



Show Elizabeth G. Taylor
Executive Director

August 18, 2018

Board of Directors

Robert N. Weiner
Chair
Arnold & Porter, LLP

Ann Kappler
Vice Chair
Prudential Financial, Inc.

Miriam Harmatz
Secretary
Florida Health Justice Project

Nick Smirensky, CFA
Treasurer
New York State Health
Foundation

Ian Heath Gershengorn
Jenner & Block

Robert B. Greifinger, MD
John Jay College of
Criminal Justice

John R. Hellow
Hooper, Lundy & Bookman, PC

Rod J. Howard
CapKey Advisors

Michele Johnson
Tennessee Justice Center

Lourdes A. Rivera
Center for Reproductive Rights

William B. Schultz
Zuckerman Spaeder

Donald B. Verrilli, Jr.
Munger, Tolles & Olson

Ronald L. Wisor, Jr.
Hogan Lovells

Senior Advisor to the Board
Rep. Henry A. Waxman
Waxman Strategies

General Counsel
Marc Fleischaker
Arent Fox, LLP

VIA ELECTRONIC SUBMISSION

Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: Mississippi Medicaid Workforce Training Initiative 1115
Demonstration Waiver Application.

Dear Sir/Madam:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and under-served people. We appreciate the opportunity to provide these comments on Mississippi's revised 1115 Demonstration Waiver Application.

NHeLP recommends that the Department of Health & Human Services (HHS) not approve Mississippi's application. These changes do not comply with § 1115 of the Social Security Act and will harm Medicaid enrollees' access to vital health care services.

I. HHS authority and § 1115

To be approved pursuant to § 1115, the application must:

- propose an "experiment[], pilot or demonstration,"
- waive compliance only with requirements in 42 U.S.C. § 1396a,
- be likely to promote the objectives of the Medicaid Act, and
- be approved only "to the extent and for the period necessary" to carry out the experiment.¹

¹ 42 U.S.C. § 1315(a).

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish rehabilitation and other services to help these individuals attain or retain the capacity for independence and self-care.²

II. Work Requirements

Mississippi is seeking to impose a work requirement on non-disabled adults, specifically low-income parents and caretakers eligible under Section 1931. Mississippi would require individuals to report work activities monthly, and individuals who failed to comply would lose coverage at the start of the following month.³ Mississippi also proposes to apply this requirement to individuals who receive transitional medical assistance (TMA), which would continue to be available for a period of two years only if the individual complies with the work and associated reporting requirements.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Mississippi to condition Medicaid eligibility on compliance with work activities. The Medicaid Act does not allow states to impose work requirements. Medicaid is a medical assistance program, and although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance as far as practicable to all individuals who meet the eligibility criteria established in federal law. The Medicaid Act does not include participation in work activities in the list of eligibility criteria. As courts have held, imposing additional eligibility requirements is illegal.⁴

Nor is the Secretary authorized to waive the provisions governing TMA.⁵ The Secretary, therefore, may not permit Mississippi to impose additional reporting requirements for TMA beneficiaries, as the frequency and content of TMA reporting is prescribed by statute.⁶

² See 42 U.S.C. § 1396-1.

³ Application at 5. See also Revised Application at 4, 6.

⁴ See, e.g., *Camacho v. Texas Workforce Comm'n*, 408 F.3d 229, 235 (5th Cir. 2005) (enjoining Texas regulation that terminated Medicaid coverage of TANF recipients who were substance abusers or whose children were not getting immunizations or check-ups or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

⁵ See 42 U.S.C. § 1396r-6(c)(1).

⁶ *Id.* § 1396r-6(b)(2)(B).

Section 1115 cannot be used to short-circuit these Medicaid protections. There is simply no basis for finding that work requirements, for Medicaid or TMA, are likely to assist in promoting the objectives of the Medicaid Act.⁷ Unlike some other public benefits programs, Medicaid is not a work program; it is a medical assistance program. Put simply, conditioning Medicaid eligibility on completion of work activities blocks access to medical assistance.

The Cited Studies on Work and Health Do Not Support Imposing a Work Requirement

Mississippi asserts that work activities improve health.⁸ CMS made the same assertion in its January 11, 2018 Dear State Medicaid Director (DSMD) Letter. However, as we explained in our January 11, 2018 response to the DSMD Letter (attached and incorporated herein by reference), the research CMS cited does not support the conclusion that a work requirement will make people healthier.⁹

Like the DSMD, the State's application oversimplifies the relationship between work and health and the two additional articles it cites do not support the State's proposal to impose work *requirements*. Instead, the first article discusses local, community-led, neighborhood programs that offer a variety of voluntary, community-based work *supports* to families.¹⁰ There is no discussion of the type of mandatory, punitive requirement that the State proposes here, and notably Mississippi is not proposing to expand access to work supports as recommended by this article. The second article cited by Mississippi does not present original research but rather summarizes a portion of the available literature.¹¹ Moreover, that article highlights that one of the primary mechanisms through which employment can promote health is by expanding access to

⁷ By contrast, as far back as the 1970s, states obtained § 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct "rigorous evaluations of the impact," typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep't of Health & Human Servs., *State Welfare Waivers: An Overview*, <http://aspe.hhs.gov/hsp/isp/waiver2/waivers.htm>.

⁸ Revised Application at 5.

⁹ Letter from Jane Perkins, Nat'l Health Law Program, to Brian Neale, Dir. Ctrs. for Medicare & Medicaid Servs. (Jan. 11, 2018) (attached).

¹⁰ Michael J. Austin, Kathy Lemon & Ericka Leer, Promising *Practices for Meeting the Multiple Needs of Low-Income Families in Poverty Neighborhoods*, 21 J. OF HEALTH & SOCIAL POL., 95-117 (2005).

¹¹ Nanette Goodman, LEAD Ctr., *The Impact of Employment on Health Status and Health Care Costs of Working-age People with Disabilities* (2015).

health insurance and that health insurance promotes better health outcomes.¹² Thus, this study underscores why Mississippi’s proposal, which will take away health insurance from individuals who do not work or report work activities, will harm health outcomes. In short, the literature cited in the DSMD Letter and in Mississippi’s Application do not provide any evidentiary support for the assertion that terminating health insurance for failing to comply with work requirements will improve health outcomes.

Nor do any of the additional studies CMS has reviewed in the past when considering other states’ proposals. For instance, CMS has reviewed a Robert Wood Johnson report evaluating the relationship between employment and health.¹³ But that article shows that the quality of employment matters. Stable, high-paying jobs in safe working environments might be associated with better health outcomes, but “working poor” status “is associated with health challenges as well.”¹⁴ Other studies elaborate on this point, finding that “high strain” jobs, or jobs with little reward or recognition, can actually increase poor health outcomes, such as high blood pressure and cardiovascular disease.¹⁵ The Robert Wood Johnson report also reiterates that access to health insurance that comes with stable employment accounts for a large part of the link between employment and health.¹⁶ It is health insurance, not employment alone, that results in improved outcomes. Further reducing access to health insurance among low-wage earners will not improve health outcomes.

When CMS last considered this request, it also looked at a handful of studies finding a correlation between volunteering and health.¹⁷ Mississippi is proposing to *require* volunteering, and two studies CMS reviewed found that any positive correlations from volunteering were diminished when volunteering was seen as obligatory.¹⁸ Critically,

¹² *Id.* at 4.

¹³ Robert Wood Johnson Found., *Issue Brief: How Does Employment--or Unemployment--Affect Health?* (2013).

¹⁴ *Id.*

¹⁵ Douglas Jacobs, Health Affairs Blog, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health* (2018)

<https://www.healthaffairs.org/doi/10.1377/hblog20180730.371424/full/>.

¹⁶ Robert Wood Johnson Found., *supra* note 13.

¹⁷ For instance, CMS reviewed the following studies: Jens Detollenaere, Sara Willems & Stijn Baert, *Volunteering, Income and Health*, 12 PLOS One e0173139 (2017); Robert Grimm, Jr. et al., Corp. for Nat’l & Community Service, *The Health Benefits of Volunteering: A Review of Recent Research* (2007); Peggy A. Thoits & Lyndi N. Hewitt, *Volunteer Work and Well-Being*, 42 J. OF HEALTH AND SOCIAL BEHAVIOR 115 (2001).

¹⁸ Grimm, Jr. et al., *supra* note 17; Thoits & Hewitt, *supra* note 17. See also Larisa Antonisse & Rachel Garfield, Kaiser Family Found., *The Relationship Between Work and Health: Findings*

none of these reports evaluated the negative health effects of losing health insurance for failure to complete mandatory volunteering. There are other problems with CMS's reliance on these studies: they do not distinguish between correlation and causation, and two studies posited that better health and strong social ties encouraged volunteering, rather than the reverse.¹⁹ Another report focused on the health benefits for an older adult population and found a weaker correlation between health and volunteering among younger adults.²⁰

Even if it were true that work and/or volunteering leads to better health, Mississippi is ignoring the detrimental effect that its waiver proposal will have on the thousands of people who will be unable to meet the requirement and lose Medicaid coverage as a result. Without insurance coverage, these individuals will certainly suffer worse health outcomes and increased medical debt and financial insecurity. (See the discussion below on coverage loss and its consequences.)

In addition to jeopardizing the health of adults enrolled in Medicaid, the proposed work requirement puts the health and well-being of their children at risk. Mississippi has not expanded Medicaid under the Affordable Care Act, which means the population affected by the work requirements is exclusively parents and caretakers. Research shows a strong correlation between parents having Medicaid coverage and their children also having insurance coverage and receiving recommended preventive services.²¹ In addition, the costs of childcare are high. The average cost of center-based care for school-aged children in Mississippi is \$1,889 for the nine months of the school year, and

from a Literature Review (2018), <https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/>.

¹⁹ See Detollenaere, Willems & Baert, *supra* note 17; Thoits & Hewitt, *supra* note 17.

²⁰ Grimm, Jr. et al., *supra* note 17.

²¹ Maya Venkataramani et al., *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 PEDIATRICS e20170953 (2017), <http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf>; Georgetown Univ. Health Pol. Inst., Ctr. for Children & Families, *How Mississippi's Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children* (2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/04/Mississippi-Work-Requirement-Report.pdf>; M. Karpman and G. Kenney, Urban Inst., *Quicktake: Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017* (2017) <http://hrms.urban.org/quicktakes/health-insurance-coverage-childrenparents-march-2017.html>; Ctr. on Budget & Pol. Priorities, *Harm to Children From Taking Away Medicaid From People for Not Meeting Work Requirements* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/4-4-18health.pdf>.

\$999 for the summer.²² That is a total of \$2,888 for center-based care throughout the year. While family child care is less expensive, it still averages \$1,481 for a full year (\$851 for 9-months of the school year and \$567 for the summer).²³ As a result, parents frequently rely on multiple, unstable childcare arrangements, especially when they have low-wage work with variable schedules.²⁴ But numerous studies find a relationship between childcare stability, attachment, and child outcomes, including effects on social competence, behavior outcomes, cognitive outcomes, language development, school adjustment, and overall well-being.²⁵ The effect of parental low-wage jobs and childcare instability may particularly impact children living in poverty.²⁶ Notably, Mississippi is not proposing to increase resources for affordable, quality childcare. Allowing Mississippi to implement the work requirement despite evidence that it will likely harm the health of low-income children would be contrary to the purpose of the Medicaid Act.

The Work Requirement Will Lead to Substantial Coverage Losses

All evidence indicates that the work requirement will lead to substantial numbers of individuals losing Medicaid coverage.²⁷ In fact, this appears to be the State's express goal. According to the State's initial application, these changes are necessary because it "continue[s] to see an increase in expenditures," and notes that the proposed work requirements are an avenue to "explore cost savings."²⁸

²² Child Care Aware of America, *Child Care in America: 2016 State Fact Sheets*, at 109 (2017), <http://usa.childcareaware.org/wp-content/uploads/2016/07/2016-Fact-Sheets-Full-Report-02-27-17.pdf>.

²³ *Id.* Moreover, childcare subsidies are not widely available. In fact, in Mississippi there were close to 10,000 children on the waitlist for a childcare subsidy in 2016. Nat'l Women's Law Ctr., *Red Light Green Light: State Childcare Assistance Policies 2016* 31, Table 2 (2016), <https://nwlc.org/wp-content/uploads/2016/10/NWLC-State-Child-Care-Assistance-Policies-2016-final.pdf>.

²⁴ Gina Adams et al., Urban Inst., *Child Care Instability: Definitions, Context, and Policy Implications* (2010), <https://www.urban.org/sites/default/files/publication/29446/412278-Child-Care-Instability-Definitions-Context-and-Policy-Implications.PDF>.

²⁵ *Id.* at 7.

²⁶ *Id.* at 8.

²⁷ See, e.g., Leighton Ku et al, *Medicaid Work Requirements: Who's At Risk?*, HEALTH AFFAIRS BLOG (Apr. 12, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170412.059575/full/>; Robin Garfield et al., Kaiser Family Found., *Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses* (2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses>.

²⁸ Application at 2.

The State’s budget neutrality estimates reveal that the State anticipates that approximately 5,000 individuals will lose Medicaid coverage in the first year that these changes are implemented, and approximately 20,000 will lose coverage over four years.²⁹ That represents a loss of coverage nearly 9% of Mississippi’s parent and caretaker population.

Mississippi’s prediction is likely an under-estimate.³⁰ Arkansas began implementing a work requirement for the Medicaid expansion population on June 1, 2018. Of the almost 25,815 enrollees who were subject to the requirement that month, 7,464—approximately 29%—did not meet the requirement.³¹ In July 2018, 43,794 enrollees were subject to the work requirement, and 12,722 did not comply.³²

There are several reasons that a large number of beneficiaries are likely to lose coverage. First, many individuals—whether on Medicaid or receiving TMA—simply will not be able to consistently comply with the requirements and will lose coverage. Second, the administrative burdens of reporting compliance or proving an exemption will cause a significant decline in enrollment. Notably, it appears that Mississippi’s enrollment estimates assumed that the “[a]dministrative element of proving work will not deter enrollment.”³³ As discussed below, the research conclusively refutes that assumption. Finally, individuals will not transition to employer-sponsored insurance (ESI): ESI is not widely available and even when it is offered, it is not affordable. As a result, the proposal will result in significant coverage losses well beyond the 5000 people projected by the State, decreased access to medically necessary medical assistance, increased administrative costs for the Medicaid agency, and increased financial burdens on Mississippi’s Medicaid population.

²⁹ Application at 15 (Attachment A – Budget Neutrality Demonstration), estimating that the waiver will decrease enrollment by 58,995 member months in the first year of the demonstration. The estimated number of individuals affected annually is calculated by dividing the total number of member months by 12. This results in a likely underestimate, as there may be people who lose coverage for less than 12 months.

³⁰ See Aviva Aron-Dine, Ctr. on Budget & Pol. Priorities, *Eligibility Restrictions in Recent Medicaid Waivers Would Cause Many Thousands of People to Become Uninsured 1-2* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/8-9-18health.pdf>.

³¹ Arkansas Dep’t of Human Servs., *Arkansas Works Program June 2018 Report* (attached).

³² Arkansas Dep’t of Human Servs., *Arkansas Works Program July 2018 Report* (attached).

³³ Application at 24.

Individuals Will Have Difficulty Completing 80 Hours of Work Each Month

Data shows that Medicaid enrollees are already working a substantial amount. Nationally, almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves.³⁴ In fact, 66% of Mississippi's Medicaid enrollees who are not receiving disability benefits have a worker in their family (including 57% with a full-time worker).³⁵

But regularly working individuals will still lose coverage. Mississippi's proposal ignores the reality of low-wage work. One recent study identified that between 2002 and 2017, the ten most common jobs among Medicaid and SNAP recipients were nursing aides, orderlies, and attendants; cashiers; cooks; truck, delivery, and tractor drivers; retail sales clerks; janitors; laborers outside construction; waiter/waitresses; supervisors and proprietors of sales jobs; and housekeepers, maids, butlers, and stewards.³⁶ Approximately one third of SNAP and Medicaid recipients worked in one of these occupations.³⁷ Among Mississippi's Medicaid enrollees, over half work in agriculture and the service industry (52%).³⁸

³⁴ Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

³⁵ Rachel Garfield, Robin Rudowitz, & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, Appendix, Kaiser Family Foundation (Dec. 07, 2017): <https://www.kff.org/report-section/understanding-the-intersection-of-medicare-and-work-appendix/>. (Table 1, "Family Work Status" column).

³⁶ See Kristin F. Butcher & Diane Whitmore Schanzenbach, Ctr. on Budget & Pol. Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours*, in *Volatile Jobs* figure 6 (2018), https://www.cbpp.org/research/food-assistance/most-workers-in-low-wage-labor-market-work-substantial-hours-in-volatile?utm_source=CBPP+Email+Updates&utm_campaign=8db3a19904-EMAIL_CAMPAIGN_2018_07_23_03_37&utm_medium=email&utm_term=0_ee3f6da374-8db3a19904-111113873.

³⁷ *Id.* (adding percentages in figure 6 for a total of 32.9%); see also Josh Bivens & Shawn Fremstad, Economic Pol. Inst., *Why Punitive Work-Hours Tests In SNAP And Medicaid Would Harm Workers And Do Nothing To Raise Employment* (July 26, 2018), <https://www.epi.org/publication/why-punitive-work-hours-tests-in-snap-and-medicare-would-harm-workers-and-do-nothing-to-raise-employment/> (reporting data from 2016 listing the most common occupations for workers receiving SNAP or Medicaid).

³⁸ Rachel Garfield, Robin Rudowitz, & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, Appendix, Kaiser Family Foundation (Dec. 07, 2017): <https://www.kff.org/report-section/understanding-the-intersection-of-medicare-and-work-appendix/> (Table 3).

But these jobs do not provide consistent, livable wages.³⁹ Most workers with Medicaid (78%) are paid hourly, and 36% of them earn an hourly wage at or below \$10/hour.⁴⁰ These jobs also have variable and unpredictable schedules, often set by employers with no possibility for changes, making it difficult (or impossible) for individuals to make up for a loss of hours in a given month.⁴¹ Eighty-three percent of part-time workers report having unstable work schedules, and 41% of hourly workers between ages 26 and 32 receive one week or less notice of their schedules.⁴²

Data regarding the current labor market underscores the volatility of the low-wage market, even in the long-term: Medicaid enrollees face low wages, stagnant wage growth, and volatile job prospects.⁴³ Evidence shows that even when individuals in the low-wage market work a substantial amount in one year, due to the nature of the work and the labor market, there is no guarantee that workers see increased work or wages in the next year.⁴⁴ In fact, those who had substantial work in one year were likely to experience drops in their income, hours, and wages in the next year.⁴⁵

Moreover, the fields that Medicaid beneficiaries work in experience high rates of *involuntary* part-time employment—meaning they wanted to work full time hours but were only offered part-time hours—with retail and the leisure & hospitality industries ranking highest.⁴⁶ Thus, even when workers do work a substantial number of hours

³⁹ See Susan J. Lambert, Peter J. Fugiel & Julia R. Henly, *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot*, University of Chicago, (2014) available at https://ssascholars.uchicago.edu/sites/default/files/work-scheduling-study/files/lambert.fugiel.henly_precarious_work_schedules.august2014_0.pdf; Stephanie Luce, Sasha Hammad & Darrah Sipe, Retail Action Project, *Short Shifted*, September 2014, http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits*, September 2015, <http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>.

⁴⁰ Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>.

⁴¹ Lambert, Fugiel & Henly, *supra* note 39; Luce, Hammad & Sipe, *supra* note 39; Ben-Ishai, *supra* note 39; Bivens & Fremstad, *supra* note 37; Tanya L. Goldman, Pronita Gupta, Eduardo Hernandez, Ctr. for Law & Social Pol., *The Struggles of Low Wage Work* (2018), https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf.

⁴² Goldman, Gupta, & Hernandez, *supra* note 41.

⁴³ See Butcher & Whitmore Schanzenbach, *supra* note 36.

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ Bivens & Fremstad, *supra* note 37; Goldman, Gupta, & Hernandez, *supra* note 41.

throughout the year, they are likely to experience periods with less or no work.⁴⁷ As a result of the churn and volatility in the low-wage market, one estimate showed that almost half of low-income workers would fail a work-hours test in at least one month over the course of one year.⁴⁸

The State's proposal also does nothing to address the barriers to work many individuals face. Lack of internet can make finding work more difficult. Mississippi has the lowest rate of access to broadband in the country. Just 61% of the population has access to broadband internet, and many do not use computers or email.⁴⁹ Lack of transportation and lack of access to affordable childcare, also create barriers to work and contribute to fluctuating hours and spells of unemployment.⁵⁰ Twenty-four percent of Mississippi's Medicaid population reports that the reason they are not working is due to caretaking responsibilities.⁵¹ The costs of childcare explain why: an individual working 20 hours a week at minimum wage (\$7.25) would need to work for almost 20 weeks just to afford center-based care, and 10 weeks to afford FCC care. But the State's proposal provides no additional support for families who need child care assistance, and the federal government has made clear that Medicaid funds are not available for these services.

Nor will volunteering or other un-paid activities be a viable solution for Medicaid enrollees. The same barriers to finding work—lack of internet access and lack of transportation—make it difficult for low-income individuals to complete volunteer activities. Families will also need to find childcare in order to complete *any* of the required activities—including unpaid activities such as volunteering or training that do

⁴⁷ Kaiser Family Foundation, *What do Different Data Sources Tell Us About Medicaid and Work?* (July 23, 2018), <https://www.kff.org/medicaid/fact-sheet/what-do-different-data-sources-tell-us-about-medicaid-and-work/>.

⁴⁸ Aviva Aron-Dine et al., Ctr. on Budget & Pol. Priorities, *Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/4-11-18health.pdf>;

⁴⁹ Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015 8* (2017), <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf>; Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>.

⁵⁰ See generally Chandra Childers, Inst. for Women's Pol. Research & Women's Found. of Mississippi, *Women's Access to Quality Jobs in Mississippi* (2018) <https://iwpr.org/wp-content/uploads/2018/02/Womens-Access-to-Quality-Jobs-in-Mississippi-full-report.pdf>.

⁵¹ Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* 10 (2018) <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

not provide any additional income. Mississippi's proposal will, in practice, impose an additional tax, in the form of added childcare costs, on families with children.

Moreover, conditioning Medicaid on unpaid work could run afoul of other laws the Secretary is not permitted to waive, such as the Fair Labor Standards Act (FLSA), which requires that all individuals be compensated in an amount equal to at least the minimum wage in exchange for hours they work.⁵² Mississippi includes among the list of possible work activities, several unpaid options, including "volunteering with approved agencies."⁵³ Requiring beneficiaries to work for state-approved agencies, without paying them at least minimum wage violates the FLSA, its implementing regulations, and Department of Labor guidelines.⁵⁴ FLSA concerns will also limit the number of recurring, stable volunteer opportunities that are available.⁵⁵

The work requirement will also hit individuals with chronic and disabling conditions particularly hard, and CMS and Mississippi's characterization of the community engagement requirements as applying only to "able-bodied" adults does nothing to resolve these concerns. There is no definition of "able-bodied" adults. Even though individuals may not have a disability that meets the strict SSI standard, they may still face substantial barriers to work. Moreover, many individuals who *do* have a disability that meets the SSI standards rely on Medicaid while their applications for disability benefits are pending—a process that regularly lasts years.⁵⁶

⁵² See 29 U.S.C. § 206(a)(1)(C).

⁵³ Application at 4; Revised Application at 3.

⁵⁴ See 29 U.S.C. § 206. Dep't of Labor, *How Workplace Laws Apply to Welfare Recipients 2* (1997), <http://nclaj.org/wp-content/uploads/2015/11/LaborProtectionsAndWelfareReform.pdf>

⁵⁵ See e.g., Dep't of Labor, Wage and Hour Division, *Fact Sheet #14A: Non-Profit Organizations and the Fair Labor Standards Act 2* (2015), <https://www.dol.gov/whd/regs/compliance/whdfs14a.pdf>.

⁵⁶ Recent data shows that when an initial decision denying disability benefits is appealed, the average length of time spent waiting for an administrative law judge's decision has increased from 353 days in 2012 to 596 days in 2017. Terrence McCoy, "597 days. And still waiting," WASHINGTON POST (Nov. 20, 2017) http://www.washingtonpost.com/sf/local/2017/11/20/10000-people-died-waiting-for-a-disability-decision-in-the-past-year-will-he-be-next/?utm_term=.5cd5c1d51f37. But appeals to an ALJ are often necessary; in recent years, as many as half of the decisions initially denying benefits have been reversed at a hearing or subsequent review Social Security Administration, "Outcomes of Applications for Disability Benefits," Table 72 https://www.ssa.gov/policy/docs/statcomps/ssi_asr/2016/sect10.pdf (showing SSI "allowance" rates at the hearing level or above of 38% in 2014 and 45% in 2015); Social Security Administration, "Outcomes of Applications for Disability Benefits," Table 63 https://www.ssa.gov/policy/docs/statcomps/di_asr/2016/sect04.pdf (showing SSDI "allowance" rates at the hearing level or above of 53.7% in 2014 and 48.8% in 2015).

Thus, many individuals in the parent/caretaker population do in fact have chronic or disabling conditions that prevent them from working. A recent study by the Kaiser Family Foundation found that nationwide, 36% of adult Medicaid enrollees who were not receiving disability benefits and did not have a job were not working because they were dealing with illness or disability.⁵⁷ In Mississippi, the numbers are even more dramatic: Nearly half (48%) of adult enrollees not receiving disability benefits cited illness or disability as the reason for not working.⁵⁸ Further data suggests that illness and poor health are significant factors keeping individuals from working. While 59% of individuals who reported being in “excellent” or “very good” health were working, that number dropped to just 20% for individuals in “fair/poor” health.⁵⁹

People with disabilities also experience discrimination at various stages of employment, including at hiring, resulting in low employment rates and wage levels; for instance, employees with disabilities that would not affect their job performance are 26% less likely to be considered for employment.⁶⁰ In addition, people with disabilities are also nearly twice as likely to be employed part time because they cannot find a job with more hours or their hours have been cut back as compared to people without a disability.⁶¹

While the State proposes to exempt individuals who are “physically or mentally unable to work,” evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be and are more likely than other individuals to lose benefits.⁶² Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical or mental

⁵⁷ Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* 4 (2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

⁵⁸ *Id.*

⁵⁹ *Id.* at Table 4b.

⁶⁰ Mason Ameri et al., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior* (2015) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2663198.

⁶¹ U.S. Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics—2016* (June 21, 2017), <https://www.bls.gov/news.release/pdf/disabl.pdf>.

⁶² See, e.g., Andrew J. Cherlin et al., *Operating within the Rules: Welfare Recipients' Experiences with Sanctions and Case Closings*, 76 SOC. SERV. REV. 387, 398 (2002) (finding that individuals in “poor” or “fair” health were more likely to lose TANF benefits than those in “good,” “very good,” or “excellent health”) (attached); Vicki Lens, *Welfare and Work Sanctions: Examining Discretion on the Front Lines*, 82 SOC. SERV. REV. 199 (2008) (attached).

health conditions are disproportionately likely to be sanctioned for not completing the work requirement.⁶³

There is similar evidence from the SNAP program. Researchers have expressed concern that states might incorrectly determine that many of the nearly 20% of all SNAP participants who have a disability, but do not receive disability benefits, are subject to the work requirement.⁶⁴ One study found that one-third of SNAP participants referred to an employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of those individuals indicated that the condition limited their daily activities. In addition, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.⁶⁵ In another example, when Georgia reinstated the SNAP work requirement and time limits for “able-bodied adults without dependents” in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement lost benefits after only three months.⁶⁶ State officials acknowledged that hundreds of enrollees had been wrongly classified as “able-bodied” when they were actually unable to work.⁶⁷

Data from Maine likewise demonstrates that “hardship” extensions in its TANF program were not effective at protecting individuals with a disability. The Maine Department of

⁶³ See, e.g., Yeheskel Hasenfeld et al., Univ. of Pennsylvania School of Social Pol. and Practice *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (2004), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers; Vicki Lens, *supra* note 62; MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>; Mathematica Pol. Research, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments* (2008) https://www.acf.hhs.gov/sites/default/files/opre/conducting_in_depth.pdf; Pamela Loprest, Urban Inst., *Disconnected Welfare Leavers Face Serious Risks* (2002) <http://www.urban.org/sites/default/files/publication/59036/310839-Disconnected-Welfare-Leavers-Face-Serious-Risks.PDF>.

⁶⁴ See Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities* 4, 14 (2014), <https://researchondisability.org/docs/publications/snap-paper-8-23-2014-with-appendix.pdf?sfvrsn=2>.

⁶⁵ Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.

⁶⁶ *Correction: Benefits Dropped Story*, U.S. NEWS & WORLD REPORT, May 26, 2017, <https://www.usnews.com/news/best-states/georgia/articles/2017-05-25/work-requirements-drop-thousands-in-georgia-from-food-stamps>.

⁶⁷ *Id.*

Health and Human Services (DHHS) reported that while nearly 90% of parents receiving TANF for five years or longer have a disability themselves or are caring for a disabled family member, only 17% of families terminated due to the time limits received a disability-related extension.⁶⁸ Several beneficiaries reported being denied disability-related extensions, though they were in the process of applying—and were ultimately approved—for SSI benefits.⁶⁹ Furthermore, beneficiaries reported being discouraged from applying for extensions by DHHS caseworkers and confusion about the process for applying for hardship extensions.⁷⁰

Because conditioning Medicaid eligibility on completion of the work requirement will disproportionately harm individuals with chronic and disabling conditions, the requirement implicates the civil rights protections contained in the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act.⁷¹ These laws make it illegal for states to take actions that have a discriminatory impact on people with disabilities, and they cannot be waived under § 1115 or under any other authority of the Secretary.⁷²

Evidence also shows that the work requirement may disproportionately harm people of color. Seventy-one percent of Mississippi's Medicaid population is African American. But studies have found that caseworkers are more likely to sanction African American (as opposed to white) TANF participants for noncompliance with program requirements.⁷³ Moreover, national studies have documented that states with higher percentages of black enrollees are significantly more likely to adopt restrictive eligibility

⁶⁸ Thomas Chalmers McLaughlin & Sandra S. Butler, Maine Equal Justice Partners & Maine Women's Lobby, *Families in Focus: Moving Beyond Anecdotes: Lessons from a 2010 Survey of Maine TANF Families* (2011), <http://www.mejp.org/content/families-focus-moving-beyond-anecdotes>; Sandra S. Butler, Maine Equal Justice Partners, *TANF Time Limits, One Year Later: How Families are Faring*, www.mejp.org/sites/default/files/TANF-Time-Limits-Study-March2014.pdf.

⁶⁹ Thomas Chalmers McLaughlin & Sandra S. Butler, Maine Equal Justice Partners & Maine Women's Lobby, *Families in Focus: Moving Beyond Anecdotes: Lessons from a 2010 Survey of Maine TANF Families* (2011), <http://www.mejp.org/content/families-focus-moving-beyond-anecdotes>.

⁷⁰ *Id.*

⁷¹ 42 U.S.C. § 12312; Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794 (prohibiting recipients of federal funds from discriminating on the basis of disability). *See also*

⁷² *See Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

⁷³ Sanford F. Schram et al., *Deciding to Discipline: Race, Choice, and Punishment in the Frontlines of Welfare Reform*, 74 AM. SOCIOLOGICAL REV. 398, 414-15 (June 2009) (attached).

requirements.⁷⁴ These studies raise serious concerns that approving work requirements in Mississippi will increase racial disparities both within Mississippi and between Mississippi and other states.

Administrative Burdens Will Result In Coverage Losses

Second, many individuals—including many individuals who are already working or who fall within an exemption—will be confused by the requirement and may lose coverage due to documentation errors.⁷⁵ In Arkansas, during the first month of the work requirements, 15,511 were deemed to be meeting the requirements based on SNAP data, leaving 10,304 enrollees who needed to report hours or an exemption. Of those 10,304, only 2,395 reported an exemption and 445 reported sufficient hours, leaving 7,464 who did not report at all or reported insufficient hours.⁷⁶

Duplicative research shows that when states impose new administrative requirements on Medicaid enrollees, enrollment declines.⁷⁷ For example, in 2003, Texas experienced a nearly 30% enrollment decline after it increased premiums, established a waiting

⁷⁴ Joe Soss, Richard C. Fording & Sanford F. Schram, *The Color of Devolution: Race, Federalism, and the Politics of Social Control*, 52 AM. J. OF POLITICAL SCI. 536, 543-49 (2008), <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.526.4139&rep=rep1&type=pdf>; Joe Soss et al., *Setting the Terms of Relief: Explaining State Policy Choices in the Devolution Revolution*, 45 AM. J. OF POLITICAL SCI. 378, 385-89 (2001), <http://urban.hunter.cuny.edu/~schram/ssvosettingthetermsofrelief.pdf>.

⁷⁵ See, e.g., Robin Garfield et al., *supra* note 27; Jennifer Wagner & Judith Solomon, Ctr. on Budget & Pol. Priorities, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/5-23-18health2.pdf>; Julia B. Isaacs et al., Urban Inst., *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance* (2016), <http://www.urban.org/sites/default/files/publication/78846/2000668-Changing-Policies-to-Streamline-Access-to-Medicaid-SNAP-and-Child-Care-Assistance-Findings-from-the-Work-Support-Strategies-Evaluation.pdf>.

⁷⁶ Arkansas Dep't of Human Servs. June Report, *supra* note 31.

⁷⁷ See Wagner & Solomon, *supra* note 75, at 3-4 (noting that when Washington increased documentation requirements and other changes that made it harder to enroll and maintain continued enrollment, enrollment dropped; enrollment rebounded when the State went back to its prior processes); Michael Perry, Susan Kannel, R. Burciaga Valdez, and Christina Chang, Kaiser Family Found., *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* (2000), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf>; Leighton Ku et al., Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care* 12-16 (2009) <http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>.

period, and moved from a 12- to 6-month renewal period for children in CHIP.⁷⁸ Similarly, when Washington State increased documentation requirements, moved from a 12- to 6-month renewal period, and ended continuous eligibility for children in Medicaid and CHIP in 2003, enrollment dropped sharply.⁷⁹ Enrollment quickly rebounded when the State reinstated the 12-month renewal period and continuous eligibility.⁸⁰

There are several reasons for this. Inevitably, the State will make mistakes in implementing the requirement, causing some number of erroneous coverage losses.⁸¹ In addition, many enrollees will not be able to navigate the reporting process to show that they are meeting the requirement or qualify for an exemption.⁸² Mississippi's low rate of internet access—just 61%—will make reporting hours or exemptions more difficult for many individuals.⁸³ Many individuals likewise lack transportation or have difficulty affording public transportation, which could make providing documentation to the State in a timely manner even more difficult. These logistical barriers have been

⁷⁸ Kaiser Family Found., *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (Feb. 28, 2018), <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/> (citing Kaiser Family Found., *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act*, (June 4, 2013), <https://www.kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/>).

⁷⁹ *Id.* (citing Donna Cohen Ross and Laura Cox, Kaiser Family Found., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, A 50 State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and CHIP* (2004), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/beneath-the-surface-barriers-threaten-to-slow-progress-on-expanding-health-coverage-of-children-and-families-pdf.pdf>; Laura Summer and Cindy Mann, Commonwealth Fund, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies* (2006), <http://www.commonwealthfund.org/publications/fund-reports/2006/jun/instability-of-public-health-insurance-coverage-for-children-and-their-families--causes--consequence>).

⁸⁰ Kaiser Family Found., *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (Feb. 28, 2018), <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>.

⁸¹ See Wagner & Solomon, *supra* note 75 at 13-14.

⁸² *Id.* at 12-13; Robin Garfield et al., *supra* note 27; Margot Sanger-Katz, *Hate Paperwork? Medicaid Recipients Will Be Drowning In It*, N.Y. TIMES, Jan. 18, 2018, <https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?nytap=true&r=0>.

⁸³ Ryan & Lewis, *supra* note 49, <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf>.

documented in the SNAP program as well, where otherwise eligible individuals lose coverage due to reporting requirements at recertification.⁸⁴

Others may be dissuaded from even trying to enroll in the first place, given the perceived complexity of the work requirements.⁸⁵ In 2000, a survey of parents revealed that the perceived hassle of applying, the complexity of rules and regulations, and confusion about how to apply were all significant factors that prevented parents from even trying to enroll their children in Medicaid.⁸⁶

Finally, confusion will result in significant coverage losses. One consistent finding from past waivers is that beneficiaries are often confused about the program's requirements and therefore do not participate.⁸⁷ Adding complicated work requirements, with a host of exemptions and exceptions, will create confusion and uncertainty about the program's rules. Moreover, most Medicaid enrollees do not directly interact with a caseworker when applying for or renewing coverage and will only receive information about the work requirements through long, complex paper notices.⁸⁸ Navigating the notices, reporting, and exemption processes may be especially challenging for

⁸⁴ Gregory Mills *et al.*, Urban Inst., *Understanding the Rates, Causes, and Costs of Churning in the Supplemental Nutrition Assistance Program (SNAP) - Final Report* 74-77 (2014) <https://fns-prod.azureedge.net/sites/default/files/ops/SNAPChurning.pdf>; Colin Gray, Upjohn Inst., *Working Paper 18-288, Why Leave Benefits on the Table? Evidence from SNAP* (May 2018), http://research.upjohn.org/cgi/viewcontent.cgi?article=1306&context=up_workingpapers.

⁸⁵ Michael Perry *et al.*, Kaiser Family Found., *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* 10-12 (2000) <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf>; Judith Solomon, Ctr. on Budget & Pol. Priorities, *Locking People Out of Medicaid Coverage Will Increase Uninsured, Harm Beneficiaries' Health* (2018) https://www.cbpp.org/research/health/locking-people-out-of-medicaid-coverage-will-increase-uninsured-harm-beneficiaries#_ftn3.

⁸⁶ Perry *et al.*, *supra* note 85 at 10-12.

⁸⁷ See MaryBeth Musumeci *et al.*, Kaiser Family Found., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* (Jan. 31, 2017), <https://www.kff.org/report-section/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana-key-findings/> (describing confusion about content of notices sent in Michigan, and confusion among beneficiaries, advocates, and providers over Indiana's POWER accounts, how premiums were calculated, and other program features); See also Leighton Ku *et al.*, Ass'n for Community Affiliated Plans, *supra* note 77 at 3 (describing that "families often do not know when their Medicaid certification periods expire, may be dropped without knowing it, and do not know why they lost coverage. Those who have been disenrolled typically say they wanted to retain their insurance coverage, but did not know how to do so.").

⁸⁸ See Wagner & Solomon, *supra* note 75 at 12.

individuals with mental illness that affects cognitive functioning.⁸⁹ Finally, individuals who have limited English proficiency or limited reading skills may find these notices particularly confusing. In these ways, adding additional reporting and verification requirements is likely to also exacerbate health disparities within Mississippi.⁹⁰

In short, the evidence shows that reducing enrollees' administrative burdens increases coverage.⁹¹ Congress recognized this relationship, drafting the Affordable Care Act to: prohibit states from requiring an in-person interview for Medicaid applicants; require them to rely on electronic data matches to verify eligibility to the greatest extent possible before requesting documentation from applicants; and to conduct annual eligibility redeterminations without requesting information from beneficiaries if eligibility can be determined using electronic data.⁹²

The State's proposal to add the administrative burden of establishing exemptions, and monthly reporting requirements for those that are working or qualify for an exemption, directly undercuts those efforts and will decrease enrollment.

Even Individuals Who Comply With the Work Requirements Will Lose Coverage

Mississippi's proposal puts families in a "catch-22."⁹³ Individuals who comply with Mississippi's work requirements will necessarily end up in a coverage gap and become uninsured.⁹⁴ Mississippi has set the income limit for the parent and caretaker

⁸⁹ Richard G. Frank, Commonwealth Fund, *Work Requirements and Medicaid: What Will Happen to Beneficiaries with Mental Illnesses or Substance Use Disorders?* (2018) <http://www.commonwealthfund.org/publications/q-anda/2018/may/work-requirements-and-medicaid>.

⁹⁰ Michael Perry et al., Kaiser Family Found., *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* 9 (2000), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf>.

⁹¹ Kaiser Family Found., *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (2018), <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>.

⁹² See Wagner & Solomon, *supra* note 75 at 12; Kaiser Family Found., *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (2018), <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>.

⁹³ See Jessica Schubel, Ctr. on Budget & Pol. Priorities, *Mississippi's Revised Medicaid Waiver Has Same Flaws as Original Version* (July 17, 2018), <https://www.cbpp.org/blog/mississippis-revised-medicaid-waiver-has-same-flaws-as-original-version>.

⁹⁴ Community Catalyst, *Work Requirements: A One-Way Ticket to the Coverage Gap. An Analysis of the Incompatibility of Work Requirements with Income Eligibility Levels in Medicaid*

population at just 27% FPL. Thus, the income limit for a family of two is \$4,385 annually, or just over \$84 a week. But, an individual who works 20 hours a week at the federal minimum wage would earn \$145 a week, or \$7,540 annually, leaving their family ineligible for Medicaid. The outcome is the same for a family of four.⁹⁵

Proponents of imposing a work requirement on Medicaid enrollees claim that individuals who lose Medicaid coverage due to increased income will not become uninsured, but will instead find jobs that provide private health coverage. The State also claims that by adding a second year of Transitional Medical Assistance (TMA), individuals will be able to transition more easily to employer-sponsored insurance.

This does not address the up-front problem: People are being terminated from Medicaid coverage for failing to meet work requirements. Moreover, the State's own estimates show that TMA will not fix the catch-22. The State expects just 1,280 individuals will be enrolled on TMA each year.⁹⁶ That is just 2% of the 56,467 individuals in Mississippi's parent and caretaker population.⁹⁷

There are several reasons individuals will not be able to rely on TMA for consistent coverage under Mississippi's proposal.

First, Mississippi proposes applying the same monthly reporting requirements to individuals eligible for TMA. But it is nonsensical to add monthly reporting requirements to TMA: TMA was established by Congress in order to support families who are already transitioning to work, by extending Medicaid coverage to families who became ineligible due to increased income from employment. As discussed above, creating additional administrative burdens will result in significant numbers of eligible individuals losing coverage for failing to report their hours.⁹⁸ Moreover, individuals who lose TMA due to reporting requirements necessarily will have incomes above the Medicaid limits, and

Non-Expansion States (2018),

<https://www.communitycatalyst.org/resources/publications/document/2018/Community-Catalyst-Work-Requirements-and-Medicaid-Eligibility-in-Non-Expansion-States-Analysis.pdf>.

⁹⁵ *Id.* at 5 (Jan. 2018).

⁹⁶ Revised Application at 8; *id.* at 6 (defining Population 2).

⁹⁷ *Id.* at 5 ("In calendar year 2017, there were 19,213 new applicants and 37,254 beneficiaries at re-determination who were eligible for Medicaid in the low-income parent and other caregiver relatives category of eligibility.").

⁹⁸ Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, Ctr. on Budget & Pol. Priorities *Medicaid Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes* (2018), <https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen>.

thus end up in a coverage gap—creating the exact opposite effect of what Congress intended when it added TMA.

Second, studies of cash assistance programs show that work requirements do not increase stable employment.⁹⁹ Thus, individuals who rely on TMA are susceptible to the same unpredictable hours and volatile labor markets, causing people to lose health coverage as their hours fluctuate below an average of 20 hours a week, but remain above the low income thresholds for parents and caretakers.

Finally, TMA remains time-limited. Mississippi only proposes to provide TMA for two years. But evidence from TANF shows that even individuals who leave the program because of work do not experience lasting increases in income.¹⁰⁰ For instance, Kansas

⁹⁹ See LaDonna Pavetti, Ctr. on Budget & Pol. Priorities, *Work Requirements Don't Work* (2018), <https://www.cbpp.org/blog/work-requirements-dont-work>, LaDonna Pavetti, Ctr. on Budget & Pol. Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016), <https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows>; LaDonna Pavetti, Ctr. on Budget & Pol. Priorities, *Evidence Doesn't Support Claims of Success of TANF Work Requirements* (2018), <https://www.cbpp.org/research/family-income-support/evidence-doesnt-support-claims-of-success-of-tanf-work-requirements>; Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. POL'Y ANALYSIS & MGMT. 231, 234 (2016); Gayle Hamilton et al., Manpower Demonstration Research Corp., *National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs* (2001), https://www.mdrc.org/sites/default/files/full_391.pdf; Heather Hahn et al., Urban Inst., *Work Requirements in Social Safety Net Program: A Status Report of Work Requirements in TANF, SNAP, Housing Assistance, and Medicaid* (2017), <https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf>; Administration for Children and Families, Department of Health and Human Services, *Characteristics and Financial Circumstances of TANF Recipients, Fiscal Year 2013*, Table 43, https://www.acf.hhs.gov/sites/default/files/ofa/tanf_characteristics_fy2013.pdf (In 2013, only 9.6% of recipients left the TANF program due to finding employment, while almost four times as many individuals (36%) left as a result of sanctions or a failure to comply with the verification and eligibility procedures); Tazra Mitchell & LaDonna Pavetti, Ctr. on Budget & Pol. Priorities, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (2018), <https://www.cbpp.org/research/family-income-support/life-after-tanf-in-kansas-for-most-unsteady-work-and-earnings-below> (TANF work requirements in Kansas did not result in measurable uptick in employment among TANF parents. Instead, work was common, but unsteady, resulting in inconsistent earnings and periods of unemployment); Musumeci & Zur, *supra* note 64.

¹⁰⁰ For instance, in 2012, among Kansans who had a job, 26.4% made between 0%-100% FPL; 46% made between >100% - 200% FPL; 15.9% made between >200% - 300%; and only 11.6% make >300%. See Rebecca Thiess, Economic Pol. Inst., *The Future of Work: Trends and Challenges for Low-Wage Workers* (2012), <http://www.epi.org/publication/bp341-future-of-work/>. Evaluations of Maine's SNAP program likewise demonstrate that the requirements are

parents who reported they were employed when they left TANF in 2014 had an average monthly income of \$1,107, which would equal \$13,284 annually (or 80% FPL for a family of two).¹⁰¹ A more recent analysis of state-collected data on employment and earnings of Kansas parents leaving TANF cash assistance between October 2011 and March 2015 suggests, however, that the long-term results in Kansas are actually much worse than previous evidence suggested. In Kansas, almost two thirds of parents had “deep poverty earnings,” (earnings below 50 percent FPL), in the year after exiting TANF.¹⁰² Four years after exiting the program, the numbers were nearly the same.¹⁰³ For parents who were terminated from TANF due to time limits, median income was even lower, just \$1,370 (7 percent FPL).¹⁰⁴ The TANF-to-poverty ratio in Kansas provides further evidence that the reduction in Kansas’ TANF caseload did not translate to economic improvement for the State’s low-income families. Instead, it simply means that TANF is reaching fewer people: just 10% of Kansas families with children in poverty receive TANF assistance.¹⁰⁵ Thus, after two years, many low-wage workers in Mississippi will lack access to Medicaid and TMA, and will still not be able to afford either ESI (if their jobs offer it, see *infra*) or private insurance.

ineffective. Maine’s evaluation of its own SNAP program was based on flawed and unreliable data, and as a result, reached flawed and misleading conclusions. In particular, the State’s analysis incorrectly attributed the rise in SNAP recipients’ wages during the relevant timeframe to the program’s requirements, instead of the overall growth in the economy over the same time period. But, SNAP beneficiaries’ wages did not rise faster than the overall economy, and there is no basis for attributing that growth over a short time period to the requirements. Nor did the study consider the effects on individuals who *lost* SNAP benefits as a result of the requirements. Later analysis reveals that two-thirds of individuals who lost SNAP benefits due to work requirements remained unemployed, with neither wages nor SNAP benefits at the end of the year following termination. See Dottie Rosenbaum Ed Bolen, Ctr. on Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit* (2016) <http://www.cbpp.org/research/food-assistance/snap-reports-present-misleading-findings-on-impact-of-three-month-time>; Maine Equal Justice Partners, *Work Requirements Do Not Work and Have Harmful Consequences* 5 (2017)

<http://www.mejp.org/sites/default/files/WorkRequirement-FullReport-1Feb2018.pdf>.

¹⁰¹ Meg, Wingerter, “Do ‘welfare to work’ numbers add up?” Kansas Health Institute (Apr. 14, 2016), <http://www.khi.org/news/article/numbers-dont-support-welfare-to-work-claim>.

¹⁰² Mitchell & Pavetti, *Life after TANF*, *supra* note 99.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ Ife Floyd, LaDonna Pavetti, and Liz Schott, “TANF Reaching Few Poor Families,” Center on Budget and Policy Priorities (Dec. 13, 2017), <https://www.cbpp.org/research/family-income-support/tanf-reaching-few-poor-families>. In fact, between 1996 and 2016 the number of families with children living in deep poverty in Kansas has grown from 14,400 to 16,100. See Kansas’ TANF Cash Assistance is Disappearing for Poor Families,” Center on Budget and Policy Priorities https://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ks.pdf.

Once individuals lose coverage—whether Medicaid or TMA—they are likely to face a coverage gap. The State offers no data or estimates about what will happen to those individuals, but does acknowledge that “this waiver in and of itself is not enough to guarantee successful transitions to other health insurance.”¹⁰⁶

Evidence confirms that the vast majority will face a coverage gap.¹⁰⁷ Individuals below 100% FPL do not have access to Marketplace subsidies, and access to employer sponsored insurance is rare. According to the Kaiser Family Foundation, only 30% of workers in households with income below 100% of FPL had access to insurance through their employer, compared to nearly 80% of workers in households with income above 400% of FPL.¹⁰⁸ In Mississippi specifically, the chances of finding employer sponsored insurance are even lower: estimates of the number of adults living below the poverty line that are covered by employer-sponsored insurance range from 22% down to 14%.¹⁰⁹

Nationally, among part-time workers, only 13% of those with incomes below poverty and 20% of those with incomes between 100 and 125 % of FPL had an offer of insurance.¹¹⁰

¹⁰⁶ Application at 19; Revised Application at 13. Even if the State assumes that the 1,280 individuals who gain TMA are subtracted from the 5,000 who are expected to lose Medicaid coverage in the first year, that still leaves 3,720 individuals who will lose access to Medicaid or TMA in the first year alone.

¹⁰⁷ See Aviva Aron-Dine, *Eligibility Restrictions*, *supra* note 30.

¹⁰⁸ Kaiser Family Found., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates: 1999-2014* (2016) <http://files.kff.org/attachment/issue-brief-trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-2>.

¹⁰⁹ See Georgetown University Health Pol. Institute, Ctr. for Children & Families, *How Mississippi’s Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children* (April 2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/04/Mississippi-Work-Requirement-Report.pdf> (reporting 22% covered based on data retrieved from the American Community Survey Fact Finder, “Health Insurance Coverage Status and Type by Ratio of Income to Poverty Level in the Past 12 Months by Age” (Washington: United States Census Bureau, 2016), https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_16_1YR_B27016&prodType=table); see Georgetown University Health Pol. Institute, Ctr. for Children & Families, *How Mississippi’s Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children* (August 2018), <https://ccf.georgetown.edu/wp-content/uploads/2018/08/Proposed-Medicaid-Work-Requirement-Mississippi.pdf> (reporting 14% covered by ESI based on data from Kaiser Family Found., *Health Insurance Coverage of the Nonelderly (0-64) with Incomes below 100% Federal Poverty Level (FPL)* (2016) <https://www.kff.org/other/state-indicator/nonelderly-up-to-139-fpl/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22mississippi%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>).

¹¹⁰ *Id.*

Another study reached a similar conclusion, finding that among private-sector workers in the bottom fourth of the wage distribution, two-thirds lacked access to health care benefits from their employer.¹¹¹ A report based on 2017 data found that 78% of very low-wage workers (bottom 10% of earners) did not have health care through their jobs, leaving just 22% with access to ESI.¹¹² The numbers are even lower for dental, vision, and outpatient prescription drug coverage. According to the U.S. Bureau of Labor Statistics' Employee Benefits Survey, in 2016 and 2017, among private-sector workers in the bottom fourth of the wage distribution, just 16% had access to dental coverage and 8-9% had access to vision insurance.¹¹³

And even if ESI is offered, it is unaffordable. According to the United States Bureau of Labor Statistics, among private-sector workers in the lowest 25% of wages, workers are still responsible for an average of 24% of the premium costs, equaling \$133.75 each month.¹¹⁴

Evidence from TANF confirms this: among “welfare-leavers” there were significant reductions in insurance coverage that were not offset by smaller increases in private coverage.¹¹⁵ Moreover, imposing work requirements in TANF actually led to an *increase* in extreme poverty in some areas of the country, as individuals who did not secure employment also lost their eligibility for cash assistance.¹¹⁶

¹¹¹ Bivens & Fremstad, *supra* note 37.

¹¹² Goldman, Gupta, & Hernandez, *supra* note 41.

¹¹³ U.S. Bureau of Labor Statistics, Employee Benefits Survey, Healthcare Benefits, March 2016, *Table 9: Healthcare benefits: Access, Participation, And Take-Up Rates, Private Industry Workers, March 2016*, <https://www.bls.gov/ncs/ebs/benefits/2016/ownership/private/table09a.pdf>; U.S. Bureau of Labor Statistics, Employee Benefits Survey, Healthcare Benefits, March 2017, *Table 9: Healthcare Benefits: Access, Participation, and Take-Up Rates, Private Industry Workers, March 2017*, <https://www.bls.gov/ncs/ebs/benefits/2017/ownership/private/table09a.pdf>.

¹¹⁴ U.S. Bureau of Labor Statistics, Employee Benefits Survey, Healthcare Benefits, March 2016, *Table 10: Medical Care Benefits: Share Of Premiums Paid By Employer and Employee, Private Industry Workers, March 2016*, <https://www.bls.gov/ncs/ebs/benefits/2016/ownership/private/table10a.pdf> (percentage of premium); U.S. Bureau of Labor Statistics, Employee Benefits Survey, Healthcare Benefits, March 2016, *Table 11: Medical Care Benefits, Single Coverage: Employer and Employee Premiums By Employee Contribution Requirement, Private Industry Workers, March 2016*, <https://www.bls.gov/ncs/ebs/benefits/2016/ownership/private/table11a.pdf>.

¹¹⁵ Antonisse & Garfield, Kaiser Family Found., *supra* note 18.

¹¹⁶ Pavetti, *Work Requirements Don't Cut Poverty*, *supra* note 99. Mitchell & Pavetti, *Life After TANF in Kansas* *supra* note 99 (analysis of long-term results of TANF work requirements in Kansas show evidence of extreme poverty among families who lost benefits: Parents who left due to work sanctions had median earnings averaging \$2,175 (or 11% FPL) after four years.

Taken together, the evidence demonstrates that the work requirement will lead to a large number of individuals, including those who work or are exempt from the requirement, losing Medicaid coverage and remaining uninsured, with serious consequences for their health and well-being and the health and well-being of their children. These outcomes are in direct conflict with the objectives of the Medicaid Act.

A far more productive (and permissible) approach would be to connect Medicaid enrollees to properly-resourced voluntary employment programs, an activity that does not need waiver approval from CMS.¹¹⁷ Studies show that these voluntary employment programs increase employment and income among low-income individuals. For example, a rigorous evaluation of Jobs Plus, a voluntary employment program for public housing residents, found that the program produced substantial and sustained gains in earnings when fully implemented.¹¹⁸ In addition, Montana has implemented a voluntary workforce promotion program (HELP-Link) for the Medicaid expansion population. The State targets Medicaid enrollees who are looking for work or better jobs, assesses their needs, and then connects them with individualized job support and training services.¹¹⁹ During HELP-Link's first three years, 22,000 Medicaid enrollees received services.¹²⁰ The State has reported that program participants have high employment rates, and the majority of participants had higher wages after completing the program.¹²¹

More than one-third of them had no earnings, nearly 7 in 10 had no earnings or earnings below the deep-poverty level, and more than 8 in 10 had no earnings or earnings below the poverty level).

¹¹⁷ The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

¹¹⁸ Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), <http://files.eric.ed.gov/fulltext/ED514703.pdf>.

¹¹⁹ See Hannah Katch, Ctr. on Budget & Pol. Priorities, *Promising Montana Program Offers Services to Help Medicaid Enrollees Succeed in the Workforce* (2018), <https://www.cbpp.org/research/health/promising-montana-program-offers-services-to-help-medicaid-enrollees-succeed-in-the>.

¹²⁰ *Id.*

¹²¹ Montana Dep't of Labor & Industry, *HELP-Link Program Update* (2018), https://dphhs.mt.gov/Portals/85/Documents/healthcare/March%202018%20HELP_Link_Fact_Sheet.pdf.

The Work Requirement Will Be Expensive

The administrative costs associated with implementing the work requirement are high.¹²² Mississippi will have to develop new computer systems and identify new data sources to track work hours or participation in work-related activities and to identify and evaluate exemptions. In fact, Mississippi's application explains that the State's eligibility data does not currently capture "certain data elements that would exempt an individual from participation in workforce training or community engagement."¹²³ According to a report from Fitch Ratings, Medicaid administrative costs in Kentucky have already increased sharply - more than 40% - after preparing to implement the Kentucky HEALTH waiver.¹²⁴ Other states have likewise described increased costs associated with Medicaid waiver proposals that require additional monitoring of individuals' behavior. For instance, Michigan estimated that a work requirement would cost the State \$15 to \$30 million every year.¹²⁵ Minnesota projected implementing a work requirement would cost local governments \$121 million in 2020 and \$163 million in 2021.¹²⁶ Other states have experienced increased staffing and administrative costs as waivers add administrative complexity and increase monitoring of enrollees. One study indicated that Indiana's Medicaid managed care organizations had to increase administrative staffing ratios and devote more time to meet the state's requirements for oversight of the POWER accounts.¹²⁷ Officials in Arkansas estimated that administrative costs for that state's health savings accounts in Medicaid were over \$1,100 per participating beneficiary per year.¹²⁸

The costs to Mississippi will continue to rise as the waiver is implemented. The State must, among other things, track work hours or participation in work-related activities,

¹²² See, e.g., Bruce Japsen, *Trump's Medicaid Work Rules Hit States With Costs And Bureaucracy*, Forbes, July 22, 2018, <https://www.forbes.com/sites/brucejapsen/2018/07/22/trumps-medicaid-work-rules-hit-states-with-costs-and-bureaucracy/#36553b3866f5>; Wagner & Solomon, *supra* note 75, at 15-16 (listing state estimates of the cost associated with implementing a work requirement).

¹²³ Revised Application at 5.

¹²⁴ *Id.*

¹²⁵ Wagner & Solomon, *supra* note 75, at 15-16.

¹²⁶ *Id.* at 15-16. See also Mattie Quinn, *Implementing States' Medicaid Wishes Won't be Cheap*, Governing, Feb. 19, 2018, www.governing.com/topics/health-human-services/gov-medicaid-work-requirements-states-cost-implement.html.

¹²⁷ Zylla E, Planalp C, Lukanen E, Blewett L, Medicaid and CHIP Payment and Access Commission, *Section 1115 Medicaid expansion waivers: implementation experiences*, (2018). https://www.macpac.gov/wp-content/uploads/2018/02/SECTION-1115-MEDICAID-EXPANSION-WAIVERS_IMPLEMENTATION-EXPERIENCES.pdf.

¹²⁸ *Id.*

process requests for exemptions and good cause exceptions; process an increased volume of re-applications (when individuals lose coverage for failure to meet the work requirement, but then complete the requirement or fall within an exemption the following month); and handle an increased volume of administrative appeals for individuals who lose coverage due to the work requirement.¹²⁹ Evidence shows that churn on and off Medicaid increases both administrative and medical costs to the state.¹³⁰ Because the work requirement will result in increased churning between enrollment, suspension, and disenrollment, the State will incur substantially higher administrative costs per-beneficiary than continuous enrollment.¹³¹

These estimates do not take into account the increased uncompensated care costs that hospitals and community health centers will face when individuals who do not comply with the work requirement lose coverage.¹³²

Notably, Mississippi is requesting to incur these expenses to target a very small portion of the Medicaid expansion population. A recent study by the Kaiser Family Foundation confirms that the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.¹³³ Adult Medicaid enrollees who are not receiving disability benefits and do not have a job are not working because they are: going to school (15%); taking care of their home or family (30%); retired (9%); unable to find work (6%); or dealing with illness or disability (36%).¹³⁴ In fact, a spokesperson for the Mississippi Division of Medicaid estimated that just 15,000 to 20,000 people would be required to

¹²⁹ Wagner & Solomon, *supra* note 75, at 4-6 (providing a list of added administrative burdens for states that implement a Medicaid work requirement); Musumeci & Zur, *supra* note 63 (citing Government Accountability Office, *Temporary Assistance for Needy Families: Potential Options to Improve Performance and Oversight* (2013), <http://www.gao.gov/assets/660/654614.pdf>.)

¹³⁰ Leighton Ku et al., Ass'n for Community Affiliated Plans, *supra* note 77 at 1.

¹³¹ *Id.*

¹³² See, e.g., Jessica Schubel & Matt Broaddus, Ctr. on Budget & Pol. Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains* (2018), <https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage>.

¹³³ Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work* (2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work> (finding that almost 80% of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60% are working themselves).

¹³⁴ *Id.* at 4.

complete the required hours.¹³⁵ Spending millions of dollars to impose the work requirement on such a small percentage of Medicaid enrollees—while cutting coverage for one quarter to one third of that population—is not in line with the objectives of the Medicaid program.

III. Consequences of Coverage Loss

Not surprisingly, it is well-documented that gaps in coverage lead to worse health outcomes, including premature mortality.¹³⁶ These negative outcomes occur for a number of reasons. Churning on and off of coverage can result in higher use of the emergency room, including for conditions like asthma and diabetes that can be managed in an outpatient setting when people have consistent access to treatment.¹³⁷ Even brief lapses in coverage can cause people skip medications or other regular treatment, and result in worse health outcomes and increased use of the emergency department.¹³⁸ Gaps in coverage, and even switching between forms of coverage, make it less likely that people establish relationships with health care providers, and can

¹³⁵ See Emily Wagster Pettus, “Mississippi Seeks OK for Job Training for Some on Medicaid,” U.S. News & World Report (Nov. 15, 2017), <https://www.usnews.com/news/best-states/mississippi/articles/2017-11-15/mississippi-considers-job-training-for-some-on-medicaid>.

¹³⁶ Benjamin D. Sommers *et al.*, *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 NEW ENGLAND J. MEDIC. 586 (2017), <http://www.nejm.org/doi/full/10.1056/NEJMsb1706645>; Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. OF HEALTH ECONOMICS 392 (2017), https://www.mitpressjournals.org/doi/full/10.1162/ajhe_a_00080; Allyson G. Hall *et al.*, *Lapses in Medicaid Coverage: Impact on Cost and Utilization Among Individuals with Diabetes Enrolled in Medicaid*, 48 MEDIC. CARE 1219 (2008), <https://www.ncbi.nlm.nih.gov/pubmed/19300311?dopt=Abstract>; Andrew Bindman *et al.*, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 ANNALS INTERNAL MEDICINE 854 (2008) (attached); Woolhandler S, Himmelstein DU. *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANN INTERN MED. 424 (2017); <http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly>; Aviva Aron-Dine, *Eligibility Restrictions*, *supra* note 30.

¹³⁷ Leighton Ku and Erika Steinmetz, Ass’n for Community Affiliated Plans, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid* (2013), <http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%2009-10-13.pdf>.

¹³⁸ Leighton Ku *et al.*, Ass’n for Community Affiliated Plans, *supra* note 77 at 1, 5-6; Julia Paradise & Rachel Garfield, Kaiser Family Found., *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence* 4-5 (2013) <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf>

degrade the quality of care and health outcomes for Medicaid enrollees.¹³⁹ Likewise, continuous insurance coverage is associated with earlier cancer identification and outcomes.¹⁴⁰

Consistent Medicaid coverage is also essential for financial wellbeing.¹⁴¹ First of all, contrary to Mississippi's suggestion that Medicaid creates a disincentive to work, Medicaid is actually a critical work support; having coverage allows individuals to access the care and services they need to obtain and maintain work.¹⁴² For example, more than half of individuals enrolled in the Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue working. Among enrollees who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.¹⁴³

Medicaid also dramatically reduces the consequences of medical debt. Medical debt is a major contributor to bankruptcies across the country.¹⁴⁴ The financial benefits of Medicaid coverage have been repeatedly documented and have contributed to lower rates of bankruptcy.¹⁴⁵ For instance, The Oregon Health Insurance Experiment found

¹³⁹ Ku et al., *supra* note 77 at 1, 5-6.

¹⁴⁰ *Id.* at 6.

¹⁴¹ See, e.g., Georgetown Univ. Health Pol. Inst., Ctr. for Children and Families, *Medicaid: How Does it Provide Economic Security for Families* (2017), <http://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf>; Jesse Cross-Call, Ctr. on Budget & Pol. Priorities, *More Evidence Medicaid Expansion Boosts Health, Well-Being* (2018), <https://www.cbpp.org/blog/more-evidence-medicaid-expansion-boosts-health-well-being> (highlighting data showing that health coverage reduces poverty and Medicaid expansion improves financial security); Louija Hou et al., *National Bureau of Economic Research Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being*, (2016), <http://nber.org/papers/w22170>; Dahlia K. Remler et al., *Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act*, 36 HEALTH AFFAIRS 1828 (2017) (attached); Paradise & Garfield, *supra* note 138 at 5-6.

¹⁴² Inst. for Healthcare Pol. & Innovation, Univ. of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (2017), <http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches>; Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly* (2017), <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

¹⁴³ Ohio Dep't of Medicaid, *supra* note 142.

¹⁴⁴ David U. Himmelstein, et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. OF MEDICINE 741 (2009), http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

¹⁴⁵ Tal Gross, Matthew J. Notowidigdo, *Health Insurance And The Consumer Bankruptcy Decision: Evidence From Expansions of Medicaid*, 95 J. PUB. EC. 767, 776 (July 2011), (attached).

that Medicaid coverage reduced the likelihood of borrowing money or skipping bills to pay for medical care by 40% and reduced the probability of having a medical debt collection by 25%.¹⁴⁶

Evidence since the passage of the ACA also demonstrates how access to Medicaid—rather than private insurance through the Marketplace or ESI—reduces medical debt and promotes financial security. For instance, one national study found that Medicaid expansion reduced difficulty paying medical bills among low-income parents, and reduced stress and severe psychological distress.¹⁴⁷ Ohio’s evaluation of its Medicaid expansion likewise reported substantial reductions in medical debt and improved ability to pay for non-medical bills.¹⁴⁸

Additional studies of the Medicaid expansion show significant improvements in financial well-being. One study of credit report data found that when compared to low-income areas in non-expansion states, low-income areas in expansion states had significant reductions in unpaid non-medical bills and in the amount of non-medical debt sent to third-party collection agencies.¹⁴⁹ Another national study comparing Medicaid expansion and non-expansion states found that medical debt fell by almost twice as much in expansion states (13%) compared to non-expansion states (7%).¹⁵⁰ And a third study showed that Medicaid expansion reduced the incidence of newly-accrued medical debt by 30% to 40%, and reduced the number of bankruptcies compared to non-expansion states.¹⁵¹ That study also examined the indirect consequences of unpaid medical debt, including reduced, or higher-priced, access to credit markets, and found that following expansion, credit scores improved significantly.¹⁵²

¹⁴⁶ Finkelstein *et al.* *The Oregon Health Insurance Experiment: Evidence from The First Year*, 127 Q J Econ. 1057, 1057 (2012), <http://www.nber.org/papers/w17190.pdf>.

¹⁴⁷ Stacey McMorrow, *et al.*, *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress For Low-Income Parents*, 36 HEALTH AFFAIRS 808 (2017) (attached).

¹⁴⁸ Ohio Dep’t of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, 39-40 (2017), <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

¹⁴⁹ Louija Hou *et al.*, *National Bureau of Economic Research Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being* (2016), <http://nber.org/papers/w22170>.

¹⁵⁰ Aaron Sojourner & Ezra Golberstein, *Health Affairs, Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction* (2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170724.061160/full/>.

¹⁵¹ Kenneth Brevoort, Daniel Grodzicki, & Martin B. Hackmann, Nat’l Bureau of Economic Research, *Medicaid and Financial Health* 3 (2017) (attached).

¹⁵² *Id.* at 3-4

Conclusion

In summary, work requirements stand Medicaid's purpose on its head by creating barriers to coverage and the pathway to health that the coverage represents. This punitive policy would cover fewer people and increase the ranks of the uninsured. The obvious consequence? More delays in treatment, more gaps in coverage, poorer health outcomes and higher uncompensated care costs in hospitals and federally qualified health centers. Mississippi's proposal is inconsistent with the standards of § 1115 and with other provisions of law and should be rejected.

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Sarah Grusin (grusin@healthlaw.org).

Sincerely,



Jane Perkins
Legal Director