CLASP

Policy solutions that work for low-income people

February 6, 2019

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

Re: TennCare II Demonstration, Amendment 38

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 Tennessee's TennCare II Demonstration, Amendment 38 and raises serious concerns about the effects of the amendment, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Tennessee.

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.

The proposal would have a dramatic and negative impact on access to care for deeply poor parents (leading to negative effects for their children as well). There is no reason to believe that people who lose health coverage for not working a set number of hours per month 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. 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.

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 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.

It is also 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]

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

CLASP does not support Tennessee's proposal to take away health coverage from parents who do not meet new work requirements. Our comments focus on the harmful impact the proposed work requirements will have on Tennesseans and the state. Tennessee is proposing to implement a work requirement for beneficiaries who are between the ages of 19-64, 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 20 hours per week to stay enrolled in Medicaid. The penalty for not complying with the work requirement four out of every six months is disenrollment from Medicaid for at least one month or until the requirements are met.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Tennessee 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.

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. Tennessee'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 Tennessee appears to be in direct conflict with the law.

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.[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.

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. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement 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 Tennessee's new administrative complexity and red tape is that ***eligible*** people will lose their health insurance because the application, enrollment, and monthly processes to maintain coverage are too cumbersome. Recent evidence from Arkansas' first six months of implementing work requirements also suggests that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. In total, over 18,000 Arkansas

Medicaid beneficiaries have lost coverage since the state implemented its work requirements in June.[11] These individuals represent about 22 percent of the state's first cohort of Medicaid beneficiaries subject to the work requirement.[12] 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.[13]

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 hours 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.[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.

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

Tennessee'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

Medicaid enrollees must meet the work requirement for four months out of every six-month period in order to maintain coverage. Enrollees who lose exempt or employment status and are no longer compliant with the requirement at least four months of the six-month period will have their benefits suspended. These benefits will remain suspended until the Medicaid enrollee demonstrates compliance with the requirement for one month.

Once suspended 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.[15] Further, during the minimum one-month lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics. This will only lead to poorer health outcomes and higher uncompensated costs for providers.

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.[16] 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.[17]

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.[18] 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.[19]

When the beneficiary re-enrolls in Medicaid after their benefits are suspended, 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.[20] Public programs will end up spending more to bring these beneficiaries back to health.

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 Tennessee'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 in order 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, Tennessee does not have enough funding to ensure all eligible families can access child care assistance.[21]

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. Tennessee proposes to exempt individuals who are disabled or designated as physically or mentally incapable of work. Also, Tennessee takes a step backwards as the application eliminated a proposed exemption for individuals with a pending SSI/SSDI application. We know that many people who are not able to work due to disability or unfitness are not likely 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 Tennessee, this rate increases to 41 percent.[22]

New research shows a correlation between Medicaid expansion and an increased employment rate for persons with disabilities.[23] 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.[24] Jeopardizing access to Medicaid for persons with disabilities by the policies proposed in Tennessee's proposal will ultimately create a disincentive for employment among persons with disabilities. Tennessee will best serve persons with disabilities by not imposing a work requirement in their existing Medicaid program and by expanding Medicaid as intended by the Affordable Care Act (ACA).

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,[25] 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.

Budget neutrality information is insufficient

The state's proposal does not include budget neutrality information that is necessary to evaluate the anticipated impact of the proposal. The proposal does not provide any estimate of the number of people who are expected to become disenrolled from Medicaid. In particular, the proposal states, "Of the members who will be impacted by the community engagement requirement, it is estimated that a significant number are already working, or will be deemed to be in compliance with the requirement by virtue of their participation in the SNAP or TANF work program, or will qualify for an exemption to the requirement." For all other individuals, Tennessee simply proposes to "provide linkages to resources." As described above, we know from Arkansas' work requirement demonstration that even people who are exempt lose coverage. If a similar share of beneficiaries subject to the new rules lose Medicaid coverage in Tennessee as in Arkansas, approximately 68,000 parents could lose their health insurance under the proposal, according to independent analysis from Georgetown University and Tennessee Justice Center.[26] This lack of information is unacceptable and Tennessee should provide details about the anticipated change in enrollment in the state. Without this detail, it is impossible to fully understand the impact of the proposal.

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.[27]

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.[28] 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.[29]

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.[30]

Conclusion

For all the reasons laid out above, CMS should reject Tennessee's approach to encouraging work. If Tennessee is serious about encouraging work, helping people move into jobs that allow for self-sufficiency, 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. Tennessee 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.

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**) and Renato Rocha (**rrocha@clasp.org**) with any questions.

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