



Show Elizabeth G. Taylor
Executive Director

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

August 18, 2018

VIA ELECTRONIC SUBMISSION

The Honorable Alex Azar, Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., S.W.
Washington, D.C. 20201

Re: Kentucky HEALTH Project

Dear Secretary Azar:

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 comment once again on the Kentucky HEALTH project.

NHeLP recommends that the Department of Health & Human Services (HHS) reject the Kentucky HEALTH application. The project, both as proposed and as previously approved with Special Terms and Conditions (STCs), does not comply with the requirements of § 1115 of the Social Security Act. Kentucky HEALTH will have a devastating effect on low-income individuals across the State. The project will cause large numbers of individuals to lose access to health coverage. Those who manage to remain enrolled in Medicaid will have reduced access to the health care services they need to maintain their health and contribute to their communities. Congress established Medicaid demonstration projects to promote the objectives of the program. By blocking, rather than facilitating, access to Medicaid coverage, Kentucky HEALTH undermines, rather than promotes, those objectives.

I. HHS Authority and § 1115

For the Secretary to approve Kentucky HEALTH pursuant to § 1115, it must:

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

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain capability for independence or self-care.² As explained below, the Kentucky HEALTH proposal is inconsistent with the provisions of § 1115.

II. Medicaid Expansion in Kentucky

Expansion has been a success for Kentuckians and for the Commonwealth. Between 2013 and 2016, Kentucky experienced the largest decrease of any state in the rate of adults uninsured.³ Hundreds of thousands of Kentuckians enrolled through the Medicaid expansion have accessed a wide range of health care services, leading to improved health outcomes.⁴ After the expansion, low-income individuals are more likely to get regular care for their chronic health conditions and are less likely to skip medication due to cost.⁵ They are also much more likely to report being in “excellent” health.⁶ One study found that expansion in Kentucky has been associated with earlier breast cancer

¹ 42 U.S.C. § 1315(a).

² *Id.* at § 1396-1. See also *Stewart v. Azar*, ___ F.Supp. 3d ___, 2018 WL 3203384 (D.D.C. 2018).

³ Dan Witters, *Kentucky, Arkansas Post Largest Drops in Uninsured Rates*, GALLUP NEWS, Feb. 8, 2017, <http://news.gallup.com/poll/203501/kentucky-arkansas-post-largest-drops-uninsured-rates.aspx>; see also Joseph A. Benitez et al., *Kentucky’s Medicaid Expansion Showing Early Promise on Coverage and Access to Care*, 35 HEALTH AFFAIRS 528 (2016) (attached).

⁴ See Deloitte, *Commonwealth of Kentucky Medicaid Expansion Report 2014* at 50, 68 (2015), https://jointhehealthjourney.com/images/uploads/channel-files/Kentucky_Medicaid_Expansion_One-Year_Study_FINAL.pdf; Benjamin Sommers et al., *Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults*, 36 HEALTH AFFAIRS (2017) (attached).

⁵ Benjamin Sommers et al., *supra* note 4. See also Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* 4- 6 (2018), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review>.

⁶ Benjamin Sommers et al., *supra* note 4, at 1126.

diagnoses and improved quality of breast cancer care.⁷ Not surprisingly, increased access to care has also translated to improved financial security for low-income individuals. For example, among individuals who gained coverage under Medicaid expansion, average annual out-of-pocket spending decreased by \$337, and the number of individuals who reported trouble paying medical bills decreased by 58%.⁸ In fact, the Commonwealth has experienced one of the “largest percentage-point reductions” in past-due medical debt.⁹

Expansion has also boosted the economy in Kentucky. Between 2013 and 2015, Kentucky experienced the largest reduction in uncompensated care of any state, increasing the financial viability of hospitals and affording them more flexibility in spending.¹⁰ Increased Medicaid expenditures have increased economic activity, with one study estimating that each dollar spent on expansion in 2020 will generate “\$1.35 – \$1.80 of economic activity in Kentucky.”¹¹ In addition, Medicaid expansion has led to job growth in the health sector, and these jobs tend to have higher wages and stronger wage growth than other private sector jobs.¹² In 2014 alone, the Medicaid expansion created more than 12,000 jobs in health care and related fields.¹³

III. Kentucky HEALTH Will Reduce Medicaid Coverage

With Kentucky HEALTH, the Commonwealth is seeking to implement a number of policies that will transform Medicaid “as part of a comprehensive entitlement and workforce reform effort.”¹⁴ If approved, the waiver will unquestionably reduce Medicaid enrollment. In fact, Kentucky estimates that approximately 95,000 individuals will lose

⁷ Nicolas Ajkay et al., *Early Impact of Medicaid Expansion and Quality of Breast Cancer Care in Kentucky*, 226 J. AM. COLL. SURGEONS 498 (2018) (attached).

⁸ Benjamin Sommers, *supra* note 4, at 1126;

⁹ Michael Karpman & Kyle J. Caswell, Urban Inst., *Past-Due Medical Debt among Nonelderly Adults, 2012-15* (March 2017),

https://www.urban.org/sites/default/files/publication/88586/past_due_medical_debt.pdf

¹⁰ MACPAC, *Report to Congress on Medicaid and CHIP*, Table 3A-4, at 91 (March 2018),

<https://www.macpac.gov/wp-content/uploads/2018/03/Report-to-Congress-on-Medicaid-and-CHIP-March-2018.pdf> (noting the amount and share of uncompensated care dropped from \$561 million in 2013, or 4.6 % of total operating expenses, to \$215 million in 2015, or 1.6 % of total operating expenses.); *see also* Deloitte, *supra* note 4, at 35.

¹¹ Dustin Pugel, Ky. Ctr. For Economic Policy, *Medicaid Boosts Kentucky's Economy, New Barriers to Coverage Will Hold Us Back*, KY POLICY BLOG, (June 15, 2018), <https://kypolicy.org/medicaid-boosts-kentuckys-economy-new-barriers-coverage-will-hold-us-back/>.

¹² *Id.*

¹³ Deloitte, *supra* note 4, at 27-28.

¹⁴ *Strengthening Access and Accountability to Work in Welfare Programs: Hearing Before the Subcomm. on Higher Education and Workforce Development of the H. Comm. On Education and Workforce*, 115th Cong. (March 15, 2018) (statement of Adam M. Meier, Dep. Chief of Staff for Policy, Office of Ky. Governor Matt Bevin), https://edworkforce.house.gov/uploadedfiles/testimony_meier_3.15.18.pdf.

Medicaid coverage over the course of the project. Independent scholars have indicated that the actual coverage losses are likely to be substantially larger.¹⁵ In contrast, the Commonwealth has not provided any evidence indicating that Kentucky HEALTH will in any way promote access to medical assistance. As such, the project runs directly counter to the purpose of the Medicaid program, which is to provide medical assistance to low-income individuals. The relevant literature overwhelmingly demonstrates that the Kentucky HEALTH eligibility requirements will result in significant coverage losses, which will negatively affect the health of low-income individuals in Kentucky.

A. Work Requirements

Kentucky is once again proposing to require enrollees to complete 80 hours per month of specified work or community engagement activities and to document and report their participation each month to remain eligible for Medicaid. Enrollees who are subject to the requirement for a particular month, do not meet it, and are unable to show that one of the narrow “good cause” exceptions applies will have their coverage suspended until they: (1) meet the work requirement in a particular month; (2) take a health or financial literacy course; or (3) reach their eligibility redetermination date, at which point Kentucky will terminate coverage.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Kentucky 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.¹⁶

Section 1115 cannot be used to short-circuit these Medicaid protections. There is simply no basis for finding that work requirements are likely to assist in promoting the

¹⁵ See Brief of Deans, Chairs, and Scholars as Amici Curiae in Support of Plaintiffs, *Stewart v. Azar*, ___F.Supp. 3d___, 2018 WL 3203384 (D.D.C. 2018).

¹⁶ 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).

objectives of the Medicaid Act.¹⁷ Unlike some other public benefits programs, Medicaid is not a work program; it is a medical assistance program. The purpose of Medicaid is to enable states to furnish medical assistance to low-income individuals who cannot afford the costs of medically necessary services and to furnish rehabilitation and other services to help such individuals attain or retain capability for independence or self-care.¹⁸ Put simply, conditioning Medicaid eligibility on completion of work activities blocks access to medical assistance.

1. 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.¹⁹ Researchers have estimated that between 45,000 to 103,000 individuals could lose coverage due to the work requirement alone.²⁰

Recent data from Arkansas suggests that this projection is too conservative, and that nearly a third of Kentucky HEALTH enrollees subject to the work requirement will not be able to comply.²¹ Arkansas began implementing a work requirement for the Medicaid expansion population on June 1, 2018. Of the 25,815 enrollees who were subject to the requirement that month, 7,464 did not meet the requirement.²² In July 2018, 43,794 enrollees were subject to the work requirement, and 12,722 did not comply.²³ There is no reason to expect a different outcome in Kentucky.

There are several reasons why beneficiaries will lose coverage. First, many individuals simply will not be able to comply with the requirements. Second, the administrative

¹⁷ 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>.

¹⁸ 42 U.S.C. § 1396-1.

¹⁹ 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>.

²⁰ See Aviva Aron-Dine, Ctr. On Budget & Policy Priorities, *Eligibility Restrictions in Recent Medicaid Waivers Would Cause Many Thousands of People to Become Uninsured* (2018), <https://www.cbpp.org/research/health/eligibility-restrictions-in-recent-medicaid-waivers-would-cause-many-thousands-of>.

²¹ *Id.*

²² Arkansas Dep’t of Human Servs., *Arkansas Works Program June 2018 Report* (attached).

²³ Arkansas Dep’t of Human Servs., *Arkansas Works Program July 2018 Report* (attached).

burdens of reporting compliance or proving an exemption will cause a significant decline in enrollment. Finally, employer-sponsored insurance (ESI) and Marketplace coverage are not universally available to the Medicaid population, and even where they are available, they are not affordable. As a result, the proposal will result in significant coverage losses, decreased access to medically necessary medical services, and increased financial burdens for low-income individuals across Kentucky.

a. Individuals Will Have Difficulty Completing 80 Hours of Work Each Month

Data shows that Medicaid enrollees are already working. 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.²⁴ In Kentucky, Medicaid enrollees who are already working average 36 hours of work a week during the weeks they have work.²⁵ But, only 64% of the group worked both 50 weeks and 20 hours a week in the previous year, meaning that 36% of enrollees who are already working would not meet the threshold for work activities.²⁶

This is not surprising given the realities of low-wage work. Most workers with Medicaid (78%) are paid hourly, and 36% of them earn an hourly wage at or below \$10/hour.²⁷ 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.²⁸ Approximately one-third of SNAP and Medicaid recipients worked in one of these occupations.²⁹ These jobs do not provide

²⁴ 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>

²⁵ Anuj Gangopadhyaya and Genevieve M. Kenney, Urban Inst., *Who Could Be Affected by Kentucky's Medicaid Work Requirements, and What Do We Know about Them?* 3 (2018), <https://www.urban.org/research/publication/updated-who-could-be-affected-kentuckys-medicaid-work-requirements-and-what-do-we-know-about-them>.

²⁶ *Id.* at 3

²⁷ Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>.

²⁸ See Kristin F. Butcher & Diane Whitmore Schanzenbach, Ctr. On Budget & Policy Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours*, in *Volatile Jobs* figure 6 (2018), <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>.

²⁹ *Id.* (adding percentages in figure 6 for a total of 32.9%); See also Josh Bivens and Shawn Fremstad, Economic Policy 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->

consistent, predictable hours each month – they 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.³⁰ 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.³¹

Moreover, these fields experience high rates of *involuntary* part-time employment—meaning workers wanted to work full-time hours but were only offered part-time hours—with the retail, trade, and leisure and hospitality industries ranking highest.³² Thus, even when workers do work a substantial number of hours throughout the year, they are likely to experience periods with less or no work.³³ As a result of the churn and volatility in the low-wage labor 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 the year.³⁴

Nor will volunteering or other un-paid activities be a viable solution for Medicaid enrollees. The same barriers to finding work, such as lack of internet access and lack of transportation, make it difficult for low-income individuals to complete volunteer activities. 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

[hours-tests-in-snap-and-medicaid-would-harm-workers-and-do-nothing-to-raise-employment/](#) (reporting data from 2016 listing the most common occupations for workers receiving SNAP or Medicaid).

³⁰ Susan J. Lambert et al., Univ. of Chicago, *Precarious Work Schedules among available at Early-Career Employees in the US: A National Snapshot* (2014),

https://ssascholars.uchicago.edu/sites/default/files/work-scheduling-study/files/lambert.fugiel.henly_precarious_work_schedules.august2014_0.pdf; Stephanie Luce et al., Retail Action Project, *Short Shifted* (2014),

http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben- Ishai, Ctr. for Law and Social Policy, *Volatile Job Schedules and Access to Public Benefits* (2015)

<http://www.clasp.org/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>; Josh Bivens & Shawn Fremstad, Economic Policy 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-medicaid-would-harm-workers-and-do-nothing-to-raise-employment/>;

Tanya L. Goldman et al., Ctr. for Law and Social Policy, *The Struggles of Low Wage Work* (2018),

https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf.

³¹ Tanya L. Goldman et al., *supra* note 30.

³² Josh Bivens & Shawn Fremstad, *supra* note 30; Tanya L. Goldman et al., *supra* note 30.

³³ Kaiser Family Found., *What do Different Data Sources Tell Us About Medicaid and Work?* (2018), <https://www.kff.org/medicaid/fact-sheet/what-do-different-data-sources-tell-us-about-medicaid-and-work/>.

³⁴ Aviva Aron-Dine et al., Ctr. On Budget & Policy 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>.

minimum wage in exchange for hours they work.³⁵ FLSA concerns will also limit the number of recurring, stable volunteer opportunities that are available.

The work requirement will also hit individuals with chronic and disabling conditions particularly hard, and the State’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 health-related barriers to work. Moreover, many individuals who *do* have a disability that meets the SSI standard rely on Medicaid while their applications for disability benefits are pending—a process that regularly lasts years.³⁶

And to be clear, many individuals in the expansion 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.³⁷ In Kentucky, the numbers are even more dramatic: 51% of adult Medicaid enrollees who were not receiving disability benefits reported not working because of an illness or disability.³⁸ A separate study reports that among Medicaid enrollees in Kentucky who are likely subject to the work requirement and not already working, 41% report one or more serious health limitations.³⁹ Twenty-one percent report serious problems concentrating, remembering, or making decisions, and 26% report serious problems walking or climbing stairs.⁴⁰

³⁵ See 29 U.S.C. § 206(a)(1)(C); Dep’t of Labor, *How Workplace Laws Apply to Welfare Recipients 2* (1997), <http://nclj.org/wp-content/uploads/2015/11/LaborProtectionsAndWelfareReform.pdf>.

³⁶ Recent data shows that when a disability denial 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 denials have been reversed at a hearing or subsequent review. Soc. Security Admin., *Outcomes of Applications for Disability Benefits* Table 63, 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 and SSDI “allowance” rates at the hearing level or above of 53.7% in 2014 and 48.8% in 2015).

³⁷ 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>

³⁸ *Id.* at 10 (Appendix, Table 2).

³⁹ Anuj Gangopadhyaya and Genevieve M. Kenney, *supra* note 25.

⁴⁰ Anuj Gangopadhyaya and Genevieve M. Kenney, *supra* note 25, at 3.

Moreover, of the Medicaid enrollees in Kentucky who are likely subject to the work requirement and not already working, nearly half (48%) are above age 50, and, therefore, more than twice as likely to develop a disability than younger adults.⁴¹ Age and disabilities can create barriers to working, especially where work is physically demanding and involves standing, lifting, or other physical activities.⁴²

In addition, people with disabilities experience discrimination at various stages of employment, including at hiring, resulting in low employment rates and wage levels; for example, employees with disabilities that would not affect their job performance are 26% less likely to be considered for employment.⁴³ In addition, compared to people without a disability, people with a disability are 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.⁴⁴

While Kentucky proposes to exempt individuals who are “medically frail” or who have a verified, acute medical condition that would prevent them from working, evidence from other programs with similar exemptions shows that individuals with disabilities are not exempted as they should be and are more likely than other individuals to lose benefits.⁴⁵ Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical or mental health conditions are disproportionately likely to be sanctioned for not completing the work requirement.⁴⁶

⁴¹ MaryBeth Musumeci, Julia Foutz & Rachel Garfield, Kaiser Family Found., *How Might Older Nonelderly Medicaid Adults with Disabilities Be Affected By Work Requirements in Section 1115 Waivers?* (Mar. 30, 2018), <https://www.kff.org/medicaid/issue-brief/how-might-older-nonelderly-medicaid-adults-with-disabilities-be-affected-by-work-requirements-in-section-1115-waivers/>.

⁴² *Id.* at 5.

⁴³ 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.

⁴⁴ 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>.

⁴⁵ 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).

⁴⁶ See, e.g., Yeheskel Hasenfeld *et al.*, *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper, Univ. of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers; Vicki Lens, *supra* note 45; MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>; Mathematica Policy 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.,

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.⁴⁷ 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.⁴⁸ 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.⁴⁹ State officials acknowledged that hundreds of enrollees had been wrongly classified as “able-bodied” when they were actually unable to work.⁵⁰

Moreover, data from Maine – which Kentucky cites as a positive example – demonstrates that “hardship” extensions in its TANF program were not effective at protecting individuals with a disability. The Maine Department of 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.⁵¹ Several beneficiaries reported being denied disability-related extensions even though they were in the process of applying for – and ultimately received – SSI benefits.⁵² Furthermore, beneficiaries reported being discouraged from applying for

Disconnected Welfare Leavers Face Serious Risks (2002), <http://www.urban.org/sites/default/files/publication/59036/310839-Disconnected-Welfare-Leavers-Face-Serious-Risks.PDF>.

⁴⁷ 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>.

⁴⁸ Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_204-2015-v3.pdf.

⁴⁹ *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>.

⁵⁰ *Id.*

⁵¹ 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.

⁵² Thomas Chalmers McLaughlin & Sandra S. Butler, *supra* note 51.

extensions by TANF caseworkers and confusion about the process for applying for hardship extensions.⁵³

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.⁵⁴ 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.⁵⁵

Evidence also shows that the work requirement may disproportionately harm people of color. One study found that caseworkers are more likely to sanction African American (as opposed to white) TANF participants for noncompliance with program requirements.⁵⁶ The study raises serious concerns that people of color will be more likely to lose Medicaid coverage due to the work requirement, further increasing racial disparities in Kentucky.

b. 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/or the reporting process and will lose coverage due to documentation errors.⁵⁷

Duplicative research shows that when states impose new administrative requirements on Medicaid enrollees, enrollment declines.⁵⁸ For example, in 2003, Texas experienced

⁵³ Thomas Chalmers McLaughlin & Sandra S. Butler, *supra* note 51.

⁵⁴ 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).

⁵⁵ See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

⁵⁶ 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).

⁵⁷ See, e.g., Robin Garfield et al., *supra* note 19; Jennifer Wagner & Judith Solomon, Ctr. On Budget & Policy 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>.

⁵⁸ See Wagner & Solomon, *supra* note 57, at 3-4; Michael Perry et al., 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., *Improving Medicaid's Continuity of Coverage and Quality of*

a nearly 30% enrollment decline after it increased premiums, established a waiting period, and moved from a 12- to 6-month renewal period for children in CHIP.⁵⁹ 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.⁶⁰ Enrollment quickly rebounded when the State reinstated the 12-month renewal period and continuous eligibility.⁶¹

There are several reasons for this. Inevitably, the State will make mistakes in implementing the requirement, causing some number of erroneous coverage losses.⁶² Indeed, when Kentucky launched its new electronic eligibility system in 2016, thousands of individuals erroneously lost coverage as a result of glitches and errors in the new computer system.⁶³

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.⁶⁴ For example,

Care, Association for Community Affiliated Plans 12-16 (2009)
<http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>.

⁵⁹ 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-medicicaid-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-medicicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/>).

⁶⁰ *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process*, *supra* note 59 (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* (Oct. 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>; and Laura Summer and Cindy Mann, Commonwealth Fund, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies* (June 2006), <http://www.commonwealthfund.org/publications/fund-reports/2006/jun/instability-of-public-health-insurance-coverage-for-children-and-their-families--causes--consequence>).

⁶¹ *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process*, *supra* note 59.

⁶² See Wagner & Solomon, *supra* note 57 at 13-14.

⁶³ Deborah Yetter, *New Ky benefits system disrupting aid for many*, COURIER JOURNAL, March 25, 2016, <https://www.courierjournal.com/story/news/politics/2016/03/25/new-ky-benefits-system-disrupting-aid-many/82206656/>.

⁶⁴ See Wagner & Solomon, *supra* note 57 at 12-13; Robin Garfield et al., *supra* note 19; 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?nytapp=true&_r=0.

research shows that in Kentucky, 42% of Medicaid enrollees lack broadband access and 19% lack any Internet access.⁶⁵ Many individuals likewise lack transportation, which could make providing documentation to the Medicaid agency in a timely manner even more difficult.⁶⁶ The logistical barriers that prevent individuals from providing required paperwork have been documented in the SNAP program as well, where otherwise eligible individuals lose coverage due to reporting requirements at recertification.⁶⁷

Others may be dissuaded from enrolling in the first place, given the perceived complexity of the work requirements.⁶⁸ 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.⁶⁹

Finally, confusion will result in significant coverage losses. One consistent finding from past waiver projects adding various accounts, premiums, or cost-sharing, is that beneficiaries are often confused about the program's requirements, and therefore do not participate. Adding complicated work requirements, with a host of exemptions, exceptions, and supposed "on-ramps" back to eligibility will create confusion and uncertainty about the program's rules.⁷⁰ Moreover, most Medicaid enrollees do not directly interact with a caseworker when applying for or renewing coverage and will only

⁶⁵ Anuj Gangopadhyaya and Genevieve M. Kenney, *supra* note 25.

⁶⁶ Anuj Gangopadhyaya and Genevieve M. Kenney, *supra* note 25.

⁶⁷ 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* (2018), http://research.upjohn.org/cgi/viewcontent.cgi?article=1306&context=up_workingpapers.

⁶⁸ Michael Perry *et al.*, *supra* note 58; Judith Solomon, Ctr. on Budget & Policy 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.

⁶⁹ Michael Perry *et al.*, *supra* note 58, at 10-12.

⁷⁰ See MaryBeth Musumeci *et al.*, Kaiser Family Found., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* (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.*, *Improving Medicaid's Continuity of Coverage and Quality of Care*, Association for Community Affiliated Plans, 3 (2009) <http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf> (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.").

receive information about the work requirements through long, complex paper notices.⁷¹ Navigating the notices, reporting, and exemption processes may be especially challenging for individuals with a mental illness that affects cognitive functioning.⁷² Individuals who have limited English proficiency or are less-educated may find these notices particularly confusing. Thus, adding additional reporting and verification requirements is likely to also exacerbate health disparities within Kentucky.⁷³

In short, the evidence shows that reducing enrollees' administrative burdens increases coverage.⁷⁴ 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.⁷⁵ The Commonwealth's proposal to require monthly reporting for enrollees who are working or qualify for an exemption directly undercuts those efforts and will decrease enrollment.

c. Employer-Sponsored Insurance and Marketplace Coverage Are Unavailable and Unaffordable for the Kentucky HEALTH Population

Proponents of imposing a work requirement on Medicaid enrollees claim that individuals who lose Medicaid coverage will not become uninsured. Instead, the work requirement will lead people to jobs, and these jobs will provide private health coverage. However, redundant research refutes both elements of this claim.

First, studies of cash assistance programs show that work requirements do not increase stable, long-term employment.⁷⁶ Kentucky's reliance on Maine's preliminary report on

⁷¹ See Wagner & Solomon, *supra* note 57 at 12.

⁷² 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>.

⁷³ Michael Perry *et al.*, *supra* note 58, at 9.

⁷⁴ *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process*, *supra* note 59.

⁷⁵ See Wagner & Solomon, *supra* note 57 at 12; *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process*, *supra* note 59.

⁷⁶ See LaDonna Pavetti, Ctr. On Budget & Policy Priorities, *Work Requirements Don't Work* (2018), <https://www.cbpp.org/blog/work-requirements-dont-work>; LaDonna Pavetti, Ctr. On Budget & Policy 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 & Policy Priorities, *Evidence Doesn't Support Claims of Success of TANF Work Requirements* (2018), <https://www.cbpp.org/research/family-income-support/evidence->

SNAP work requirements is misplaced.⁷⁷ More recent studies show that the evaluation was based on flawed and unreliable data, and as a result, reached flawed and misleading conclusions.⁷⁸ 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.⁷⁹ 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.⁸⁰

There is no reason to expect better employment outcomes for Medicaid enrollees in Kentucky, particularly given the poor economic conditions in some areas of the

[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) (attached); 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>; Admin. for Children & Families, Dep't of Health & Human Servs., *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 and LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (Jan. 23, 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); MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>.

⁷⁷ See *Kentucky HEALTH: Helping to Engage and Achieve Long Term Health* 17 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-pa.pdf> (hereinafter "Application").

⁷⁸ 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>.

⁷⁹ Maine Equal Justice Partners, *supra* note 78, at 5.

⁸⁰ *Id.*

Commonwealth. In fact, recognizing the lack of available employment, the U.S. Department of Agriculture has waived the work requirement and time limits for “able-bodied adults without dependent children” enrolled in SNAP in 100 of the 120 counties in Kentucky.

Data regarding the current labor market underscores why work requirements will not result in long-term employment. Medicaid enrollees face low wages, stagnant wage growth, and volatile job prospects.⁸¹ Evidence shows that even when individuals in the low-wage market work a substantial amount in one year, there is no guarantee they see increased work or wages in the next year.⁸² In fact, those who had substantial work in one year were likely to experience drops in their income, hours, and wages the following year.⁸³

For similar reasons, the work requirements are also unlikely to increase incomes long-term. In fact, 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 lost their eligibility for cash assistance.⁸⁴ Even if individuals do meet the work requirements, they are unlikely to obtain sustainable gains in income. An individual who works full-time (40 hours a week) for the full year (52 weeks) at the federal minimum wage (\$7.25 an hour) would earn an annual salary just over \$15,000 a year, still below the 138% of FPL income threshold for the Medicaid expansion population for a family of one. Thus, there is no guarantee that work will reduce demand for Medicaid.⁸⁵

⁸¹ See Kristin F. Butcher & Diane Whitmore Schanzenbach, Ctr. On Budget & Policy Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours*, in *Volatile Jobs* (2018), <https://www.cbpp.org/research/poverty-and-inequality/most-workers-in-low-wage-labor-market-work-substantial-hours-in>.

⁸² *Id.*

⁸³ *Id.*

⁸⁴ LaDonna Pavetti, Ctr. On Budget & Policy 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>. Tazra Mitchell and LaDonna Pavetti, Ctr. On Budget & Policy 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>.

⁸⁵ See also MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017) <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>.

Kansas's experience reinforces the conclusion that even those individuals who leave TANF because of work do not experience a significant or lasting increase in income.⁸⁶ Kansas 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% of the FPL for a family of two).⁸⁷ However, a more recent analysis of state-collected data on employment and earnings of Kansas parents leaving TANF between October 2011 and March 2015 shows that the long-term results in Kansas are much worse than previous evidence suggested. Almost two thirds of parents had "deep poverty earnings," earnings below 50% of FPL, in the year after exiting TANF.⁸⁸ Four years after exiting the program, the numbers were nearly the same.⁸⁹ At that time, the median earnings of parents who left due to work sanctions were especially low: \$2,175 (or 11% of FPL).⁹⁰ 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.⁹¹ For parents who were terminated from TANF due to time limits, median income was even lower, just \$1,370 (7% of FPL).⁹²

The TANF-to-poverty ratio in Kansas provides further evidence that the reduction in Kansas's 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.⁹³

Thus, the research from TANF shows that threatening to take Medicaid coverage away will not improve employment outcomes or increase income. In contrast, the research examining the relationship between Medicaid enrollment and employment shows that Medicaid is itself a critical work support. Medicaid coverage allows individuals to access

⁸⁶ 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% made >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/>.

⁸⁷ Meg Wingenter, *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>.

⁸⁸ Mitchell & Pavetti, *supra* note 84.

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ Ife Floyd, LaDonna Pavetti, and Liz Schott, Ctr. on Budget & Policy Priorities, *TANF Reaching Few Poor Families* (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 grew from 14,400 to 16,100. See Ctr. on Budget and Policy Priorities, *Kansas' TANF Cash Assistance is Disappearing for Poor Families*, https://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ks.pdf.

the care and services they need to obtain and maintain work.⁹⁴ 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.⁹⁵

Claims that Medicaid creates a work disincentive ignore this more recent and robust evidence from states' experience with the Medicaid expansion. For instance, the recent report from the White House's Council of Economic Advisors relies solely on data that pre-dates the 2014 Medicaid expansion. The lead finding in that report, regarding the rates of employment for Medicaid beneficiaries, is drawn from December 2013 data. Moreover, by relying on a single month of data, the CEA report overestimates the percent of individuals who are not working – due to the realities of seasonal work and volatile work schedules (as described in detail above), individuals might work few or no hours one month, but full-time the following month. Likewise, each of the studies the CEA cites concerning the relationship between Medicaid coverage and labor force participation predates, or relies on data that pre-dates the Medicaid expansion.⁹⁶ But, more recent findings “rule out the large change found in one influential pre-ACA study,” relied on by the CEA.⁹⁷ Moreover, each of the CEA studies also take a short-term view – they do not examine how gaining or losing Medicaid relates to employment over the

⁹⁴ Inst. for Healthcare Policy & 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>.

⁹⁵ Ohio Dep't of Medicaid, *supra* note 94.

⁹⁶ The CEA report cites three studies and a 2014 CBO estimate of the ACA's overall economic impact: Garthwaite, C., Gross, T., and Notowidigdo, M. J., *Public health insurance, labor supply, and employment lock*, 129 QUARTERLY J. ECONOMICS 653 (2014); Dave, D., Decker, S. L., Kaestner, R. and Simon, K. I., *The effect of Medicaid expansions in the late 1980s and early 1990s on the labor supply of pregnant women*, 1 AM. J. HEALTH ECONOMICS 165 (2015); L. Dague et al., *The effect of public insurance coverage for childless adults on labor supply*, 9 AM. ECONOMIC J.: ECONOMIC POLICY 124 (2017). While Dague et al was published in 2017, it relied on data from Wisconsin in 2009 and cautioned that extrapolating to the Medicaid expansion in general might not be possible.

⁹⁷ Angshuman Gooptu et al., *Medicaid Expansion Did Not Result In Significant Employment Changes Or Job Reductions In 2014*, 35 HEALTH AFFAIRS 747 (2015) (attached). See also Robert Kaestner et al., Nat'l Bureau of Economic Research, *Effects of ACA Medicaid Expansions on Health Insurance Coverage and Labor Supply* (2015) (“Given this evidence, it appears that the Medicaid expansions did not have a significant effect on labor supply in the two years subsequent to its implementation. Moreover, the small and relatively precise estimates rule out all but the smallest negative effects of the Medicaid expansions on labor supply.”) (attached).

long-term. A recent comprehensive literature review shows that there is a positive, or at worst, neutral impact of the Medicaid expansion on labor force participation.⁹⁸

There are other reasons to question the studies cited by the CEA. In particular, the Garthwaite et al., study is widely regarded as an outlier and has been criticized for a problematic research design that analyzed changes in broad demographic groups, rather than studying the effects on individuals who were and were not on Medicaid.⁹⁹ Moreover, that study was not specific to Medicaid, but analyzed “public insurance,” which included Medicaid, Medicare, and military coverage.¹⁰⁰ Thus, the weight of evidence strongly disputes the notion that there is any meaningful work disincentive from receipt of Medicaid benefits.

Second, even Medicaid enrollees who do find employment are unlikely to have access to health coverage through their employer. 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.¹⁰¹ For part-time workers, only 13% of those with incomes below poverty and 20% of those with incomes between 100 and 25 % of FPL were offered health insurance by their employer.¹⁰² 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.¹⁰³ 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.¹⁰⁴ 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

⁹⁸ See Larisa Antonisse et al., Kaiser Family Found., *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review* (2018), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Medicaid-Expansion-Under-the-ACA-Updated-Findings-from-a-Literature-Review>.

⁹⁹ See e.g., Bowen Garrett and Robert Kaestner, Urban Inst., *The Best Evidence Suggests the Effects of the ACA on Employment Will Be Small* 4 (2014), <https://www.urban.org/sites/default/files/publication/44321/413109-the-best-evidence-suggests-the-effects-of-the-aca-on-employment-will-be-small.pdf>.

¹⁰⁰ *Id.*

¹⁰¹ 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>.

¹⁰² *Id.*

¹⁰³ Josh Bivens and Shawn Fremstad, Economic Policy Inst., *Why Punitive Work-Hours Tests In SNAP And Medicaid Would Harm Workers And Do Nothing To Raise Employment* (2018) <https://www.epi.org/publication/why-punitive-work-hours-tests-in-snap-and-medicaid-would-harm-workers-and-do-nothing-to-raise-employment/>.

¹⁰⁴ Tanya L. Goldman et al., *supra* note 30.

distribution, just 16% had access to dental coverage and 8-9% had access to vision insurance.¹⁰⁵

Given these figures, researchers have estimated that fewer than 2,000 Kentucky HEALTH enrollees could gain access to ESI.¹⁰⁶ This number stands in stark contrast to the thousands and thousands of low-income individuals who will lose health coverage as a result of the work requirement.

And even if ESI is offered, it is unaffordable for this group. 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.¹⁰⁷ Evidence from TANF confirms this: among “welfare-leavers” there were significant reductions in health insurance coverage that were not offset by smaller increases in private coverage.¹⁰⁸

Third, like ESI, Marketplace coverage is not an adequate substitute for Medicaid for the expansion population. Individuals with incomes below 100% of FPL do not have access to subsidized coverage through the Marketplace. In addition, research shows that not providing *Medicaid* coverage for individuals with incomes from 101-138% of FPL could lower coverage rates and increase out-of-pocket expenses.¹⁰⁹ One comprehensive study found that among individuals in this income bracket, access to Medicaid coverage (as opposed to access to a Marketplace plan) reduced the uninsurance rate by 4.5% and total average out-of-pocket spending by nearly 34% (or \$344 annually).¹¹⁰ In fact, the study found that

¹⁰⁵ 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>.

¹⁰⁶ Aviva Aron-Dine, *supra* note 20.

¹⁰⁷ 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>.

¹⁰⁸ Antonisse & Garfield, Kaiser Family Found., *supra* note 135.

¹⁰⁹ Fredric Blavin et al., *Medicaid Versus Marketplace Coverage for Near-Poor Adults: Effects On Out-of-Pocket Spending and Coverage*, 37 HEALTH AFFAIRS 299 (2018) (attached).

¹¹⁰ *Id.* at 304-305.

Medicaid expansion was associated with lower average out-of-pocket premium spending (-\$125), a lower probability of having a high out-of-pocket premium spending burden (that is, premium spending more than 10 percent of income) (-2.6 percentage points), and a lower probability of having any out-of-pocket premium spending (-7.5 percentage points). . . . Medicaid expansion was associated with lower average cost-sharing spending (-\$218) and a lower probability of having any cost-sharing (-7.0 percentage points).¹¹¹

For individuals who do enroll in a marketplace plan despite the costs, the heightened cost-sharing amounts reduce access to care. As discussed in section III.B. below, even small cost-sharing amounts (\$1-\$5) deter individuals from accessing care.¹¹² Data from Wisconsin confirms that absent Medicaid coverage, a substantial number of individuals become uninsured. When Wisconsin eliminated Medicaid coverage for adults with incomes from 101-200% of FPL in 2014, over 62,000 people lost Medicaid coverage, and 42% of them were uninsured or their insurance status was unknown—despite access to subsidized insurance on the Marketplace.¹¹³ Differences in out-of-pocket spending may also be exacerbated in rural areas, where premiums on the Marketplace are higher, which may in turn exacerbate the number of individuals that remain uninsured.¹¹⁴

Taken together, the evidence demonstrates that the work requirement will lead to a large number of individuals, including those who are already working and those who qualify for an exemption from the requirement, losing Medicaid coverage and remaining uninsured, with serious consequences for their health and well-being. This outcome is in direct conflict with the objectives of the Medicaid Act.

A far more productive (and permissible) approach would be to connect Medicaid expansion enrollees to properly resourced voluntary employment programs, an activity

¹¹¹ *Id.* at 303.

¹¹² Samantha Artiga, Petry Ubri, and Julia Zur, Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

¹¹³ Kids Forward, *The Wisconsin Approach to Medicaid Expansion* (2017), <http://kidsforward.net/assets/Medicaid-Approach.pdf>.

¹¹⁴ Abigail R. Barker et al., RUPRI Ctr. for Rural Health Policy Analysis *Health Insurance Marketplaces: Premium Trends in Rural Areas* (2016), <https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2016/HIMs%20rural%20premium%20trends.pdf>.

that does not need waiver approval from CMS.¹¹⁵ 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.¹¹⁶ 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.¹¹⁷ During HELP-Link's first three years, 22,000 Medicaid enrollees received services.¹¹⁸ The State has reported that program participants have high employment rates, and the majority of participants had higher wages after completing the program.¹¹⁹

2. The Work Requirement Will Be Expensive

The administrative costs associated with implementing the work requirement are high.¹²⁰ 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.¹²¹ Kentucky is spending close to \$374 million over two years on the project.¹²² Other states have likewise described significantly increased costs associated with waiver projects that condition Medicaid on work

¹¹⁵ The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

¹¹⁶ 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>.

¹¹⁷ See Hannah Katch, Ctr. On Budget & Policy 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>.

¹¹⁸ *Id.*

¹¹⁹ 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.

¹²⁰ 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 57, at 15-16 (listing state estimates of the cost associated with implementing a work requirement).

¹²¹ Bruce Japsen, *supra* note 120.

¹²² Deborah Yetter, *Bevin's Medicaid changes actually mean Kentucky will pay more to provide health care*, LOUISVILLE COURIER JOURNAL, Feb. 14, 2018, <https://www.courier-journal.com/story/news/politics/2018/02/14/kentucky-medicaid-changes-bevin-work-requirements/319384002/>.

activities. For instance, Michigan estimated that a work requirement would cost the State \$15 to \$30 million every year.¹²³ Minnesota projected implementing a work requirement would cost local governments \$121 million in 2020 and \$163 million in 2021.¹²⁴

The costs to Kentucky would continue to rise if Kentucky HEALTH were implemented. The State must, among other things, track work hours or participation in work-related activities, 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.¹²⁵ Evidence shows that churn on and off Medicaid increases both administrative and medical costs to the state. Because the work requirement will result in increased churning between enrollment, suspension, and disenrollment, Kentucky will incur substantially higher administrative costs per-beneficiary than continuous enrollment.¹²⁶ Hospitals and community health centers will also face increased uncompensated care costs when individuals who do not comply with the work requirement lose coverage.¹²⁷

Notably, Kentucky 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.¹²⁸ Adult Medicaid enrollees who are not receiving disability

¹²³ Wagner & Solomon, *supra* note 57, at 15-16.

¹²⁴ Wagner & Solomon, *supra* note 57, 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.

¹²⁵ Wagner & Solomon, *supra* note 57, at 4-6 (providing a list of added administrative burdens for states that implement a Medicaid work requirement); MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017) <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience> (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>.)

¹²⁶ Leighton Ku et al., *Improving Medicaid's Continuity of Coverage and Quality of Care*, Association of Community Affiliated Plans 1 (2009), <http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>.

¹²⁷ See, e.g., Jessica Schubel & Matt Broaddus, Ctr. on Budget & Policy 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>.

¹²⁸ 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>

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%).¹²⁹ Spending millions of dollars to target such a small percentage of Medicaid enrollees—while cutting coverage for others—is not consistent with the objectives of the Medicaid program.

3. The Studies Cited by Kentucky and CMS on Work and Health Do Not Support Imposing a Work Requirement

Kentucky maintains that the work requirement will “improve health and well-being” by incentivizing work and community engagement. 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.¹³⁰

Nor do any of the additional studies CMS considered when it last evaluated Kentucky HEALTH. For instance, CMS reviewed a Robert Wood Johnson report evaluating the relationship between employment and health.¹³¹ That article shows that the quality of employment matters. Stable, high-wage jobs in safe working environments might be associated with better health outcomes, but “working poor” status “is associated with health challenges as well.”¹³² Other studies explain that “high strain” jobs, or jobs with little reward or recognition, can increase poor health outcomes, such as high blood pressure and cardiovascular disease.¹³³ The Robert Wood Johnson report also explains that the increased access to health insurance that comes with stable employment accounts for a large part of the link between employment and health.¹³⁴ 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.

(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).

¹²⁹ *Id.* at 4.

¹³⁰ Letter from Jane Perkins, Nat'l Health Law Program, to Brian Neale, Dir. Ctrs. for Medicare & Medicaid Servs. (Jan. 11, 2018) (attached).

¹³¹ Robert Wood Johnson Foundation, *Issue Brief: How Does Employment—or Unemployment—Affect Health?* (2013) https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360.

¹³² *Id.*

¹³³ Douglas Jacobs, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health*, HEALTH AFFAIRS BLOG (Aug. 6, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180730.371424/full/>

¹³⁴ Robert Wood Johnson Found., *How Does Employment—or Unemployment—Affect Health?* (2013) https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360.

There are also good reasons to question whether these studies are applicable to the Medicaid population, or applicable to *required* work as a condition of Medicaid eligibility. As a recent comprehensive literature review concludes, “the large body of research on the link between work and health indicates that proposed policies requiring work as a condition of Medicaid eligibility may not necessarily benefit health among Medicaid enrollees and their dependents, and some literature also suggests that such policies could negatively affect health.”¹³⁵

When CMS last considered this request, it also looked at a handful of studies finding a correlation between volunteering and health.¹³⁶ Kentucky is proposing to *require* volunteering, and two studies CMS reviewed found the positive correlation diminished when volunteering was seen as obligatory.¹³⁷ Critically, none evaluated the 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.¹³⁸ Another report focused on the health benefits for an older adult population and found a weaker correlation between health and volunteering among younger adults.¹³⁹ A comprehensive literature review concluded that there is “limited existing evidence that volunteer activities benefit health outcomes.”¹⁴⁰

Even if it were true that working and/or volunteering leads to better health, Kentucky is ignoring the detrimental effect that the work requirement 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 suffer worse health outcomes and increased medical debt and financial insecurity. (See the extensive discussion below on coverage loss and its consequences.)

¹³⁵ Larisa Antonisse & Rachel Garfield, Kaiser Family Found., *The Relationship Between Work and Health: Findings from a Literature Review* (2018), <https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/>.

¹³⁶ 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. HEALTH & SOCIAL BEHAVIOR 115 (2001).

¹³⁷ Robert Grimm, Jr. et al., *supra* note 136; Peggy A. Thoits & Lyndi N. Hewitt, *Volunteer Work and Well-Being*, 42 J. HEALTH & SOCIAL BEHAVIOR 115 (2001).

See also Antonisse & Garfield, Kaiser Family Found., *supra* note 135.

¹³⁸ See Jens Detollenaere, Sara Willems & Stijn Baert, *supra* note 136; Peggy A. Thoits & Lyndi N. Hewitt, *supra* note 136.

¹³⁹ Robert Grimm, Jr. et al., *supra* note 136.

¹⁴⁰ Antonisse & Garfield, Kaiser Family Found., *supra* note 135.

In addition to jeopardizing the health of adults enrolled in the Medicaid expansion, the proposed work requirement puts the health and well-being of their children at risk. Research shows a strong correlation between parents having Medicaid coverage and their children receiving recommended preventive services.¹⁴¹

B. Premiums

Kentucky received permission to impose premiums of up to 4% of household income on individuals enrolled in Kentucky HEALTH. In general, individuals subject to the requirement will not receive Medicaid coverage until the first day of the month in which they pay the premium. Once enrolled, individuals above 100% of FPL who do not pay their monthly premium will be terminated from Medicaid and prohibited from re-enrolling for six months. They will also have money deducted from their My Rewards account. Individuals below 100% of FPL who do not pay their monthly premium will: (1) have money deducted from their My Rewards account; (2) lose access to their My Rewards account for a period of six months; and (3) be subject to cost sharing in lieu of premiums for a period of six months.

Section 1115 does not permit the Secretary to allow Kentucky to implement these premiums and associated consequences for failure to pay. First, the Medicaid Act prohibits states from charging premiums to individuals with household income below 150% of FPL.¹⁴² These limits exist outside of § 1396a, and as a result, cannot be waived under § 1115. Time and again, Congress has made clear its intent to insulate the substantive limits on premiums and cost-sharing from waiver under § 1115. In 1982, Congress removed the substantive limits on premiums and cost-sharing from § 1396a and transferred them to a new § 1396o, which imposes independent obligations on states.¹⁴³ Since then, Congress has made repeated changes to the limits, confirming that changes in the flexibilities available to states to charge premiums must come from Congress, not from HHS.¹⁴⁴

¹⁴¹ 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>.

¹⁴² 42 U.S.C. §§ 1396o(a)(1), (c)(1), 1396o-1(b)(1).

¹⁴³ Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.

¹⁴⁴ See Omnibus Reconciliation Act of 1987, Pub. L. No. 100-203, § 4101(d)(1), 101 Stat. 1330, 1330-141 to -142 (authorizing premiums on pregnant women and infants with incomes over 150% of FPL); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6408(d)(3)(B), (C), 103 Stat. 2106, 2269 (codified at 42 U.S.C. § 1396o(d)) (authorizing premiums for certain working individuals with disabilities who have incomes over 150% of FPL); Deficit Reduction Act of 2005, Pub. L. 109-171, § 6041-6043, 120 Stat 6, 81, 85, 86 (2006) (adding 42 U.S.C. § 1396o-1).

Second, the premiums and associated consequences are not experimental and conflict with the objectives of the Medicaid Act. Redundant research proves that premiums deter and reduce enrollment among low-income individuals.¹⁴⁵ Numerous studies, conducted over the course of almost two decades, have examined the effects of imposing premiums in Medicaid and CHIP.

These studies show the same patterns – people facing premiums are less likely to enroll, more likely to drop coverage, and more likely to become uninsured.¹⁴⁶ These effects become more pronounced as income decreases.¹⁴⁷

¹⁴⁵ See, e.g., Samantha Artiga et al., Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), <http://files.kff.org/attachment/Issue-Brief-The-Effects-of-Premiums-and-Cost-Sharing-on-Low-Income-Populations>; Brendan Saloner et al., *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016), <http://pediatrics.aappublications.org/content/137/3/e20152440>.

¹⁴⁶ See, e.g., Leighton Ku & Teresa Coughlin, *Sliding Scale Premium Health Insurance Programs: Four States' Experiences*, 36 INQUIRY 471 (1999/2000) (finding that among low-income enrollees, premiums as low as 1% of household income reduce enrollment by approximately 15%, and premiums of 3% of household income reduce enrollment by approximately 50%) (attached); Utah Dep't of Health, Office of Health Care Statistics, "Utah Primary Care Network Disenrollment Report" (2004) (requiring Medicaid enrollees below 150% of FPL to pay a yearly fee of \$50 forced approximately 5% of all participants not to renew enrollment in the program after one year, and the majority of those individuals reported not having insurance) (attached); Leighton Ku & Victoria Wachino, Ctr. on Budget & Policy Priorities, *The Effect of Increased Cost-sharing in Medicaid: A Summary of Research Findings* 7 (2005), <https://www.cbpp.org/archiveSite/5-31-05health2.pdf> (compiling existing research and concluding "[e]vidence indicates that premiums reduce Medicaid participation and make it harder for individuals to maintain stable and continuous enrollment" and noting that at least four states reconsidered, abandoned, or discontinued policies to implement premiums in Medicaid or CHIP due to concerns about declining enrollment and adverse health consequences); Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 INQUIRY 378, 380 (2006) (finding that imposing premiums on CHIP enrollees reduced initial enrollment and led to substantial disenrollment, and in some states disproportionately affected non-white individuals) (attached); Margo Rosenbach et al, Mathematica Pol. Research, Inc., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (2007), <http://www.mathematica-mpr.com/publications/pdfs/schipdecade.pdf> (noting that premiums and lockout provisions have been found to reduce retention in CHIP and that lockout provisions have been associated with both an increase in disenrollment and substantial decrease in reenrollment among individuals who lost coverage); Laura Dague, *The effect of Medicaid premiums on enrollment: A regression discontinuity approach* 37 J. HEALTH ECONOMICS 1 (2014), <https://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf> (finding that an increase in premiums from \$0 to \$10 each month reduced the likelihood of individuals remaining enrolled in Medicaid/CHIP for a full year by 12%).

¹⁴⁷ See, e.g., Samantha Artiga et al., *supra* note 145; Abdus S, Hudson J, Hill SC, Selden TM, *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFFAIRS 8, (2014), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2014.0182?url_ver=Z39.88-2003&rfr_id=ori%3Arid%3Acrossref.org&rfr_dat=cr_pub%3Dpubmed (finding that a premium increase of \$10 per month reduced enrollment in Medicaid and CHIP, with a greater effect on children below 150% of FPL); Georgetown Univ. Health Pol'y Inst., Ctr. for Children & Families, *Cost Sharing for Children and Families in Medicaid and CHIP* (2009), <http://ccf.georgetown.edu/wp->

For example, after Oregon imposed premiums ranging from \$6 to \$20 on certain Medicaid enrollees below 100% of FPL, nearly half of the affected enrollees lost coverage within the first six months. Of those who lost coverage, 40% identified the increase in premiums as the main reason for their disenrollment, and the percentage was much higher (68%) for individuals with income below 25% of FPL.¹⁴⁸ Further research examined the impact of the premiums after thirty months and found that only 33% of enrollees required to pay premiums remained continuously enrolled in the program over the thirty months, compared with 69% of enrollees not subject to premiums, and 32% of people who were required to pay premiums and lost Medicaid coverage remained uninsured.¹⁴⁹

In addition, recent data gathered from several states that have imposed premiums on the very populations that will be required to pay premiums under Kentucky HEALTH are similarly concerning. A significant portion of Medicaid enrollees who are subject to premiums cannot pay them, and in states that terminate enrollees if they do not pay premiums, thousands of Medicaid enrollees have lost coverage.¹⁵⁰ For example, evaluations of Indiana's § 1115 project indicate that premiums created barriers to both enrollment and continuous coverage. During the first year of the project, 23% of

[content/uploads/2012/03/Cost_sharing.pdf](#) (compiling research from eleven states showing that new or increased premiums reduce enrollment and/or increase disenrollment in CHIP and highlighting the disproportionate impact on lower-income children); Jill Boylston Herndon et al., *The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 HEALTH SERVS. RES. 458 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442374/> (finding that increasing premiums from \$15 to \$20 for children in families from 151-200% of FPL decreased length of enrollment, with a greater decrease among lower income children).

¹⁴⁸ Bill J. Wright et al., *The impact of increased cost sharing on Medicaid enrollees*, 24 HEALTH AFFAIRS 1106 (2005), <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.24.4.1106>.

¹⁴⁹ Bill J. Wright et al., *Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out*, 29 HEALTH AFFAIRS 2311 (2010), <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.0211>.

¹⁵⁰ See, e.g., Michigan Dep't of Health & Human Servs., *Michigan Adult Coverage Demonstration Section 1115, (01/01/2016 – 03/31/2016)* (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jan-mar-2016.pdf> (reporting that Medicaid enrollees paid 30% of premiums owed over the course of the quarter); Iowa Dep't of Human Servs., *CMS Quarterly Report, Iowa Wellness Plan, 4th Quarter 2015* (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-oct-dec-2015.pdf> (reporting that in November 2015, 6476 Medicaid enrollees were required to pay premiums as a condition of eligibility, and 3520 enrollees were terminated for not having paid premiums); State of Indiana, *Healthy Indiana Plan Section 1115 Quarterly Report (11/2015-01/2016)* (2016) <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-qtrly-rpt-nov-jan-2016-03312016.pdf> (reporting that nearly 40% of enrollees below 100% of FPL did not pay monthly premiums during the previous year, and during the previous quarter, 1,680 enrollees were terminated for not having paid premiums).

individuals who were found eligible for Medicaid and required to pay premiums as a condition of eligibility did not pay the initial premium, and as a result, did not receive coverage.¹⁵¹ In addition, the State terminated nearly 7% of enrollees who were required to pay premiums for failure to pay, with the termination rate increasing in the final months of the reporting period.¹⁵² Overall, 55% of individuals who were found eligible for the program did not pay at least one monthly premium, meaning they never received coverage, were terminated from the program, or were shifted to a plan with fewer benefits and higher cost sharing.¹⁵³ More recent data from Indiana paint an even darker picture. During the third year of the project, 18% of all enrollees with incomes above 100% of FPL lost Medicaid coverage for failure to pay their monthly premiums.¹⁵⁴ Notably, the statistic understates the effect of the premiums, as not all enrollees with incomes above 100% of FPL are required to pay premiums to maintain their Medicaid eligibility (*i.e.*, people who are pregnant, medically frail, or on transitional medical assistance). These findings add to the volume of research noted above showing that the Kentucky HEALTH premiums will deter and reduce enrollment.

Moreover, while enrollees below 100% of FPL will not lose coverage if they cannot pay the premiums, they will face significant harm, as they will be required to pay cost sharing for a period of six months. Nearly four decades of research demonstrates that imposing cost sharing on low-income individuals reduces access to medically necessary care and correlates with increased risk of poor health outcomes.¹⁵⁵ Enrollees in the expansion population will also lose all access to vision and dental services. (See section IV.B. below.)

¹⁵¹ The Lewin Group, *HIP 2.0: Power Account Contribution Assessment* ii (2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf> (examining data from Feb. 1, 2015 – Dec. 1, 2016). While half of these individuals reapplied and received coverage at a later date, the premium requirement left them without coverage for a period of time. The other half of these individuals never received Medicaid coverage. *Id.* at 12.

¹⁵² *Id.* at ii.

¹⁵³ *Id.* at 8-11.

¹⁵⁴ State of Ind., *Healthy Indiana Plan Demonstration, Section 1115 Annual Report, Demonstration Year 3 (02/01/17 – 01/31/18)* (2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2018-043018.pdf>.

¹⁵⁵ See, e.g., Leighton Ku & Victoria Wachino, *supra* note 146; Laura Snyder & Robin Rudowitz, Kaiser Fam. Found., *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* 11 (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>; David Machledt & Jane Perkins, Nat'l Health Law Program, *Medicaid Premiums and Cost Sharing* 2-14 (2014), file:///C:/Users/Catherine%20McKee/Downloads/NHeLP_IssueBriefMedicaidCostSharing_03262014.pdf.

In its application, Kentucky makes the incredible claim that charging Medicaid enrollees premiums will improve health outcomes, pointing to data from Indiana’s § 1115 project for support.¹⁵⁶ First, Kentucky mistakes correlation for causation with regard to imposing premiums and health care utilization. Indiana’s evaluation compares two disparate groups – those who paid premiums and those who did not – that differ markedly in health status, income, and other demographic factors known to correlate with care utilization. The evaluation does not control for these confounding factors and does not acknowledge that only the group that did not pay premiums was required to pay cost sharing for most services received. As discussed above, redundant evidence shows that cost sharing inhibits utilization of services and drug adherence. In fact, cost sharing would explain why the group that did not pay premiums showed better use of generic medications over brand name drugs.¹⁵⁷ Kentucky also ignores the health care utilization patterns for the tens of thousands of individuals who lost coverage due to Indiana’s premium policies. Those individuals had reduced access to care.¹⁵⁸ In short, there is no evidence to support the notion that imposing premiums on low-income enrollees will improve their health outcomes.

Kentucky also appears to claim that Kentucky HEALTH is necessary to maintain the long-term fiscal sustainability of its Medicaid program. However, implementing the premiums and associated consequences will be expensive. In fact, research shows that the costs of administering premiums in state Medicaid programs often exceeds the amount of the premiums collected from enrollees.¹⁵⁹ Thus, any money Kentucky will save by implementing the proposed premium policy will come from reduced enrollment in Medicaid.

¹⁵⁶ Application at 31 (citing The Lewin Group, *Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report* (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-eval-rpt-07062016.pdf>).

¹⁵⁷ The Lewin Group, *Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report* 83 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-eval-rpt-07062016.pdf>.

¹⁵⁸ *HIP 2.0: Power Account Contribution Assessment*, *supra* note 151 at 21-22.

¹⁵⁹ See e.g., Arizona Health Care Cost Containment System, *Fiscal Impact of Implementing Cost Sharing and Benchmark Benefit Provisions of the Federal Deficit Reduction Act of 2005* (2006), <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.482.6057&rep=rep1&type=pdf>; Tricia Brooks, Georgetown Ctr. for Children and Families, *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters* (2013), <https://ccf.georgetown.edu/2013/12/04/handle-with-care-how-premiums-are-administered-in-medicaid-chip-and-the-marketplace-matters/> (noting Virginia stopped imposing premiums on CHIP enrollees after data showed the State spent \$1.39 to collect each \$1 in premiums).

Finally, Kentucky appears to contend that the premiums and associated consequences will promote continuous coverage by preparing Medicaid enrollees to pay premiums in private insurance. This is nonsense. Many Medicaid enrollees are already familiar with private insurance. In addition, as described in detail above, the evidence shows that the Kentucky HEALTH premiums will undoubtedly interrupt continuous Medicaid coverage, leaving many individuals without any insurance at all.

C. Administrative Lockouts

Kentucky is seeking permission to impose a six-month lockout penalty on enrollees who do not complete the redetermination process in a timely way (the “redetermination lockout”). Kentucky is also proposing to impose a six-month lockout penalty on enrollees who do not report changes in household circumstances that affect their eligibility (the “reporting lockout”). The lockouts run directly counter to the purpose of the Medicaid program, as they will reduce coverage and access to health services. They also do not serve any experimental purpose.

In 2016, CMS rejected a request from Indiana to implement a redetermination lockout, finding that the penalty “is not consistent with the objectives of the Medicaid program, which include ensuring access to affordable coverage.”¹⁶⁰ CMS listed a number of reasons why completing redetermination could be “challenging” for low-income individuals, such as language access issues, frequent moves and other barriers to receiving mail, as well as disabling health conditions, including mental illness.¹⁶¹ CMS also expressed concerns that the lockout could impair access to treatment and medication that could prevent existing conditions from worsening.¹⁶² Notably, these same barriers often prevent Medicaid enrollees from reporting changes in income or household composition within the prescribed time period.

Data from Kentucky indicates that many enrollees will be subject to the redetermination lockout. According to Kentucky, in an average month, 8% of enrollees do not complete the redetermination process.¹⁶³ In December 2016, Kentucky terminated 8,264 individuals for not completing their renewal, and re-enrolled 4,981 of those individuals

¹⁶⁰ Letter from Vikki Wachino, Dir., CMS, to Tyler Ann McGuffee, Insurance and Healthcare Policy Dir., Office of Gov. Michael R. Pence, State of Indiana (July 29, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf> .

¹⁶¹ *Id.*

¹⁶² *Id.*

¹⁶³ Ky. Cabinet for Health & Family Servs., Responses to Questions from Ctrs. for Medicare & Medicaid Servs. (April 28, 2017) (attached).

(after the individuals submitted the required documentation within the grace period).¹⁶⁴ Thus, if the redetermination lockout were in place during that month, 3,283 individuals would have been prohibited from re-enrolling in the program for six months.

Kentucky contends that the lockouts are designed to encourage enrollees to comply with existing Medicaid rules. However, as CMS has recognized, enrollees often miss administrative deadlines due to circumstances outside of their control. Imposing an additional penalty on individuals who fail to meet the deadlines will do nothing to address those problems. Instead, it will only increase the complexity of the Medicaid program in Kentucky, which will deter enrollment (see section III.A.1.b. above) and cause otherwise eligible individuals to lose coverage.

Kentucky also claims that the lockouts are necessary to: (1) prepare individuals for private coverage; and (2) protect program integrity. Again, Congress did not design Medicaid to prepare individuals for private coverage. In addition, it is not clear how the lockouts could provide that preparation, as private insurance plans do not include similar administrative requirements. For example, private plans do not require enrollees to report changes in income or household characteristics. Private plans also do not require documentation for renewal of eligibility every year.

To the extent that Kentucky intends to target fraudulent conduct with the reporting lockout, existing federal law already gives Kentucky ample authority to address fraud. States must refer cases of suspected fraud to law enforcement officials.¹⁶⁵ Individuals convicted of fraud face substantial fines and imprisonment and may be prohibited from enrolling in Medicaid for up to one year.¹⁶⁶ There is no basis for allowing Kentucky to deny Medicaid coverage to eligible enrollees who have not been convicted of any wrongdoing. In addition, there is no evidence indicating that enrollee fraud is a problem in Kentucky.¹⁶⁷

Simply put, Kentucky designed the lockouts to take coverage away from individuals as punishment for failing to meet administrative deadlines. They will reduce Medicaid coverage, creating coverage gaps among low-income individuals in Kentucky. For a

¹⁶⁴ *Id.*

¹⁶⁵ 42 C.F.R. §§ 455.15.

¹⁶⁶ 42 U.S.C. § 1320a-7b(a).

¹⁶⁷ See Sara Rosenbaum et al., George Washington Univ. Dep't of Health Policy, *Health Care Fraud: An Overview 2* (2009), https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_EFDA_D1BC-5056-9D20-3D3D36632A4F2163.pdf (noting that enrollees commit only 10% of all health care fraud).

detailed discussion of the health and financial harms associated with this coverage loss, see section III.F. below.

D. Good Cause Exceptions and “On-ramps”

The approved “good cause exceptions” and “on-ramps,” most of which were already part of the waiver proposal when it was submitted to CMS, will not mitigate the coverage loss and other harmful consequences associated with the work requirement, premiums, and administrative lockouts. First, the “good cause exceptions” cover a narrow range of relatively extreme circumstances, as well as exceptions required by federal laws prohibiting disability discrimination. They do nothing to address the primary reasons that enrollees will not be able to comply with the new eligibility requirements. With respect to premiums, for example, HHS has previously recognized that many enrollees simply do not have the money to pay the premiums.¹⁶⁸ Others face logistical barriers to submitting the money every month. In fact, one-quarter of all households with annual income below \$15,000 are unbanked, meaning no one in the household has a savings or checking account.¹⁶⁹ Evidence from Arkansas shows that the good cause exceptions will have little to no effect on the number of enrollees who lose coverage due to Kentucky HEALTH. Arkansas has similar good cause exceptions in place for its work requirement. In July 2018, four enrollees requested good cause exceptions, and three enrollees have received one, while 12,722 individuals did not meet the work requirement.¹⁷⁰

Second, for many of the same reasons, the “on-ramp” will be useless for individuals. Again using premiums as an example, to end the lockout or penalty period early, enrollees must pay all past-due premiums owed (two months), pay the premium for the month of re-enrollment, and complete a financial or health literacy course. Certainly, many (if not most) individuals will not be able to come up with the money to pay three times the amount of their regular monthly premium at once. And, completing a financial or health literacy course will not be feasible for individuals who do not have access to transportation and/or childcare (if the classes are in-person) or lack of internet access (if

¹⁶⁸ U.S. Dep’t of Health & Human Servs., Office of the Assistant Secretary for Planning and Evaluation, *Financial Condition and Health Care Burdens of People in Deep Poverty* (2015), <http://aspe.hhs.gov/basic-report/financial-condition-and-health-care-burdens-people-deep-poverty>. (concluding that individuals below 100% of FPL are sensitive to even nominal increases in out-of-pocket medical costs and must choose between health care and other basic needs like child care and transportation).

¹⁶⁹ Fed. Deposit Insurance Corp., *2015 National Survey of Unbanked and Underbanked Households*, Appendix Tables at 9 (2016), <https://www.fdic.gov/householdsurvey/2015/2015appendix.pdf>.

¹⁷⁰ Arkansas Dep’t of Human Servs., *Arkansas Works Program July 2018 Report* (attached).

the classes are virtual). Notably, in Kentucky, 42% of Medicaid enrollees lack broadband access and 19% lack any Internet access.¹⁷¹

E. No Retroactive Coverage

Kentucky is proposing to eliminate retroactive coverage for individuals in Kentucky HEALTH, with the exception of pregnant women and former foster youth. Eliminating retroactive coverage is not experimental and is not likely to promote the objectives of the Medicaid Act. The waiver will reduce access to coverage among low-income individuals, leading to an increase in unmet health needs and a decrease in financial security.

While Kentucky did not provide estimates of the number of people who will face medical costs due to the waiver or the average amount of those costs, evidence from other states is telling. For example, Iowa estimated that waiving retroactive coverage in its Medicaid program would decrease coverage by 3,344 people every month and over 40,000 people every year.¹⁷² When Indiana received permission to waive retroactive coverage in 2015, CMS required the State to continue to provide some retroactive coverage to parents. The State reported to CMS that 13.9% of parents who enrolled in Medicaid needed retroactive coverage, with their costs incurred averaging \$1,561 per person.¹⁷³ In addition, data from New Hampshire show that between August 2014 and November 2015, 4,657 individuals in the Medicaid expansion population benefited from retroactive coverage, which paid for more than \$5 million in medical expenses.¹⁷⁴ These figures confirm that eliminating retroactive coverage will cause financial hardship to many Kentucky HEALTH enrollees.

¹⁷¹ Anuj Gangopadhyaya and Genevieve M. Kenney, *supra* note 25.

¹⁷² See Iowa Dep't of Human Servs., *Section 1115 Demonstration Amendment, Iowa Wellness Plan*, at Attachment A (2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa4.pdf>.

¹⁷³ MaryBeth Musumeci & Robin Rudowitz, Kaiser Family Found., *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States* 4 (2017), <https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/> (citing Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Services, to Tyler Ann McGuffee, Insurance & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>).

¹⁷⁴ See N. H. Dep't of Health & Human Servs., *Retroactive Coverage Waiver Submission* (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf>

In addition, eliminating retroactive coverage will result in increased uncompensated care costs for hospitals.¹⁷⁵ When Ohio requested a waiver of retroactive coverage, one report estimated that the waiver would result in roughly \$2.5 billion more in uncompensated costs for hospitals over a five year period.¹⁷⁶ Iowa's waiver was opposed on similar grounds, with the Iowa Hospital Association warning that the waiver would "place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients . . . translate into increased bad debt and charity care for Iowa's hospitals and . . . affect the financial stability of Iowa's hospitals, especially in rural communities."¹⁷⁷

Ultimately, many providers will likely stop providing care to individuals who are eligible for Medicaid but have not enrolled, meaning that low-income individuals will experience a substantial delay in receiving medically necessary care. Notably, Congress passed the retroactive coverage requirement in part to avoid this very problem.¹⁷⁸

Paradoxically, Kentucky contends that eliminating retroactive coverage will promote continuous coverage by encouraging individuals to enroll in Medicaid even when they are healthy.¹⁷⁹ However, low-income individuals do not actively delay seeking Medicaid coverage until they become sick or injured. Medicaid eligibility rules are complicated, and individuals often do not know that they qualify for Medicaid coverage, much less understand that Medicaid has a retroactive coverage policy and what that means.¹⁸⁰ In fact, Congress passed the retroactive coverage requirement with this in mind, describing the purpose of the requirement as "protecting persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either

¹⁷⁵ Jessica Schubel, Ctr. on Budget & Policy Priorities, *Ending Medicaid's Retroactive Coverage Harms Iowa's Medicaid Beneficiaries and Providers* OFF THE CHARTS (Nov. 9, 2017), <https://www.cbpp.org/blog/ending-medicaids-retroactive-coverage-harms-iowas-medicaidbeneficiaries-and-providers>.

¹⁷⁶ Virgil Dickson, *Ohio Medicaid Waiver could cost hospitals \$2.5 billion*, MODERN HEALTHCARE, April 22, 2016, <http://www.modernhealthcare.com/article/20160422/NEWS/160429965>.

¹⁷⁷ Virgil Dickson, *Hospitals balk at Iowa's proposed \$37 million Medicaid cuts*, MODERN HEALTHCARE, August 8, 2017, <http://www.modernhealthcare.com/article/20170808/NEWS/170809906>.

¹⁷⁸ Amends. to the Soc. Sec. Act 1969-1972: Hrg. on H.R. 17550 Before the S. Comm. on Fin., 91st Cong. 1262 (1970) (stmt. of Elliot L. Richardson, Sec'y, Dep't of Health, Educ., & Welfare) (noting that Congress wanted to encourage providers to "furnish necessary medical assistance and ensure financial protection to otherwise eligible persons during the retroactive period") (attached).

¹⁷⁹ Application at 20.

¹⁸⁰ See also Alexia Fernandez Campbell, *These 2 Medicaid provisions prevent medical debts from ruining people's lives*, Vox, July 19, 2017, <https://www.vox.com/policy-and-politics/2017/7/19/15949250/medicaid-medical-bankruptcy> (highlighting the story of a man who did not realize he was eligible for Medicaid until after he faced \$500,000 in medical bills and a family friend informed him that Medicaid may be able to help).

because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying.”¹⁸¹ Imagine, for example, a man who recently suffered a pay cut, is eligible for Medicaid, but is not aware of his eligibility. He is in a serious car accident on the 30th of the month and receives emergency treatment in a hospital. His condition is severe enough that he cannot apply for Medicaid until the 1st of the following month. Without retroactive coverage in place, he will be responsible for the costs of the services he received in the previous month.

Kentucky also claims that eliminating retroactive coverage is necessary to familiarize Medicaid enrollees with private insurance coverage. As noted above, this is not one of the objectives of the Medicaid Act. Simply put, imposing a potentially devastating financial penalty on low-income individuals is a particularly cruel and ineffective method of education that cannot be squared with the objectives of the Medicaid Act.

In short, eliminating retroactive coverage will harm low-income people as well as health care providers. The waiver will not only fail to advance the objectives of the Medicaid program, but it will actively undermine the goals of providing coverage, care, and related financial protection to low-income individuals. It will inevitably saddle some Kentucky HEALTH enrollees with massive medical debt, increase financial strains on hospitals and providers, and increase the likelihood that hospitals and providers are no longer able to provide quality care to people who need it.¹⁸² The effect of the waiver will be even more pronounced due to the other features of Kentucky HEALTH, which will cause individuals to churn on and off of Medicaid coverage.

F. Consequences of Coverage Loss

Not surprisingly, it is well-documented that gaps in coverage lead to worse health outcomes, including premature mortality.¹⁸³ These negative outcomes occur for a

¹⁸¹ *Cohen by Cohen v. Quern*, 608 F. Supp. 1324, 1332 (N.D. Ill. 1984) (quoting H. Rep. No. 92-231, 92d Cong., 2d Sess., reprinted in [1972] U.S. Code Cong. & Ad. News 4989, 5099).

¹⁸² See Michelle Andrews, *Some States Roll Back Retroactive Medicaid, A Buffer For The Poor—And For Hospitals*, KAISER HEALTH NEWS, November 14, 2017, <https://khn.org/news/some-states-roll-back-retroactive-medicaid-a-buffer-for-the-poor-and-for-hospitals/>

¹⁸³ 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>; 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 MED. 854 (2008), <https://www.ncbi.nlm.nih.gov/pubmed/19075204?dopt=Abstract>; Woolhandler S, Himmelstein DU. *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*,

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.¹⁸⁴ Even brief lapses in coverage can cause people to skip medications or other regular treatment.¹⁸⁵ Gaps in coverage, and even switching between forms of coverage, make it less likely that people establish relationships with health care providers, and can degrade the quality of care and health outcomes for Medicaid enrollees.¹⁸⁶ Likewise, continuous insurance coverage is associated with earlier cancer identification and outcomes.¹⁸⁷

Continuous coverage is also essential for financial wellbeing.¹⁸⁸ Medical debt is a major contributor to bankruptcies across the country.¹⁸⁹ The financial benefits of Medicaid coverage have been repeatedly documented and have contributed to lower rates of bankruptcy.¹⁹⁰ For instance, one study found that Medicaid coverage reduced the likelihood of borrowing money or skipping bills to pay for medical care by 40% and

¹⁸⁴ Leighton Ku and Erika Steinmetz, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid*, Association for Community Affiliated Plans (2013), <http://www.communityplans.net/Portals/0/Policy/Medicaid/GW%20Continuity%20Report%20%209-10-13.pdf>.

¹⁸⁵ Leighton Ku et al., *Improving Medicaid's Continuity of Coverage and Quality of Care*, Association for Community Affiliated Plans 1, 5-6 (2009)

<http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf>. See also Rebecca Meyerson et al., *Medicaid Eligibility Expansions May Address Gaps In Access to Diabetes Medications*, 37 HEALTH AFFAIRS 1200 (2018) (attached).

¹⁸⁶ *Improving Medicaid's Continuity of Coverage and Quality of Care*, supra note 185, at 1, 5-6.

¹⁸⁷ *Id.* at 6.

¹⁸⁸ See, e.g., Georgetown Univ. Health Policy 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 & Policy 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).

¹⁸⁹ David U. Himmelstein, et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741 (2009), http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

¹⁹⁰ Tal Gross & Matthew J. Notowidigdo, *Health Insurance And The Consumer Bankruptcy Decision: Evidence From Expansions of Medicaid*, 95 J. PUB. EC. 767, 776 (2011), <https://www.sciencedirect.com/science/article/abs/pii/S0047272711000168>.

reduced the probability of having a medical debt collection by 25%.¹⁹¹

Evidence since the passage of the ACA also demonstrates how access to Medicaid—rather than private insurance through the Marketplace or an employer—reduces medical debt and promotes financial security. For instance, one national study of low-income parents found that Medicaid expansion reduced difficulty paying medical bills and reduced stress and severe psychological distress.¹⁹² Ohio’s evaluation of its Medicaid expansion likewise reported substantial reductions in medical debt and improved ability to pay non-medical bills.¹⁹³

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.¹⁹⁴ Another national study found that medical debt fell by almost twice as much in expansion states (13%) compared to non-expansion states (7%).¹⁹⁵ And a third study showed that Medicaid expansion reduced the incidence of newly-accrued medical debt by 30% to 40%, and also reduced the number of bankruptcies compared to non-expansion states.¹⁹⁶ 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.¹⁹⁷

The changes sought in the Kentucky HEALTH waiver would reverse the progress of Medicaid expansion, resulting in onerous and expensive barriers to coverage that will financially burden Medicaid enrollees and restrict access to vital health care services.

¹⁹¹ Finkelstein *et al.* *The Oregon Health Insurance Experiment: Evidence from The First Year*, 127 Q. J. Econ. 1057, 1057 (2012), available at <http://www.nber.org/papers/w17190.pdf>.

¹⁹² McMorrow S, Gates JA, Long SK, Kenney GM, *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress For Low-Income Parents*, 36 HEALTH AFFAIRS 808 (2017) (attached).

¹⁹³ 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>.

¹⁹⁴ 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>.

¹⁹⁵ 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/>.

¹⁹⁶ Kenneth Brevoort, Daniel Grodzicki, & Martin B. Hackmann, Nat’l Bureau of Economic Research, *Medicaid and Financial Health 3* (2017) (attached).

¹⁹⁷ *Id.* at 3-4.

IV. Kentucky HEALTH Will Reduce Access to Services

A. NEMT

Kentucky proposes to eliminate NEMT for the Medicaid expansion population. This is nothing more than a cut in benefits. As such, it has no experimental or demonstration purpose. In addition, eliminating NEMT runs counter to the objectives of the Medicaid Act, as it will reduce access to medically necessary services for Kentucky HEALTH enrollees.

We have been working with state Medicaid advocates and directly with Medicaid beneficiaries for over four decades. In our experience, NEMT is essential to the Medicaid program. Many people who live in poverty simply do not have the means to access medically necessary services on their own. Access to private vehicles is lower and transportation barriers are higher among lower-income populations, and Medicaid beneficiaries in particular.¹⁹⁸ Public transportation (if available) is often too expensive, too limited, and/or too infrequent to use.¹⁹⁹ Friends or family may be unable or unwilling to take off work to drive an enrollee to an appointment. In addition, domestic violence survivors or young adults may need confidential access to a provider and depend on NEMT to help get them to the appointment. In one study, more than 7% of Medicaid beneficiaries reported that transportation was a primary barrier to accessing timely primary care. In contrast, less than 1% of privately insured individuals reported the same problem.²⁰⁰

¹⁹⁸ Samina T. Syed et al., *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976, 989 (2013), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4265215/>; Sarah Rosenbaum et al., George Washington Univ. School of Pub. Health & Health Servs., *Medicaid's Medical Transportation Assurance: Origins, Evolution, Current Trends, and Implications for Health Reform* (2009), http://web1.ctaa.org/webmodules/webarticles/articlefiles/Medical_Transportation_Assurance_Report.pdf. See also Suzanne Bentler et al., Univ. of Iowa Pub. Policy Ctr., *Evaluation of the Iowa Health and Wellness Plan: Member Experiences in the First Year*, 27 (April 2015), http://ppc.uiowa.edu/sites/default/files/ihawp_survey_interactive.pdf (Fig. 3.18 shows lower income Medicaid expansion beneficiaries more than twice as likely to require transportation help and three times as likely to have an unmet transportation need).

¹⁹⁹ See, e.g., Dr. Edward Jennings & Shana Steinbach, *Kentucky Public Transportation Services Available By County, Report Prepared for the Kentucky Developmental Disabilities Council* (2011), <https://www.hdi.uky.edu/Media/Default/Documents/KYTransportationServicesAvailablebyCountyJointCouncilsReport.pdf> (noting the limited availability of public transportation).

²⁰⁰ Paul T. Cheung et al., *National Study of Barriers to Timely Primary Care and Emergency Department Utilization Among Medicaid Beneficiaries*, 60 ANNALS EMERGENCY MED. 4e2 (July 2012), [http://www.annemergmed.com/article/S0196-0644\(12\)00125-4/fulltext](http://www.annemergmed.com/article/S0196-0644(12)00125-4/fulltext).

Data from Kentucky confirm that Medicaid enrollees rely on NEMT to access health care appointments. From June 2014 to June 2015, individuals in the expansion population used over 140,000 NEMT trips.²⁰¹ Similarly, data from Indiana and Iowa, which received permission to eliminate NEMT for the expansion population, demonstrate that many enrollees cannot access care without NEMT.²⁰² It must be noted that Iowa's and Indiana's evaluations were deeply flawed, principally because they: (1) used inappropriate and dissimilar comparison groups; and (2) had poor survey response rates (in Indiana) and potential response bias. However, even with these limitations, Iowa's evaluation shows that a significant subset of Medicaid expansion adults (13%) reported an unmet health care need due to lack of adequate transportation.²⁰³ The percentage was even higher among enrollees with income below 100% of FPL (15%).²⁰⁴ Roughly one-quarter of all Iowa Medicaid enrollees worried some or a lot about the cost of transportation to providers, and again, enrollees with lower incomes reported significantly more concerns.²⁰⁵ Indiana's most recent evaluation likewise shows that lack of transportation caused enrollees in the expansion population to forgo medically necessary care.²⁰⁶

Notably, data from Iowa also indicate that women, people of color, and younger people are significantly more likely to report a transportation barrier.²⁰⁷ In addition, people in relatively poorer health (58% higher odds), with multiple physical ailments (63%), or who have any functional deficit (245%) were all much more likely to report unmet

²⁰¹ Application at 45.

²⁰² Suzanne Bentler et al., *supra* note 196, at 27.

²⁰³ *Id.*

²⁰⁴ *Id.*

²⁰⁵ *Id.*

²⁰⁶ The Lewin Group, *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver* (Nov. 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-nemt-final-evl-rpt-11022016.pdf> (finding that among enrollees who scheduled and missed an appointment and did not have NEMT, 80% reported lack of transportation as one of the reasons for missing their appointment, and 20% reported lack of transportation as the sole reason for missing their appointment).

²⁰⁷ Suzanne Bentler et al., Univ. of Iowa Pub. Policy Ctr., *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 26 (Mar. 2016), https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health (finding that women were 24% more likely to report an unmet transportation need, and Black enrollees had 83% higher odds of reporting a transportation barrier). See also Alina Salganicoff et al., Kaiser Family Found., *Women and Health Care in the Early Years of the Affordable Care Act: Key Findings from the 2013 Kaiser Women's Health Survey* (2014), <https://kaiserfamilyfoundation.files.wordpress.com/2014/05/8590-women-and-health-care-in-the-early-years-of-theaffordable-care-act.pdf> (finding that prior to Medicaid expansion, nearly one in five low-income women nationwide (18%) cited transportation problems as a reason for forgoing medical care).

transportation needs.²⁰⁸ Eliminating NEMT in Kentucky will disproportionately harm these populations, likely exacerbating existing health care disparities.

Significantly, evaluators in Indiana and Iowa found ongoing unmet transportation needs among enrollees that on paper had access to NEMT. The persistence of those unmet needs suggests an ineffective or poorly publicized NEMT benefit in those states. In fact, Indiana's most recent survey revealed that the overwhelming majority of Medicaid enrollees did not know if they had access to NEMT services or incorrectly identified whether or not their plan provided NEMT.²⁰⁹ Iowa's evaluators did call for further research to understand "the causes of unmet NEMT need, how to better promote access to NEMT, and how barriers to transportation affect access to needed health care services."²¹⁰ However, Kentucky is not proposing to investigate these legitimate research questions. Its draft evaluation plan does not even so much as mention the general waiver of NEMT.²¹¹

Not surprisingly, research demonstrates that effective NEMT services improve access to health care. For example, research shows that transportation barriers can reduce adherence to medications.²¹² Studies also indicate that individuals with common chronic conditions like asthma or diabetes are more likely to complete the recommended care management visits when they have access to effective NEMT.²¹³ Better adherence to medications and care management visits can improve control of chronic conditions,

²⁰⁸ Suzanne Bentler et al., Univ. of Iowa Pub. Policy Ctr., *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 26 (Mar. 2016),

https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health.

²⁰⁹ *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver*, *supra* note 204, at 28-31.

²¹⁰ Suzanne Bentler et al, Univ. of Iowa Pub. Policy Ctr., *Report in Brief: Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 1 (Aug. 2016),

http://ppc.uiowa.edu/sites/default/files/nemt_brief.pdf.

²¹¹ Application at 57-62.

²¹² Timothy E. Welty et al., *Effect of Limited Transportation on Medication Adherence in Patients with Epilepsy*, 50 J. AM. PHARM. ASSOC. 698 (2010) (attached); Ramzi G. Salloum et al., *Factors Associated with Adherence to Chemotherapy Guidelines in Patients with Non-small Cell Lung Cancer*, 75 LUNG CANCER 255 (2012) (attached).

²¹³ See, e.g., Jinkyung Kim et al., *Transportation Brokerage Services and Medicaid Beneficiaries' Access to Care*, 44 HEALTH SERVS. RES. 145 (2009), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2669622/>; Leela V. Thomas & Kenneth R. Wedel, *Nonemergency Medical Transportation and Health Care Visits among Chronically Ill Urban and Rural Medicaid Beneficiaries*, 29 SOC. WORK IN PUB. HEALTH 629 (2014) (attached); P. Hughes-Cromwick et al., Transportation Research Board, *Cost Benefit Analysis of Providing Non-Emergency Medical Transportation* (Oct. 2005), https://altarum.org/sites/default/files/uploaded-publication-files/05_project_report_hsd_cost_benefit_analysis.pdf.

reducing costly hospitalizations or emergency department visits. In fact, research shows that NEMT is in fact cost effective for states.²¹⁴

According to Kentucky, the purpose of this cut in benefits is to make Medicaid coverage more closely resemble private insurance. However, Congress did not create the Medicaid program to familiarize low-income individuals with common features of private coverage. In fact, states are required to provide NEMT to Medicaid enrollees precisely because it addresses a barrier to care that occurs more commonly among lower-income populations.²¹⁵

In sum, there is simply no basis to conclude that eliminating NEMT for the expansion population in Kentucky will yield any useful information or promote the objectives of the Medicaid program. Instead, it will reduce access to medically necessary care.

B. My Rewards Account and Deductible Account

Kentucky designed Kentucky HEALTH to resemble a high-deductible commercial health plan.²¹⁶ All enrollees except for pregnant women will have two accounts: (1) a deductible account, which will have a \$1,000 balance at the beginning of every 12-month eligibility period and will decrease in value as an enrollees receive non-preventive services; and (2) a My Rewards account, which enrollees in the expansion population use to pay for vision services, dental services, and over-the-counter medications. If enrollees have money remaining in their deductible account at the end of the 12-month eligibility period, they may transfer up to 50% of the balance to their My Rewards account.

Enrollees are unlikely to fully understand how the accounts and incentives work. Even assuming that enrollees do understand the accounts, the incentives will deter individuals from seeking medically necessary services. In addition, the proposed My Rewards account structure will leave many Kentucky HEALTH enrollees without adequate access to vision and dental services. Thus, the deductible and My Rewards accounts are neither experimental nor consistent with Medicaid's objectives.

²¹⁴ P. Hughes-Cromwick et al., *supra* note 211; J. Joseph Cronin, Jr., et al., Florida State Univ., *Florida Transportation Disadvantaged Programs Return on Investment Study* (2008), http://tmi.cob.fsu.edu/roi_final_report_0308.pdf; The Stephen Group, *Recommendations to the Ark. Health Reform Task Force* (2015), <http://www.arkleg.state.ar.us/assembly/2015/Meeting%20Attachments/836/I14099/TSG%20Volume%20II%20Recommendations.pdf>.

²¹⁵ Samina T. Syed et al, *supra* note 196, at 989.

²¹⁶ Application at 28.

Evidence from other states that have implemented similar accounts in their § 1115 projects shows that enrollees are not aware of them, and those who are do not understand their features or use them.²¹⁷ Enrollees in Indiana's § 1115 project have a POWER account, which is coupled with number of incentives. For example, the State deducts the cost of non-preventive services received, and at the end of the year, certain enrollees who have money remaining in their account have their monthly premiums reduced (or even eliminated) for the following year. An interim evaluation of Indiana's project found that 40% of enrollees reported never having heard of the POWER account.²¹⁸ Of those who had heard of the account, roughly a quarter incorrectly thought they did not have one, meaning that fewer than half of all enrollees even knew they had an account.²¹⁹ Further, slightly over half of enrollees incorrectly thought that receiving preventive services would result in deductions from their POWER account, while another 40% of enrollees reported not knowing if they could receive preventive services at no-cost.²²⁰ This suggests that instead of encouraging enrollees to seek preventive care, the POWER account structure may actually discourage enrollees from receiving preventive services. The evaluation also shows poor understanding of the rollover policy, making it hard to imagine it is influencing enrollee behavior.²²¹ Notably, in year three of the project, only 34-50% of enrollees (depending on the managed care plan) received a preventive exam, far below the State's goal of 85%.²²²

Healthy behavior incentives implemented in Iowa have been similarly ineffective. As part of its § 1115 project, Iowa required certain enrollees to pay a monthly premium, but not if they received a wellness exam and completed a health risk assessment. Yet, the vast majority of enrollees did not complete these activities.²²³ In fact, 90% of enrollees

²¹⁷ *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, *supra* note 70.

²¹⁸ Ind. Family & Social Servs. Admin., *Indiana Health Indiana Plan 2.0: Interim Evaluation Report* 65 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf>.

²¹⁹ *Id.*; Judith Solomon, Ctr. on Budget & Policy Priorities, *Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved* 6 (2016), <https://www.cbpp.org/sites/default/files/atoms/files/8-1-16health.pdf>.

²²⁰ *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report*, *supra* note 157, at 66-67.

²²¹ *Id.* at 66-68; see also David Machledt, Nat'l Health Law Program, *Indiana Medicaid Demonstration Raises Concerns* (2017), <http://www.healthlaw.org/publications/search-publications/indiana-medicaid-demonstration-raises-concerns#.W2plw9JKjIU>.

²²² *Indiana HIP 2.0: Annual Report for Demonstration Year Three* 32 (Apr. 30, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-annl-rpt-feb-jan-2018-043018.pdf>.

²²³ Natoshia M. Askelson *et al.*, *Health Behaviors Incentive Program Evaluation Interim Report* 19, 47 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-bhvrs-int-rpt-mar-2016.pdf>.

reported not knowing about the incentives, and even clinic managers had “very limited awareness and knowledge” of them.²²⁴ The same outcome occurred in Michigan, which offered financial incentives to enrollees to complete a health risk assessment. More than 85% of Medicaid enrollees failed to do so, in part because “[m]ost beneficiaries did not know” about the reward.²²⁵

The evidence suggests that Kentucky enrollees will not fully understand the overly complicated deductible and My Rewards accounts, making it unlikely that they will influence enrollees’ behavior in a positive way. Even if enrollees do understand the accounts, they create a perverse incentive for people who need significant vision or dental services. For example, these enrollees may forgo other medically necessary care, such as treatment for diabetes or high blood pressure, so that they can transfer money from their deductible account into their My Rewards account. Thus, the incentive structure may lead to worse overall health outcomes and disproportionately harm enrollees with chronic or disabling conditions.²²⁶

The rollover policy aside, the My Rewards account will not provide adequate access to medically necessary vision and dental services. Expansion enrollees will have to pay out-of-pocket for vision and dental services unless they have sufficient funds in their My Rewards account to pay for the care. In its application, Kentucky listed how much money enrollees can earn for completing various activities. Given these amounts, many enrollees will simply be unable to accrue enough money in their account to pay for their vision and dental needs.²²⁷ All of the barriers that will prevent individuals from meeting the work requirement (see section III.A.1. above) will likewise prevent individuals from

²²⁴ *Id.*; Hannah Katch et al., Ctr. On Budget & Policy Priorities, *Are Medicaid Incentives an Effective Way to Improve Health Outcomes* 6 (2017), <https://www.cbpp.org/sites/default/files/atoms/files/1-24-17health.pdf>.

²²⁵ Mich. Dep’t of Health & Human Services, *Michigan Adult Coverage Demonstration Section 1115 Annual Report* 13 (2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-annual-report-DY6.pdf>; Univ. of Mich. Inst. For Healthcare Policy & Innovation, *MI Health Account Statements: Early Experiences of Beneficiaries Report Summary* 5 (2015), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-annual-report-DY6.pdf>.

²²⁶ Indiana’s original HIP project included a “deductible” account with a rollover opportunity, but barely one-third of enrollees had any funds left in their account after a year, eliminating any possible rollover incentive for the vast majority of participants and favoring enrollees who are already healthy. Ind. Family & Soc. Servs. Admin. (“FSSA”), *Healthy Indiana Plan Demonstration Section 1115 2013 Annual Report & Interim Evaluation Report* 31 (Oct. 2014), <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-pa.pdf>.

²²⁷ See, e.g., Ky. Cabinet for Health & Family Servs., *Dental Fee Schedule* (2018), <https://chfs.ky.gov/agencies/dms/DMSFeeRateSchedules/DentalFeeScheduleEffectiveJan2018.pdf> (listing, for example, the price of a molar root canal as \$481).

completing extra work-related activities and accumulating money in their My Rewards account. Moreover, individuals below 100% of FPL who do not pay their monthly premiums will lose access to their My Rewards account. Enrollees who cannot afford to pay their monthly premiums certainly will not be able to afford much more expensive vision and dental services.

Restricting access to vision and dental services for the Medicaid expansion population will lead to worse overall health outcomes, and ultimately, increased Medicaid spending. As a U.S. Surgeon General report explains, oral health is essential to overall health.²²⁸ In addition, untreated oral health problems often lead individuals to seek care in the emergency room. In 2009, preventable dental conditions were the cause of 830,000 emergency room visits nationwide, and hospital care for dental conditions is nearly ten times as expensive as preventive dental care.²²⁹ Emergency room visits for dental conditions cost about \$1.6 billion nationwide.²³⁰ Similarly, the CDC has declared vision loss a serious public health problem, as “people with vision loss are more likely to report depression, diabetes, hearing impairment, stroke, falls, cognitive decline, and premature death,” as well as “substantially compromis[ed] quality of life.”²³¹ Further, the cost of vision loss is estimated to exceed \$35 billion.²³²

Notably, untreated dental problems can make it more difficult for individuals to get a job, both because of chronic pain and because of concerns about their appearance. Nearly 30% of low-income adults say the appearance of their mouth and teeth affects their ability to interview for a job.²³³ Thus, by restricting access to dental services, Kentucky is directly undermining its own stated goal of promoting employment among Medicaid expansion enrollees.

²²⁸ Dep’t of Health & Human Servs., U.S. Pub. Health Serv., *Oral Health in America: A Report of the Surgeon General* (2000), <https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf>.

²²⁹ Pew Ctr. on the States, *A Costly Dental Destination: Hospital Care Means States Pay Dearly* 1, 3 (2012), <http://www.pewtrusts.org/-/media/assets/2012/01/16/a-costly-dental-destination.pdf>.

²³⁰ Cassandra Yarbrough *et al.*, *Estimating the Cost of Introducing a Medicaid Adult Dental Benefit in 22 States*, American Dental Association 2 (2016), http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0316_1.ashx.

²³¹ Ctrs. for Disease Control & Prevention, *Why is Vision Loss a Public Health Problem?* (2015), https://www.cdc.gov/visionhealth/basic_information/vision_loss.htm.

²³² *Id.* (citing Rein DB, *et al.*, *The economic burden of major adult visual disorders in the United States*, ARCH. OPHTHALMOL. 1754–1760 (2006)).

²³³ Am. Dental Ass’n, Health Policy Inst., *Oral Health and Well-Being in the United States* (2015), <https://www.ada.org/~media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/US-Oral-Health-Well-Being.pdf?la=en>.

Finally, Kentucky will incur significant administrative costs to operate the two accounts. 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.²³⁴ Officials in Arkansas estimated that administrative costs for that State’s HSA-like accounts in Medicaid totaled more than \$1,100 per participating enrollee per year.²³⁵ As detailed above, the evidence shows that the increased spending is not likely to improve access to care or health outcomes, and as a result, is not likely to promote the objectives of the Medicaid program.

C. Heightened Cost Sharing for Non-emergency Use of the Emergency Room

The Medicaid Act permits states to charge enrollees with household income below 150% of FPL up to \$8 for non-emergency use of the emergency room.²³⁶ Kentucky is seeking permission to increase these charges to: \$20 for the first visit, \$50 for the second visit, and \$75 for each subsequent visit. Kentucky will assess the charge by deducting money from an enrollee’s My Rewards account.

Under the Medicaid Act, the Secretary may only allow Kentucky to exceed the \$8 cap if five tightly circumscribed criteria are met.²³⁷ After providing notice and comment, the Secretary must find that the waiver is for a demonstration project that:

- (1) will test a unique and previously untested use of copayments,
- (2) is limited to a period of not more than two years,
- (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
- (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and
- (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.²³⁸

²³⁴ Zylla E et al., Medicaid and CHIP Payment and Access Comm’n, *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.

²³⁵ *Id.*

²³⁶ 42 U.S.C. §§1396o-1(e), 1396o(a)(3), (b)(3); 42 C.F.R. § 447.54(b).

²³⁷ 42 U.S.C. § 1396o(f)(1)-(5).

²³⁸ *Id.*

The proposed Kentucky HEALTH policy does not comply with any of these criteria. First and foremost, the proposed policy is not unique or previously untested. In fact, existing, peer-reviewed research has found that imposing cost sharing for non-emergency use of the emergency department does not reduce emergency room use among Medicaid and CHIP enrollees.²³⁹

Second, Kentucky is requesting to impose the cost sharing for longer than two years (five years). Third, the proposed cost sharing cannot reasonably be expected to provide any benefits to enrollees. As noted above, substantial research shows that charging Medicaid enrollees for non-emergency use of the emergency room does not reduce emergency department use. Moreover, cost sharing does nothing to address the root causes of those “non-urgent” visits, such as unmet health needs and lack of access to primary care settings.²⁴⁰ In contrast, heightened cost sharing for non-emergency use of the emergency room poses risks to enrollees. Individuals who incur the charge will simply face reduced access to vision and dental services, which could make them more likely to need to visit the emergency room in the future. (See section IV.B. above).

Fourth, the record demonstrates that the Kentucky HEALTH cost sharing is not based on a reasonable hypothesis. According to Kentucky, the purpose of the cost sharing is to discourage inappropriate use of the emergency room. However, research shows that

²³⁹ See, e.g., David J. Becker et al., *Co-payments and Use of Emergency Department Services in the Children’s Health Insurance Program*, 70 MED. CARE RES. REV. 514 (2013) (finding that imposing a \$20 charge on CHIP enrollees for “nonurgent” emergency room visits did not reduce use of the ED for low-severity conditions) (attached), Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use of the Emergency Departments*, 29 HEALTH AFFAIRS 1643 (2010), <https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0906> (finding that heightened cost sharing for non-emergency use of the ED did not alter use of the ED among Medicaid enrollees), Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2091743> (finding that charging Medicaid enrollees for non-emergency use of the ED did not decrease use of the ED or increase use of outpatient providers). See also The Lewin Group, *Healthy Indiana Plan 2.0: 2016 Emergency Room Co-Payment Assessment* 32 (2017), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-2016-emrgncy-room-copymt-assessment-rpt-10042017.pdf> (non-peer reviewed evaluation finding “no discernable patterns” in number of non-emergency ED visits between test and control groups after Indiana imposed heightened cost sharing on Medicaid enrollees in test group for non-emergency use of ED).

²⁴⁰ See, e.g., Ctrs. for Medicare & CHIP Servs., *Informational Bulletin, Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf>.

very few Medicaid enrollees use the emergency room for non-urgent conditions.²⁴¹ In fact, data from Kentucky shows that less than 10% of all Medicaid managed care enrollees used the emergency room for a non-urgent condition in 2015.²⁴² More importantly, as described above, existing research disproves the hypothesis Kentucky is purporting to test – heightened cost sharing will decrease non-emergency use of the emergency room. In fact, CMS has recognized that other strategies, such as improving access to primary care services and providing targeted case management services for enrollees who frequently use the emergency room, have been effective in reducing emergency room use among Medicaid enrollees.²⁴³ According to CMS, “[e]xperience and research suggests that narrow strategies to reduce ED usage by attempting to distinguish need on a case by case basis have had limited success in reducing expenditures to date, due in part to the very reasons for higher rates of utilization by Medicaid beneficiaries including unmet multiple health needs and the limited availability of alternative health care services. However, broader strategies – such as expanding primary care access, ‘superutilizer’ programs, and targeting the needs of people with behavioral health and substance abuse issues – appear to have considerable promise.”²⁴⁴ In addition, Kentucky has given no indication that it plans to test the hypothesis in a methodologically sound manner, including the use of control groups.

Fifth and finally, the proposed Kentucky HEALTH cost sharing is not voluntary, and Kentucky has not stated that it will assume liability for preventable damage to the health of enrollees resulting from involuntary participation.

Even if the Secretary did have the authority allow Kentucky to implement its proposed cost sharing policy without meeting these five criteria – which he does not – the policy would not be approvable under § 1115. As the evidence above proves, there is nothing experimental about charging Medicaid enrollees increased cost sharing for non-

²⁴¹ Anna S. Somers et al., Ctr. for Studying Health System Change, *Research Brief No. 23, Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms* (2012), <http://www.hschange.org/CONTENT/1302/1302.pdf> (finding that only about 10% of Medicaid emergency room visits are “nonurgent,” a rate on par a rate par with visits by nonelderly enrollees in private insurance).

²⁴² Application at 30 (noting that in 2015, “nearly 125,000 Medicaid managed care enrollees “utilized a hospital emergency room for a non-urgent condition”); Kaiser Family Found., *Total Medicaid Managed Care Enrollment 2016*, <https://www.kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (reporting 1,284,134 Medicaid managed care enrollees in Kentucky). Notably, these figures include populations that will not be enrolled in Kentucky HEALTH.

²⁴³ CMSC Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014), <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf>

²⁴⁴ *Id.* at 7-8 (citing Wash. State Health Care Auth., *Emergency Department Utilization: Assumed Savings from Best Practices Implementation* (2013)).

emergency use of the emergency room, and the policy is not likely to promote the objectives of the Medicaid program.

V. Conclusion

In summary, while NHeLP supports the use of § 1115 to implement experimental projects that are likely to promote the objectives of the Medicaid Act, we strongly object to any efforts to use § 1115 to skirt essential provisions that Congress has placed in the Medicaid Act to protect Medicaid beneficiaries and ensure that the program operates in their best interests. As demonstrated above, the Kentucky HEALTH project is inconsistent with the standards of § 1115 and with other provisions of law.

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 on this proposed rule for purposes of the Administrative Procedure Act.

We appreciate your consideration of our comments. If you have questions about these comments, please contact Catherine McKee (mckee@healthlaw.org) or me.

Respectfully submitted,



Jane Perkins
Legal Director
perkins@healthlaw.org