CLASP

Policy solutions that work for low-income people

August 31, 2018

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Granite Advantage 1115 Waiver Amendment and 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 the 1115 Waiver Amendment and Extension 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 New Hampshire.

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.

New Hampshire's proposal would have a dramatic and negative impact on access to care for a broad range of people. This waiver takes a big step backwards in coverage and rolls back important coverage gains. We therefore believe that it is inconsistent with the goals of the Medicaid program.

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"[1] of the Medicaid Act.

A waiver that does not promote the provision of health care would not be permissible. This waiver proposals' attempt to transform Medicaid and reverse its core function will result in many adults 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.

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

New Hampshire's proposal requests authority to continue implementation of work and community engagement requirements. The proposal would require individuals who are not excluded or exempt to participate in at least 100 hours per calendar month in one or more community engagement activities.

CLASP strongly opposes proposals to take health coverage away from individuals who do not meet work requirements. Work requirements—and suspension of Medicaid benefits for failure to comply—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.

Individuals with disabilities and illnesses would be affected

Even though the waiver states that those who are unable to participate due to illness or incapacity would be exempt, individuals with disabilities are likely to be adversely affected. A Kaiser Family Foundation (KFF) 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 New Hampshire, this rate increases to 49 percent.[3] 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 an extended period. In particular, this proposal requires all exemptions to be certified by a medical professional—but the work requirements are imposed as soon as the individual begins receiving benefits. It is likely that people will be stuck in a "catch-22" situation where they can't prove that they can't work because they can't get insurance because they aren't working.

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, 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 percent of which indicated that the condition limited their daily activities. Additionally, nearly 20 percent of the individuals had filed for SSI or SSDI within the previous 2 years.[4]

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.[5] 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. Access to employment services on a voluntary basis can certainly be beneficial for some, but work requirements most often serve as a mechanism to take away crucial support for low-income individuals.

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[6] In states that have expanded Medicaid, persons with disabilities no longer have to qualify for SSI in order to be eligible for Medicaid. This change in policy allows persons with disabilities to access health care without having to meet the criteria for SSI eligibility, including an asset test. Other research that shows a drop in SSI applications in states that have expanded Medicaid supports the theory that access to Medicaid is an incentive for employment.[7] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed by New Hampshire will ultimately create a disincentive for employment among persons with disabilities.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet Work requirements do not reflect the realities of our economy

This provision may also affect many people who work, but do not consistently meet the minimum hours of work per week threshold. Work requirements do not reflect the realities of today's low-wage jobs. Low-wage work in America does not fit into the "9 to 5" concept that many politicians and state administrators have of work. About half of low-wage hourly workers have schedules outside the traditional Monday-Friday, 9-5 routine and are patching together two or more part-time jobs to support their families.[8] Frequently, they aren't getting traditional employment benefits (such as health insurance) that middle- and upper-income Americans receive with their jobs. Recent data show that 5 million workers reported working part-time, despite wanting full-time jobs. Involuntary part-time work is a symptom of the low-wage labor market that makes it difficult for people to gain economic security.[9]

Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week-to-week.[10] Many workers are assigned to "call-in shifts", providing no guarantee of work, but preventing them from scheduling other work or activities.[11] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[12] both industries well known for their variable and seasonal hours of employment. Individuals with variable hours of employment may also lose coverage if they fail to keep up with the requirement to document their hours of employment.[13] 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.

Disenrollment would lead to worse health outcomes, higher costs

Work requirements will have profound implications for the health care outcomes of beneficiaries and will ultimately lead to increased costs to states. Once terminated from Medicaid coverage because of failure to meet the work requirements, beneficiaries will likely become uninsured.
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.[14] 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.[15]

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.[16] 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.[17]

When the beneficiary re-enrolls in Medicaid, they will be sicker and have higher health care needs. Public programs will end up spending more to bring these beneficiaries back to health.
In addition, the proposed policy of increasing the work requirement based on the duration of participation has negative effects. This policy incentives people to enroll in Medicaid only when they are sick, rather than using their limited months during times when they are well. This will have negative consequences for enrollees and for the program. People will not receive preventative care, early treatment for new illnesses, or consistent treatment of chronic diseases, which will make them less healthy and drive up costs.

Access to Medicaid supports work

CLASP strongly opposes implementing a work requirement for Medicaid. The proposal to implement a work requirement is based on a false assumption that people are not working, do not wish to work, or need to be incentivized to do so. In fact, nearly 8 in 10 Medicaid enrollees live in working families, and the majority are working themselves.[18] A recent Kaiser Family Foundation (KFF) study found that the overwhelming majority of non-working Medicaid recipients were ill or disabled, attending school, caring for others, or seeking work. [19] Likewise, a 2016 report from the American Enterprise Institute found similar results – non-parents are most likely to not be working due to disability or illness.[20]

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 most unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment.[21] Data from Michigan reinforces this finding, with 55 percent of unemployed Medicaid enrollees reporting that health care through Medicaid makes it easier to search for employment.[22] This simply makes sense – people must be healthy in order to seek, obtain, and maintain employment. Without the support of Medicaid, health concerns would threaten employment stability.

Limiting Parents' Coverage Hurts Children

Limiting parents' coverage will have negative implications for their children's coverage and health. Research repeatedly demonstrates that children are more likely to have health insurance when their parents have health insurance. New research shows that when parents have insurance their children are

more likely to receive annual check-ups and well child visits.[23] Limiting parents' coverage will have a trickle-down effect on children's coverage – children will become uninsured and will be less likely to receive annual check-ups and well-child visits.

Work requirements add complexity and administrative costs

Simply put, this waiver application significantly increases red tape for applicants and enrollees, while also greatly expanding administrative burdens by making the program complex. Medicaid has a well-established low administrative overhead cost relative to private insurance, but the proposal will create larger government and be extremely costly for the state to implement. Components of this modification request, and the underlying waiver, in practice only create additional bureaucratic burdens for people who are working and struggling to meet their basic needs.

The national Kaiser report with findings that between 1.4 and 4 million people will lose coverage due to work requirements also finds that the majority of coverage loses are due to paperwork issues and barriers rather than ineligibility for Medicaid. The report finds that even in the low-end estimate of 1.4 million people losing coverage, 62 percent of those losing coverage would be working or exempt, and therefore lose coverage due to red tape and paperwork rather than a change in their eligibility status.[24]

Further, 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 it 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. 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.

Lastly, recent evidence from Arkansas' first and second month of implementing work requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. Over 6,500 Medicaid beneficiaries have one month of non-compliance and over 5,400 beneficiaries have two months of non-compliance of the new requirement. These Medicaid enrollees will lose coverage if they have three months of non-compliance. 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.[25]

Citizenship and Residency Documentation Requirement Would Result in Eligible People Missing Out on Coverage, is Costly, and Does Not Further Medicaid Program's Objectives

CLASP opposes New Hampshire's unprecedented proposal that adults eligible for the Medicaid expansion verify that they are United States citizens by providing two forms of identification and verify that they are residents of New Hampshire by providing a New Hampshire driver's license or a non-driver's picture identification card. This proposal would result in eligible people missing out on coverage, would be costly to the state and federal government, and does not further the objectives of the Medicaid program.

The citizenship documentation requirement New Hampshire is seeking to impose is not allowable under federal rules and adds red tape that will result in eligible people being delayed or deterred from obtaining benefits. The New Hampshire proposal would require expansion adults to verify that they are United States citizens by providing two forms of identification and verify that they are residents of New Hampshire by providing a New Hampshire driver's license or a non-driver's picture identification card. By implication, qualified immigrants who are eligible for Medicaid could not enroll, because they couldn't prove they are citizens. It isn't clear that the state actually intends to bar otherwise eligible legal immigrants from the program but that would be the consequence of requiring documentation of *citizenship* from all applicants and such a limitation on eligibility is not allowable under the law.

The requirements that New Hampshire is attempting to impose are not only unnecessary and would create a significant barrier to keeping people insured — they would also violate the Medicaid statute. The key provisions governing proof of immigration status and citizenship are in parts of the Social Security Act that cannot be waived. Section 1137 governs verification of immigration status and section 1903(x) is the core provision governing verification of citizenship. Neither of these provisions can be waived under section 1115 which only allows waivers of provisions in section 1902.

Moreover, the state hasn't provided any justification for this proposal, which is not surprising given there isn't any evidence that current procedures aren't sufficient to guarantee that only eligible citizens and qualified immigrants are participating in New Hampshire's Medicaid program. The requirements New Hampshire is proposing would be unnecessarily burdensome for consumers and for the state. Many eligible people would likely be unable to provide the documents because they aren't readily available and obtaining them would take time and money, which in turn would result in delays or outright denials of coverage as New Hampshire experienced in 2006 after implementing the burdensome paper-based citizenship documentation requirement under the Deficit Reduction Act of 2005.

During this time, New Hampshire Healthy Kids (NHHK), processed child applications for the state's Children's Health Insurance Program (CHIP) and Medicaid. Prior to implementing the burdensome paper-based citizenship documentation requirement, 34 percent of applications received monthly by NHHK included all of the documents needed to verify eligibility. During the first six-months of implementing the new burdensome citizenship documentation requirement, only 16 percent of applications received by NHHK had all documents needed to verify eligibility.

Adding the requirements New Hampshire proposes is unnecessary. Existing Medicaid regulations require verification of citizenship and noncitizen status for Medicaid enrollees. In fact, state and federal governments have spent millions of dollars establishing systems that electronically verify citizenship or eligible immigration status accurately and efficiently through the Social Security Administration (SSA) which verifies U.S. citizenship and the Department of Homeland Security (DHS) which verifies immigration status and U.S. citizenship for certain individuals. Applicants must provide their names, dates of birth, and Social Security or relevant immigration numbers, which are then matched against information held by these agencies. The majority of people have their status verified quickly, accurately, and securely using these processes. Some people can't instantly be verified and they must provide additional information or documents to prove their status. In cases where individuals must provide documentation to prove their citizenship many do not have to provide two forms of proof—as would be the requirement under this policy— several forms of proof are sufficient by themselves to prove citizenship under law including U.S. issued passports, certificates of U.S. citizenship and certificates of naturalization.

The new documentation requirements included in New Hampshire's proposal would cause massive delays in coverage for many Medicaid beneficiaries. The current process that verifies citizenship or immigration status through data matches allows most people to have their circumstances verified quickly and accurately. The quick decision helps ensure that the state sends people who aren't eligible for Medicaid to the Marketplace without significant delay.

Moreover, New Hampshire's proposal seeks to impose a restrictive and burdensome residency requirement that would only accept New Hampshire driver's license or a non-driver's picture identification card as evidence of state residency. Similar to the experience with burdensome and restrictive citizenship documentation, this requirement will result in eligible consumers unable to meet the requirement and as a result will get delayed coverage or miss out in coverage altogether. Similar to the citizenship proposal, the state provides no evidence that suggests that the current procedure is resulting in ineligible people being enrolled.

Imposing an Asset Test Is Not Allowable and Would Undermine the Current System

The proposal would impose a $25,000 asset test on beneficiaries even though the ACA explicitly prohibits HHS from granting waivers to allow them.[26] The ACA eliminated asset tests and made other changes to Medicaid rules for most beneficiaries to align eligibility for Medicaid, the Children's Health Insurance Program, and subsidized marketplace coverage for children and adults in order to create a system where people can easily transition between insurance affordability programs as their incomes and circumstances change. Allowing an asset test in Medicaid would undermine this system, and states cannot vary from the ACA's rules.

Removing Conditions Around Existing Retroactive Coverage Does Not Further the Objectives of the Medicaid Program

New Hampshire's proposal would remove conditions around its existing retroactive coverage waiver, which would allow the state to waive the statutory provision requiring that Medicaid reimburse medical costs incurred by Medicaid beneficiaries for up to three months before they apply if they were eligible during the retroactive period.

Retroactive coverage, which has been a feature of Medicaid since 1972, helps prevent medical bankruptcy and provides financial security to vulnerable beneficiaries by making Medicaid payments available for expenses incurred during the three-month period before application if the beneficiary was eligible for Medicaid during that period. Data from Indiana show how important retroactive coverage is for low-income parents in the state who incurred costs prior to enrollment. Medicaid paid $1,561 on average on behalf of parents who incurred medical costs prior to enrolling in Medicaid.[27]

The state's proposal claims that eliminating retroactive coverage would encourage beneficiaries to obtain and maintain health coverage, even when they are healthy, as well as increase continuity of care by reducing gaps in coverage when beneficiaries move in and out of Medicaid or sign up for Medicaid only when sick. Regardless of whether these are appropriate objectives for a waiver, eliminating retroactive coverage would not facilitate early enrollment or increase continuity of care without significant outreach and education about Medicaid eligibility. It would instead lead to increased financial insecurity and instability for low-income families and higher uncompensated care costs for Medicaid providers. It is also worth noting that all the other major features of New Hampshire's waiver would lead to more

interruptions and gaps in coverage and disruption in access to care; to the extent CMS believes continuity of coverage is an important objective of the Medicaid program, this should have been an additional reason to reject work requirements, asset tests and additional citizenship and residency documentation requirements.

As the court recognized in vacating approval of Kentucky's waiver, the primary objective of Medicaid is to provide affordable coverage, including when an individual moves in and out of the program, or is sick and otherwise eligible for Medicaid. Taking months of coverage away from people and exposing them to financial harm does not promote the objectives of Medicaid. While New Hampshire's retroactive coverage waiver request would only apply to Medicaid expansion adults, including low-income parents, the financial insecurity that would result from it wouldn't just affect these adults — it would also affect their children. Without retroactive coverage, parents may go without needed medical care and incur significant medical debt for care they receive prior to the effective date of enrollment. Research shows that children's development can be negatively affected by issues resulting from poverty, such as toxic stress.[28]

In addition to helping individuals get the care they need, retroactive coverage ensures the financial stability of hospitals and other safety net providers as it allows them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care, helping them meet their daily operating costs and maintain quality of care. Under waivers that eliminate retroactive coverage, a hospital would no longer get paid for, say, providing an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident, increasing the hospital's uncompensated care costs.

In its comments submitted during the state comment period, the New Hampshire Hospital Association expressed concern over the state's proposal to eliminate retroactive coverage. Specifically, it stated that this "policy change could result in fewer services covered and ultimately increased uncompensated care for hospitals," and that "it is counterintuitive to remove this important coverage policy."[29]

Recent Reports Do Not 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 and, simply put, do not provide supporting evidence for work requirements in Medicaid as the research does not look at the effects on health coverage. 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.[30]

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.[31] 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.[32]

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.[33]

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 your consideration of these comments. If you have any questions, please contact Suzanne Wikle at **swikle@clasp.org**.

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