

February 22, 2018

The Honorable Alex Azar
Secretary,
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC

Dear Secretary Azar,

Thank you for the opportunity to comment on the proposed Section 1115 Medicaid demonstration submitted by the state of Mississippi on January 16, 2018. Mississippi is seeking permission to impose a work requirement on two mandatory categories of Medicaid beneficiaries; parents and caretaker relatives who have incomes below 27 percent of the poverty line (\$468 per month for a family of 3), and parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA), because their income rose above 27 percent of the poverty line due to employment or increased earnings.

We urge you to deny the state's request which, according to the state's own estimates, will result in thousands of parents in deep poverty losing Medicaid coverage over the five-year duration of the waiver. When parents lose Medicaid coverage, their children are at risk for losing it as well.¹ By putting families in deep poverty – including those parents who are transitioning from welfare to work -- at risk of losing their health coverage and piling up medical debt, this proposal undermines the objectives of the Medicaid program.

Our specific comments are as follows:

Mississippi has not provided a legitimate hypothesis for the proposed demonstration, and the demonstration is unlikely to meet the objectives the state has provided. The application explicitly states that the driving force behind the state's proposal is to cut costs because the state "continue(s) to see an increase in expenditures" in its Medicaid budget. Saving money is not an acceptable basis for a Section 1115 demonstration.

The state also cites the need to:

"Strengthen our Medicaid program by establishing policies that will increase participants' ability to obtain and maintain employment and employer-sponsored health care, *slow down the rising costs of health care spending (emphasis added)*, and familiarize individuals with private health insurance practices, particularly for those with fluctuating incomes."

There is nothing in the proposed demonstration that would allow the state to accomplish any of these objectives even if they were proper objectives for a Medicaid waiver. The proposal does nothing to slow the rising costs of health care. The proposal also does nothing to increase the likelihood that employers of low-wage workers will offer them affordable health insurance.

¹ Karpman, M. and G. Kenney. "Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017" Urban Institute, September 7, 2017.

Only 12 percent of nonelderly adults with incomes below the poverty line have employer-sponsored insurance.² There is also no evidence that the waiver will “familiarize” beneficiaries with private insurance practices – which is a questionable goal in any event.

The state’s request for enhanced federal Medicaid matching funds (90 percent) for workforce training activities isn’t allowable. We expect you will reject the request for federal matching funds, as your recent State Medicaid Director letter is clear that workforce training activities aren’t eligible for federal Medicaid match either at a state’s regular matching rate or at an enhanced match.³ While we agree that this is the correct interpretation of federal law, the lack of resources for work supports underscores the problems with allowing states to condition eligibility for Medicaid on compliance with a work requirement without ensuring that resources for support services such as child care, transportation, job training, and other services are available to them.

The state’s request to apply a work requirement to very vulnerable Medicaid beneficiaries is counterproductive, costly, and will likely result in thousands of very poor parents becoming uninsured. The income eligibility limit for parents/caretaker relatives subject to the work requirement in Mississippi is one of the lowest in the country – approximately \$468 a month for a family of three.

As we have commented previously, federal law does not permit work requirements in Medicaid. The law defines the factors states can consider in defining who is eligible for Medicaid, and it does not require an individual to be working or seeking work as a permissible factor.⁴ Your recent guidance makes it clear that you do not share this interpretation of the law,⁵ but we again respectfully disagree. The guidance attempts to justify a work requirement by misinterpreting research showing that people with jobs have better health and higher incomes than people without jobs, and claiming that requiring people to work will make them healthy. However, the causal relationship is more likely in the other direction — namely, that healthy people are likelier to have jobs than those in poor health.⁶

In fact, Mississippi’s proposal could end up keeping parents from gaining employment, because without health services, it could be more difficult for them to find and hold a job. Ohio’s Department of Medicaid found that three-quarters of Medicaid expansion enrollees who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs.⁷

²Kaiser Family Foundation analysis of National Health Interview Survey. Available at <https://www.kff.org/slideshow/employer-sponsored-insurance-offer-and-coverage-rates/>

³Centers for Medicare and Medicaid Services, “Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries” SMD 18-002, January 11, 2018, p. 7.

⁴Jane Perkins, “Medicaid Work Requirements: Legally Suspect,” National Health Law Program, March 2017

⁵Op. cit. SMD 18-002, January 11, 2018.

⁶For example, one of the studies cited in the 1/11/18 SMD explicitly states that “these findings do not necessarily imply that income has a causal effect on life expectancy” Chetty, Raj et al. *The Association Between Income and Life Expectancy in The United States, 2001-2014* Journal of the American Medical Association, April 26, 2016.

⁷Ohio Department of Medicaid, “Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly,” <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

An analysis of the state’s budget neutrality projections finds that approximately 5,000 persons will lose coverage in the first year, with comparable coverage losses in subsequent years. .⁸

[Recent press reports](#) quote Mississippi state officials as estimating that approximately 15,000-20,000 of 56,000 currently enrolled parents would be subject to the work requirements after exemptions. The state’s budget neutrality spread sheet shows a reduction in member months equivalent to a loss of coverage in the first year for almost 5,000 parents. It is very unlikely that they will find other health insurance as persons under the poverty line are not eligible for federal advanced premium tax credits for use in the marketplace nor do they have the discretionary income to purchase private insurance. As noted, offers of affordable employer-sponsored insurance are rare for low-wage workers under the poverty line.

Children are also at risk should the state’s proposal be approved. It appears from the budget neutrality documents that the declines in enrollment expected by the state are anticipated solely in the affected eligibility groups (i.e. Section 1931 parents and Transitional Medical Assistance (TMA) beneficiaries). However, it is probable that additional coverage losses may occur among children in these families. Research is clear that when parents have health insurance their children are more likely to be insured.⁹ Children whose parents are insured are almost always insured themselves, whereas 21.6 percent of children whose parents are uninsured are also uninsured.¹⁰ As this proposal will likely result in more parents becoming uninsured, their children are also at greater risk of becoming uninsured.

Moreover, the provision of Medicaid coverage to low-income parents helps parents afford the health care they need and (among other benefits) improves their mental health status¹¹ — the loss of Medicaid coverage will reverse these gains and keep vulnerable parents from improving their family’s economic fortunes, putting them at risk for medical debt and even bankruptcy.

Applying a work requirement to TMA beneficiaries is illogical given that they are, by definition, already working. The purpose of TMA is to provide Medicaid to low-income families for a transitional period after they become ineligible due to a new job or increased hours of employment.

The State proposes to layer additional reporting requirements on these working parents to ensure that they have fulfilled their workforce training requirement. This makes absolutely no sense. It won’t incentivize these parents to work because they are already working, and it will create an administrative burden that could result in the loss of Medicaid coverage due to failure to meet the additional reporting requirements.

⁸ These projections (as is customary in budget neutrality documents) are represented in per member months so we have divided them by 12 to get a yearly estimate. It is also possible that more people lose coverage for some period of time, come back in, and fall off again.

⁹ See Hudson, Julie and Asako Moriya, “Medicaid Expansion for Adults Had Measurable “Welcome Mat” Effects on Their Children,” *Health Affairs* September, 20117.

¹⁰ Karpman and Kenney, op cit.

¹¹ McMorrow, Stacey et al, “Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Distress for Low-Income Parents,” *Health Affairs* May 2017.

The exemption process in the proposal is ill-defined and does not protect vulnerable populations. The proposal includes some poorly defined exemptions such as “being a primary caregiver for a person who cannot care for himself or herself.” It is not clear what this means with respect to children and which parents are exempt. Further, the proposal exempts persons receiving treatment for cancer but not persons receiving treatment for other serious conditions such as cardiovascular disease or diabetes.

There is no clear process that would ensure that persons suffering from opioid addiction have access to “appropriate Medicaid coverage and treatment” as specified in SMD 18-002. The state exempts those taking part in an alcohol or other drug treatment program, but this does not ensure that those who are addicted to opioids but not able to access treatment, which is often in short supply, do not lose their Medicaid coverage.

Administrative costs for this proposal are unknown and may be high – especially on a per capita basis. It is impossible to tell from Mississippi’s proposal what administrative costs the state would incur and whether the state is seeking enhanced federal match (i.e. 90/10) to cover these costs. While states generally don’t include administrative costs in their budget neutrality assessments, we believe states should provide an estimate of these costs especially if they are asking the federal government to foot most of the costs.

For all of these reasons, we urge you to reject Mississippi’s request. Thank you for your consideration of our comments. If you need any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

Autistic Self Advocacy Network
Center for Autism and Related Disorders
Center for Reproductive Rights
Center on Budget and Policy Priorities
Children's Defense Fund
Epilepsy Foundation
Family Voices
Georgetown University Center for Children and Families
First Focus
HIV Medicine Association
Justice in Aging
National Association of Community Health Centers
National Center for Law and Economic Justice
National Council for Behavioral Health
National Employment Law Project
National Health Care for the Homeless Council
National Multiple Sclerosis Society
National Partnership for Women & Families
United Way Worldwide