CLASP

Policy solutions that work for low-income people

February 21, 2018

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

Re: State of Mississippi Medicaid Reform Demonstration Project, 1115 Demonstration Waiver Amendment

Dear Secretary Azar,

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

CLASP submits the following comments in response to the 1115 Waiver Demonstration 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 Mississippi. In particular, the policies would have a dramatic and negative impact on access to care for deeply poor parents (leading to negative effects for their children as well). The state's own estimate is that in the first year of the waiver, nearly 5,000 fewer people would be covered under Medicaid each month, and this is likely an underestimate. There is no reason to believe that these people will be transitioning to employer-sponsored insurance or earning enough to qualify for subsidies under the Affordable Care Act. This waiver thus takes a big step backwards in coverage. We therefore believe that it is inconsistent with the goals of the Medicaid program, notwithstanding the January 11, 2018 guidance from the Centers for Medicare and Medicaid Services (CMS).

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.

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[1]. A waiver that does not promote the provision of 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 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."[2] 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.

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.[3] 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.[4] Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.[5] 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.[6]

Work Requirements

CLASP does not support Mississippi's proposal to implement work requirements, referred to as "workforce training activities" in the proposal, for the non-disabled Medicaid population. Our comments that follow focus on the harmful impact the proposed work requirements will have on low-income Mississippians and the state.

Mississippi is proposing to implement a work requirement for "non-disabled adults currently covered under traditional Medicaid, including low-income parents and caretakers eligible under Section 1931 and individuals eligible for transitional medical assistance." Those who are subject to the work requirements will have to work or participate in other qualifying activities for 20 hours per week in order to stay enrolled in Medicaid. Mississippi notes that some populations will be exempt from the work requirement. The penalty for not complying with the work requirement is disenrollment from Medicaid until compliance is met.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges CMS to reject this request. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventative and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

The request for a work requirement is especially troublesome given Mississippi's extremely low income eligibility limit for Medicaid for non-disabled adults. Non-disabled adults in Mississippi are only eligible for Medicaid if they are living in extremely deep poverty (under 27 percent of the poverty level, equivalent to

just $5,513.40 *annually* for a family of three) and raising dependent children. These families are facing enormous struggles to make ends meet. Placing extra burdens on these families for the adults to receive health care is not only immoral, but may actually make it harder for them to find and keep employment.

In addition, section 1931 of the Social Security Act ensures Medicaid eligibility for adults with children who would have been eligible for the Aid to Families with Dependent Children (AFDC) program according to 1996 income guidelines, regardless of whether they currently receive cash assistance. Mississippi's request to implement a work requirement for this population (if they don't qualify for an exemption) would effectively eliminate this guarantee of coverage. This request by Mississippi appears to be in direct conflict with the law.

Work Requirements Do Not Promote Employment

Using TANF and SNAP as models to create a work requirement for Medicaid is misguided and short-sighted. Lessons learned from 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.[7] 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.[8] Medicaid expansion enrollees from Ohio[9] and Michigan[10] 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.

Work Requirements Do Not Lead to Employer Sponsored Insurance

The waiver request assumes that if participants become employed, they will be able to transition onto 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 in their employer offered insurance.[13] People working multiple part-time jobs or in the gig economy are particularly unlikely to have access to employer-provided insurance.

Work Requirements Grow Government Bureaucracy and Increase Red Tape

The addition of a work requirement to Medicaid 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 is a significant undertaking that will require new administrative costs and possibly new technology expenses to update IT systems. Lessons from other programs show that the result of this 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.

The waiver language states that the data needed to identify when people are exempt from the work requirement are not currently tracked. Developing a new system to track reasons for exemptions and the number of hours worked by those subject to the work requirement will be administratively burdensome, and likely costly to the state.

Work Requirements Do Not Reflect the Realities of Our Economy

Work requirements 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.[14] 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.

Work Requirements are Likely to Increase Churn

Mississippi states that the addition of work requirements to Medicaid will contribute to decreasing churn in Medicaid. In reality, the addition of work requirements is likely to have the opposite effect and 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 preventative care if they are not continuously enrolled in Medicaid.

Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lost coverage because of the work requirement. Although Mississippi is proposing to exempt individuals who receive Social Security Disability Insurance (SSDI) and Supplemntal Security Income (SSI), have been determined unable to work, or have been diagnosed with a mental illness, in reality many people are not able to work due to disability or disease 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.[15] In Mississippi, this rate increases to 48 percent. And, 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,[16] 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. The end result is that many people with disabilities will in fact be subject to the work requirement and will be at risk of losing health coverage.

For all the reasons laid out above, the state should reconsider their approach to encouraging work. If Mississippi is serious about encouraging work, helping people move into jobs that allow for self-sufficiency (and affordable ESI), and improving its state's health ranking 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. Mississippi could opt to expand Medicaid as intended by the ACA, which will ensure that people have consistent access to Medicaid and close the coverage gap. Instead, the state is asking to place additional barriers between the state's most vulnerable families and their health care.

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

[1] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," National Health Law Program, 2017, **http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRlBFWnHIU.**

[2] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., Health Insurance Coverage and Health — What the Recent Evidence Tells Us, New England Journal of Medicine, July 21, 2017. **http://www.nejm.org/doi/full/10.1056/NEJMsb1706645**.

[3] Jack Shonkoff, Andrew Garner, "The Lifelong Effects of Early Childhood Adversity and Toxic Stress," Pediatrics, December 2011, **http://pediatrics.aappublications.org/content/early/2011/12/21/peds.2011-2663**.

[4] Stephanie Schmit and Christina Walker, "Seizing New Policy Opportunities to Help Low-Income Mothers with Depression," CLASP, 2016, **http://www.clasp.org/resources-and-publications/publication-1/Opportunities-to-Help-Low-Income-Mothers-with-Depression-2.pdf.**

[5] National Scientific Council on the Developing Child and National Forum on Early Childhood Program Evaluation, "Maternal Depression Can Undermine the Development of Young Children," Center on the Developing Child, Harvard University, Working Paper 8, 2009, **http://developingchild.harvard.edu/resources/maternal-depression-can-undermine-the-development-of-young-children.**

[6] Maya Venkataramani, Craig Evan Pollack, Eric T. Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," Pediatrics. 2017;140(6):e20170953, **http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf.**

[7] Jessica Gehr, "Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers," CLASP, June 2017, **https://www.clasp.org/sites/default/files/publications/2017/08/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf.**

[8] Jessica Gehr and Suzanne Wikle, "The Evidence Builds: Access to Medicaid Helps People Work," February 2017, CLASP, **https://www.clasp.org/publications/fact-sheet/evidence-builds-access-medicaid-helps-people-work.**

[9] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, **http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.**

[10] Renuka Tipirneni, Jeffrey Kullgren, John Ayanian, Edith Kieffer, Ann-Marie Rosland, Tammy Chang, Adrianne Haggins, Sarah Clark, Sunghee Lee, and Susan Goold, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 2017, **http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.**

[11] Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2016, **https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D** and KFF "Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100% FPL)" 2016, **https://www.kff.org/other/state-indicator/poor-adults**.

[12] Brynne Keith-Jennings and Vincent Palacios, "SNAP Helps Millions of Low-Wage Workers," Center on Budget and Policy Priorities, May 2017, **http://www.cbpp.org/research/food-assistance/snap-helps-millions-of-low-wage-workers.**

[13] U.S. Department of Labor, "Table 2. Medical care benefits: Access, participation, and take-up rates," Bureau of Labor Statistics, December 2017, **https://www.bls.gov/news.release/ebs2.t02.htm**.

[14] Liz Ben-Ishai, "Volatile Job Schedules and Access to Public Benefits" CLASP, September 2015, **https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf.**

[15] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work, February 2017, **http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.**

[16] Ohio Association of Foodbanks, Comprehensive Report: Able-Bodied Adults Without Dependents, 2015, **http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_2014-2015-v3.pdf**.