

August 4, 2018

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

Dear Secretary Azar:

The undersigned organizations appreciate the opportunity to comment on Utah's requests to amend its section 1115 Primary Care Network (PCN) demonstration project. In its requests, Utah proposes to make several eligibility and benefit changes:

1. Increase Medicaid eligibility for adults with incomes up to 100 percent of the poverty line while receiving the enhanced Medicaid expansion federal matching rate for expenditures associated with this new eligibility group;
2. Cap enrollment on low-income adults made eligible for Medicaid through the demonstration based on the availability of funding;
3. Take away Medicaid coverage from adults for not meeting job search and training requirements on low-income adults made eligible for Medicaid through the demonstration;
4. Extend dental benefits to adults in the demonstration's Targeted Adult Medicaid eligibility group who are receiving substance use disorder (SUD) treatment;
5. Provide family planning services and supplies to adults with incomes up to 100 percent of the poverty line; and
6. Provide crisis stabilization services to children and young adults who are, or are at risk of being placed, in state custody.

We support the state's proposal to extend family planning services and supplies to adults with incomes up to 100 percent of the poverty line, and crisis stabilization services to youth in state custody or at risk of being placed in state custody. These additional services will increase and strengthen coverage for low-income Utahans and improve health outcomes, both of which promote the objectives of the Medicaid program.

We also support Utah's proposal to expand access to dental coverage, as dental coverage is important for all Medicaid beneficiaries. Utah's proposal would extend dental coverage only to members of the Targeted Adult demonstration population who are receiving treatment for substance use disorders, although access to dental care is important for all people with substance use disorders regardless of whether they are actively engaged in treatment, have recently had a relapse, or have discontinued SUD treatment because they have progressed in their recovery.

We urge you, however, to reject the state's request to increase Medicaid eligibility for adults with incomes up to 100 percent of poverty line and provide the state with federal funds at the enhanced federal matching rate designated for Medicaid expansion to 138 percent of the poverty line. We also urge you to reject the state's request to take away Medicaid coverage from adults not meeting work requirements and cap enrollment based on the availability of funding as these proposals would reduce coverage and therefore fail to promote the objectives of the Medicaid program. Finally, we remain concerned with the state's approach that provides limited coverage to parents in order to balance the costs of the expansion of coverage to adults without children.

Partial Medicaid Expansion Should Not be Approved at the Enhanced Match Because It Falls Short of Full Expansion with Respect to Coverage and Access to Care

Millions of low-income adults with incomes up to 138 percent of the federal poverty line gained coverage and increased access to care under the Affordable Care Act's (ACA) Medicaid expansion, improving their physical and financial health. For example, Medicaid expansion increased the share of low-income adults with a personal physician, getting check-ups, and getting recommended preventive care such as cholesterol and cancer screenings, and it decreased the share delaying care due to costs, skipping medications due to costs, or relying on the emergency room for care, among other improvements, studies have found.¹ Improvements have been especially important for people with chronic conditions; for example, studies have shown that Medicaid expansion was associated with improved glucose monitoring for beneficiaries with diabetes, and better hypertension control.² Other health benefits associated with Medicaid expansion include lower rates of self-reported psychological distress, fewer days of poor mental health, and improved general health, according to a recent comprehensive review of the evidence.³

In addition to improving access to care and health outcomes for Medicaid beneficiaries, expanding coverage also has increased financial security by lowering medical debt and reducing the risk of medical bankruptcy. Expanding Medicaid coverage results in people having fewer and smaller unpaid medical bills and fewer debts sent to third-party collection agencies, studies have found.⁴ Moreover, with fewer and lower unpaid medical bills, adults who gained coverage through the Medicaid expansion have been found to have better credit, qualifying them for lower-interest mortgages and auto and credit card loans.⁵

While Utah's limited expansion proposal would provide some coverage, it falls short of full expansion for many. First, it would cover 60,000 to 80,000 fewer people than under full expansion. These near-poor adults (adults with incomes between 100 and 138 percent of the poverty line) should be eligible for Medicaid under the ACA, but instead would be left with less comprehensive and

¹ See Benjamin D. Sommers *et al.*, "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance," *Journal of the American Medical Association*, October 2016, <http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2542420>. For a review of the literature, see Assistant Secretary for Planning and Evaluation, "Medicaid Expansion Impacts on Insurance Coverage and Access to Care," Department of Health and Human Services, updated January 18, 2017, <https://aspe.hhs.gov/system/files/pdf/255516/medicaidexpansion.pdf>.

² Olena Mazurenko *et al.*, "The Effects of Medicaid Expansion Under the ACA: A Systematic Review," *Health Affairs*, June 2018, <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2017.1491>

³ *Ibid.*

⁴ Matt Broaddus, "Study: Medicaid Expansion Improves Low-Income Peoples' Financial Health, Too," Center on Budget and Policy Priorities, November 14, 2017, <https://www.cbpp.org/blog/study-medicaid-expansion-improves-low-income-peoples-financial-health-too>, and Broaddus, "Medicaid Improves Financial Well-Being, Research Finds," Center on Budget and Policy Priorities, April 28, 2016, <http://www.cbpp.org/blog/medicaid-improves-financial-well-being-research-finds>.

⁵ Kenneth Brevoort, Daniel Grodzicki, and Martin Hackmann, "Medicaid and Financial Health," National Bureau of Economic Research, November 2017, <http://www.nber.org/papers/w24002.pdf>.

affordable coverage. Medicaid coverage better meets their needs than the commercial coverage through the marketplace. For example, these adults would face:

- **Higher premiums.** Medicaid generally doesn't impose premiums on beneficiaries with incomes below 150 percent of the poverty line. Under Utah's limited expansion proposal, however, near-poor adults would be required to pay monthly premiums of 2 percent of income for "benchmark" coverage through the ACA marketplaces. Research has found that even modest premiums significantly reduce coverage among low-income individuals.⁶
- **Higher out-of-pocket costs.** Medicaid also has stronger protections on out-of-pocket costs than commercial coverage through the marketplace. Co-pays are generally set at nominal levels, and out-of-pocket spending on premiums and co-pays is capped at 5 percent of an individual's quarterly or monthly income, or about \$600 per year for a person at the poverty line. While marketplace plans offer cost-sharing assistance to low-income individuals, they would still face significantly higher out-of-pocket costs than in Medicaid, making it more difficult to afford going to the doctor, or filling a prescription. A wide range of studies have found that even relatively small levels of cost-sharing, ranging from \$1 to \$5, are associated with reduced use of care, including necessary services.⁷
- **Fewer benefits that ensure access to care and treatment.** Medicaid provides additional and important benefits to near-poor adults that aren't available in marketplace plans. For example, Medicaid covers non-emergency medical transportation to ensure that lack of transportation doesn't prevent near-poor adults from getting to the doctor. This is an important benefit for near-poor adults as 3.6 million people miss or delay medical care each year because they lack available or affordable transportation.⁸
- **Fewer opportunities to enroll in coverage.** Another important feature of Medicaid is the ability for near-poor adults to enroll at any point during the year rather than during the time-limited open enrollment period for commercial coverage through the marketplace. For people with complex medical and life conditions, signing up for coverage during a time-limited period may not be realistic. Medicaid ensures that these individuals don't lose out on coverage by allowing them to enroll at any point during the year.

We urge CMS to reject Utah's limited expansion proposal as it falls short of full Medicaid expansion with respect to coverage and access to care and shouldn't be approved at enhanced match. The Medicaid expansion match should be reserved for states that take up full Medicaid expansion as the ACA envisions. Moreover, we see no justification in the statute for a partial

⁶ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost-Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 1, 2017, <https://www.kff.org/report-section/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings-table-2/>.

⁷ Artiga, Ubri, and Zur.

⁸ MaryBeth Musumeci and Robin Rudowitz, "Medicaid Non-Emergency Medical Transportation: Overview and Key Issues in Medicaid Expansion Waivers," Kaiser Family Foundation, February 24, 2016, <https://www.kff.org/medicaid/issue-brief/medicaid-non-emergency-medical-transportation-overview-and-key-issues-in-medicaid-expansion-waivers/>.

expansion with enhanced match such as Utah is contemplating to be approved through Section 1115 authority. We urge CMS to deny Utah's request.

Limiting Medicaid Enrollment Does Not Further the Objectives of Medicaid

Utah proposes to limit the number of adults without children in its new waiver eligibility group to "stay within its appropriated budget." Medicaid is a key component of health reform's continuum of coverage, which assures non-elderly adults access to coverage even if their income fluctuates or their job status changes over time. Limiting enrollment in the new waiver eligibility group also doesn't further the objectives of the Medicaid program as amended by the Affordable Care Act (ACA). Before the enactment of the ACA states, including Utah, were permitted to cap enrollment for adults not otherwise eligible for Medicaid so they could meet budget neutrality requirements. States had to ensure that their demonstrations did not cost the federal government more than it would spend without the expansion of coverage to adults not otherwise eligible for Medicaid. This is no longer the case since the ACA changed Medicaid law and expanded Medicaid to all non-elderly adults with incomes up to 138 percent of the poverty line. Expansions of coverage to adults who could be covered under Medicaid expansion should not be capped or limited by state appropriation as Utah proposes.

Job Search and Training Requirements Should Not Be Required as a Condition of Medicaid Eligibility

Utah is proposing to take away Medicaid coverage from low-income adults for not meeting job search and training requirements. The proposal would require these beneficiaries to participate in online job search or training within the first three months of enrollment (or within the first three months after the policy is implemented) or lose eligibility for coverage. The proposal does not describe the specific activities or minimum participation requirements beneficiaries would be required to meet. Once beneficiaries have met the requirement, they would be eligible for Medicaid for 12 months.

As the Congressional Budget Office recently stated, "Under current law, states may not condition the receipt of Medicaid on any criteria related to a person's employment status."⁹ 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 in determining Medicaid eligibility.¹⁰ The Secretary should reject Utah's request to impose job search and training requirements first and foremost because they are contrary to the goal of Medicaid. While they're not as harsh as other proposals, these requirements would still harm Utah's Medicaid beneficiaries. In addition, they would be administratively complex, costly, and likely result in inaccurate determinations of eligibility.

Work and work-related requirements, such as what Utah is proposing, are contrary to the core mission of Medicaid to provide health coverage to low-income people so they can get the health

⁹ Congressional Budget Office, "Preliminary Analysis of Legislation That Would Replace Subsidies for Health care With Block Grants," September 25, 2017, <https://www.cbo.gov/publication/53126>.

¹⁰ Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program, March 2017.

care services they need. Imposing a job search and training requirement to “encourage skills development” and “promote gainful employment,” as stated in one of Utah’s proposed hypotheses for this policy, does not improve health outcomes or expand access to care. In fact, taking away Medicaid for not meeting these requirements runs counter to one of the primary objectives of Medicaid, which is to provide coverage to low-income people, as a recent court opinion has found. Moreover, a loss in coverage would undermine people’s health outcomes and access to care.¹¹

Research shows that most people with Medicaid coverage who can work do so, and for people who face major obstacles to employment, harsh requirements such as limiting their eligibility for coverage will not help overcome them. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Most Medicaid workers (78 percent) are paid hourly, and 36 percent of these hourly workers earn a wage at or below \$10 per hour.¹² Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.¹³

Physical and behavioral health conditions that limit an individual’s ability to work are much more common among beneficiaries of public benefits than among the general population, research shows.¹⁴ Many of those most in need of Medicaid coverage – those with substance use disorders, mental health conditions, and other disabilities – will be least able to meet the proposed requirement and are most likely to be harmed by it.

In addition to physical and behavior health barriers, Medicaid beneficiaries subject to Utah’s proposed job search and training requirements would face technological barriers that could prevent them from complying with reporting requirements. Research shows that 30 percent of Medicaid adults report that they never use a computer, 28 percent don’t use the internet and 41 percent don’t use email.¹⁵

Because most adult Medicaid beneficiaries under 65 who don’t qualify based on disability are already working, research shows that a small share (6 percent) of adult Medicaid beneficiaries are the

¹¹ U.S. District Court for the District of Columbia, *Stewart v. Azar*, https://ecf.dcd.uscourts.gov/cgi-bin/show_public_doc?2018cv0152-74

¹² Rachel Garfield, Robin Rudowitz, MaryBeth Musumeci, and Anthony Damico, “Implications of Work Requirements in Medicaid: What Does the Data Say,” Kaiser Family Foundation, June 12, 2018, <https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/>

¹³ Rachel Garfield, Robin Rudowitz, and Anthony Damico, “Understanding the Intersection of Medicaid and Work,” Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

¹⁴ Julia Paradise and Rachel Garfield, “What is Medicaid’s Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence,” Kaiser Family Foundation, August 2013, <http://www.kff.org/report-section/what-is-medicaid-impacts-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence-issue-brief/>.

¹⁵ Garfield, *et al.*, “Implications of Work Requirements in Medicaid: What Does the Data Say.”

target of work and work-related requirements.¹⁶ But coverage would still be at risk for beneficiaries who are working or are exempt as working people will still need to comply with the reporting requirements and people who can't work because of a health condition or other reason would have to prove they are exempt. For example, nearly 8,000 Arkansas Medicaid beneficiaries had to report compliance with the state's rigid new work requirement by July 5. Of that group, only 445¹⁷ — less than 6 percent of those who had to report — successfully navigated the complex requirements and reporting structure to log their hours. Over 7,000 others now have one month of non-compliance with the new requirement and will lose coverage if they have two more.

In addition to potential beneficiary harm, Utah's proposed work search and training requirement would be administratively burdensome and costly to implement. In order to track individuals who are not receiving SNAP, the state would be required to implement new procedures, system changes, and hire new eligibility workers. The state would also need to establish systems for verifying exemptions, screening, tracking, and sanctions.

The administrative challenges associated with implementing this work requirement would be more pronounced than in Utah's implementation of SNAP. SNAP requires substantial interactions with participants, including interviews and frequent reporting. Medicaid currently has a streamlined eligibility determination process which relies heavily on online applications and electronic data verification. State experience implementing work requirements in TANF also suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.¹⁸

Recent Reports on Policies That Take Coverage Away From People Who Don't Meet Work Requirements Are Deeply Misleading

Recent reports from the White House Council on Economic Advisors (CEA)¹⁹ and the conservative Foundation for Government Accountability²⁰ understate the extent to which Medicaid beneficiaries actually work and paint a misleading picture of people who need and receive benefits. By looking at work among adults in a single month while they are receiving assistance, the CEA substantially overstates the extent of their joblessness, as large numbers of enrollees who aren't working have recently worked or will work soon. The fact that most Medicaid beneficiaries who can

¹⁶ Garfield, *et al.*, "Implications of Work Requirements in Medicaid: What Does the Data Say."

¹⁷ Max Brantley, "Work Rule 'works' in first month report; 26 percent flunk," *Arkansas Times*, July 13, 2018, <https://www.arktimes.com/ArkansasBlog/archives/2018/07/13/work-rule-works-in-first-month-report-26-percent-flunk>.

¹⁸ Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

¹⁹ Council of Economic Advisors, "Expanding Work Requirements in Non-Cash Welfare Programs," July 2018, <https://www.whitehouse.gov/wp-content/uploads/2018/07/Expanding-Work-Requirements-in-Non-Cash-Welfare-Programs.pdf>.

²⁰ Nicholas Horton, Victoria Eardley, "Obamacare's Not Working: How Medicaid Expansion is Fostering Dependency," Foundation for Government Accountability, July 12, 2018, <https://thefga.org/solution/welfare-reform/work-requirements/medicaid-work-requirements/>.

work either are working or between jobs is well known, but completely absent from the CEA report. Writing for a National Bureau of Economic Research paper, leading researchers Hilary Hoynes and Diane Schanzenbach found that over the past 25 years, Medicaid — along with the rest of the safety net — has become far more targeted to working families and families with incomes somewhat above the poverty line, while supports for poor families that do not have earnings have declined.²¹

These reports ignore the fact that Medicaid is a critical work support that help low wage workers maintain employment and weather the vagaries of the low wage labor market. In fact, many workers need Medicaid, both during periods when their earnings aren't enough to afford health coverage and during periods of joblessness.²² Moreover, Medicaid serves as a critical work support for people with chronic health conditions by providing access to care that supports workforce participation. In studies of adults who gained coverage in Ohio and Michigan through the Medicaid expansion, majorities said that gaining health coverage has helped them look for work or remain employed.²³

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.²⁴ 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.²⁵

²¹ Hilary W. Hoynes and Diane Whitemore Schanzenbach, “Safety Net Investments in Children,” National Bureau of Economic Research, March 2018, <http://www.nber.org/papers/w24594.pdf>.

²² Aviva Aron-Dine, Raheem Chaudry, and Matt Broaddus, “Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements,” Center on Budget and Policy Priorities, April 11, 2018, <https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements>.

²³ 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>. See also Kara Gavin, “Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches,” University of Michigan Health Lab, June 27, 2017, <http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches>.

²⁴ MaryBeth Musumeci, Julia Foutz, and Rachel Garfield, “How Might Medicaid Adults with Disabilities Be Affected By Work Requirements in Section 1115 Waiver Programs?” Kaiser Family Foundation, January 26, 2018, <https://www.kff.org/medicaid/issue-brief/how-might-medicaid-adults-with-disabilities-be-affected-by-work-requirements-in-section-1115-waiver-programs/>.

²⁵ Rachel Garfield and Robin Rudowitz, “Understanding the Intersection of Medicaid and Work,” Kaiser Family Foundation, January 5, 2018, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

For beneficiaries who face major employment barriers such as a chronic illness, rigid work requirements have generally not led to stable employment, studies have shown.²⁶ They instead take support away from struggling individuals and families. One way that people lose assistance is that they get tripped up by new red tape and bureaucratic hurdles that will result in assistance being taken away. Documentation and paperwork requirements already have been shown to reduce enrollment in Medicaid, and people with serious mental illness or physical impairments may face particular challenges in meeting these new documentation and paperwork requirements.²⁷

Our comments include citations to supporting research and documents for the benefit of CMS in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposed rule for purposes of the Administrative Procedures Act.

Thank you for your willingness to consider our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Judith Solomon (Solomon@cbpp.org).

CC: Seema Verma, Brian Neale, Judith Cash

Center on Budget and Policy Priorities
Community Catalyst
Epilepsy Foundation
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
Justice in Aging
National Center for Law and Economic Justice
National Multiple Sclerosis Society
The Children's Dental Health Project

²⁶ LaDonna Pavetti, "Evidence Doesn't Support Claims of Success of TANF Work Requirements," Center on Budget and Policy Priorities, April 3, 2018, <https://www.cbpp.org/research/family-income-support/evidence-doesnt-support-claims-of-success-of-tanf-work-requirements>.

²⁷ Rachel Garfield, Robin Rudowitz, and MaryBeth Musumeci, "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses," Kaiser Family Foundation, June 27, 2018, <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses/>.