Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

October 18, 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 Section 1115 Medicaid demonstration, titled the "Medicaid Workforce Initiative," submitted by the state of Alabama on July 31, 2018 and updated on September 10, 2018. Alabama is seeking permission to impose a work requirement on two mandatory categories of Medicaid beneficiaries; parents and caretaker relatives who have incomes below 18 percent of the poverty line ($312 per month for a family of 3), and parents and caretaker relatives who qualify for Transitional Medical Assistance (TMA) because their earned income has increased.

Summary

We urge you to deny the state's request. By its own estimates, the state's proposal will result in thousands of parents in deep poverty losing Medicaid coverage over the five-year duration of the waiver – with approximately 14,700 projected to become uninsured by the fifth year. The vast majority of these parents are likely to become uninsured. When parents lose Medicaid coverage, their children are at risk for losing it as well.[1] Children also stand to be negatively affected as parents lose coverage by the heightened economic insecurity caused by any member of the family being uninsured.

By putting families who are in deep poverty at risk of losing their health coverage and piling up medical debt, this proposal cannot be compatible with the objectives of the Medicaid program. We would like to draw your attention to research we conducted about which families in Alabama would be affected by the state's plan. The full report is attached for your consideration at Appendix 1. In short, *families headed by women, families living in rural areas and small towns, and especially African-American families will be disproportionately harmed by this proposal.*

There can be no justification for approving the state's request as *the state's plan creates a fundamental contradiction that has the practical effect of eliminating Medicaid coverage for many of these parents.* It is worth noting here that parents affected by the proposal are a **mandatory** coverage group in the

[1] Karpman, M. and G. Kenney. "Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017" (Washington: Urban Institute, September 7, 2017) available at http://hrms.urban.org/quicktakes/health-insurance-coverage-children-parents-march-2017.html.

Medicaid statute at §1902(a)(10)(A)(i)(I). Because Alabama's income eligibility threshold for parents/caretaker relatives is extremely low (18 percent of the poverty line for a family of three), parents who comply with the new work requirement and work 20 hours a week at minimum wage—much less 35 hours per week, as those with children over age 6 will be required to do—will earn too much to remain eligible. And those who do not meet the required work/employment-related activity hours will also lose their Medicaid for noncompliance. This creates a "Catch-22 situation" which is indefensible, unjust, counterproductive and unlawful.

The state's request to extend TMA coverage by 6 months does nothing to change these fundamental features of its proposal. It would merely delay the inevitable for those parents who manage to meet the work/employment-related activity requirements for the entire 18-month TMA period. The state's own projections tell the tale. In the first year, about 10,600 would lose their mandatory Medicaid coverage as parents or caretakers; almost all of those would be covered through TMA. In the second year, about 14,600 would lose their mandatory parent/caretaker coverage, and the majority would be covered through TMA. By the third year, however, when parent/caretaker enrollment has declined by 15,100 and the 18-month TMA coverage has expired, the state projects that 13,800 will have lost all Medicaid coverage. By the fifth year, the number losing both parent/ caretaker coverage and TMA will, by the state's projections, rise to 14,700.

We again urge you to reject the state's request. Some additional comments on the revised proposal follow:

Alabama has not provided a legitimate hypothesis for the proposed demonstration, and the demonstration is unlikely to meet the state's ostensible objective of helping Medicaid beneficiaries enter the workforce.

Alabama is clear on the purpose of the demonstration: To reduce the number of parent/caretaker beneficiaries enrolled in Alabama Medicaid. At page 1, the state notes that over the past 5 years, enrollment in this mandatory eligibility group has "more than doubled from 31,889 to more than 74,000". The state is proposing a work requirement for "able bodied" parents and caretakers in order to reduce enrollment in this mandatory eligibility group. This is confirmed by the state's budget neutrality projections in Tables 2 and 3, which show that enrollment in this mandatory group will be reduced by 10,600 in the first year of the demonstration, rising to 16,000 by the fifth. Over the course of the demonstration, the state expects to save a total (federal and state funds) of $238.2 million (Table 4). This, the state notes on page 2, "will allow Alabama to have a more sustainable Medicaid program."

Saving money is not an acceptable basis for a Section 1115 demonstration. Saving money by reducing the number of extremely poor parents enrolled in a mandatory Medicaid eligibility group is unacceptable and incompatible with the purposes of the program.

The state attempts to justify its disenrollment initiative by claiming that it will "assist able-bodied POCR recipients improve their health outcomes and improve their economic stability, which will assist the state in having healthier citizens." The state does not explain how taking mandatory Medicaid coverage away from parents in deep poverty will improve their health outcomes, much less those of their children. Nor does it explain how conditioning mandatory Medicaid eligibility on work/employment-related activities requirements will actually enable very poor parents to have stable, well-paying employment that offers affordable health insurance. The state neither brings nor

requests any new resources to address affordable child care, inadequate transportation, or high rates of unemployment in rural areas – in other words, the many serious barriers these very low-income families face in finding and holding a good job.

An analysis of the state's budget neutrality projections finds that approximately 13,800 persons will lose coverage by the third year, with growing coverage losses in subsequent years.[2]

The state's budget neutrality Tables 2 and 3 show a reduction in member months equivalent to a loss of coverage in the third year for over 13,800 parents/caretaker relatives. These coverage losses continue throughout implementation of the waiver, with approximately 14,700 losing coverage by the fifth year. It is very unlikely that these parents will find other health insurance. Alabama has not taken up the Medicaid expansion for low-income adults, and persons with incomes under the poverty line are not eligible for federal advanced premium tax credits for use in the marketplace. Nor do these individuals have the discretionary income to purchase private insurance. Offers of affordable health insurance from employers for low wage and part time workers are very rare in Alabama and elsewhere. Only 22 percent of nonelderly adults with incomes below the poverty line in Alabama have employer-sponsored insurance.[3]

New data from Arkansas suggests that Alabama's coverage losses could be even greater than the budget neutrality numbers suggests.

Arkansas is currently implementing a Medicaid work requirement and coverage lockout under a Secretary-approved demonstration. The state requires individuals to go online and report work hours or an exemption or face losing coverage after three months of noncompliance. Arkansas does not terminate coverage until beneficiaries are out of compliance for three months. Alabama's termination rule is similar. As a result, we can expect Alabama's disenrollment results to be similar.

As of September 1st, 2018 – the first month of terminations – more than 4,300 beneficiaries lost Medicaid coverage.[4] This month another 4,100 lost coverage. There is clear evidence that beneficiaries are unaware of the new policy and losing coverage for failure to comply with reporting rules.[5]

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[2] These projections are calculated from the state budget neutrality Tables 2 and 3. The difference between the With Waiver and Without Waiver enrollment (in member months) was divided by 12 months to approximate the increase/decrease in the number of beneficiaries enrolled per year. It is possible that more people lose coverage for some period of time, regain coverage, then lose coverage again within a demonstration year.

[3] "Health Insurance Coverage of the Nonelderly Adults (19-64) Living in Poverty," (Washington: Kaiser Family Foundation, 2016). https://www.kff.org/other/state-indicator/poor-adults/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

[4] Appendix 2 contains our two blog posts analyzing this new data as well as both months of data that Arkansas has released.

[5] Rudowitz, Robin and Musumeci, MaryBeth, "A Look at State Data for Medicaid Work Requirements in Arkansas" (Washington: Kaiser Family Foundation, October 16, 2018), available at https://www.kff.org/medicaid/issue-brief/a-look-at-state-data-for-medicaid-work-requirements-in-arkansas/. Also see Alker, Joan, "Coverage Losses Begin from Mean-spirited Trump Administration Medicaid Policy," available at https://ccf.georgetown.edu/2018/09/13/coverage-losses-begin-from-mean-spirited-trump-administration-medicaid-policy/.

One important consequence of eligibility termination for noncompliance with work requirements is "churn." Disruptions in coverage lead to periods of uninsurance, when beneficiaries are disenrolled, then reenrolled, even though they continue to be eligible during the period of disenrollment, and regardless of whether they are in a course of treatment or develop a medical condition during disenrollment. Multiple studies suggest that eligibility churn is associated with increases in emergency room visits, higher levels of unmet health care needs during periods of uninsurance, more frequent use of costly treatments for conditions that could have been prevented through early detection and care, and significantly higher administrative costs.[6] Churn also makes it virtually impossible to monitor the quality of care that Medicaid beneficiaries are receiving.

Periods of uninsurance expose families with children to medical debt and even bankruptcy – a prospect that undermines the financial stability and economic prospects of these families. It is well established in the research literature that Medicaid reduces financial barriers to obtaining needed care and improves a family's economic security.[7]

Children are also at risk should the state's proposal be approved.

It appears from the budget neutrality Tables 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.[8] Children whose parents are insured are almost always insured themselves, whereas 21.6 percent of children whose parents are uninsured are also uninsured.[9] 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 economic status — 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. One recent study found that Medicaid is the third-largest anti-poverty program in the United States and kept at least 2.6 million Americans from falling into poverty in 2010.[10]

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[6] L. Ku and E. Steinmetz, "Bridging the Gap: Continuity and Quality of Coverage in Medicaid" (Washington: George Washington University, Association for Community Affiliated Plans, September 10, 2013) available at http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf.;
Irvin, C. et al. "Discontinuous Coverage in Medicaid and Implications for 12-Month Continuous Coverage" (Washington: Mathematica Policy Research, October 24, 2001), available at https://www.mathematica-mpr.com/our-publications-and-findings/publications/discontinuous-coverage-in-medicaid-and-the-implications-of-12month-continuous-coverage-for-children.;
M. Carlson, J. DeVoe, and B. J. Wright, "Short-Term Impacts of Coverage Loss in a Medicaid Population: Early Results from a Prospective Cohort Study of the Oregon Health Plan" (2006) Annals of Family Medicine 4(5): 391-398.

[7] For an overview of the research findings, see "Medicaid: How Does It Provide Economic Security for Families?" (Washington: Georgetown University Center for Children and Families, March 2017), available at https://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf.

[8] J.L. Hudson and A.S. Moriya, "Medicaid Expansion for Adults Had Measurable "Welcome Mat" Effects on Their Children," *Health Affairs* 36, no. 9 (September 2017).

[9] M. Karpman and G. Kenney, op cit.

[10] B.D. Sommers and D. Oellrich. "The Poverty Reducing Effect of Medicaid" *Journal of Health Economics* 32, no. 5, (September 2013).

Medicaid Coverage is Critical to the Health of Low-Income Children and Families

Medicaid coverage is extremely important to low-income children and families in Alabama and elsewhere. The research on this point is clear. Children with Medicaid coverage have better access to needed care than do uninsured children. Compared to uninsured children, children with Medicaid or CHIP are significantly more likely to have a regular source of care and to have a physician visit and dental visit in the last two years.[11] Children with Medicaid or CHIP are also more likely to receive preventive care and have a personal physician or nurse than children who are uninsured.[12] The same study found that children who are uninsured are more likely to have unmet medical and dental needs than children with Medicaid/CHIP coverage.[13] Mothers covered by Medicaid are more likely than uninsured mothers to have a regular source of care, a doctor visit, and to receive preventive care.[14]

Research also underscores the value of Medicaid for parents – especially with respect to mental health. A study that focused on Medicaid eligibility expansions for parents between 1997 and 2009 found improved mental health outcomes for low-income parents.[15] Medicaid coverage may play a particularly important role improving access to mental health care; participants in the Oregon Experiment reported significantly better mental health with no significant changes in physical health one year after gaining coverage.[16]

For very low-income women like those who will be affected by Alabama's proposed enrollment cuts, Medicaid's effectiveness in treating depression is vital, as depression is epidemic among these women. With respect to deeply poor families (those with incomes under half the poverty level), evidence of the high incidence of depression comes from several studies. Disconnected single mothers are those who are neither working nor on cash assistance, live in deep poverty, and average just over $9,000 in annual household income for all family members. These women had high rates of maternal depression that were far greater than those of other impoverished groups.[17] A review of home visiting program reports aimed at poor and high-risk mothers with young children found the rates of maternal depression ranging from 29 percent to 61 percent in each study.[18]

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[11]R. Rudowitz, S. Artiga, and R. Arguello, "Children's Health Coverage: Medicaid, CHIP and the ACA" (Washington: Kaiser Family Foundation, March 2014), available at https://www.kff.org/health-reform/issue-brief/childrens-health-coveragemedicaid-chip-and-the-aca.

[12] A.R. Kreidler et al., "Quality of Health Insurance Coverage and Access to Care for Children in Low-Income Families" JAMA Pediatrics 170, no. 1 (January 2016): 43-51, available at https://jamanetwork.com/journals/jamapediatrics/fullarticle/2470859.

[13] Ibid.

[14] S. Long, T. Coughlin, and J. King, "How Well Does Medicaid Work in Improving Access to Care?" Health Services Research 40, no.1 (February 2005): 39-58.

[15] S. McMorrow et al., "Medicaid Expansions from 1997 to 2009 Increased Coverage and Improved Access and Mental Health Outcomes for Low-Income Parents" Health Services Research 51, no. 4 (August 2016): 1347-1367, available at https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.12432.

[16] K. Baicker et. al., "The Oregon Experiment—Effects of Medicaid on Clinical Outcomes" The New England Journal of Medicine 368, no. 18 (May 2013): 1713-1722, available at https://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

[17] P. Loprest, "Disconnected Families and TANF," Washington: The Urban Institute (May 2012), available at https://www.urban.org/research/publication/disconnected-families-and-tanf.; O. Golden, M. McDaniel, P. Loprest, and A. Stanczyk, "Disconnected Mothers and the Wellbeing of Children: A Research Report," (Washington: The Urban Institute, May 2013), available at https://www.urban.org/research/publication/disconnected-mothers-and-well-being-children-research-report.

[18] R. Ammerman, F. Putnam, N. Bosse, A. Teeters, and J. Van Ginkel, "Maternal Depression in Home Visiting: A Systematic Review." Aggression and Violent Behavior 15, no. 3 (2010): 191–200.

Our comments include numerous references to supporting research. We have provided active hyperlinks for most of these references. We request that the full text of each of the studies for which we have provided active hyperlinks be included in the administrative record and be considered by CMS and Secretary in determining whether or not to approve the State of Alabama's proposal.

For all of these reasons, we urge you to reject Alabama's request. Thank you for your consideration of our comments. If you need any additional information, please contact Joan Alker (jca25@georgetown.edu) or Andy Schneider (andy.schneider@georgetown.edu).

Appendix 1

https://ccf.georgetown.edu/wp-content/uploads/2018/03/AL-Work-Requirements-update-8-18.pdf