improve the health of young adults who often have significant health care needs and are more likely to be uninsured than their peers –youth up to age 26 previously in foster care and enrolled in Medicaid. This provision was also intended to reduce disparities in access to health insurance between former foster youth and other young adults who can stay on their parents' private insurance until age 26.

For youth who enter into foster care, between 35 and 60 percent have at least one chronic or acute health condition that needs treatment.[37] The chronic health issues that impact youth involved in the foster care system continue to be problematic for youth who ultimately age out of the foster care system. Youth who have aged out of foster care are more likely than their general peers to have a health condition that limits their daily activities.[38] Despite the intention of the ACA and the evidence surrounding the health of these youth, Michigan's proposal takes away health coverage from former foster youth who are older than 21 years of age and do not work a set number of hours per month, jeopardizing their general health and well-being over time.[39]

Budget neutrality information is insufficient

The proposal states that 400,000 enrolled beneficiaries could be impacted by proposed policies in the waiver application, but the state does not provide estimates of how many people will lose their Medicaid coverage. Michigan should provide details about the anticipated change in enrollment in the state and corresponding budget implications. Without this detail, it is impossible to fully understand the impact of the proposal.

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.[40]

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.[41] 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.[42]

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.[43]

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

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