July 19, 2017

Utah Dept. of Health Medicaid and Health Financing
PO Box 143101
Salt Lake City, UT 84114-3101

Re: *Amendment Request to Utah Section 1115 PCN Demonstration Waiver (Amendment #20)*

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 Amendment Request to Utah Section 1115 PCN Demonstration Waiver and raises serious concerns about its impact on the coverage and health outcomes of low-income Medicaid beneficiaries in Utah. 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."[1] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health, and should be withdrawn. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

Capped Enrollment

The state is proposing to cap enrollment at a total of 25,000 people for adults without dependent children. This is an arbitrary cap, driven entirely by budget constraints and not at all by the needs of the population. It creates a de facto lottery for health care, providing unequal access to health care. The caps on enrollment will have negative consequences for Utahns and providers alike. Utahns who are denied access to care due to the capped enrollment will delay needed care – including substance use treatment. Given that adults who need substance use treatment are central to the "adults without dependent children" eligibility criteria, delaying or denying this critical care for substance use is immoral.

The waiver seeks permission for the state to establish sub-group caps in addition to the overall cap. The subgroups—including individuals who are chronically homeless, individuals involved in the justice system and in need of substance use or mental health treatment, and individuals needing substance use or mental health treatment—are some of the most vulnerable patients with high health care needs. Without

appropriate treatment and care, their health care needs will go untreated, likely becoming more acute and in turn, more expensive. Lacking insurance, these individuals will seek emergency care in hospitals, which will become uncompensated expenses to the health care system.

An enrollment cap is an extreme disincentive for an enrollee to increase their earnings and creates a steep "cliff effect." An individual who takes a job and therefore earns too much to qualify for this program will have no guarantee of being able to restore coverage if the job ends. Capping enrollment takes away the security of the safety-net, causing those who are enrolled to prioritize remaining enrolled over increasing their income, particularly if they know the job may not be permanent. The fear that enrollment will be capped, leaving someone unable to re-enter the program should they experience another financial downturn is counterproductive to many of the goals alluded to throughout the rest of the waiver. This is particularly critical given the very low income limits for the program. Similarly, those who lose coverage due to procedural or bureaucratic practices may not be able to re-enroll, even if they remain eligible.

The proposal also notes that if enrollment is closed, at least 10-day prior notice will be given. This proposal is lacking in details. For example, to whom will the notice be given? Will all applicants in the process of submitting enrollment paperwork be notified? Will current beneficiaries be notified that their ability to reenroll could change if their status changes through the year? The state also does not explain how it will allocate coverage if demand exceeds the level of the cap.

Limitation on the Number of Eligible Months

The state proposes a lifetime limit on the number of total months someone can receive Medicaid, either through Primary Care Network (PCN) or in the Adult without Dependent Children category. Both populations would be limited to a total of 60 months of health insurance over a lifetime.

CLASP strongly opposes this waiver proposal to limit Medicaid eligibility to 60 months. Using Temporary Assistance for Needing Families (TANF) as a framework is misguided for several reasons. The most misguided aspect of this framework is assuming the need for health care is temporary and that individuals who use Medicaid will be able to secure access to and afford employer-based health insurance if they are provided job search services.

This does not reflect the nature of low-wage work. Many Medicaid beneficiaries work, but for low-wage workers, employer-sponsored insurance is often either not offered or is prohibitively expensive. Only 12 percent of workers earning the lowest wages[2] had employer-provided health insurance in 2016.[3] Even at higher wages, part-time workers have less access to health coverage—just 22 percent of part-timers have access to health insurance coverage compared to 73 percent of full-timers.[4] This means that even when unemployed Medicaid recipients obtain jobs, they are highly likely to continue to need health coverage through Medicaid.

There is no evidence offered that such time limits will promote work. In fact, because providing access to coverage is an important way to support work, this proposal will likely reduce employment outcomes. A recent report from Ohio found that providing access to affordable health care through Medicaid helps enrollees to seek and maintain employment. More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three-quarters of unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment. [5] Similar findings in Michigan echo this basic fact – people need to be healthy in order to seek work and maintain employment.[6] Medicaid serves a critical role to help people achieve a level of wellness that allows them to succeed in the workforce. Without the support of Medicaid, health concerns would threaten employment stability.

The lifetime limit of 60 months is especially egregious for those who suffer from chronic conditions or need prescription coverage to stay healthy enough to work. For example, someone managing diabetes or in need of mental health prescriptions needs that medical care for more than 60 months in their lifetime. As previously noted, most low-wage jobs do not provide employer-sponsored health insurance, so Medicaid truly is the only option for access to care. This limit fails to recognize the reality that chronic disease or serious illness do not have a time clock and may prevent individuals from participating in work activities. It would make it nearly impossible for people subject to this requirement to receive ongoing care, with severe consequences for their health.

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.[7] These now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

Even before beneficiaries reach the time limit, this may have adverse effects, as healthy individuals may opt to forgo coverage in order to "bank" their months of eligibility for future need. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[8] Medicaid will end up spending more to bring these beneficiaries back to health.

Tracking these time limits would significantly add complexity and cost to the administration of the Medicaid program. Utah would also need to develop a whole new system to track months towards the time limits and send notices to clients.

Work Requirements

The state proposes a work requirement for all individuals in the Primary Care Network, with the potential to add a work requirement for Adults without Dependent Children at a later time.

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.[9] 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. [10] 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.[11]

The KFF study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI benefits—reported illness or disability as their primary reason for not working.[12] People with chronic conditions that impact their ability to work but do not qualify them for disability benefits will be at high risk of losing access to care. Chronic conditions are, by definition, not time-limited and often impact individuals for extended periods. While the proposal states that the work requirement will not apply to beneficiaries who are diagnosed with a mental illness or who are physically or mentally unable to work, the evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits.

The evidence from SNAP is most relevant, as this provision is clearly modeled after the SNAP work requirements 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 whom indicated that the condition limited their daily activities. Additionally, nearly 20 percent of the individuals had applied for SSI or SSDI within the previous 2 years.[13]

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.[14] 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.

This provision may also affect many people who work, but do not consistently meet the high threshold of 30 hours per week. Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week-to-week.[15] Many workers are assigned to "call-in shifts," providing no guarantee of work, but preventing them from scheduling other work or activities.[16] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[17] 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.[18]

We also note the complexity of overlaying work requirements on a capped program, both for the current PCN program when it has capped enrollment and the proposal for caps on enrollment for the adults without dependent children population. The proposal says that an individual who was disenrolled may become eligible again after participating for three months in work supports—but if the program is at its cap, this individual will not be allowed to reenroll despite having fully met their obligations.

Finally, we note that the type of low-intensity job search program proposed under this waiver is unlikely to help beneficiaries obtain stable high quality employment that offers employer-sponsored health coverage. Overall, the evidence from many rigorous evaluations of welfare-to-work programs shows that employment increases among recipients subject to work requirements were modest and faded over time. Even among those who found work, stable employment at a living wage was rare, and the vast majority remained poor.[19] If approved, the main consequence of work requirements in Medicaid would be that people will lose access to health coverage, as discussed above.[20]

Policies will lead to worse health outcomes, higher costs

When combined with capped enrollments, both time limits and 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 or because they have reached their 60 month lifetime limit, 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.[21] 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.[22]

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.[23] 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.[24]

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.

Higher Copays for Emergency Department Use

The state would apply a $25 co-pay on all non-emergency use of the emergency department for current eligibles and for Adults without Dependent Children. But it provides no guidelines for what this process will be and how it will be administered or reviewed.

CMS did grant Indiana a waiver for ED co-pays for people who use the emergency room in non-emergency situations, and the results of this waiver have not yet been evaluated. Utah should not replicate—or go further than—Indiana until the results of this implementation have been formally evaluated.

If a co-pay is charged for non-emergency use, it should only be applied for uses of emergency services that are inappropriate based on clearly defined criteria that take into consideration what a reasonable layperson would do. There are many situations that are true emergencies, but where inpatient treatment is not needed. The waiver proposal does not outline any proposal for how to determine appropriate use of the ED.

Furthermore, the co-pay for even the lowest income beneficiaries is significantly higher than co-pays traditionally allowed under Medicaid. The proposed charges of $25 mean that beneficiaries would face unacceptable choices between needed care or having the money needed for basic needs.

Eliminates Retroactive and Presumptive Eligibility

The state requests permission to waive retroactive eligibility for Adults without Dependent Children, and to eliminate presumptive eligibility for current eligible and Adults without Dependent Children.

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

The state believes that these policies will incentive beneficiaries to enroll in coverage before a health crisis. However, for a beneficiary who is not working, this waiver request directly contradicts itself. Because of the time limit, a beneficiary has a disincentive to enroll in coverage when these “healthy” months will count against their total Medicaid eligibility. The rational choice in many cases will be to wait until there is an acute health crisis before they enroll.

Change Eligibility through State Administrative Rule

We also raise a strong concern about the state's request to circumvent the waiver process and to make major eligibility changes without seeking approval from CMS. The authority requested by the state far exceeds the kind of administrative changes that should be allowed without a new waiver and formal public comment process. The implications of changing eligibility without a waiver and public comment process are far-reaching for low-income Utahns, social service agencies, and a wide range of providers. As such, all stakeholders should be informed of proposed changes and those changes should be subject to a transparent process that allows for stakeholder input.

In summary, the waiver amendment undermines the goal of Medicaid by proposing several flawed policy ideas. Collectively, the proposals in the amendment will have the effect of reducing enrollment and increasing barriers to care while at the same time greatly increasing state administrative bureaucracy. The proposals are bad for Utahns and should be swiftly rejected as out of line with the goals of Medicaid.

Thank you for your consideration of these comments.

If you have any questions, please contact Suzanne Wikle at swikle@clasp.org or (202) 906-8027.

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