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October 26, 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: Healthy Michigan Plan § 1115 Extension Application

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 provide these comments on Michigan's § 1115 Waiver Application.

NHeLP supports Michigan's decision to expand Medicaid to low-income adults, but recommends that the Department of Health & Human Services (HHS) reject Michigan's proposed § 1115 project that would increase premiums and impose unlawful conditions of eligibility, including required healthy behavior and work-related activities. In previous comments, we have detailed why even the existing premiums and cost sharing structure decrease enrollment and access to care and should not have

been approved.¹ Subsequent evidence has shown that the existing premiums and healthy behavior policies are increasing medical debt and depressing enrollment. The proposed changes will only exacerbate these problems, and also do not comply with § 1115 of the Social Security Act, as they will block, rather than facilitate, access to Medicaid coverage.

I. HHS authority and § 1115

For the Secretary to approve the project 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.²

The purpose of Medicaid is to enable states to furnish medical assistance to individuals whose income is too low to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain capability for independence or self-care.³ As explained below, Michigan’s proposed project is inconsistent with these provisions of § 1115.

We also note that opposition to the State’s proposed changes is nearly universal. The State received over 1000 comments during its public process: 84 percent opposed some or all of the proposed changes, 15 percent expressed general support for Medicaid expansion, and only 1 percent supported the new waivers.⁴ Despite this opposition, the State has moved forward with its application pursuant to a state legislative mandate.

¹ See National Health Law Program, *Comments on Healthy Michigan Plan § 1115 Application* (Submitted Dec 21, 2013) (attached); National Health Law Program, *Comments on Michigan’s Second Waiver Proposal to Amend the Healthy Michigan Plan Demonstration* (Submitted Oct 2, 2015) (attached); National Health Law Program, *Comments on Healthy Michigan Plan (HMP) § 1115 Extension Application* (Submitted Jan. 21, 2018) (attached).

² 42 U.S.C. § 1315(a).

³ See *id.* § 1396-1.

⁴ Mich. Dept. of Health & Human Servs., *Section 1115 Demonstration Extension Application: Healthy Michigan Plan*, 1171 (Sept. 10, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf>. (Hereinafter “Mich. 1115 Application”)

II. Work requirements are not consistent with the purpose of Medicaid

Michigan currently covers more than 650,000 low-income Michiganders through its Healthy Michigan Medicaid expansion program.⁵ Of those, some 400,000 expansion adults would be affected by the proposed work requirement. Michigan would require expansion adults ages 19 to 62 to complete 80 hours of work activities per month to maintain eligibility, unless they qualify for an exemption.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Michigan to condition Medicaid eligibility on compliance with work activities. The Medicaid Act does not allow states to impose work requirements. Unlike some other public benefits programs, Medicaid is not a work program; it is a medical assistance program. The Medicaid Act does not include participation in work activities in the list of eligibility criteria. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires them to provide medical assistance as far as practicable to all individuals who meet the eligibility criteria established in federal law. As courts have held, imposing additional eligibility requirements is illegal.⁶

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 objectives of the Medicaid Act.⁷ Conditioning Medicaid eligibility on completion of work activities blocks access to medical assistance.

⁵ *Id.* at 4.

⁶ 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 with substance use disorder or whose children were not getting immunizations or check-ups or were missing school because regulation was inconsistent with Medicaid and TANF statutes).

⁷ By contrast, as far back as the 1970s, states obtained § 1115 waivers to test work requirements in the AFDC program (which, unlike Medicaid, does have work promotion as a purpose of the program). These waivers required states to conduct “rigorous evaluations of the impact,” typically requiring the random assignment of one group to a program operating under traditional rules and another to a program using the more restrictive waiver rules. United States Dep’t of Health & Human Servs., *Setting the Baseline: A Report on State Welfare Waivers – An Overview* (Jun. 1997), <https://aspe.hhs.gov/report/setting-baseline-report-state-welfare-waivers>.

A. The Work Requirement Will Lead to Substantial Coverage Losses

All evidence indicates that Michigan's work requirement will lead to substantial numbers of individuals losing Medicaid coverage.⁸ The State's projections suggest, in contrast, that coverage would slightly increase under these new restrictions.⁹

Based on what we know about Medicaid coverage and on the troubling implementation of Arkansas' work requirement, which began in June 2018, Michigan's estimates are wholly unrealistic. In Arkansas, nearly one in five enrollees subject to a similar work requirement since July 2018 lost coverage in the first two months after work requirement penalties kicked in. The state ends coverage after three months of non-compliance, just as Michigan proposes. In total 8,462 enrollees have been terminated.¹⁰ Over twelve thousand more low-income Arkansans already have one or two months of noncompliance and risk losing coverage in the coming months.¹¹ In September, the Chairperson of the federal Medicaid and CHIP Payment and Access Commission (MACPAC), an advisory body for Congress, suggested that the Commission agrees these statistics raised "a serious level of concern" about the new work requirement, while other commissioners characterized them as "a serious red flag" and suggested that Arkansas consider suspending its demonstration.¹²

Beneficiaries will lose coverage under the proposed work requirement for different reasons. First, the administrative burdens of reporting compliance or proving an exemption will cause significant enrollment declines across the whole population of Medicaid expansion adults, even for those who are working or should be exempt. Second, many individuals will not be able to consistently work sufficient hours and will lose coverage due to non-compliance.

Contrary to the State's estimates, Michigan's work requirement, if approved, will cause substantial coverage loss and erode many of the documented health and financial benefits

⁸ 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>.

⁹ Mich. 1115 Application, at 16.

¹⁰ Estimates from combining August and September enrollment reports. 8,462 individuals terminated for not complying with the work requirement of 43,794 subject to the work requirement since July. Ark. Dep't of Human Servs., *Arkansas Works Program August 2018 Report* (attached); Ark. Dep't of Human Servs., *Arkansas Works Program September 2018 Report* (attached).

¹¹ Ark. Dep't of Human Servs., *Arkansas Works Program September 2018 Report* (attached).

¹² James Romoser, Inside Health Pol'y, *MACPAC Alarmed by Initial Data on Arkansas Medicaid Work Requirements* (Sept. 14, 2018), <https://insidehealthpolicy.com/inside-cms/macpac-alarmed-initial-data-arkansas-medicaid-work-requirements> (attached).

Michigan's Medicaid expansion has realized.¹³ Those who lose coverage will have few alternative coverage options and will remain largely uninsured. The loss of coverage will decrease access to medically necessary services, increase financial insecurity for low-income parents and children, and place their health at risk.

i) *Administrative burdens will result in coverage losses*

Many individuals—including many individuals who are already working or who fall within an exemption—will lose coverage due to additional administrative burdens associated with the work requirement.¹⁴ Repeated research has shown that adding new administrative requirements for Medicaid enrollees decreases enrollment.¹⁵ For example, in 2003 Texas experienced a nearly 30 percent enrollment decline after it increased premiums, established a waiting period, and cut the renewal period for children in CHIP from 12 to 6 months.¹⁶ Similarly, when Washington State increased documentation requirements, halved the renewal period to 6-months, and ended continuous eligibility for children in

¹³ See, e.g. Sarah Miller et al., *The ACA Medicaid Expansion in Michigan and Financial Health* (2018), <http://www.nber.org/papers/w25053>.; Renuka Tipirneni et al., Inst. for Healthcare Pol'y & Innovation at the Univ. of Mich., *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches* (June 27, 2017), <http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches>.

¹⁴ See, e.g., Robin Garfield et al., *supra* note 8; Jennifer Wagner & Judith Solomon, Ctr. on Budget & Pol. Priorities, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/5-23-18health2.pdf>; Julia B. Isaacs et al., Urban Inst., *Changing Policies to Streamline Access to Medicaid, SNAP, and Child Care Assistance* (2016), <http://www.urban.org/sites/default/files/publication/78846/2000668-Changing-Policies-to-Streamline-Access-to-Medicaid-SNAP-and-Child-Care-Assistance-Findings-from-the-Work-Support-Strategies-Evaluation.pdf>.

¹⁵ See Wagner & Solomon, *supra* note 14, at 3-4 (noting that when Washington increased documentation requirements and other changes that made it harder to enroll and maintain continued enrollment, enrollment dropped; enrollment rebounded when the State went back to its prior processes); Michael Perry, Susan Kannel, R. Burciaga Valdez, and Christina Chang, Kaiser Family Found., *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* (2000), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf>; Leighton Ku et al., Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care 12-16* (2009) http://www.communityplans.net/Portals/0/ACAP_percent20Docs/Improving_percent20Medicaid_percent20Final_percent20070209.pdf.

¹⁶ Kaiser Family Found., *Implications of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Process* (2018), <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/> (citing Kaiser Family Found., *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act*, (June 4, 2013), <https://www.kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/>).

Medicaid and CHIP in 2003, enrollment dropped sharply.¹⁷ Enrollment quickly rebounded when the State reinstated the 12-month renewal period and continuous eligibility.¹⁸

Additional administrative steps create new coverage barriers. First, states and their contractors inevitably make implementation mistakes, causing some number of delays and erroneous terminations.¹⁹ In Arkansas, programming glitches created widespread problems accessing the State's reporting website.²⁰ After Indiana began requiring Medicaid enrollees to pay premiums in 2015, reports detailed widespread beneficiary confusion, and some enrollees lost coverage despite having paid their premiums.²¹

Second, many enrollees fail to receive adequate notice of or simply do not understand the requirements, and as a result, do not comply. Evaluations of past § 1115 projects document frequent and widespread confusion about program policies.²² In-depth interviews with 18 adult Medicaid enrollees in Arkansas revealed "a profound lack of awareness"

¹⁷ *Id.* (citing Donna Cohen Ross and Laura Cox, Kaiser Family Found., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, A 50 State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and CHIP* (2004), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/beneath-the-surface-barriers-threaten-to-slow-progress-on-expanding-health-coverage-of-children-and-families-pdf.pdf>; Laura Summer and Cindy Mann, Commonwealth Fund, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies* (2006), <http://www.commonwealthfund.org/publications/fund-reports/2006/jun/instability-of-public-health-insurance-coverage-for-children-and-their-families--causes--consequence>).

¹⁸ Kaiser Family Found., *supra* note 16.

¹⁹ See Wagner & Solomon, *supra* note 14 at 13-14.

²⁰ See Dee Mahan, Families USA, *Red Tape Results in Thousands of Arkansans Losing Coverage* (2018), <https://familiesusa.org/product/red-tape-results-thousands-arkansans-losing-coverage>.

²¹ Jake Harper, Ind. Pub. Media, *IN's Medicaid Model Could Spread – But It's Not Working for Everyone* (Jan. 28, 2017), <https://indianapublicmedia.org/news/ins-medicaid-model-spread-but-working-112015/>. State evaluations have also documented a lack of awareness of key basic features of Indiana's program after implementation. See, e.g., Lewin Group, *Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report*, 66 (July 6, 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>.

²² See MaryBeth Musumeci *et al.*, Kaiser Family Found., *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana* (Jan. 31, 2017), <http://files.kff.org/attachment/Issue-Brief-An-Early-Look-at-Medicaid-Expansion-Waiver-Implementation-in-Michigan-and-Indiana> (describing confusion about content of notices sent in Michigan, and confusion among beneficiaries, advocates, and providers over Indiana's POWER accounts, how premiums were calculated, and other program features); See *also* Leighton Ku *et al.*, Ass'n for Community Affiliated Plans, *supra* note 15 at 3 (describing that "families often do not know when their Medicaid certification periods expire, may be dropped without knowing it, and do not know why they lost coverage. Those who have been disenrolled typically say they wanted to retain their insurance coverage, but did not know how to do so.").

about the work requirement, with two-thirds of the enrollees having not even heard of the requirement.²³

Third, even individuals who understand their obligations will face challenges navigating the reporting process to show that they either meet the requirement or qualify for an exemption or good cause exception.²⁴ More than one in four Michigan households (25.6%) lack broadband internet access.²⁵ Nationwide, half of households with incomes under \$25,000 have either no computer or no broadband at home.²⁶ Many low-income families have difficulty accessing affordable transportation as well.²⁷ As a result, they may not be able to secure necessary verification documents from medical providers or employers or provide those documents to the State in a timely manner.²⁸ These kinds of logistical barriers have been documented in the SNAP program; research shows that individuals frequently lose coverage due to reporting requirements at recertification.²⁹

Navigating the new notices, reporting, and exemption and good cause exception processes may be especially challenging for individuals with substance use disorders and/or with mental illness that affects their cognitive function.³⁰ In addition, individuals who have limited

²³ Jessica Greene, *Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFFAIRS BLOG, Sept. 5, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.

²⁴ Mich. 1115 Application, at 12-13; Robin Garfield et al., *supra* note 8; Margot Sanger-Katz, *Hate Paperwork? Medicaid Recipients Will Be Drowning In It*, N.Y. TIMES, Jan. 18, 2018, <https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?nytap=true&r=0>.

²⁵ Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015 8* (2017), <https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf>.

²⁶ *Id.* at 9; Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>.

²⁷ Samina T. Syed, Ben S. Gerber & Lisa K. Sharp, *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. COMMUNITY HEALTH 976 (2013) (attached).

²⁸ Mich. 1115 Application, at 12 (noting that medical professionals may be asked to verify work limitations for beneficiaries with certain medical conditions.)

²⁹ Gregory Mills et al., Urban Inst., *Understanding the Rates, Causes, and Costs of Churning in the Supplemental Nutrition Assistance Program (SNAP) - Final Report 74-77* (2014) <https://fns-prod.azureedge.net/sites/default/files/ops/SNAPChurning.pdf>; Colin Gray, Upjohn Inst., *Working Paper 18-288, Why Leave Benefits on the Table? Evidence from SNAP* (May 2018), http://research.upjohn.org/cgi/viewcontent.cgi?article=1306&context=up_workingpapers.

³⁰ Richard G. Frank, Commonwealth Fund, *Work Requirements and Medicaid: What Will Happen to Beneficiaries with Mental Illnesses or Substance Use Disorders?* (2018) https://www.commonwealthfund.org/publications/journal-article/2018/may/work-requirements-and-medicare-what-will-happen-beneficiaries?_ga=2.145100723.66621944.1539959203-1037196924.1539959203.

English proficiency or limited reading skills may find notices particularly confusing. Thus, the additional reporting and verification requirements are likely to exacerbate health disparities within Michigan.³¹

Conversely, reducing enrollees' administrative burdens increases coverage.³² Congress recognized and acted on this relationship to reduce administrative red tape, drafting the Affordable Care Act to:

- prohibit states from requiring an in-person interview for Medicaid applicants;
- eliminate asset tests for most Medicaid eligibility groups;
- require states to rely on electronic data matches to verify eligibility to the greatest extent possible before requesting documentation from applicants; and
- conduct annual eligibility redeterminations without requesting information from beneficiaries if eligibility can be determined using electronic data.³³

Michigan's proposal to require periodic reporting for enrollees who are working or qualify for an exemption directly undercuts those efforts and will decrease enrollment while increasing administrative costs for the state.

ii) *Individuals will struggle to complete 80 hours per month of work or related activities*

Data shows that Medicaid enrollees are already working a substantial amount. Almost 80 percent of adult Medicaid enrollees who do not receive Social Security disability benefits (SSI) live in families with at least one worker. Nearly 60 percent work themselves.³⁴

But many workers struggle to work consistently 80 hours every month due to the nature of the low-wage labor market. 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. Approximately one third of SNAP and

³¹ Michael Perry *et al.*, *supra* note 15, at 9.F.

³² Kaiser Family Found., *supra* note 16.

³³ See Wagner & Solomon, *supra* note 14 at 12; Kaiser Family Found., *supra* note 16.

³⁴ See Kristin F. Butcher & Diane Whitmore Schanzenbach, Ctr. on Budget & Pol. Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours*, in *Volatile Jobs* figure 6 (2018), https://www.cbpp.org/research/food-assistance/most-workers-in-low-wage-labor-market-work-substantial-hours-in-volatile?utm_source=CBPP+Email+Updates&utm_campaign=8db3a19904-EMAIL_CAMPAIGN_2018_07_23_03_37&utm_medium=email&utm_term=0_ee3f6da374-8db3a19904-111113873.

Medicaid recipients worked in one of these occupations.³⁵ Similarly, in Michigan one third of working Medicaid adult enrollees work in agriculture or the service industry.³⁶ These jobs do not provide consistent, predictable hours each month; they have variable 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.³⁷ Eighty-three percent of part-time workers report having unstable work schedules, and 41 percent of hourly workers between ages 26 and 32 receive one week or less notice of their schedules.³⁸

Moreover, these sectors experience high rates of *involuntary* part-time employment—meaning workers want to work full-time hours but are only offered part-time hours—with the retail and leisure and hospitality industries ranking highest.³⁹ 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.⁴⁰ Almost half of low-income workers would fail a work-hours test in at least one month over the course of one year due to the churn and volatility in the low-wage market.⁴¹

³⁵ *Id.* (adding percentages in figure 6 for a total of 32.9 percent); see also Josh Bivens & Shawn Fremstad, Economic Pol. Inst., *Why Punitive Work-Hours Tests In SNAP And Medicaid Would Harm Workers And Do Nothing To Raise Employment* (July 26, 2018), <https://www.epi.org/publication/why-punitive-work-hours-tests-in-snap-and-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).

³⁶ Rachel Garfield, Robin Rudowitz, & Anthony Damico, Understanding the Intersection of Medicaid and Work, Appendix, Kaiser Family Foundation (Dec. 07, 2017): <https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix/> (Table 3).

³⁷ Susan J. Lambert, Peter J. Fugiel & Julia R. Henly, *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot* (2014) (attached); Stephanie Luce, Sasha Hammad & Darrah Sipe, City Univ. of N.Y. and Retail Action Project, *Short Shifted*, (2014) http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf; Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits* (2015), <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>; Bivens & Fremstad, *supra* note 35; Tanya L. Goldman, Pronita Gupta, Eduardo Hernandez, Ctr. for Law & Social Pol., *The Struggles of Low Wage Work* (2018), https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf.

³⁸ Goldman, Gupta, & Hernandez, *supra* note 37.

³⁹ Bivens & Fremstad, *supra* note 35; Goldman, Gupta, & Hernandez, *supra* note 37.

⁴⁰ Kaiser Family Foundation, *What do Different Data Sources Tell Us About Medicaid and Work?* (July 23, 2018), <https://www.kff.org/medicaid/fact-sheet/what-do-different-data-sources-tell-us-about-medicaid-and-work/>.

⁴¹ Aviva Aron-Dine et al., Ctr. on Budget & Pol. Priorities, *Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/4-11-18health.pdf>.

Notably, individuals whose hours fluctuate regularly will often struggle to complete other activities at the last minute in months when their work hours fall short. Thus, the variation and volatility of the low-wage market significantly complicates compliance.

In addition to the realities of the low-wage labor market, other barriers will impede low-income Medicaid expansion enrollees from working 80 hours every month. As noted above, poor access to the internet can make finding work more difficult. Lack of transportation, illness and inadequate access to affordable child care also contribute to fluctuating hours and even job loss.⁴² An individual working 20 hours a week at Michigan's minimum wage (\$9.25) would need to spend 69% of their annual earnings just to cover the average cost of unsubsidized child care.⁴³

Under the State's proposal, individuals will be able to satisfy the work requirement by participating in specific unpaid activities, such as volunteering, technical training, and internships. But these un-paid activities will not be a viable pathway to compliance for many Medicaid enrollees. The same barriers to finding work – lack of internet access, transportation, and child care – make it difficult for low-income individuals to complete volunteer or other unpaid activities. After all, they still need to find a way to get to their internship or class, and parents will need to find child care to complete *any* of the alternative unpaid 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 minimum wage in exchange for hours they work.⁴⁴ FLSA concerns will also limit the number of recurring, stable volunteer opportunities that are available.⁴⁵

The requirement to work 80 hours per month will hit individuals with chronic and disabling conditions particularly hard. Michigan's characterization of the work requirement as applying only to "able-bodied" adults does nothing to resolve these concerns.⁴⁶ There is no

⁴² See generally Chandra Childers, Inst. for Women's Pol. Research & Women's Found. of Mississippi, *Women's Access to Quality Jobs in Mississippi* (2018) <https://iwpr.org/wp-content/uploads/2018/02/Womens-Access-to-Quality-Jobs-in-Mississippi-full-report.pdf>.

⁴³ Calculations based on \$6600 average costs for annual facility-based care in Michigan in 2016. Child Care Aware of America, *Child Care in America: 2016 State Fact Sheets*, 7 (2017), <http://usa.childcareaware.org/wp-content/uploads/2016/07/2016-Fact-Sheets-Full-Report-02-27-17.pdf>.

⁴⁴ See 29 U.S.C. § 206(a)(1)(C).

⁴⁵ See e.g., Dep't of Labor, Wage and Hour Division, *Fact Sheet #14A: Non-Profit Organizations and the Fair Labor Standards Act 2* (2015), <https://www.dol.gov/whd/regs/compliance/whdfs14a.pdf>.

⁴⁶ Mich. 1115 Application, at 11.

simple or comprehensive way to define “able-bodied” adults. Even though individuals may not have a disability that meets the strict Social Security Income (SSI) standard, they may still face substantial health-related barriers to work or other activities. 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.⁴⁷

To be clear, many expansion adults do in fact have chronic or disabling conditions that create serious barriers to work. Michigan’s 2016 enrollee survey found that 69 percent of adult enrollees reported at least one chronic condition, and nearly one in five (18%) had a functional limitation.⁴⁸ Those with chronic conditions were less likely to be working (44.1%) compared to enrollees with no chronic conditions (59.8%).⁴⁹ A recent study by the Kaiser Family Foundation found that in Michigan, 39 percent of adult Medicaid enrollees who were not receiving Social Security disability benefits and did not have a job were not working due to illness or disability.⁵⁰

On top of the challenges to employment because of physical or cognitive barriers, people with disabilities also 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 percent less likely to be considered for employment.⁵¹ 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

⁴⁷ 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).

⁴⁸ Susan Door Goold and Jeffrey Kullgren, Inst. for Healthcare Policy & Innovation at Univ. of Mich., *Report on the 2016 Healthy Michigan Voices Enrollee Survey*, 3 (June 21, 2017); see Mich. 1115 Application, at 811.

⁴⁹ *Id.* at 5.

⁵⁰ Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work*, Table 2 (2018), <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>.

⁵¹ 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.

a job with more hours or their hours have been cut back.⁵² Others experience difficulties obtaining necessary work supports or reasonable accommodations from their employer.

Though Michigan proposes to exempt individuals who self-report as “medically frail” or have a licensed medical professional attest they have a medical condition that limits them from meeting the work requirement, evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be. They are, in fact, more likely than others to lose benefits due to noncompliance with prescribed activities.⁵³ Numerous studies of state Temporary Assistance for Needy Families (TANF) programs have found that participants with physical or mental health conditions are disproportionately sanctioned for not completing the work requirement or related work activities.⁵⁴

Similarly, researchers of the SNAP program have expressed concern that states might incorrectly apply the work requirement to many of the nearly 20 percent of all SNAP participants living with a disability who do not receive disability benefits.⁵⁵ One study found that one-third of SNAP participants referred to an employment and training program in order to maintain their benefits reported a physical or mental limitation, and 25 percent of those participants indicated that the condition limited their daily activities. In addition,

⁵² 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>.

⁵³ 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).

⁵⁴ See, e.g., Yeheskel Hasenfeld et al., Univ. of Pennsylvania School of Social Pol. and Practice *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (2004), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers; Vicki Lens, *supra* note 53; MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>; Mathematica Pol. Research, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments* (2008) https://www.acf.hhs.gov/sites/default/files/opre/conducting_in_depth.pdf; Pamela Loprest, Urban Inst., *Disconnected Welfare Leavers Face Serious Risks* (2002), <http://www.urban.org/sites/default/files/publication/59036/310839-Disconnected-Welfare-Leavers-Face-Serious-Risks.PDF>.

⁵⁵ 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>.

almost 20 percent had filed for SSI or SSDI within the previous two years.⁵⁶ 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 percent of nearly 12,000 individuals subject to the requirement lost benefits after only three months.⁵⁷ State officials acknowledged that hundreds of enrollees had been wrongly classified as “able-bodied” when they were actually unable to work.⁵⁸

Likewise, “hardship” extensions in Maine’s TANF program did not effectively protect people with disabilities. The Maine Department of Health and Human Services (DHHS) reported that while nearly 90 percent of parents receiving TANF for five years or longer have a disability themselves or are caring for a disabled family member, only 17 percent of families terminated due to the time limits received a disability-related extension.⁵⁹ Several beneficiaries reported disability-related extension denials while they were applying for—and ultimately received—SSI benefits.⁶⁰ Beneficiaries also reported being discouraged from applying for extensions by TANF caseworkers and confusion about the process for applying for hardship extensions.⁶¹

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.⁶² 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.⁶³

In addition to disproportionately harming people with disabilities, work requirements may disproportionately harm people of color. Studies have found that caseworkers are more

⁵⁶ Ohio Association of Foodbanks, *Franklin County Work Experience Program Comprehensive Report: Able-Bodied Adults Without Dependents* (2015) (attached).

⁵⁷ *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>.

⁵⁸ *Id.*

⁵⁹ 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.

⁶⁰ Thomas Chalmers McLaughlin & Sandra S. Butler, *supra* note 59.

⁶¹ *Id.*

⁶² 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).

⁶³ See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

likely to sanction African American (as opposed to white) TANF participants for noncompliance with program requirements.⁶⁴

Finally, Michigan indicates that in some cases individuals may qualify for a good cause temporary exemption.⁶⁵ Recent data from Arkansas underscores that these exceptions will have little to no effect on the number of enrollees who lose coverage due to the work requirement. In July 2018, only four enrollees requested good cause exceptions, and three enrollees received one, while 12,722 individuals did not meet the work requirement.⁶⁶ In September 2018, Arkansas granted 140 good cause exemptions, while 16,757 individuals did not meet the work requirement that month, and 4,109 individuals lost coverage after their third month not meeting the requirements.⁶⁷

Taken together, Michigan's work requirement raises serious concerns that the State's project, if approved, will cause significant numbers of people to lose coverage, with a disproportionate impact on people with disabilities and people of color.

iii) *Employer sponsored insurance is unavailable and unaffordable for low-wage workers*

Michigan speculates little on what will happen to individuals who lose Medicaid coverage – other than suggesting they may find jobs that offer health insurance. All available evidence indicates that few individuals will secure stable jobs due to the work requirement. Thousands of Michiganders in the Medicaid expansion find jobs every month with no work requirement, but they face an unstable labor market and often remain Medicaid eligible. The State seems unwilling to provide the necessary resources or training to expand opportunities to higher positions. Those workers may lose access to affordable health insurance if they fail to meet the work requirement or if they face high premiums for Medicaid after 48 months. Redundant research suggests that employer-sponsored insurance will remain out of reach for the majority of low-income workers.

First, studies of cash assistance programs show that mandatory work requirements do not increase stable, long-term employment, and may in fact exacerbate deep poverty.⁶⁸ In fact,

⁶⁴ 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).

⁶⁵ Mich. 1115 application, at 11; see also 2018 Mich. Pub. Acts 208 § 107a(1)(d).

⁶⁶ Ark. Dep't of Human Servs., *Arkansas Works Program July 2018 Report* (attached).

⁶⁷ Ark. Dep't of Human Servs., *Arkansas Works Program August 2018 Report* (attached).

⁶⁸ 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/sites/default/files/atoms/files/6-6-16pov3.pdf>; LaDonna Pavetti, Ctr. on Budget

imposing work requirements in TANF actually led to an *increase* in extreme poverty in some areas of the country, as individuals who did not secure employment also lost their eligibility for cash assistance.⁶⁹ One robust literature review found that any employment increases attributable to TANF work requirements were modest and faded over time; that work requirements did not help individuals with major employment barriers to find work or increase stable employment in most cases; and that most beneficiaries' incomes remained below poverty.⁷⁰

Individuals who leave TANF due to increased earnings do not experience lasting income increases.⁷¹ For instance, Kansas parents who reported having a job when they left TANF

& Pol. Priorities, *Evidence Doesn't Support Claims of Success of TANF Work Requirements* (2018), <https://www.cbpp.org/research/family-income-support/evidence-doesnt-support-claims-of-success-of-tanf-work-requirements>; Sandra K. Danziger *et al.*, *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. POL'Y ANALYSIS & MGMT. 231, 234 (2016) (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; Administration for Children and Families, Department of Health and Human Services, *Characteristics and Financial Circumstances of TANF Recipients, Fiscal Year 2013*, Table 43, https://www.acf.hhs.gov/sites/default/files/ofa/tanf_characteristics_fy2013.pdf (In 2013, only 9.6 percent of recipients left the TANF program due to finding employment, while almost four times as many individuals (36 percent) left as a result of sanctions or a failure to comply with the verification and eligibility procedures); Tazra Mitchell & LaDonna Pavetti, Ctr. on Budget & Pol. Priorities, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (2018), <https://www.cbpp.org/research/family-income-support/life-after-tanf-in-kansas-for-most-unsteady-work-and-earnings-below> (TANF work requirements in Kansas did not result in measurable uptick in employment among TANF parents. Instead, work was common, but unsteady, resulting in inconsistent earnings and periods of unemployment); Musumeci & Zur, *supra* note 54.

⁶⁹ Pamela Loprest & Austin Nichols, Urban Inst., *Dynamics of Being Disconnected from Work and TANF* (2011), <http://www.urban.org/research/publication/dynamics-being-disconnected-work-and-tanf>; Pavetti, *Work Requirements Don't Cut Poverty*, *supra* note 68. Mitchell & Pavetti, *Life After TANF in Kansas* *supra* note 68 (analysis of long-term results of TANF work requirements in Kansas show evidence of extreme poverty among families who lost benefits: Parents who left due to work sanctions had median earnings averaging \$2,175 (or 11 percent FPL) after four years. 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).

⁷⁰ Heather Hahn *et al.*, Urban Inst., *Work Requirements in Social Safety Net Programs: A Status Report of Work Requirements in TANF, SNAP Housing Assistance, and Medicaid* (2017), <https://www.urban.org/research/publication/work-requirements-social-safety-net-programs-status-report-work-requirements-tanf-snap-housing-assistance-and-medicaid>.

⁷¹ For instance, in 2012, among Kansans who had a job, 26.4 percent made between 0 percent - 100 percent FPL; 46 percent made between >100 percent - 200 percent FPL; 15.9 percent made between >200 percent - 300 percent; and only 11.6 percent make >300 percent. See Rebecca Thiess, Economic Pol. Inst., *The Future of Work: Trends and Challenges for Low-Wage Workers* (2012), <http://www.epi.org/publication/bp341-future-of-work/>. Evaluations of Maine's SNAP program likewise demonstrate that the requirements are ineffective. Maine's evaluation of its own SNAP

in 2014 earned only \$1,107 per month, or \$13,284 annually (80 percent FPL for a family of two).⁷² A more recent analysis of state-collected data on employment and earnings of Kansas parents leaving TANF cash assistance between October 2011 and March 2015 suggests, however, that the long-term results in Kansas are even worse. Almost two thirds of parents had “deep poverty earnings” (earnings below 50 percent FPL) in the year after exiting TANF.⁷³ Four years after exiting the program, the numbers had not budged.⁷⁴ Parents terminated from TANF due to time limits, earned even less, a median of just \$1,370 annually (7 percent FPL).⁷⁵ The TANF-to-poverty ratio in Kansas further shows that Kansas’ reduced TANF caseload did not help the State’s low-income families escape poverty. Rather, TANF now reaches fewer people while leaving the rest behind; only 10 percent of Kansas families with children in poverty receive TANF assistance.⁷⁶

Current labor market data underscore why work requirements will not promote long-term employment and increases in income. Medicaid enrollees face low wages, stagnant wage growth, and volatile job prospects.⁷⁷ Even when individuals in the low-wage market work a substantial amount in one year, due to the nature of the work and the labor market, they may not see opportunities for advancement, increased work, or wages in the following

program was based on flawed and unreliable data, and as a result, reached flawed and misleading conclusions. In particular, the State’s analysis incorrectly attributed the rise in SNAP recipients’ wages during the relevant timeframe to the program’s requirements, instead of the overall growth in the economy over the same time period. But SNAP beneficiaries’ wages did not rise faster than the overall economy, and there is no basis for attributing that growth over a short time period to the requirements. Nor did the study consider the effects on individuals who *lost* SNAP benefits as a result of the requirements. Later analysis reveals that two-thirds of individuals who lost SNAP benefits due to work requirements remained unemployed, with neither wages nor SNAP benefits at the end of the year following termination. See Dottie Rosenbaum & Ed Bolen, Ctr. on Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit* (2016) <http://www.cbpp.org/research/food-assistance/snap-reports-present-misleading-findings-on-impact-of-three-month-time>; Maine Equal Justice Partners, *Work Requirements Do Not Work and Have Harmful Consequences* 5 (2017) <http://www.mejp.org/sites/default/files/WorkRequirement-FullReport-1Feb2018.pdf>.

⁷² Meg, Wingerter, “Do ‘welfare to work’ numbers add up?” Kansas Health Institute (Apr. 14, 2016), <http://www.khi.org/news/article/numbers-dont-support-welfare-to-work-claim>.

⁷³ Mitchell & Pavetti, *Life after TANF*, *supra* note 68.

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Ife Floyd, LaDonna Pavetti, and Liz Schott, Ctr. on Budget & Pol’y Priorities, *TANF Reaching Few Poor Families* (Dec. 13, 2017), <https://www.cbpp.org/research/family-income-support/tanf-reaching-few-poor-families>. In fact, between 1996 and 2016 the number of families with children living in deep poverty in Kansas has grown from 14,400 to 16,100. See Ctr. on Budget & Pol’y Priorities, *Kansas’ TANF Cash Assistance is Disappearing for Poor Families*, https://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ks.pdf.

⁷⁷ See Butcher & Whitmore Schanzenbach, *supra* note 34.

year.⁷⁸ In fact, those who had substantial work in one year were likely to experience drops in their income, hours, and wages in the next.⁷⁹

In contrast, research examining the relationship between Medicaid enrollment and employment shows that Medicaid is itself a critical work support. Medicaid coverage allows individuals to access the care and services they need to obtain and maintain work.⁸⁰ 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.⁸¹ A more recent evaluation of Ohio's Medicaid expansion reinforces this conclusion. A 2018 survey showed that 83.5% of the employed expansion population reported that Medicaid made it easier to work, and 60% of the unemployed expansion population said that Medicaid made it easier to look for work.⁸² Michigan's 2016 enrollee survey reported similar results, with 69% of working enrollees reporting Medicaid helped them do a better job, and 55% of out of work enrollees reporting the coverage helped them in their job search.⁸³

As noted above, Medicaid-enrolled workers are unlikely to have access to health coverage through their employer. According to the Kaiser Family Foundation, only 30 percent of workers in households with income below 100 percent of FPL had access to insurance through their employer, compared to nearly 80 percent of workers in households with income above 400 percent of FPL.⁸⁴ Among part-time workers, only 13 percent of those with incomes below poverty and 20 percent of those with incomes between 100 and 125 percent of FPL had an offer of insurance.⁸⁵ Another study found that among private-sector workers in the bottom fourth of the wage distribution, two-thirds lacked access to health care benefits from their employer.⁸⁶ A report based on 2017 data found that 78 percent of

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Tipirneni, *supra* note 13; Ohio Dep't of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* (2017), <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

⁸¹ Ohio Dep't of Medicaid (2017), *supra* note 80.

⁸² *Id.* at 21-22.

⁸³ Goold and Kullgren, *supra* note 48, at 6; Mich. 1115 Application, at 815.

⁸⁴ Kaiser Family Found., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates: 1999-2014*, 2 (2016) <http://files.kff.org/attachment/issue-brief-trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-2>. Another Kaiser Family Foundation study found that only a third of Medicaid workers (including adults with incomes up to 138 percent FPL) have an ESI offer, and that figure does not account for its cost. Rachel Garfield et al., *supra* note 26, at 4.

⁸⁵ Kaiser Fam. Found., *supra* note 84, at 4.

⁸⁶ Bivens & Fremstad, *supra* note 35.

very low-wage workers (bottom 10 percent of earners) did not have health care through their jobs, leaving just 22 percent with access to ESI.⁸⁷

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, only 16 percent of private-sector workers in the bottom fourth of the wage distribution had access to dental coverage and 8-9 percent had access to vision insurance.⁸⁸

And even where ESI is offered, it is often unaffordable. According to the United States Bureau of Labor Statistics, private-sector workers in the lowest 25 percent of wages are still responsible for an average of 24 percent of their premium costs, equaling \$133.75 each month.⁸⁹ That does not include cost sharing or other out-of-pocket expenses. Evidence from TANF confirms that uninsurance increases when people leave the program; "welfare-leavers" faced significant health coverage reductions that small increases in private coverage did not offset.⁹⁰

iv) *Conclusion: Work requirements will reduce enrollment, not boost employment*

Taken together, the evidence demonstrates that Michigan's work requirement will cause a large number of individuals, including those who work or are exempt from the requirement, to lose Medicaid coverage. Many will remain uninsured, with serious consequences for their health and well-being and the health and well-being of their children. These outcomes directly contradict the objectives of the Medicaid Act.

⁸⁷ Goldman, Gupta, & Hernandez, *supra* note 37.

⁸⁸ 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>.

⁸⁹ 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>.

⁹⁰ 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/..](https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/)

A far more productive (and permissible) approach would be to connect Medicaid enrollees to adequately resourced voluntary employment programs, a policy that needs no CMS waiver.⁹¹ Studies show that these voluntary employment programs, properly resourced, can 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 substantial and sustained earnings gains for participants when fully implemented.⁹² Montana's voluntary workforce promotion program, HELP-Link, supports Medicaid expansion adults. 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.⁹³ During HELP-Link's first three years, 22,000 Medicaid enrollees received services.⁹⁴ The State has reported that program participants have high employment rates, and the majority of participants had higher wages after completing the program.⁹⁵ Michigan could go this route without any waiver at all. However, the State has not taken the necessary steps to increase its resources for child care assistance, transportation assistance, job training, and case management that are hallmarks of successful employment interventions. Instead, Michigan's proposal puts the onus of compliance directly onto Medicaid families.

B. The work requirement and other proposed changes will create more expensive bureaucracy

The administrative costs associated with implementing the work requirement are high.⁹⁶ Michigan has estimated that a work requirement would cost the State \$15 to \$30 million every year.⁹⁷ Other states have found even higher implementation costs. According to a

⁹¹ The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

⁹² 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>.

⁹³ See Hannah Katch, Ctr. on Budget & Pol. Priorities, *Promising Montana Program Offers Services to Help Medicaid Enrollees Succeed in the Workforce* (2018), <https://www.cbpp.org/research/health/promising-montana-program-offers-services-to-help-medicaid-enrollees-succeed-in-the>.

⁹⁴ *Id.*

⁹⁵ Montana Dep't of Labor & Industry, *HELP-Link Program Update* (2018), https://dphhs.mt.gov/Portals/85/Documents/healthcare/March_percent202018_percent20HELP_Link_Fact_Sheet.pdf.

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

⁹⁷ Wagner & Solomon, *supra* note 14, at 15-16.

report from Fitch Ratings, Medicaid administrative costs in Kentucky have increased sharply - more than 40 percent - after preparing to implement the Kentucky HEALTH waiver, which included a work requirement, health expense accounts, and premium component.⁹⁸ Minnesota projected the implementation of a work requirement would cost local governments \$121 million in 2020 and \$163 million in 2021.⁹⁹

Other states have likewise described increased staffing and administrative costs associated with Medicaid waiver projects that require additional monitoring of individuals' behavior. One study indicated that Indiana's Medicaid managed care organizations had to increase administrative staffing ratios and devote more time to meet the State's requirements for oversight of the POWER accounts.¹⁰⁰ Officials in Arkansas estimated that administrative costs for that State's health savings accounts in Medicaid were over \$1,100 per participating beneficiary per year, and they abandoned the project.¹⁰¹ Arizona found that while premiums and higher cost sharing would bring in \$5.7 million in new revenues, it would cost the state three times more (\$15.8 million) to implement and administer the policy.¹⁰²

Michigan anticipates spending millions of dollars to implement the work requirement and other proposed changes. 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; track cumulative enrollment months for each enrollee; and handle an increased volume of administrative appeals for individuals who lose coverage due to the work requirement or other new conditions of eligibility.¹⁰³ Alaska estimated the added cost of work requirement-related appeals alone would exceed \$500,000 per year.¹⁰⁴

⁹⁸ Japsen, *supra* note 96.

⁹⁹ Wagner & Solomon, *supra* note 14, 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.

¹⁰⁰ Zylla E, Planalp C, Lukanen E, Blewett L, Medicaid and CHIP Payment and Access Commission, *Section 1115 Medicaid expansion waivers: implementation experiences*, (2018), <https://www.macpac.gov/wp-content/uploads/2018/02/SECTION-1115-MEDICAID-EXPANSION-WAIVERS-IMPLEMENTATION-EXPERIENCES.pdf>.

¹⁰¹ *Id.*

¹⁰² Ariz. 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>.

¹⁰³ Wagner & Solomon, *supra* note 14, at 4-6 (providing a list of added administrative burdens for states that implement a Medicaid work requirement); Musumeci & Zur, *supra* note 54 (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>.)

¹⁰⁴ State of Alaska, SB 193 Med. Assistance Work Requirement, Fiscal Note 1 (Mar. 28, 2018), <http://www.legis.state.ak.us/PDF/30/F/SB0193-1-2-032818-ADM-Y.PDF>.

In addition, evidence shows that churn on and off Medicaid increases both administrative and medical costs to the state.¹⁰⁵ Because the work requirement will increase churn, the State will incur substantially higher administrative costs per-beneficiary than continuous enrollment.¹⁰⁶ Hospitals and community health centers will also face increased uncompensated care costs when individuals lose coverage as a result of the work requirement, premiums or failing to complete healthy behaviors.¹⁰⁷

Notably, Michigan is requesting to incur these added administrative expenses for the whole expansion population just to target a small portion who: (1) are able to work but are not currently working; and (2) would not return to work on their own without a requirement. As noted above, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.¹⁰⁸ Adult Medicaid enrollees who are not receiving disability benefits and do not have a job are not working because they are: going to school (15 percent); taking care of their home or family (30 percent); retired (9 percent); unable to find work (6 percent); or dealing with illness or disability (36 percent).¹⁰⁹ Spending millions of dollars to impose the work requirement in hopes of changing behavior for the tiny remaining fraction of Medicaid enrollees – while cutting coverage for others– is not in line with the objectives of the Medicaid program.

C. The Literature on Work and Health Does Not Support Imposing a Work Requirement

Michigan asserts that requiring work activities will “promote work and community engagement and provide incentives to beneficiaries to increase their sense of purpose, build a healthy lifestyle, and further the positive physical and mental health benefits associated with work.”¹¹⁰ For support, Michigan’s application cites several of the same supporting studies CMS referred to in its January 11, 2018 Dear State Medicaid Director (DSMD) Letter.¹¹¹ However, as we explained in our January 11, 2018 response to the

¹⁰⁵ Leighton Ku et al., Ass’n for Community Affiliated Plans, *supra* note 15 at 1.

¹⁰⁶ *Id.*

¹⁰⁷ See, e.g., Jessica Schubel & Matt Broaddus, Ctr. on Budget & Pol. Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA’s Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains* (2018), <https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage>.

¹⁰⁸ Rachel Garfield et al., *supra* note 26, at 2 (finding that almost 80 percent of adults who are enrolled in Medicaid, but do not receive SSI, live in families with at least one worker, and almost 60 percent are working themselves).

¹⁰⁹ *Id.* at 4.

¹¹⁰ Mich. 1115 Application at 5.

¹¹¹ *Id.*

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.¹¹² The DSMD Letter oversimplifies the relationship between work and health, and none of the cited articles even considered the type of mandatory, punitive requirements that Michigan proposes here. In short, nothing in the DSMD Letter or the State's proposal provides any evidentiary support for the assertion that terminating health insurance for failing to comply with work requirements will improve health outcomes.

In fact, research evaluating the correlation between work and health shows that job quality matters.¹¹³ Stable, high-paying jobs in safe working environments might be associated with better health outcomes, but "working poor" status "is associated with health challenges as well."¹¹⁴ "High strain" jobs, or jobs with little reward or recognition, can increase poor health outcomes, such as high blood pressure and cardiovascular disease.¹¹⁵ Moreover, researchers have reiterated that access to health insurance that comes with stable employment explains a substantial part of the correlation between employment and longer life.¹¹⁶ It is health insurance, not employment alone, that helps improve outcomes.

As noted above, Michigan proposes that individuals will be able to satisfy the work requirement by participating in "volunteer work" and unpaid internships.¹¹⁷ Studies that find positive benefits from volunteering also find that the benefits diminished or disappeared when volunteering was seen as obligatory.¹¹⁸ There is no research evaluating the negative health effects of losing health insurance for failure to complete mandatory volunteering. Moreover, the existing studies of the relationship between volunteering and health have significant limitations. For example, many studies, including those cited by CMS as justifications, acknowledge that they do not distinguish between correlation and causation. Two studies noted, for example that people already in better health and with strong social ties were more

¹¹² Letter from Jane Perkins, Nat'l Health Law Program, to Brian Neale, Dir. Ctrs. for Medicare & Medicaid Servs. (Jan. 11, 2018) (attached).

¹¹³ See, e.g., Robert Wood Johnson Found., *Issue Brief: How Does Employment, or Unemployment, Affect Health?* (2013) (attached).

¹¹⁴ *Id.*

¹¹⁵ Douglas Jacobs, Health Affairs Blog, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health* (2018)

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

¹¹⁶ Robert Wood Johnson Found., *supra* note 113.

¹¹⁷ Mich. 1115 Application, at 11-12.

¹¹⁸ See, e.g., Robert Grimm, Jr., Kimberly Spring & Nathan Dietz, *The Health Benefits of Volunteering: A Review of Recent Research* (2007) (attached); Peggy A. Thoits & Lyndi N. Hewitt, *Volunteer Work and Well-Being*, 42 J. HEALTH & SOCIAL BEHAVIOR 115 (2001) (attached). See also Larisa Antonisse & Rachel Garfield, *supra* note 90.

likely to volunteer, signaling a self-selection bias.¹¹⁹ Another report found health benefits for an older adult population (over 65), but noted a weaker correlation between health and volunteering among younger adults.¹²⁰ Again, the literature on the link between volunteering and health does not support the policy that Michigan seeks to implement.

Even if it were true that work and/or volunteering leads to better health, Michigan ignores the detrimental effect that its waiver proposal would have on those enrollees who lose Medicaid coverage due to the work requirement. Without insurance coverage, many low-income Michiganders will suffer worse health outcomes alongside increased medical debt and financial insecurity. (See the discussion below on coverage loss and its consequences.)

In addition to jeopardizing the health of adults enrolled in Medicaid, the proposed work requirement puts the health and well-being of their children at risk. The work requirement will reduce parents' coverage, and research shows a strong correlation between parents having Medicaid coverage and their children also having insurance coverage and receiving recommended preventive services.¹²¹

Moreover, the work requirement will force many parents and caretakers to rely on childcare arrangements that are associated with poor child health outcomes. In 2016, the average annual costs of center-based and family-based care for a four-year old child in Michigan were \$6,722 and \$6,560, respectively.¹²² Low-income parents simply cannot afford these prices, and the State has not proposed to dedicate more resources to child care assistance. As a result, parents who manage to secure any childcare at all frequently rely on multiple, unstable childcare arrangements.¹²³ Numerous studies find a relationship

¹¹⁹ See Jens Detollenaere, Sara Willems & Stijn Baert, *Volunteering, Income and Health*, 12 PLOS ONE e0173139 (2017) (attached); Thoits & Hewitt, *supra* note 118.

¹²⁰ Grimm, Jr. et al., *supra* note 118.

¹²¹ Maya Venkataramani et al., *Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services*, 140 PEDIATRICS e20170953 (2017),

<http://pediatrics.aappublications.org/content/pediatrics/early/2017/11/09/peds.2017-0953.full.pdf>;

Georgetown Univ. Health Pol. Inst., Ctr. for Children & Families, *How Mississippi's Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children* (2018),

<https://ccf.georgetown.edu/wp-content/uploads/2018/04/Mississippi-Work-Requirement-Report.pdf>;

M. Karpman and G. Kenney, Urban Inst., *Quicktake: Health Insurance Coverage for Children and Parents: Changes Between 2013 and 2017* (2017) [http://hrms.urban.org/quicktakes/health-](http://hrms.urban.org/quicktakes/health-insurance-coverage-childrenparents-march-2017.html)

[insurance-coverage-childrenparents-march-2017.html](http://hrms.urban.org/quicktakes/health-insurance-coverage-childrenparents-march-2017.html); Ctr. on Budget & Pol. Priorities, *Harm to Children From Taking Away Medicaid From People for Not Meeting Work Requirements* (2018), <https://www.cbpp.org/sites/default/files/atoms/files/4-4-18health.pdf>.

¹²² Child Care Aware of America, *supra* note 43.

¹²³ Gina Adams et al., Urban Inst., *Child Care Instability: Definitions, Context, and Policy*

between childcare stability, attachment, and child outcomes, including effects on social competence, behavior outcomes, cognitive outcomes, language development, school adjustment, and overall well-being.¹²⁴ The effect of low-wage jobs for parents and childcare instability may particularly affect children living in poverty.¹²⁵ Allowing Michigan to implement the proposed work requirement despite evidence that it will likely harm the health and coverage of low-income children would be contrary to the purpose of the Medicaid Act

III. Increased Premiums Will Lead to Coverage Losses

In earlier comments, incorporated here, NHeLP has opposed premiums and the cumbersome, ineffective MI health accounts for low-income Michiganders under the current Healthy Michigan Plan.¹²⁶ Section 1115 does not permit the Secretary to allow Michigan to implement premiums and associated consequences for failure to pay for expansion adults. First, the Medicaid Act prohibits states from charging premiums to individuals with household income below 150% of FPL.¹²⁷ 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.¹²⁸ 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.¹²⁹

Second, the premiums and associated consequences are not experimental and conflict with the objectives of the Medicaid Act. Decades of policy research clearly shows that premiums substantially inhibit enrollment in Medicaid and CHIP programs and are not

Implications (2010), <https://www.urban.org/sites/default/files/publication/29446/412278-Child-Care-Instability-Definitions-Context-and-Policy-Implications.PDF>.

¹²⁴ *Id.* at 7.

¹²⁵ *Id.* at 8.

¹²⁶ National Health Law Program, *supra* note 1.

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

¹²⁸ Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.

¹²⁹ 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).

consistent with the objectives of the Medicaid program.¹³⁰ 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.¹³¹ These effects become more pronounced as income decreases.¹³²

¹³⁰ David Machledt & Jane Perkins, *Medicaid Premiums and Cost Sharing* (2014), <http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.WmYc06inGUk>; 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) (attached); Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, INQUIRY 378- (2006) (attached); Laura Snyder & Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid: A Review of Research Findings* (2013), <http://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417.pdf>; Brendan Saloner, Stephanie Hochhalter & Lindsay Sabik, *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016) (attached).

¹³¹ 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., *supra* note 130 (finding that imposing premiums on CHIP enrollees reduced initial enrollment and led to substantial disenrollment, and in some states disproportionately affected non-white individuals); 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), <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/rosenbach9-19-07.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%).

¹³² 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>; Salam Abdus et al., *Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children*, 33 HEALTH AFFAIRS 8, (2014) (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) (attached); Georgetown Univ. Health

For example, after Oregon imposed premiums ranging from \$6 to \$20 on certain Medicaid enrollees below 100 percent of FPL, nearly half of the affected enrollees lost coverage within the first six months. Of those who lost coverage, 40 percent 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 percent of FPL.¹³³ Further research examined the impact of the premiums after thirty months and found that only 33 percent of enrollees required to pay premiums remained continuously enrolled in the program over the thirty months, compared with 69 percent of enrollees not subject to premiums. Nearly one third of those required to pay premiums who lost Medicaid coverage remained uninsured.¹³⁴

In addition, recent data gathered from several states that have imposed premiums on the very populations that will be required to pay premiums in Michigan are similarly concerning. A significant portion of Medicaid enrollees subject to premiums cannot pay them, and in states that terminate enrollees for nonpayment, thousands of Medicaid enrollees have lost coverage.¹³⁵ 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

Pol'y Inst., Ctr. for Children & Families, *Cost Sharing for Children and Families in Medicaid and CHIP* (2009), http://ccf.georgetown.edu/wp-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).

¹³³ 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>.

¹³⁴ Bill J. Wright et al., *supra* note 130.

¹³⁵ 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).

project, 23 percent of 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.¹³⁶ In addition, the State terminated nearly 7 percent of enrollees required to pay premiums for failure to pay in subsequent months, with the termination rate increasing in the final months of the reporting period.¹³⁷ Overall, 55 percent of individuals 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.¹³⁸ More recent data from Indiana paint an even darker picture. During the third year of the project, 18 percent of all enrollees with incomes above 100 percent of FPL lost Medicaid coverage for failure to pay their monthly premiums.¹³⁹ Notably, the statistic understates the effect of the premiums, as not all enrollees with incomes above 100 percent of FPL are required to pay 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.

Despite the redundant evidence that premiums increase disenrollment, Michigan seeks to double down on its current policy and *increase* premiums to five percent of monthly income for individuals after 48 months of cumulative enrollment. One Medicaid/CHIP study that modeled the impact of premiums on low-income enrollment estimated that a premium at five percent of household income would lead to a 73 percent reduction in enrollment.¹⁴⁰ Notably, this proposed increase also flies in the face of evidence that Michigan's current policies charging premiums to individuals from 100-133 percent FPL already causes financial strain. The 2016 enrollee survey found that this higher income group was significantly more likely (by 6 percentage points) to report their health care payments were not affordable when compared to enrollees below the poverty level who had no monthly premium.¹⁴¹ A separate 2018 analysis of the impact of out-of-pocket expenses in HMP

¹³⁶ The Lewin Group, *HIP 2.0: Power Account Contribution Assessment ii* (Mar. 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.

¹³⁷ *Id.* at ii.

¹³⁸ *Id.* at 8-11.

¹³⁹ Ind. Dept. of Family & Soc. Servs. Admin., *Healthy Indiana Plan Demonstration: Section 1115 Annual Report for Demonstration Year Three* (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>

¹⁴⁰ Ku & Coughlin, *supra* note 131. This model was based on Medicaid and CHIP data from three states that had imposed premiums in CHIP or Medicaid.

¹⁴¹ Mich. 1115 Application, at 865 of PDF.

found that enrollees just above 100 percent FPL have a significantly higher rate of disenrollment than those just below it, particularly for individuals with lower health needs.¹⁴² This suggests that premiums lead to lower coverage rates.

Effectively, this proposal represents a back door mechanism for the State to impose a 48-month cumulative time limit on low-income Michiganders by making coverage too onerous to afford. The application suggests that individuals who are not current on their premium and cost-sharing requirements as they approach 48 months of eligibility will lose coverage after 48 months.¹⁴³ It is unclear if they will have to pay past debts to reenroll in the program. Michigan's proposed policy would also unfairly charge an individual with income at 101 percent FPL a higher share of their household income (5 percent) in premiums than someone earning 139 percent FPL (3.41 percent) who purchased Marketplace coverage.¹⁴⁴

This punitive premium policy, if implemented, would disproportionately affect older adults (under 65) and people with chronic conditions or disabilities.¹⁴⁵ An 2016 HMP enrollee survey found that enrollees aged 51-64 made up 27.5 percent of out of work enrollees and 42 percent of those unable to work, compared to just 20 percent of employed enrollees.¹⁴⁶ The reduced earnings in this group due to barriers to work increase their likelihood of longer term Medicaid eligibility and thus increases the likelihood they would become subject to harsh premiums. Even though the state exempts the medically frail, many enrollees will likely remain unaware of this exemption or may have conditions that present substantial barriers to work (and earnings) but do not qualify for a medically frail exemption.

The State's proposed premium increase thus contradicts the purpose of Medicaid by reducing enrollment and flouts Congress' clear intent on what constitutes "affordable" Medicaid coverage.

Even as the State seeks to increase the financial burden on some enrollees, it in other parts of the proposal it appears to acknowledge that out-of-pocket expenses inhibit access to care. The State describes a policy change to eliminate copays on medications for chronic conditions as follows:

¹⁴² Richard A. Hirth et al, Univ. of Michigan Inst. for Healthcare Pol'y & Innovation, *Report on the Impact of Cost Sharing in the Healthy Michigan Plan*, 6, 29 (July 30, 2018); see Mich. 1115 Application, at 917 of PDF.

¹⁴³ Mich. 1115 Application, at 9.

¹⁴⁴ Based on 2019 Marketplace rates.

¹⁴⁵ Goold and Kullgren, *supra* note 48; see Mich. 1115 Application, at 855 of PDF.

¹⁴⁶ *Id.*

In an effort to remove barriers to necessary care for Healthy Michigan Plan members, the Department has eliminated co-pays to promote greater access to services that prevent the progression of complications related to chronic disease. The Department believes that by eliminating co-pays for services related to chronic disease and the associated pharmaceuticals, members will be better able to achieve their health goals.¹⁴⁷

We agree that reducing financial barriers to care will help improve health outcomes, and evidence bears this out. A HMP cost sharing analysis found that, while individuals with extremely low incomes were most likely to use copay exempt medications (compared to higher income enrollees) through 30 months enrollment, their use of medications likely to require a copay dropped steeply during their second year.¹⁴⁸ The steep decline did not occur in higher income groups.

So on the one hand, the State premium policies clearly impose substantial financial burdens that make it more difficult for enrollees to maintain Medicaid coverage. On the other, the State acknowledges that it lowered copays seeking to improve access to care – and succeeded. Such findings only reinforce that Michigan’s premium program is ill-considered and not consistent with the purpose of the Medicaid program. It must be discontinued.

IV. Requiring Healthy Behaviors as a Condition of Eligibility Promises Additional Coverage Losses

The Healthy Michigan Program has already implemented a healthy behavior incentive intended to encourage enrollees to obtain health risk assessments by offering reductions in cost sharing. But the State’s independent evaluation shows the incentives remain poorly understood four years into the demonstration, and evidence from other states that have implemented similar incentives produced similar results. Still, Michigan proposes to expand this policy by requiring individuals to complete healthy behaviors to maintain coverage beyond 48 months, with requirements increasing as coverage continues.¹⁴⁹ Just as with work requirements, conditioning eligibility on healthy behaviors is not permitted under the Medicaid Act. This policy would only exacerbate coverage losses and thus is contrary to the purpose of the Medicaid Act.

¹⁴⁷ Mich. 1115 application, Attachment B at 7.

¹⁴⁸ Hirth et al., *supra* note 142, at 23.

¹⁴⁹ Mich. 1115 Application, Appendix 5, at 78 of PDF.

Michigan, which offers financial incentives to enrollees to complete a health risk assessment, has already experienced these issues with poor outreach and understanding. More than 85 percent of Medicaid enrollees failed to complete healthy behaviors, in part because “[m]ost beneficiaries did not know” about the reward.¹⁵⁰ A 2016 beneficiary survey in the State’s application packet indicates that, two years into the project, only 28 percent knew they could reduce cost sharing burden by doing an HRA.¹⁵¹ And a scant 0.1% reported that they got an HRA so they could reduce their cost sharing burden.¹⁵² Finally, the 2018 Performance Monitoring Report included with the application packet indicates that only 9.8 percent of enrollees complete their initial HRA within 150 days of enrollment, and only 10.5 percent completed an HRA in their second year of enrollment (months 11 to 15).¹⁵³ This is virtually identical to the completion rate in the 2017 report.¹⁵⁴ A 2016 survey of Michigan providers showed only 36 percent were familiar or somewhat familiar with the healthy behavior incentives in HMP.¹⁵⁵ This report estimated that only 20 percent of HMP members completed HRAs from the responding primary care providers.¹⁵⁶ In short, very few people understand Michigan’s healthy behavior incentive structure, and even fewer appear to change their behavior due to the incentives. There is no reason to believe a new punitive requirement will succeed where existing policies have largely failed, but such a requirement would substantially increase risks to beneficiaries.

Similar evidence from other states that have implemented similar accounts in their § 1115 projects shows that enrollees frequently remain unaware of the incentive or how it works.¹⁵⁷

¹⁵⁰ 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>.

¹⁵¹ Mich. 1115 application, at 26.

¹⁵² Goold and Kullgren, *supra* note 48, at 4.

¹⁵³ Mich. Dept Health & Human Servs., Medical Servs. Admin. Bureau Medicaid Care Management & Quality Assurance, *Performance Monitoring Report Healthy Michigan Plan: Composite – All Plans, 7-8* (Apr. 2018); see Mich. 1115 application, at 157-8 of PDF.

¹⁵⁴ Mich. Dept Health & Human Servs., Medical Servs. Admin. Bureau Medicaid Care Management & Quality Assurance, *Performance Monitoring Report Healthy Michigan Plan: Composite – All Plans, 7-8* (Apr. 2017); see Mich. 1115 application, at 455 of PDF.

¹⁵⁵ Susan Dorr Goold et al., Univ. of Mich. Inst. for Healthcare Pol’y & Innovation, *Primary Care Practitioners’ Views of the Impact of the Healthy Michigan Plan*, iii (Jan. 16, 2018); see Mich. 1115 Application, at 646 of PDF.

¹⁵⁶ Mich. 1115 Application, at 667 of PDF.

¹⁵⁷ Rob Saunders et al., ROBERT WOOD JOHNSON FOUND., *Are Carrots Good for Your Health? Current Evidence on Health Behavior Incentives in the Medicaid Program* (2018), https://healthpolicy.duke.edu/sites/default/files/atoms/files/duke_healthybehaviorincentives_6.1.pdf;

Enrollees in Indiana’s § 1115 project have a POWER account, which is coupled with a number of healthy behavior incentives. For example, Indiana 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 for the following year. An interim evaluation of Indiana’s project found that 40 percent of enrollees reported never having heard of the POWER account.¹⁵⁸ Of the rest, roughly a quarter incorrectly thought they did not have a POWER account, meaning that fewer than half of all enrollees even knew they had an account.¹⁵⁹ Further, slightly over half of enrollees incorrectly thought that receiving preventive services would result in deductions from their POWER account, while another 40 percent of enrollees reported not knowing if they could receive preventive services at no-cost.¹⁶⁰ 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 demonstrates widespread poor understanding of the rollover policy, making it hard to imagine it drives enrollee behavior.¹⁶¹ Notably, in year three of the project, only 34 to 50 percent of enrollees (depending on the managed care plan) received a preventive exam, far below the State’s goal of 85 percent.¹⁶²

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, well over four in five enrollees (83%) did not complete these activities.¹⁶³ In fact, 90 percent of enrollees reported not knowing about the incentives, and even clinic managers had “very limited awareness and knowledge” of them.¹⁶⁴

Hannah Katch & Judith Solomon, *Are Medicaid Incentives an Effective Way to Improve Health Outcomes?* (2017), <https://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes>.

¹⁵⁸ Lewin Group, *supra* note 21, at 65.

¹⁵⁹ *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>.

¹⁶⁰ The Lewin Group, *supra* note 21, at 66-7.

¹⁶¹ *Id.* at 66-68; see also David Machledt, Nat’l Health Law Program, *Indiana Medicaid Demonstration Raises Concerns* (2017) (attached).

¹⁶² Ind. Dept. of Family & Soc. Servs. Admin. , *supra* note 139, at 32.

¹⁶³ Natoshia M. Askelson et al., *Iowa’s Medicaid Expansion Promoted Healthy Behaviors but Was Challenging to Implement and Attracted Few Participants*, 36 HEALTH AFFAIRS 799 (2017) (attached).

¹⁶⁴ *Id.*

Even if a healthy behavior incentive was well known, such incentives often exclude or disproportionately impact people with disabilities, chronic conditions, or higher health risks.¹⁶⁵ Policies may not consider adequate accommodations or may be more stringent for people with chronic conditions, making them spend more or have difficulty maintaining coverage.

Taken together, this evidence suggests that even years after implementation, low-income Michiganders do not understand the MI Health accounts and healthy behavior incentives, making it unlikely that these mechanisms influence enrollees' behavior in a positive way. Even if enrollees do understand the accounts, the steadily increasing mandatory requirement Michigan proposes as a condition of eligibility creates a substantial burden that will reduce coverage and likely worsen health outcomes for people who lose coverage. For these reasons, the requested waiver to implement a healthy behavior requirement is not consistent with the purpose of Medicaid and must be denied.

V. HMP Coverage Losses Will Lead to Worse Health and Financial Outcomes

The above evidence clearly shows that Michigan's rosy projections of slightly increased enrollment are flat wrong. Work requirements, exorbitant premiums, and healthy behavior requirements will leave tens of thousands without coverage. Not surprisingly, gaps in coverage lead to worse health outcomes, including premature mortality.¹⁶⁶ These negative outcomes occur for a number of reasons. Churning on and off of coverage can result in higher use of the emergency room, including for conditions like asthma and diabetes that can be managed in an outpatient setting when people have consistent access to treatment.¹⁶⁷

¹⁶⁵ Jill R. Horwitz, Brenna D. Kelly & John E. DiNardo, *Wellness Incentives in the Workplace: Cost Savings through Cost Shifting to Unhealthy Workers*, 32 HEALTH AFFAIRS 468 (2013) (attached);

¹⁶⁶ 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/NEJMs1706645>; Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. OF HEALTH ECONOMICS 392 (2017), https://www.mitpressjournals.org/doi/full/10.1162/ajhe_a_00080; Allyson G. Hall *et al.*, *Lapses in Medicaid Coverage: Impact on Cost and Utilization Among Individuals with Diabetes Enrolled in Medicaid*, 48 MEDIC. CARE 1219 (2008) (attached); Andrew Bindman *et al.*, *Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions*, 149 ANNALS INTERNAL MEDICINE 854 (2008) (attached); Steffie Woolhandler and David U. Himmelstein, *The Relationship of Health Insurance and Mortality: Is Lack of Insurance Deadly?*, 167 ANN. INTERN. MED. 424 (2017); <http://annals.org/aim/fullarticle/2635326/relationship-health-insurance-mortality-lack-insurance-deadly>; Aviva Aron-Dine, Ctr. on Budget and Pol'y. Priorities, *Eligibility Restrictions in Recent Medicaid Waivers Would Cause Many Thousands of People to Become Uninsured* (Aug. 9 2018), <https://www.cbpp.org/sites/default/files/atoms/files/8-9-18health.pdf>.

¹⁶⁷ Leighton Ku and Erika Steinmetz, Ass'n for Community Affiliated Plans, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid* (2013), http://www.communityplans.net/Portals/0/Policy/Medicaid/GW_percent20Continuity_percent20Report_percent20_percent209-10-13.pdf.

Even brief lapses in coverage increase the incidence of skipped medications and foregone treatment and result in worse health outcomes and increased use of the emergency department.¹⁶⁸ 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.¹⁶⁹ Likewise, continuous insurance coverage is associated with earlier cancer identification and outcomes.¹⁷⁰

Independent studies of the Healthy Michigan Plan have also found that coverage significantly improves financial security.¹⁷¹ Other studies reinforce the finding that Medicaid expansion reduces medical debts and out-of-pocket expenses for enrollees.¹⁷² The Oregon Health Insurance Experiment found that Medicaid coverage reduced the likelihood of borrowing money or skipping bills to pay for medical care by 40 percent and reduced the probability of having a medical debt collection by 25 percent.¹⁷³ Another study of credit report data found that when compared to low-income areas in non-expansion states, low-income areas in expansion states experienced significant reductions in unpaid non-medical bills and in the amount of non-medical debt sent to third-party collection agencies.¹⁷⁴ A

¹⁶⁸ Leighton Ku et al., Ass'n for Community Affiliated Plans, *supra* note 15 at 1, 5-6; Julia Paradise & Rachel Garfield, Kaiser Family Found., *What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence* 4-5 (2013) <https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf>.

¹⁶⁹ Ku et al., *supra* note 15 at 1, 5-6.

¹⁷⁰ *Id.* at 6.

¹⁷¹ See, e.g., Sarah Miller et al., *The ACA Medicaid Expansion in Michigan and Financial Health* (2018), <http://www.nber.org/papers/w25053>.

¹⁷² See, e.g., Georgetown Univ. Health Pol. Inst., Ctr. for Children and Families, *Medicaid: How Does it Provide Economic Security for Families* (2017), <http://ccf.georgetown.edu/wp-content/uploads/2017/03/Medicaid-and-Economic-Security.pdf>; Jesse Cross-Call, Ctr. on Budget & Pol. Priorities, *More Evidence Medicaid Expansion Boosts Health, Well-Being* (2018), <https://www.cbpp.org/blog/more-evidence-medicaid-expansion-boosts-health-well-being> (highlighting data showing that health coverage reduces poverty and Medicaid expansion improves financial security); Louija Hu et al., *National Bureau of Economic Research Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being*, (2016), <http://nber.org/papers/w22170>; Dahlia K. Remler et al., *Estimating the Effects of Health Insurance and Other Social Programs on Poverty Under the Affordable Care Act*, 36 HEALTH AFFAIRS 1828 (2017) (attached); Paradise & Garfield, *supra* note 169 at 5-6. Nicole Dussault, Maxim Pinkovskiy & Basit Zafar, *Is Health Insurance Good for Your Financial Health?* Federal Reserve Bank of New York - Liberty Street Economics (2016), <http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html>; Katherine Baicker et al., *The Oregon Experiment -- Effects of Medicaid on Clinical Outcomes*, 36 NEW ENG. J. MED. 1713 (2013) (attached); Ohio Dep't of Medicaid, *supra* note, at 39-40.

¹⁷³ Finkelstein et al. *The Oregon Health Insurance Experiment: Evidence from the First Year*, 127 Q. J. ECON. 1057, 1057 (2012), <http://www.nber.org/papers/w17190.pdf>.

¹⁷⁴ Louija Hu et al., *supra* note 173.

national study found that medical debt fell by almost twice as much in expansion states (13 percent) compared to non-expansion states (7 percent).¹⁷⁵

Together, this data contradicts the State's hypothesis that its proposed changes will improve enrollees' financial well-being due increased employment. Causing major coverage losses in a program that itself already improves financial security is likely to worsen outcomes for enrollees.¹⁷⁶

Evidence also demonstrates how improved financial security due to Medicaid correlates with certain positive health outcomes and may even open up new financial opportunities. One national study found that Medicaid expansion reduced difficulty paying medical bills among low-income parents, and reduced stress and severe psychological distress.¹⁷⁷ Along with dramatically reducing financial strain, Oregon's Medicaid experiment also demonstrated significantly fewer positive screens for depression compared to a randomized control, amounting to a nearly 30 percent reduction.¹⁷⁸ A third study showed that Medicaid expansion reduced the incidence of newly-acrued medical debt by 30 percent to 40 percent and reduced the number of bankruptcies compared to non-expansion states.¹⁷⁹ 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.¹⁸⁰ Each of these studies bolsters the finding that Medicaid coverage itself improves enrollee's financial security and well-being.

VI. Conclusion

In summary, NHeLP supports voluntary programs that provide individualized employment supports to overcome barriers. Those programs do not require any waivers whatsoever, and Michigan is free to implement such a program on a voluntary basis. But Michigan's request to condition Medicaid eligibility on completion of work-related activities should be denied: all the requested waivers will do is enable the State to terminate Medicaid coverage to otherwise eligible individuals, leaving thousands in a coverage gap with no access to

¹⁷⁵ Aaron Sojourner & Ezra Golberstein, Health Affairs Blog, *Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction* (2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170724.061160/full/>.

¹⁷⁶ Mich. 1115 Application, at 7.

¹⁷⁷ Stacey McMorrow, et al, *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents*, 36 HEALTH AFFAIRS 808 (2017) (attached).

¹⁷⁸ Baicker et al, *supra* note 173.

¹⁷⁹ Kenneth Brevoort, Daniel Grodzicki, & Martin B. Hackmann, Nat'l Bureau of Economic Research, *Medicaid and Financial Health* 3 (2017) (attached).

¹⁸⁰ *Id.* at 3-4.

affordable health coverage. Similarly, the State's proposals to implement harsh premiums and required healthy behaviors will lead to coverage losses. These punitive policies will result in individuals joining the ranks of the uninsured. The obvious consequence? More gaps in coverage, decreased access to medical care, poorer health outcomes, and higher uncompensated care costs in hospitals and federally qualified health centers. Michigan's proposal is inconsistent with the standards of § 1115 and with other provisions of law and should be rejected.

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

We appreciate your consideration of our comments. If you have questions about these comments, please contact David Machledt (machledt@healthlaw.org) or Sarah Somers (somers@healthlaw.org).

Sincerely,

A handwritten signature in cursive script that reads "Jane Perkins". The signature is written in black ink on a light-colored background.

Jane Perkins
Legal Director