December 6, 2019

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: Utah 1115 Demonstration Waiver Amendment

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 Utah's application.

NHeLP supports Utah's decision to expand Medicaid to low-income adults, but recommends that the Department of Health & Human Services (HHS) reject the proposed project, which would impose a number of unlawful conditions on coverage and access to care. The project does not comply with the requirements of § 1115 of the Social Security Act, as it will block, rather than facilitate, access to Medicaid coverage and services.

I. HHS authority and § 1115

For the Secretary to approve Utah's 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.[1]

The purpose of Medicaid is to enable states to furnish medical assistance to individuals who are unable to meet the costs of necessary medical care and to furnish such

assistance and services to help these individuals attain or retain capability for independence or self-care.[2] As explained in detail below, the proposal is inconsistent with the provisions of § 1115.

II. The Project Will Reduce Medicaid Coverage

Utah seeks to implement a number of policy changes that will unquestionably reduce Medicaid enrollment. The State itself estimates that the project will lead to thousands of individuals losing coverage every year.[3] As such, the project runs directly counter to the purpose of the Medicaid program. What is more, Utah has not proposed a valid experiment. Instead, the State has indicated that it is requesting the project in an effort to reduce Medicaid spending.[4]

A. Capping Enrollment in the Expansion

Utah is seeking to cap enrollment in the adult expansion population group "when projected costs exceed annual state appropriations."[5] Capping enrollment for this population group runs counter to the objectives of the Medicaid Act. Congress designed Medicaid as an entitlement program. With very few exceptions, every person who meets the eligibility criteria outlined in the Medicaid Act receives medical assistance. As a result of the Affordable Care Act, the expansion population is described in the Medicaid Act.[6]

In addition, capping enrollment will demonstrate nothing. Utah has not even attempted to describe how not providing coverage to individuals otherwise eligible for Medicaid will yield any useful information.[7]

B. Imposing Work Requirements

Utah voters approved full Medicaid coverage for the expansion population without any additional eligibility criteria. Nevertheless, Utah is seeking to impose a work requirement on individuals in the expansion population who are not already working 30 hours per week.

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[1] 42 U.S.C. § 1315(a).
[2] *Id*. § 1396-1.
[3] Utah Dep't of Health, *Utah 1115 Demonstration Waiver Amendment* 34-35 (Nov. 1, 2019) (comparing enrollment with and without "all of the additional flexibilities and cost controls requested in this demonstration") [hereinafter Application].
[4] *See* Letter from Gary R. Herbert, Gov. of Utah, to Alex Azar, Sec'y, Dep't of Health & Human Servs. (Nov. 1, 2019).
[5] Application at 6.
[6] *See* 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).
[7] Notably, CMS recently informed Utah that it would not approve any request to impose an enrollment cap on the expansion population. *See* Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Gary R. Herbert, Gov. of Utah (Aug. 16, 2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/per-capita-cap/ut-per-capita-cap-correspondence-ltr-20190816.pdf.

Enrollees will be required to register for work with the State, complete an online evaluation, participate in online job training "modules" determined to be relevant, and apply for a certain number of jobs. Enrollees who do not complete these activities within three months will lose Medicaid eligibility until the end of their eligibility period. They may re-enroll before the end of their eligibility period if they complete the requirement or qualify for an exemption.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Utah to condition Medicaid eligibility on compliance with work activities. 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 limited list of eligibility criteria. Although states have flexibility in designing and administering their Medicaid programs, the Medicaid Act requires that they provide medical assistance, as far as practicable, to all individuals who meet the eligibility criteria established in federal law. As courts have held, imposing additional eligibility requirements is illegal.[8]

Section 1115 cannot be used to short-circuit these Medicaid protections. There is no basis for finding that the work requirements Utah describes are likely to assist in promoting the objectives of the Medicaid Act.[9] Put simply, conditioning Medicaid eligibility on completion of work activities blocks access to medical assistance.

The Work Requirement Will Lead to Substantial Coverage Losses

All evidence indicates that the work requirement will lead to substantial numbers of individuals losing Medicaid coverage.[10] In this application, Utah estimates that

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

[9] 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.

[10] *See, e.g.*, Leighton Ku et al, *Medicaid Work Requirements: Who's At Risk?*, HEALTH AFFAIRS BLOG (Apr. 12, 2017), https://www.healthaffairs.org/do/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 [hereinafter Garfield et al., *Implications of a Medicaid Work Requirement*]; Leighton Ku et al., *Medicaid Work Requirements: Will They Help the Unemployed Gain Jobs or Improve Health?*, 1 (2018), https://www.commonwealthfund.org/sites/default/files/2018-11/Ku_Medicaid_work_requirements_ib.pdf (Medicaid work requirements are "not well designed to help people get jobs or improve health and are more likely to lead to a loss of health insurance coverage.").

approximately 102,000 to 110,000 individuals will be enrolled in the adult expansion population every year.[11] Of those individuals, 70% will qualify for an exemption, leaving up to 33,000 people subject to the work requirement. Utah predicts that 20-25% of those individuals will not comply, meaning that as many as 8,200 people will lose coverage every year for failure to meet the work requirement.[12]

As troubling as that estimate is, it is likely too low. In total, Utah predicts that at most 7.5% of its adult expansion population will fail to meet the requirement. However, when New Hampshire implemented work requirements in June 2019, a full 35% of its expansion population did not meet the requirement.[13] Utah's underestimate could be due in part to the fact that it appears to assume that every individual who falls within an exemption category will actually receive an exemption. As described in more detail below, evidence from both New Hampshire and Arkansas contradicts that assumption.[14]

Whatever the precise number, there is no question that Utah's work requirement will cause significant coverage loss, eroding the health and financial benefits that come with providing Medicaid coverage to low-income people. Many individuals – including many individuals who are already working or fall within an exemption – will lose coverage due to the added administrative burdens associated with the work requirement.[15] Repeated research has shown that adding new administrative requirements for Medicaid enrollees decreases enrollment.[16] For example, in 2003 Texas experienced a nearly 30% drop in

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[11] Application at 34 (Table 6 projecting enrollment without the requested waivers). This figure excludes individuals in the targeted adult population because that group will not be subject to the work requirements.
[12] *Id*. at 6.
[13] N.H. Dep't of Health & Human Servs., *DHHS Community Engagement Report: June 2019*, https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-report-062019.pdf; *see also* Letter from Jeffrey A. Meyers, Comm'r N.H. Dep't of Health & Human Servs. to Gov. Christopher T. Sununu et al. (July 8, 2019), https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf (explaining decision to stop implementation of the work requirement to prevent the ""unintended loss of coverage for thousands of beneficiaries").
[14] The Arkansas work requirement caused 18,164 enrollees to lose coverage in only five months. *See* Ark. Dep't of Human Servs., *Arkansas Works Program December 2018 Report*, 8 (attached); *see also* Robin Rudowitz et al., Kaiser Family Found, *A Look at November State Data for Medicaid Work Requirements in Arkansas* (Dec. 2018), http://files.kff.org/attachment/Issue-Brief-A-Look-at-November-State-Data-for-Medicaid-Work-Requirements-in-Arkansas.
[15] *See, e.g.*, Garfield et al., *Implications of a Medicaid Work Requirement*; Jennifer Wagner & Judith Solomon, Ctr. on Budget & Policy Priorities, *States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries* (2018), https://www.cbpp.org/sites/default/files/atoms/files/5-23-18health2.pdf [hereinafter Wagner & Solomon, *States' Complex Medicaid Waivers*]; 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.
[16] *See* Wagner & Solomon, *States' Complex Medicaid Waivers*, at 3-4; Michael Perry et al., Kaiser Family Found., *Medicaid and Children, Overcoming Barriers to Enrollment, Findings from a National Survey* (2000), https://www.kff.org/wp-content/uploads/2013/01/medicaid-and-children-overcoming-barriers-to-enrollment-report.pdf [hereinafter Perry et al., *Medicaid and Children*]; Leighton Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care* 12-16 (2009)

enrollment after it increased premiums, established a waiting period, and moved from a 12- to 6-month renewal period for children in CHIP.[17] Similarly, when Washington increased documentation requirements, moved from a 12- to 6-month renewal period, and ended continuous eligibility for children in Medicaid and CHIP, enrollment dropped sharply.[18] Enrollment quickly rebounded when the State reinstated the 12-month renewal period and continuous eligibility.[19]

There are several reasons for this. First, states and their contractors inevitably make mistakes implementing eligibility requirements, causing some number of erroneous coverage losses.[20] In Arkansas, programming glitches created widespread problems accessing the State's work requirement reporting website.[21] In Indiana, where many Medicaid enrollees are required to pay premiums, reports have detailed widespread beneficiary confusion, and some enrollees have lost coverage despite having paid their premiums.[22]

Second, many enrollees fail to receive adequate notice of or simply do not understand the requirements, and as a result, do not comply. Utah's work requirement will include several distinct components that individuals must complete. They must: (a) register for work with

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http://www.communityplans.net/Portals/0/ACAP%20Docs/ACAP%20MCQA%20Report.pdf [hereinafter Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage*].

[17] 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* (2013), https://www.kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/).

[18] Kaiser Family Found., *Implications of Emerging Waivers* (citing Donna Cohen Ross & 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 & 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).

[19] *Id.*

[20] *See* Wagner & Solomon, *States' Complex Medicaid Waivers,* at 13-14.

[21] *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.

[22] 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-spreadbut-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. As the Indiana project has continued, so has disenrollment for failing to meet the requirements. *See, e.g.*, State of Indiana, *Section 1115 Annual Report, Healthy Indian Plan Demonstration* 15 (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.

the State; (b) complete an online evaluation; (c) participate in online job training "modules;" and (d) apply for a certain number of jobs. They must also evaluate whether they should apply for an exemption or good cause exemption from these requirements. Evaluations of past § 1115 projects have documented frequent and widespread confusion about program policies.[23] In-depth interviews with 18 adult Medicaid enrollees in Arkansas last September revealed "a profound lack of awareness" about the work requirement, with two-thirds of the enrollees having not even heard of the requirement.[24] Later focus groups conducted with 31 Medicaid enrollees in Arkansas showed many were still unaware of or confused by the new requirements in November, a full six months after the requirements went into effect.[25] And a recent study conducted by Harvard researchers confirmed that 44% of people subject to the work requirement in Arkansas had not even heard about it.[26]

Evidence from New Hampshire reveals similar problems.[27] There, the State reported that it had been unable to contact 20,000 of the approximately 50,000 people subject to the work requirements – notwithstanding mailing notices to all beneficiaries, holding public information sessions, and making tens of thousands of phone calls.[28] Although New Hampshire claimed that its outreach and reporting would differ from Arkansas's approach, the result of the work requirements was very similar.[29]

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[23] *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* Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage*, at 3 (noting 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.").

[24] Jessica Greene*, Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFFAIRS BLOG (Sept. 5, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180904.979085/full/.

[25] MaryBeth Musumeci et al., Kaiser Family Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees* (Dec. 2018), http://files.kff.org/attachment/Issue-Brief-Medicaid-Work-Requirements-in-Arkansas-Experience-and-Perspectives-of-Enrollees [hereinafter Musumeci, *Medicaid Work Requirements in Arkansas*].

[26] Benjamin Sommers et al., *Medicaid Work Requirements - Results from First Year in Arkansas*, N. ENG. J. MED., 8 (2019), https://static.politico.com/8d/24/6ef0e361444bb034aabc884b2606/sommers-arworks.pdf [hereinafter Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*].

[27] *See* Jason Moon, "Confusing Letters, Frustrated Members: N.H.'s Medicaid Work Requirement Takes Effect," N.H. PUB. RADIO (Jun. 18, 2019), https://www.nhpr.org/post/confusing-letters-frustrated-members-nhs-medicaid-work-requirement-takes-effect#stream/0.

[28] Ethan DeWitt, "New Hampshire Medicaid work requirement faces crucial test," CONCORD MONITOR (July 6, 2019), https://www.concordmonitor.com/New-Hampshire-Medicaid-work-requirement-faces-crucial-test-26791579; Gary Rayno, "Progress Made on NH Medicaid work requirement deal," EAGLE TRIBUNE (Jun. 18, 2019), https://www.eagletribune.com/news/progress-made-on-nh-medicaid-work-requirement-deal/article_fd8bc5df-4375-5e2d-a694-a3dc6c2b73f9.html

[29] Jason Moon, "N.H. Said Its Medicaid Work Requirement Would Be Different, Early Numbers Suggest Otherwise," N.H. PUBLIC RADIO (July 9, 2019), https://www.nhpr.org/post/nh-said-its-medicaid-work-requirement-would-be-different-early-numbers-suggest-otherwise#stream/0.

Certain populations could find it especially difficult to understand the new work requirement, including individuals with substance use disorders and/or with mental illness that affects their cognitive function.[30] In addition, safety net providers in Arkansas observed that individuals who have limited English proficiency or limited reading skills would struggle to comprehend notices and other information written at a high reading level in English.[31] Forty-three million adults in the U.S. have low English literacy skills, and at least 8.4 million of these individuals are functionally illiterate.[32] In this way, the work requirement is likely to exacerbate health disparities within Utah.[33]

Third, even individuals who understand their obligations under the work requirement will face challenges showing that they qualify for an exemption or good cause exemption.[34] For example, to receive an exemption for being "physically or mentally unable to meet the requirements," individuals will need to present documentation from their health care provider or some other source.[35] Reports from New Hampshire show how difficult and time-consuming it can be to get that kind of documentation.[36]

Similarly, parents of children over age six who are juggling part-time work and the required work activities will be entitled to a good cause exemption only if they are not able to fulfill the work requirement "due to childcare responsibilities."[37] However, it is not clear how broadly that good cause exemption will apply or how individuals will verify their eligibility. Will they have to collect and submit documentation showing that they could not secure

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[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-medicaid-what-will-happen-beneficiaries.

[31] Musumeci, *Medicaid Work Requirements in Arkansas*, at 6.

[32] Nat'l Ctr. for Education Statistics, Data Point: Adult Literacy in the United States (2019), https://nces.ed.gov/datapoints/2019179.asp.

[33] *See* Perry et al., *Medicaid and Children*.

[34] *See* Wagner & Solomon, *States' Complex Medicaid Waivers*, at 12-13; Garfield et al., *Implications of a Medicaid Work Requirement*; Margot Sanger-Katz, *Hate Paperwork? Medicaid Recipients Will Be Drowning In It*, N.Y. TIMES, Jan. 18, 2018, https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html?nytapp=true&_r=0.

[35] Application at 3.

[36] *See* Caitlin Andrews & Ethan DeWitt, "For 'medically frail,' judge's decision on Medicaid expansion work requirement comes as a relief," CONCORD MONITOR (Aug. 3, 2019), https://www.concordmonitor.com/Penacook-NH-medical-frailty-exemption-difficulties-26880774?utm_source=HeadlineAlerts&utm_medium=DailyNewsletter&utm_campaign=HeadlineAlerts

[37] Application at 5. A large number of parents could find themselves in that position. Utah is one of the top 10 least affordable states for before and after school care for school-aged children. Child Care Aware of America, *Parents and the High Cost of Child Care*, at 17 (2017), http://usa.childcareaware.org/wp-content/uploads/2017/12/2017_CCA_High_Cost_Report_FINAL.pdf . As of 2016, the average cost for nine months of center-based childcare for school-aged children in Utah was $5,626. *Id*. And, the average cost for three months of center-based full-time care for school-aged children was $6,406. *Id*. at 19. These prices are simply not affordable for low-income parents. Not only is childcare prohibitively expensive, but it is also in short supply. *See* Gina Adams et al., Urban Inst., *Child Care Challenges for Medicaid Work Requirements* (2019), https://www.urban.org/sites/default/files/publication/101094/medicaid_work_reqs_child_care_0.pdf.

affordable, quality childcare or that their car broke down, leaving them with childcare responsibilities?[38]

Data from Arkansas underscores that the proposed good cause exemptions will have little to no effect on the number of enrollees who lose coverage due to the work requirement.[39] Arkansas offered good cause exceptions for various unforeseen circumstances. From June to December 2018, Arkansas granted a total of 577 good cause exceptions, while 18,164 enrollees lost coverage for failure to comply with the work requirement.[40]

In addition, some workers in Utah will not fall within an exemption, but will nevertheless be unable to complete the required activities. Data show that Medicaid enrollees are already working a substantial amount. Over 80% of adult Medicaid enrollees who do not receive Social Security disability benefits (SSI) live in families with at least one worker. In Utah, a full 70% work themselves.[41] However, many workers are not working 30 hours per week, meaning they will not qualify for an exemption based on their work hours.[42] They will have to try to squeeze the required activities into their already busy schedules, which include working one or more part-time jobs.

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; waiters/waitresses; supervisors and proprietors of sales jobs; and housekeepers, maids, butlers, and stewards. Approximately one-third of SNAP and Medicaid recipients worked in

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[38] *See id*. at 15-16.

[39] Jennifer Wagner, Ctr. on Budget & Policy Priorities, *Commentary: As Predicted, Arkansas' Medicaid Waiver is Taking Coverage Away From Eligible People* (2018), https://www.cbpp.org/sites/default/files/atoms/files/12-18-18health.pdf; *see also* Judith Solomon, Ctr. on Budget & Pol'y Priorities, *Medicaid Work Requirements Can't Be Fixed* (2019), https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed.

[40] Ark. Dep't of Human Servs., *Arkansas Works Program December 2018 Report*, 3, 8 (attached). Notably, some individuals could have received a good cause exception in more than one month, meaning that far fewer than 577 individuals received such an exception.

[41] Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work: What Does the Data Say?* Appendix table 1 (2019), https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix/ [hereinafter Garfield et al., *Understanding the Intersection of Medicaid and Work*].

[42] *See id*. (finding that of the 70% of enrollees working in Utah, 42% work full-time and 27% work part-time). Notably, many low-wage workers find themselves in sectors with high rates of *involuntary* part-time employment – meaning workers want to work full-time hours but are only offered part-time hours. 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/ [hereinafter Bivens & Fremstad]; Tanya L. Goldman et al., 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 [hereinafter Goldman et al.].

one of these occupations.[43] In Utah, 50% of working Medicaid recipients have jobs in the agriculture or service industries.[44] Workers in these sectors have variable and unpredictable schedules, often set by employers with no possibility for changes.[45] In total, 83% of part-time workers report having unstable work schedules, and 41% of hourly workers between ages 26 and 32 receive one week or less notice of their schedules.[46] These unpredictable schedules will make it even harder for individuals to fit in the required work activities.

A host of additional logistical barriers, such as lack of broadband internet access and lack of transportation, will prevent individuals from completing the work activities. Nationwide, half of households with incomes under $25,000 have either no computer or no broadband at home.[47] Presumably, these individuals will need to travel to a library or community center to access the internet. However, low-income people are less likely to own a car than their middle- or upper-income peers, and many low-income families have trouble accessing affordable transportation.[48] Access to transportation is a particular problem in rural areas of Utah.[49] These kinds of logistical barriers have been documented in the SNAP program; research shows that individuals frequently lose coverage due to reporting

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[43] *See* Kristin F. Butcher & Diane Whitmore Schanzenbach, Ctr. on Budget & Policy. Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs*, figure 6 (2018), https://www.cbpp.org/sites/default/files/atoms/files/7-24-18pov.pdf (adding percentages in figure 6 for a total of 32.9%) [hereinafter Butcher & Whitmore Schanzenbach]; *see also* Bivens & Fremstad (reporting data from 2016 listing the most common occupations for workers receiving SNAP or Medicaid).

[44] Garfield et al., *Understanding the Intersection of Medicaid and Work*, at Appendix table 3.

[45] Susan J. Lambert et al., *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot* (2014) (attached); Stephanie Luce et al., 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; Goldman et al.; Michael Karpman et al., Urban Inst., *Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements*, (June 11, 2019), https://www.urban.org/sites/default/files/publication/100352/precarious_work_schedules_could_jeopardize_access_to_safety_net_programs.pdf.

[46] Goldman et al.

[47] Camille Ryan & Jamie Lewis, American Community Survey Reports, *Computer and Internet Use in the United States: 2015*, at 9 (2017), https://www.census.gov/content/dam/Census/library/publications/2017/acs/acs-37.pdf; Rachel Garfield et al., Kaiser Family Found., *Implications of Work Requirements in Medicaid: What Does the Data Say?* (Jun. 12, 2018), http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say [hereinafter Garfield et al., *Implications of Work Requirements in Medicaid: What Does the Data Say?*].

[48] Federal Highway Administration, *National Household Travel Survey Brief: Mobility Challenges for Households in Poverty* (2014), https://nhts.ornl.gov/briefs/PovertyBrief.pdf; 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).

[49] *See, e.g.*, Five Cty. Ass'n of Gov'ts, *Southwest Utah Coordinated Human Service Public Transportation Plan* 17 (2013), https://www.stgeorgeutah.com/wp-content/uploads/2013/11/2013-Southwest-Utah-Coordinated-Human-Service-Public-Transportation-Plan.pdf ("In many locations in the region, the only alternative to driving or calling on relatives and/or friends to help with transportation is taxi service. These services are a significant expense and not considered a viable option to most individuals.")

requirements at recertification.[50] While Utah proposes to give a good cause exemption to individuals who "are not able to participate due to a lack of internet or transportation," these same barriers will prevent many individuals from seeking and obtaining that good cause exemption.

The work requirement will hit individuals with chronic and disabling conditions particularly hard, and Utah's characterization of the work requirement as targeting "able-bodied" adults does nothing to resolve these concerns.[51] There is no definition of "able-bodied" adults. Even though individuals may not have a disability that meets the strict SSI standard, they may still face substantial barriers to work. Moreover, many individuals who do have a disability that meets the SSI standard rely on Medicaid while their applications for disability benefits are pending – a process that regularly lasts years.

Thus, many individuals in the expansion population do in fact have chronic or disabling conditions that prevent them from working. A recent study by the Kaiser Family Foundation found that roughly 30% of adult Medicaid enrollees who were not receiving disability benefits and did not have a job were not working because they were dealing with illness or disability.[52] Utah's proposal to exempt individuals who are "physically or mentally unable to meet the requirements" and offer a good cause exemption to individuals who have a disability and are unable to meet the requirements for reasons related to that disability will not provide sufficient protection.[53] Evidence from other programs with similar exemptions shows that, in practice, individuals with disabilities are not exempted as they should be and are more likely than other individuals to lose benefits.[54] Numerous studies of state TANF programs have found that participants with physical or mental health conditions are disproportionately likely to be sanctioned for not completing the work requirement.[55]

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[50] 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.

[51] *See* Application at 3.

[52] Garfield et al., *Understanding the Intersection of Medicaid and Work*.

[53] *See* Application at 3, 5.

[54] *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) [hereinafter Lens, *Welfare and Work Sanctions*].

[55] *See, e.g.*, Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (June 2004) (Departmental Paper, University of Pennsylvania School of Social Policy and Practice), http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers; Lens, *Welfare and Work Sanctions*; 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/ [hereinafter Musumeci & Zur, *Medicaid Enrollees and Work Requirements*]; Mathematica Pol. Research, *Assisting TANF Recipients*

Similarly, SNAP researchers have expressed concern that states might incorrectly determine that many of the nearly 20% of all SNAP participants who have a disability, but do not receive disability benefits, are subject to the work requirement.[56] One study found that one-third of SNAP participants referred to an employment and training program in order to keep their benefits reported a physical or mental limitation, and 25% of those individuals indicated that the condition limited their daily activities. In addition, almost 20% of the individuals had filed for SSI or SSDI within the previous two years.[57] In another example, when Georgia reinstated the SNAP work requirement and time limits for "able-bodied adults without dependents" in 2016, the State found that 62% of nearly 12,000 individuals subject to the requirement lost benefits after only three months.[58] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[59]

Recent evidence from the Medicaid context is also revealing. News accounts demonstrated how Arkansans with chronic conditions lost their coverage because of the work requirements.[60] A study by the Kaiser Family Foundation confirmed these reports, finding that despite the purported exemptions and safeguards in place, significant numbers of individuals with disabilities still lost coverage. The study notes that the safeguards were themselves complex and difficult to navigate and resulted in very few enrollees actually utilizing the exemptions.[61] And, the coverage losses occurred despite Arkansas "using existing data sources when possible" to confirm disability status.[62]

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

[56] *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.

[57] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults Without Dependents* (2015), http://ohiofoodbanks.org/wep/WEP-2013-2015-report.pdf.

[58] *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.

[59] *Id*.

[60] PBS News Hour, "With New Work Requirement, Thousands Lose Medicaid Coverage in Arkansas" (November 19, 2018), https://www.pbs.org/newshour/show/with-new-work-requirement-thousands-lose-medicaid-coverage-in-arkansas; Benjamin Hardy, "Locked out of Medicaid: Arkansas's Work Requirement Strips Insurance from Thousands of Working People," ARKANSAS TIMES (Nov. 19, 2018), https://arktimes.com/news/cover-stories/2018/11/19/locked-out-of-medicaid-2.

[61] MaryBeth Musumeci, Kaiser Family Found., *Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018* (Jun. 11, 2019), https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/.

[62] Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 8.

Because conditioning Medicaid eligibility on compliance with 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.[63] 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.[64]

Notably, individuals who lose access to Medicaid for failure to comply with the work requirement are extremely likely to remain uninsured.[65] First, Marketplace coverage is not an adequate substitute for Medicaid for the expansion population. Individuals with incomes below 100% of FPL will not have access to Marketplace subsidies (and the Administration is arguing in court cases that the ACA, including the Marketplace, is illegal and should be repealed in toto). In addition, research shows that not providing Medicaid coverage for individuals with incomes from 101-138% of FPL could lower coverage rates and increase out-of-pocket expenses.[66] One comprehensive study found that among individuals in this income bracket, access to Medicaid coverage (as opposed to access to a Marketplace plan) reduced the uninsurance rate by 4.5% and total average out-of-pocket spending by nearly 34% (or $344 annually).[67] In fact, the study found that

> Medicaid expansion was associated with lower average out-of-pocket premium spending (−$125), a lower probability of having a high out-of-pocket premium spending burden (that is, premium spending more than 10 percent of income) (−2.6 percentage points), and a lower probability of having any out-of-pocket premium spending (−7.5 percentage points). . . . Medicaid expansion was associated with lower average cost-sharing spending (−$218) and a lower probability of having any cost-sharing (−7.0 percentage points).[68]

Data from Wisconsin confirms that absent Medicaid coverage, a substantial number of individuals become uninsured. In 2014, Wisconsin eliminated Medicaid coverage for over 62,000 adults with incomes from 101-200% of FPL. Over four out of ten (42 percent) remained uninsured or their insurance status was unknown—despite access to subsidized

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[63] 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).
[64] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).
[65] Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*.
[66] Fredric Blavin et al., *Medicaid Versus Marketplace Coverage for Near-Poor Adults: Effects on Out-of-Pocket Spending and Coverage*, 37 HEALTH AFFAIRS 299 (2018) (attached).
[67] *Id*. at 304-305.
[68] *Id.* at 303. For individuals who do enroll in a Marketplace plan despite the costs, the heightened cost-sharing amounts reduce access to care. At lower income levels, even small cost-sharing amounts ($1-$5) deter individuals from accessing care. Samantha Artiga, Petry Ubri, and Julia Zur, Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

insurance on the Marketplace.[69] Differences in out-of-pocket spending between Medicaid and the Marketplace may also be exacerbated in rural areas, where premiums on the Marketplace are generally higher. This may increase the number of individuals who remain uninsured.[70]

Second, individuals who are working but nevertheless lose coverage for failure to comply are unlikely to have access to affordable health coverage through their employer. According to the Kaiser Family Foundation, 30% of workers in households with income below 100% of FPL had access to insurance through their employer, compared to nearly 80% of workers in households with income above 400% of FPL.[71] For part-time workers, only 13% of those with incomes below poverty and 20% of those with incomes from 100-250% of poverty had an offer.[72] Another study reached a similar conclusion, finding that among private-sector workers in the bottom fourth of the wage distribution, two-thirds lacked access to health care benefits from their employer.[73] A report based on 2017 data found that 78% of very low-wage workers (bottom 10% of earners) did not have insurance through their jobs.[74] Another study found that ESI declined from 65% to 55% from 2001 to 2015 in response to the rise in part-time employment, contract work, and alternative work arrangements.[75]

Tellingly, when Tennessee ended Medicaid coverage for approximately 170,000 low-income adults in 2005, its Medicaid coverage rate dropped by more than 5 percent, and the uninsured rate rose by approximately 5 percent.[76] The rate of private coverage among adults did not change meaningfully.[77] Likewise, 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.[78] All

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[69] Kids Forward, *The Wisconsin Approach to Medicaid Expansion* (2017), http://kidsforward.net/assets/Medicaid-Approach.pdf.
[70] Abigail R. Barker et al., RUPRI Ctr. for Rural Health Policy Analysis, *Health Insurance Marketplaces: Premium Trends in Rural Areas* (2016), https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2016/HIMs%20rural%20premium%20trends.pdf.
[71] Michelle Long et al., Kaiser Family Found., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates: 1999-2014* (2016), http://files.kff.org/attachment/issue-brief-trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-2.
[72] *Id*.
[73] Bivens & Fremstad.
[74] Goldman et al.
[75] Thomas C. Buchmueller & Robert G. Valletta, *Work, Health, and Insurance: A Shifting Landscape for Employers and Workers Alike,* 36 HEALTH AFFAIRS 214-221 (2017) (attached).
[76] Matt Broaddus, Ctr. on Budget & Policy Priorities, *Study: Insurance and Access to Care Down, With No Boost in Work Among Tennessee Adults Losing Medicaid* (2018) https://www.cbpp.org/blog/study-insurance-and-access-to-care-down-with-no-boost-in-work-among-tennessee-adults-losing.
[77] *Id*. In addition, there was no increase in the work rate, though there was a shift from full-time to part-time work following the disenrollment. Thus, taking Medicaid away from low-income adults did not increase work or access to commercial insurance. Instead, it increased uninsurance and associated negative health outcomes.
[78] 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-

these statistics point to an obvious conclusion: people who lose Medicaid coverage due to Utah's proposed work requirement are highly unlikely to find affordable alternative health coverage.

In sum, the evidence demonstrates that the work requirement will lead to a large number of individuals, including those who work or are exempt from the requirement, losing Medicaid coverage and remaining uninsured, with serious consequences for their health, well-being, and economic security (as described in Section II.G. below). These outcomes directly conflict with the Medicaid Act's core objective of furnishing affordable coverage.

The Literature on Work and Health Does Not Support Imposing a Work Requirement to Improve Health Outcomes.

Utah maintains that the work requirement will "improve health and well-being" by incentivizing work and community engagement.[79] CMS made the same assertion in its January 11, 2018 Dear State Medicaid Director (DSMD) Letter. However, as we explained in our January 11, 2018 response to the DSMD Letter (attached and incorporated herein by reference), the research CMS cited does not support the conclusion that a work requirement will make people healthier.[80] The DSMD Letter oversimplifies the relationship between work and health, misrepresents the conclusions of several cited studies, makes unsubstantiated leaps in logic, and overstates the association between work and health for low-income populations. In short, nothing in the DSMD Letter or in the State's proposal supports the assertion that terminating health insurance for failing to meet work requirements will improve health outcomes.

In fact, research evaluating the correlation between work and health shows that the relationship is "very complex" and suggests that a work requirement will be detrimental.[81] For one, job quality matters.[82] 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."[83] "High strain" jobs, or jobs with little reward or recognition, can increase poor health outcomes, such as high blood pressure and cardiovascular

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work-and-health-findings-from-a-literature-review/ [hereinafter Antonisse & Garfield, *The Relationship between Work and Health*]. *See also* Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*.

[79] Application at 3.

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

[81] Maike van der Noordt et al., *Health Effects of Employment: A Systematic Review of Prospective Studies,* 71 OCCUP. ENVIRON. MED. 730, 735 (2014) [hereinafter van der Noordt]; *see also* Antonisse & Garfield, *The Relationship between Work and Health*.

[82] *See, e.g.*, Robert Wood Johnson Found., *Issue Brief: How Does Employment, or Unemployment, Affect Health?* (2013), https://www.rwjf.org/en/library/research/2012/12/how-does-employment--or-unemployment--affect-health-.html.

[83] *Id*.

disease.[84] This is a key finding mentioned in two meta-analyses cited in the DSMD, but the letter never mentions it.[85]

Geography also matters. A British report cited in the DSMD reviews hundreds of studies of employment and health, but most are based in Europe or Australia. Of 46 annotated studies of adults (19 to 50) that looked at the relationship between health and employment, only 11 are US-based.[86] The bulk of research cited occurs in countries where universal health coverage is the norm and no one loses access to care if they lose their job. Waddell and Burton themselves actually find that "interventions which simply force claimants off benefits are more likely to harm their health and well-being."[87] In short, translating findings from mostly European studies to this Medicaid project in Utah can be misleading. A more relevant meta-analysis used 12 high-quality welfare-to-work interventions involving 27,482 individuals to examine the effects on the health of single parents. Eleven of these studies were based on data from North America. The researchers found that any effects of welfare-to-work on health were "largely of a magnitude that is unlikely to have tangible impacts" and concluded that welfare-to-work "does not have important effects on health."[88] CMS should use these findings, published in 2017, to reverse its ill-considered position on mandatory work requirements.

What is more, broad-based population studies that suggest employment is linked to better health and higher earnings are associated with longer life are not necessarily applicable to Medicaid-specific populations. For example, the DSMD cites to a 2016 JAMA study that found an association between lower unemployment rates and longer life. But the authors of that study actually found that for individuals in the lowest income quartile – the target population for Medicaid – "[un]employment rates, changes in population, and changes in the size of the labor force . . . were not significantly associated with life expectancy."[89] Other research explains that access to health insurance that comes with stable

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[84] Douglas Jacobs, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health*, HEALTH AFFAIRS BLOG (Aug. 6, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180730.371424/full/.
[85] Gordon Waddell & A. Kim Burton, *Is Work Good For Your Health & Well-Being?* EurErg Centre for Health and Social Care Research, University of Huddersfield, UK (2006) at 34 [hereinafter "Waddell & Burton"]; van der Noordt, at 735.
[86] Waddell & Burton, at 110-32.
[87] *Id.* at 112, 123.
[88] Marcia Gibson et al., *Welfare-to-Work Interventions and Their Effects on the Mental and Physical Health of Lone Parents and Their Children*, 2 Cochrane Database of Systematic Reviews, 2 & 3 (2018) (attached). Note that only half of these studies involved mandatory work requirements, and none involved the direct loss of health insurance due to non-compliance. The authors' limited analysis comparing the two types of programs "suggested that voluntary interventions that lead to increased income may have positive effect on child mental health, while mandatory interventions that increase employment but do not improve income may lead to negative impacts on maternal and child health." *Id.* at 51.
[89] Raj Chetty et al., *The Association Between Income and Life Expectancy in the United States*, 315 JAMA 1750, 1759 (2016).

employment accounts for a substantial part of the correlation between employment and longer life.[90] It is health insurance, not employment alone, that helps improve outcomes.

Perhaps the biggest complicating factor for research looking at the connection between health and employment is the key distinction between causation and correlation, another nuance that both Utah and the DSMD letter ignore. Van der Noordt et al., another meta-analysis cited in the DSMD, specifically acknowledges that the health/work association they describe is bi-directional. In other words, it may not be that work makes people healthy, but rather that healthier people are more likely to find or keep work. Van der Noordt et al. acknowledge that such health selection effects, along with other factors like publication bias, "may have caused an overestimation of the findings [that employment has a protective effect on mental health outcomes]."[91] Rather than grapple with this important factor, the DSMD misrepresents complex correlation as simple causation.

Utah references two additional studies to support its proposal.[92] Both studies found an unsurprising association between job loss and a deterioration in mental health. However, neither of the studies provides support for the idea that requiring individuals who have lost their job to meet a work requirement to maintain their health coverage will improve their mental health. In fact, both of the studies suggest that Medicaid coverage is beneficial in this situation because it could moderate the negative effect of job loss on mental health.[93] Individuals need Medicaid coverage to access services that will help them maintain their mental health, which in turn could help them find and keep a new job.[94] Moreover, the cited studies themselves acknowledge that obtaining an unsatisfactory, low-quality (low-wage, low-status) job is not correlated with improved mental health (as described above).[95] In fact, a systematic review of qualitative studies investigating the experience of lone parents subject to work requirements noted that parents most often found low-paying, precarious employment.[96] Ten of those studies noted that involvement in the welfare to work programs actually "exacerbated ill health."[97] The review concluded that "[t]his synthesis of the experiences of lone parents in mandatory [welfare to work programs]

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[90] Robert Wood Johnson Found., *Issue Brief: How Does Employment, or Unemployment, Affect Health?* (2013); *see also* Health Affairs, *Workforce Health and Productivity* (2016) (attached) ("Policies and benefits such as paid sick leave and unemployment compensation are associated with improved health outcomes.").
[91] Van der Noordt, at 735.
[92] Application at 3 (citing Karsten I. Paul & Klaus Moser, *Unemployment Impairs Mental Health: Meta-Analyses,*74 J. VOCATIONAL BEHAVIOR 264 (2009) [hereinafter Paul & Moser]; Frances M. McKee-Ryan, *Psychological and physical well-being during employment: a meta-analytic study*, 90 J. APPLIED TECH. 53 (2005) [hereinafter McKee-Ryan]).
[93] Paul & Moser (finding that both psychological intervention and higher levels of unemployment protection moderate the effect of unemployment on mental health); McKee-Ryan, at 64, 67 (finding that perceived financial strain was associated with lower mental health among unemployed individuals).
[94] *See* Paul & Moser, at 278.
[95] *See* McKee-Ryan, at 67-68.
[96] Mhairi Campbell et al., *Lone Parents, Health, Wellbeing and Welfare to Work: A Systematic Review of Qualitative Studies*, 16 BMC PUBLIC HEALTH 188, 188 (2016) (attached).
[97] *Id.* at 195.

suggests that . . . participation may do little to improve lone parents' health and wellbeing or economic circumstances, often only leading to low paid, precarious employment."[98]

Even if it were true that work leads to better health, Utah has ignored the detrimental effect that its waiver proposal would have on those enrollees who lose Medicaid coverage due to the work requirement. Without insurance coverage, low-income individuals will suffer worse health outcomes alongside increased medical debt and financial insecurity. (See the discussion in Section II.G. below.) Several of the studies in Waddell and Burton's report point to increased financial stress as a major mechanism that leads to psychological distress associated with unemployment.[99] That financial stress and resulting psychological distress would be recreated when individuals lose their health insurance.

In addition to jeopardizing the health of adults enrolled in the Medicaid expansion, the proposed work requirement puts the health and well-being of their children at risk. The work requirement will reduce parents' coverage, and research shows a strong correlation between parents having Medicaid coverage and their children receiving recommended preventive services.[100] Some parents could be dissuaded from even trying to enroll in the first place, given the perceived complexity of the work requirements.[101] In 2000, a survey of parents revealed that the perceived difficulty of applying, the complexity of rules and regulations, and confusion about how to apply were all significant factors that prevented parents from even trying to enroll their children in Medicaid.[102]

If Utah truly wants to improve the health of low-income individuals in the State, it should implement the Medicaid expansion without imposing the barriers to coverage and care created by work requirements.[103] Other states that expanded Medicaid without added conditions of eligibility saw improvements in care utilization, financial well-being, and health metrics.[104] Medicaid expansion coverage gains nationally have been extremely beneficial for individuals in small towns and rural areas.[105] In addition, full Medicaid

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[98] *Id.* at 197.
[99] Waddell & Burton, Table 2A, at 123, (citing Halvorsen 1998).
[100] 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.
[101] Perry et al., *Medicaid and Children*, at 10-12; Judith Solomon, Ctr. on Budget & Policy Priorities, *Locking People Out of Medicaid Coverage Will Increase Uninsured, Harm Beneficiaries' Health* (2018), https://www.cbpp.org/research/health/locking-people-out-of-medicaid-coverage-will-increase-uninsured-harm-beneficiaries.
[102] Perry et al., *Medicaid and Children,* at 10-12.
[103] *See* Antonisse et al., *The Effects of Medicaid Expansion under the ACA*; Sarah Miller et al., Nat'l Bureau of Economic Research*, Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data*, *Working Paper 26081* (2019) (attached).
[104] *See* Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance* 176 JAMA INTERNAL MEDICINE 1501 (2016), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420.
[105] See Jack Hoadley, Joan Alker, & Mark Holmes, Georgetown Univ. Ctr. for Children & Families and the Univ. of North Carolina, NC Rural Health Research Program, *Health Insurance Coverage in Small Towns*

expansion has been widely experienced as a financial boon to participating states.[106] And yet, Utah proposes to undercut the positive impact of its Medicaid expansion by implementing mandatory work requirements that will harm the health of low-income individuals.

Research Does Not Support Imposing a Work Requirement to Increase Employment and Financial Independence.

Utah argues that imposing a work requirement on Medicaid enrollees will lead people to employment, and with that employment will come financial independence. Redundant research refutes this claim. Harvard researchers found that the Medicaid work requirement in Arkansas did not result in any significant changes in employment.[107] In fact, the number of individuals working more than 20 hours a week declined after implementation of the work requirement.[108] Notably, the study did detect a rise in the rate of uninsured individuals.[109] In other words, the work requirement did not move people into work and off of Medicaid due to increased earnings; it caused individuals to lose Medicaid and remained uninsured.

Duplicative and rigorous studies of other public benefits programs show that work requirements do not increase stable, long-term employment.[110] In fact, imposing work

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and Rural America: The Role of Medicaid Expansion, 8 (2018), https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf.

[106] Larisa Antonisse et al., Kaiser Family Foundation, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, (Aug. 15, 2019), https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-august-2019/

[107] Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 6-9 (2019); *see also* Jennifer Wagner, Ctr. on Budget & Policy Priorities, *New Arkansas Data Contradicts Claims That Most Who Lost Medicaid Found Jobs* (Mar. 19, 2019), https://www.cbpp.org/blog/new-arkansas-data-contradict-claims-that-most-who-lost-medicaid-found-jobs.

[108] Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 7 (figure 2).

[109] *Id*. at 6-9.

[110] *See See* Leighton Ku & Erin Brantley, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage*, THE COMMONWEALTH FUND (June 21, 2019), https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage ("Several rigorous studies found that SNAP work requirements reduce enrollment and have little to no employment benefits. . . . These studies join a body of research about the damage caused by work requirements in Temporary Assistance for Needy Families and their failure to improve health or employment."); LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Work Requirements Don't Work* (2018), https://www.cbpp.org/blog/work-requirements-dont-work, LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Work Requirements Don't Cut Poverty, Evidence Shows* (2016), https://www.cbpp.org/research/poverty-and-inequality/work-requirements-dont-cut-poverty-evidence-shows [hereinafter Pavetti, *Work Requirements Don't Cut Poverty*]; LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Evidence Doesn't Support Claims of Success of TANF Work Requirements* (2018), https://www.cbpp.org/research/family-income-support/evidence-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),

requirements in TANF led to an increase in extreme poverty in some areas of the country, as individuals who did not secure employment lost their eligibility for cash assistance.[111] 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.[112]

Proponents of work requirements argue that the data show that TANF caseloads shrunk due to increased earnings. But these assertions have been shown to have been based on seriously flawed analysis.[113] More rigorous, and long-term analyses indicate that individuals who left TANF due to increased earnings did not typically experience lasting income increases.[114] For instance, Kansas parents who reported having a job when they

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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% of recipients left the TANF program due to finding employment, while almost four times as many individuals (36%) left as a result of sanctions or a failure to comply with the verification and eligibility procedures); Tazra Mitchell & LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Life After TANF in Kansas: For Most, Unsteady Work and Earnings Below Half the Poverty Line* (2018), https://www.cbpp.org/research/family-income-support/life-after-tanf-in-kansas-for-most-unsteady-work-and-earnings-below (TANF work requirements in Kansas did not result in a measurable uptick in employment among TANF parents. Instead, work was common, but unsteady, resulting in inconsistent earnings and periods of unemployment) [hereinafter Mitchell & Pavetti, *Life After TANF in Kansas*]; Musumeci & Zur, *Medicaid Enrollees and Work Requirements*.

[111] Pavetti, *Work Requirements Don't Cut Poverty*. Two recent reports from Kansas and Maine purport to indicate that the SNAP work requirement increases employment and earnings among enrollees. However, these reports reach flawed and misleading conclusions; they incorrectly "attribute rising work rates and earnings to the work requirements," when "most, if not all, of the changes would have happened without it." Dorothy Rosenbaum & Ed Bolen, Ctr. on Budget & Policy Priorities, *SNAP Reports Present Misleading Findings on Impact of Three-Month Time Limit* (2016), https://www.cbpp.org/sites/default/files/atoms/files/12-14-16fa.pdf.

[112] 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.

[113] *See, e.g.*, Erin Brantley & Leighton Ku, *Critique of a Flawed Analysis about Medicaid Work Requirements*, GW HEALTH POLICY MATTERS BLOG (Jan. 14, 2019), http://gwhealthpolicymatters.com/blog-critique-flawed-analysis-about-medicaid-work-requirements; Erin Brantley & Leighton Ku, *Work Requirements: SNAP Data Show Medicaid Losses Could Be Much Faster and Deeper Than Projected*, HEALTH AFFAIRS BLOG (Apr. 12, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180412.310199/full/; LaDonna Pavetti, Ctr. on Budget & Policy Priorities, *Evidence Doesn't Support Claims of Success of TANF Work Requirements* (2018), https://www.cbpp.org/research/family-income-support/evidence-doesnt-support-claims-of-success-of-tanf-work-requirements; LaDonna Pavetti, *Evidence Counters CEA Claims on Work Requirements*, Ctr. on Budget & Policy Priorities Blog (July 30, 2018), https://www.cbpp.org/blog/evidence-counters-cea-claims-on-work-requirements.

[114] *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 program was based on flawed and unreliable data, and as a result, reached flawed and misleading conclusions. In

left TANF in 2014 earned only $1,107 per month, or $13,284 annually (80% FPL for a family of two).[115] A more recent analysis suggests, however, that the long-term results in Kansas are even worse. Almost two thirds of parents who left TANF from 2011 to 2015 had "deep poverty earnings" (earnings below 50% FPL) in the year after exiting the program.[116] Four years later, the numbers had not budged.[117] Parents terminated from TANF due to time limits earned even less, a median of just $1,370 annually (7% FPL).[118] The TANF-to-poverty ratio in Kansas further shows that the State's reduced TANF caseload did not help low-income families escape poverty. Rather, TANF now reaches fewer people while leaving the rest behind; only 10% of Kansas families with children in poverty receive TANF assistance.[119]

There is no reason to expect better employment and earnings outcomes for Medicaid enrollees in Utah, particularly given the poor economic conditions in some areas of the State. Recognizing the lack of available jobs, the U.S. Department of Agriculture waived the work requirement and time limits for SNAP enrollees in 6 of the 29 counties in the State. In the current labor market, Medicaid enrollees face low wages, stagnant wage growth, and volatile job prospects.[120] Nothing in the application indicates that Utah plans to increase state funding to provide meaningful and effective education and training programs for individuals subject to the work requirement. In fact, Utah is proposing to require Medicaid enrollees to complete the same online work activities as SNAP enrollees.[121] As NHeLP and the National Center for Law & Economic Justice noted in our November 3, 2017 letter to CMS (attached and incorporated herein by reference), the

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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 those individuals 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.

[115] 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.

[116] Mitchell & Pavetti, *Life After TANF in Kansas*.

[117] *Id.*

[118] *Id.*

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

[120] *See* Butcher & Whitmore Schanzenbach.

[121] Application at 4.

SNAP Employment & Training program has not been effective in increasing gainful employment in Utah.[122]

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.[123] 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.[124] In a 2018 survey, more than four in five working Medicaid expansion enrollees (83.5%) 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.[125] In Michigan, another expansion state, the 2016 enrollee survey showed 69% of workers reported Medicaid helped them do a better job and 40% reported Medicaid helped them get an even better job. Fifty-five percent of out-of-work enrollees reported the coverage helped them in their job search.[126]

A far more productive (and permissible) approach would be to connect Medicaid expansion enrollees to properly resourced voluntary employment programs, an activity that does not need waiver approval from CMS.[127] Studies show that these voluntary employment programs, when adequately 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 that the program produced substantial and sustained gains in earnings when fully implemented.[128] In addition, Montana implemented a voluntary workforce promotion program (HELP-Link) to support the Medicaid expansion population. The State targets Medicaid enrollees who are looking for work or better jobs, assesses their needs, and then connects them with individualized job support and training services.[129] During HELP-Link's first three years,

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[122] *See* Letter from NCLEJ & NHeLP to Ms. Shanna Janu, Div. of Medicaid Expansion Demonstrations, CMS (Nov. 3, 2017) (attached).
[123] 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 [hereinafter Ohio Dep't of Medicaid, Ohio Medicaid Group VII Assessment (2017)].
[124] *Id*.
[125] *Id.* at 21-22.
[126] Susan Door Goold & Jeffrey Kullgren, Inst. for Healthcare Policy & Innovation at Univ. of Mich., *Report on the 2016 Healthy Michigan Voices Enrollee Survey*, 5-6 (June 21, 2017) (attached).
[127] The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.
[128] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.mdrc.org/publication/promoting-work-public-housing; 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.
[129] *See* Hannah Katch, Ctr. on Budget & Policy Priorities, *Promising Montana Program Offers Services to Help Medicaid Enrollees Succeed in the Workforce* (2018), https://www.cbpp.org/research/health/promising-montana-program-offers-services-to-help-medicaid-enrollees-succeed-in-the.

over 25,000 Medicaid enrollees received services.[130] The State has reported that program participants have high employment rates, and the majority of participants had higher wages after completing the program.[131]

The Work Requirement Will Be Expensive to Administer.

Utah did not provide an estimate of the administrative costs associated with the work requirement. All available evidence indicates that these implementation costs will be high.[132] For example, the GAO reported that the administrative costs to implement work requirements would be over $270 million in Kentucky and almost $70 million in Wisconsin.[133] According to a report from Fitch Ratings, Medicaid administrative costs in Kentucky increased by more than 40% after preparing to implement the Kentucky HEALTH project, which included a work requirement.[134] Other states have likewise estimated that the costs of implementing a work requirement would be substantial.[135] For example, Michigan estimated that a work requirement would cost the State $15 to $30 million every year.[136] Minnesota projected implementing a work requirement would cost local governments $121 million in 2020 and $163 million in 2021.[137] New Hampshire recently spent $130,000 on outreach alone—*prior to* deciding to pause implementation of its work requirement to prevent thousands of people from losing coverage.[138]

Utah counters that the administrative cost will be minimal, claiming that because the Medicaid work requirement mirrors that in SNAP, the necessary technology and infrastructure is already in place.[139] Even assuming that is true, a number of major

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[130] Montana Dep't of Labor & Industry, *HELP-Link Program 2018 Fiscal Year End Report* (2018), http://lmi.mt.gov/Portals/193/Publications/LMI-Pubs/Special%20Reports%20and%20Studies/HELP-Link_2018Report.pdf.

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

[132] *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, *States' Complex Medicaid Waivers*, at 15-16 (listing state estimates of the cost associated with implementing a work requirement).

[133] Government Accountability Office, *Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements* (Oct. 2019), https://www.gao.gov/assets/710/701885.pdf.

[134] *See* 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.

[135] Wagner & Solomon, *States' Complex Medicaid Waivers*, at 15-16.

[136] *Id*.

[137] *Id*. *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.

[138] Holly Ramer, "N.H. delays work requirement compliance deadline," CONCORD MONITOR (July 8, 2019), https://www.concordmonitor.com/New-Hampshire-delays-work-requirement-compliance-deadline-26844999.

[139] Application at 91.

expenses will remain. The State must develop a process for determining which Medicaid enrollees are subject to the work requirement, and for those enrollees, track work hours or participation in the required activities. Among other things, Utah must also: create new application forms and notices to inform Medicaid enrollees of the work requirement; process requests for exemptions (which do not mirror the SNAP exemptions) and good cause exceptions; process an increased volume of re-applications (when individuals lose coverage for failure to meet the work requirement, but then complete the requirement or fall within an exemption); and handle an increased volume of administrative appeals for individuals who lose coverage due to the work requirement.[140] Alaska estimated the added cost of work requirement-related appeals alone would exceed $500,000 every year.[141]

Evidence shows that churn on and off Medicaid increases both administrative and medical costs. Because the work requirement will result in increased churning, the State will incur higher administrative costs per-enrollee than continuous enrollment.[142] Studies show that administrative costs can be hundreds of dollars per person enrolled in a program, and that costs—both expenses and time—increase with documentation requirements.[143] These estimates do not take into account the increased uncompensated care costs that hospitals and community health centers will face when individuals who do not comply with the work requirement and lose coverage.[144]

Notably, Utah is requesting to incur these expenses to target a very small portion of individuals. A recent study by the Kaiser Family Foundation confirms that the vast majority

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[140] Wagner & Solomon, *States' Complex Medicaid Waivers*, at 4-6 (providing a list of added administrative burdens for states that implement a Medicaid work requirement); Musumeci & Zur, *Medicaid Enrollees and Work Requirements* (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).

[141] 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.

[142] Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care*, at 1.

[143] *See* Gerry Fairbrother et al., *Costs of Enrolling Children in Medicaid and SCHIP* 23 Health Affairs. 237 (2004) https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.23.1.237 (administrative costs equal $280 per child enrolled in New York's Medicaid program); Gerry Fairbrother, *How Much Does Churning in Medi-Cal Cost?*, 6-7 (2005), https://www.issuelab.org/resources/9743/9743.pdf (estimating $180 in administrative costs to re-enroll a child in California's Medicaid program).

[144] *See, e.g.*, Jessica Sharac et al., The George Washington Univ., *How Would Medicaid Losses in Approved Section 1115 Medicaid Work Experiment States Affect Community Health Centers?* (June 2019), https://www.rchnfoundation.org/wp-content/uploads/2019/06/Draft-GG-IB-59-6.19-FINAL.pdf; Randy Haught et al., The Commonwealth Fund, *How Will Medicaid Work Requirements Affect Hospitals' Finances?*, (Mar. 14, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/mar/how-will-medicaid-work-requirements-affect-hospitals-finances; Jessica Schubel & Matt Broaddus, Ctr. on Budget & Policy Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains* (2018), https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage.

of individuals enrolled in Medicaid already work or have good reason for not working.[145] Spending significantly more money to impose the work requirement in hopes of changing behavior for the small remaining fraction of Medicaid enrollees – while cutting coverage for others – is not in line with the objectives of the Medicaid program.

B. Imposing Premiums

Utah proposes to require individuals with incomes above 100% of FPL to pay monthly premiums of $20 (for single individuals) or $30 (for married couples).[146] Individuals who are unable to pay their monthly premium will be terminated from Medicaid. They will also be prohibited from re-enrolling for six months unless they pay the full amount due.[147]

The Secretary does not have the authority to allow Utah to implement these premiums and associated consequences for failure to pay. First, the Medicaid Act prohibits states from charging premiums to individuals with household income below 150% of FPL.[148] 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.[149] Since then, Congress has made repeated changes to the limits, confirming that changes in the options available to states to charge premiums must come from Congress, not from HHS.[150]

Second, the premiums are not experimental and conflict with the objectives of the Medicaid Act. Redundant research proves that premiums deter and reduce enrollment among low-income individuals.[151] Numerous studies, conducted over the course of almost

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[145] Garfield et al., *Understanding the Intersection of Medicaid and Work* (finding that of adults who are enrolled in Medicaid but do not receive SSI, almost 80% live in families with at least one worker, and over six-in-ten are working themselves).
[146] Application at 28-29. Utah also seeks to impose what it calls a "premium surcharge" of up to $30/quarter for non-emergency use of the emergency room. Because this constitutes cost sharing, as opposed to a premium, it is addressed in Section II.C, below.
[147] *Id*. at 29.
[148] 42 U.S.C. §§ 1396o(a)(1), (c)(1), 1396o-1(b)(1).
[149] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, 96 Stat. 324, 367.
[150] *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).
[151] *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 [hereinafter "Samantha Artiga et al., *The Effects of Premiums and Cost Sharing*"]; Brendan Saloner et al., *Medicaid and CHIP Premiums and Access to Care: A Systematic Review*, 137 PEDIATRICS e20152440 (2016), http://pediatrics.aappublications.org/content/137/3/e20152440.

two decades, have examined the effects of imposing premiums in Medicaid and CHIP. These studies, including from the State of Utah, show the same patterns – people facing premiums are less likely to enroll, more likely to drop coverage, and more likely to become uninsured.[152] These effects become more pronounced as income decreases.[153]

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[152] *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); 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 (finding that after Oregon imposed premiums ranging from $6 to $20, close to half of the affected enrollees lost coverage within the first six months); Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 INQUIRY 378, 380 (2006) (finding that imposing premiums on CHIP enrollees reduced initial enrollment and led to substantial disenrollment, and in some states disproportionately affected non-white individuals) (attached); Margo Rosenbach et al, Mathematica Pol. Research, Inc., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (2007), 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); Bill J. Wright et al., *Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out*, 29 HEALTH AFFAIRS 2311 (2010), https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2010.0211 (thirty months after Oregon imposed premiums, only 33% of enrollees required to pay premiums remained continuously enrolled over thirty months, compared with 69% of enrollees not subject to premiums); 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%).

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

In addition, recent data gathered from several states that have imposed premiums on the very population that will be required to pay premiums under the proposed project are similarly concerning. A significant portion of Medicaid enrollees who are subject to premiums cannot pay them, and in states that terminate enrollees if they do not pay premiums, thousands of Medicaid enrollees have lost all coverage.[154]

For example, evaluations of Indiana's § 1115 project indicate that premiums created barriers to both enrollment and continuous coverage. During the first year of the project, 23% of 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.[155] In addition, the State terminated nearly 7% of enrollees who were required to pay premiums for failure to pay, with the termination rate increasing in the final months of the reporting period.[156] More recent data from Indiana paint an even darker picture. During the third year of the project, 18% of all enrollees with incomes above 100% of FPL lost Medicaid coverage for failure to pay their monthly premiums.[157] Notably, the statistic understates the effect of the premiums, as not all enrollees with incomes above 100% of FPL are required to pay premiums to maintain their Medicaid eligibility (*i.e,*, people who are pregnant, medically frail, or on transitional medical assistance).

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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).

[154] *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 during the previous quarter, 1,680 enrollees were terminated for not having paid premiums).

[155] The Lewin Group, *HIP 2.0: Power Account Contribution Assessment* ii (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf (examining data from Feb. 1, 2015 – Dec. 1, 2016) [hereinafter The Lewin Group, *HIP 2.0: Power Account Contribution Assessment*]. 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.

[156] *Id*. at ii.

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

These findings add to the volume of research noted above showing that the premiums Utah is seeking to impose will deter and reduce enrollment. They also undercut Utah's estimate that only 3% of individuals subject to the premiums will lose coverage for failure to pay.[158] The State based its estimate on a report from the State of Washington that tracked the number of subsidized Marketplace plan enrollees who lost coverage for failure to pay their premiums.[159] The conclusions from that report are not transferable to the proposed project for several reasons. First, the populations are not comparable. For example, the Washington data includes individuals with incomes of up to 400% of FPL. As explained above, the effect of premiums on enrollment becomes more pronounced as income decreases. Second, while the Marketplace gives individuals a 90-day grace period in which to pay their premiums, Utah is seeking to terminate coverage if individuals do not pay their premiums by the end of the month it is due. This could also result in a higher percentage of individuals losing coverage.[160]

Utah appears to try to justify the coverage loss by suggesting that the premiums will make individuals "more engaged" in their health care and more likely to receive preventive care.[161] There is no evidence to support those assertions.[162] What is more, while Utah emphasizes the need to reduce its Medicaid spending, it ignores the costs of implementing the premiums and associated consequences for failure to pay.[163] Research shows that those costs will be high and could very well exceed the amount of the premiums collected from enrollees. For example, 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

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[158] *See* Application at 29.

[159] *Id*. at 97 (citing Wash. Health Benefit Exchange, *Report to Legislature: annual Grace Period Report: Subsidized Qualified Health Plan Enrollees* (2017), https://www.wahbexchange.org/wp-content/uploads/2018/01/HBE_EB_180112_Annual-Grace-Period-Report.pdf.

[160] In fact, the Washington report indicates that many individuals made use of the grace period. Approximately 19% of all enrollees entered a grace period and then paid a premium. Wash. Health Benefit Exchange, at 3.

[161] *See* Application at 96, 24.

[162] In approving other requests to impose premiums, CMS has pointed to data from Indiana's § 1115 project to support its argument that requiring individuals to pay monthly premiums leads to improved health outcomes. *See, e.g*., Letter from Paul Mango, Chief Principal Deputy Adm'r and Chief of Staff, Ctrs. for Medicare & Medicaid Servs., to Carol H. Steckel, Comm'r, Dep't for Medicaid Servs., 17 (Nov. 20, 2018) (citing The Lewin Group, *Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report* (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf.However, Indiana's evaluation compares two disparate groups – those who paid premiums and those who did not – that differ markedly in health status, income, and other demographic factors known to correlate with care utilization. The evaluation does not control for these confounding factors and does not acknowledge that only the group that did not pay premiums was required to pay cost sharing for most services received. Redundant evidence shows that cost sharing inhibits utilization of services and drug adherence. In fact, cost sharing would explain why the group that did not pay premiums showed better use of generic medications over brand name drugs. CMS also ignores the health care utilization patterns for the tens of thousands of individuals who lost coverage due to Indiana's premium policies. Those individuals had reduced access to care. The Lewin Group, *HIP 2.0: Power Account Contribution Assessment*, at 21-22.

[163] *See* Application at 97 (noting that the State has not estimated these costs).

($15.8 million) to implement and administer the policy.[164] Thus, any money Utah expects to save by implementing the proposed premiums will come from reduced enrollment in Medicaid.

C. Imposing a $10 Charge for Non-emergency Use of the Emergency Room

The Medicaid Act permits states to charge enrollees with household incomes below 150% of FPL up to $8 for non-emergency use of the emergency room.[165] Utah is seeking to charge individuals with incomes from 100-133% of FPL $10 for non-emergency use of the emergency room, up to a maximum of $30 per quarter.[166] Utah will add the charge to individuals' premium bills, meaning that if they do not pay, they will lose Medicaid coverage. Individuals will not be able to re-enroll in Medicaid for 6 months unless they pay the full amount due. The State anticipates that every month, 1500 to 2000 individuals will be subject to a charge for non-emergency use of the emergency room.[167]

While Utah labels the $10 charge a "premium surcharge," it is in fact "cost sharing" or a similar charge under the Medicaid Act, as it is based on utilization of services at the point of service.[168] The Secretary does not have the authority to permit Utah to impose the cost sharing or to terminate coverage for failure to pay.[169] The statute only allows Utah to impose cost sharing that is not otherwise permitted if five tightly circumscribed criteria are met.[170] After providing notice and comment, the Secretary must find that the waiver is for a demonstration project that:

> (1) will test a unique and previously untested use of copayments,
> (2) is limited to a period of not more than two years,
> (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
> (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and

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[164] 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) (attached). *See also* Tricia Brooks, Georgetown Ctr. for Children and Families, *Handle with Care: How Premiums Are Administered in Medicaid, CHIP and the Marketplace Matters* (2013), https://ccf.georgetown.edu/2013/12/04/handle-with-care-how-premiums-are-administered-in-medicaid-chip-and-the-marketplace-matters/ (noting Virginia stopped imposing premiums on CHIP enrollees after data showed the State spent $1.39 to collect each $1 in premiums).
[165] 42 U.S.C. §§1396o-1(e), 1396o(a)(3), (b)(3); 42 C.F.R. § 447.54(b).
[166] Application at 29.
[167] *Id*. at 30.
[168] *See* 42 U.S.C. §§ 1396o(f).
[169] Even if the charge were a "premium" under the statute, it would not be approvable for the reasons described in Section II.B. above.
[170] 42 U.S.C. § 1396o(f)(1)-(5).

(5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.[171]

Utah's proposed policy does not comply with any of these criteria. First and foremost, the proposed policy is not unique or previously untested. In fact, existing, peer-reviewed research has found that imposing cost sharing for non-emergency use of the emergency department does not reduce emergency room use among Medicaid and CHIP enrollees.[172]

Second, Utah has not limited the cost sharing to a period of two years. Third, the proposed cost sharing cannot reasonably be expected to provide any benefits to enrollees. As noted above, substantial research shows that charging Medicaid enrollees for non-emergency use of the emergency room does not reduce emergency department use. Moreover, cost sharing does nothing to address the root causes of those "non-urgent" visits, such as unmet health needs and lack of access to primary care settings.[173]. In addition, under Utah's proposal, individuals who are unable to pay the $10 charge will face the incredible penalty of losing their coverage entirely, which will only make them more likely to rely on the emergency room for their care.

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

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[171] *Id*.

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

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

Medicaid enrollees use the emergency room for non-urgent conditions.[174] More importantly, as described above, existing research disproves the hypothesis Utah is purporting to test – heightened cost sharing will decrease non-emergency use of the emergency room. In fact, CMS has recognized that other strategies, such as improving access to primary care services and providing targeted case management services for enrollees who frequently use the emergency room, have been effective in reducing emergency room use among Medicaid enrollees.[175] According to CMS, "[e]xperience and research suggests that narrow strategies to reduce ED usage by attempting to distinguish need on a case by case basis have had limited success in reducing expenditures to date, due in part to the very reasons for higher rates of utilization by Medicaid beneficiaries including unmet multiple health needs and the limited availability of alternative health care services. However, broader strategies – such as expanding primary care access, 'superutilizer' programs, and targeting the needs of people with behavioral health and substance abuse issues – appear to have considerable promise."[176] In addition, Utah has given no indication that it plans to test the hypothesis in a methodologically sound manner, including the use of control groups.

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

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

D. Eliminating Hospital Presumptive Eligibility

Utah asks to eliminate the option for hospitals to make presumptive eligibility determinations for individuals in the expansion population. By its own terms, this provision is not waivable.[177] Moreover, eliminating hospital presumptive eligibility will demonstrate nothing. The Affordable Care Act amended the Medicaid Act to require states to allow

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[174] Anna S. Somers et al., Ctr. for Studying Health System Change, *Research Brief No. 23, Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits Are For Urgent or More Serious Symptoms* (2012), http://www.hschange.org/CONTENT/1302/1302.pdf
(finding that only about 10% of Medicaid emergency room visits are "nonurgent," a rate on par with visits by nonelderly enrollees in private insurance).
[175] CMSC Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf.
[176] *Id*. at 7-8 (citing Wash. State Health Care Auth., *Emergency Department Utilization: Assumed Savings from Best Practices Implementation* (2013)).
[177] *See* 42 U.S.C. § 1396a(a)(47)(B).

hospitals to make presumptive eligibility determinations, effective January 1, 2014.[178] The state cannot possibly demonstrate something new by returning to the eligibility system that was in place before that date.

Finally, precluding hospitals from making presumptive eligibility determinations will harm low-income individuals in Utah. The purpose of hospital presumptive eligibility is to give individuals immediate Medicaid coverage and access to care until a final eligibility determination can be made. Presumptive eligibility also promotes permanent coverage by providing individuals with an additional way to apply for Medicaid.[179]

Utah suggests that "[d]ue to the availability of retroactive coverage, uncompensated care costs and individual out-of-pocket expenses will only occur when an individual was never eligible for Medicaid."[180] This is simply not correct. There are almost certainly individuals who have their health care covered due to presumptive eligibility, meet the Medicaid eligibility criteria, but do not ultimately enroll in Medicaid for one reason or another. Without presumptive eligibility, those individuals would simply go without care or incur significant medical debt. What is more, Utah glosses over the fact that it is also requesting permission to eliminate retroactive eligibility for individuals with incomes above 100% of FPL at some point in the future, as discussed in Section II.E. below.[181]

In addition, the State previously said that eliminating hospital presumptive eligibility is necessary "to encourage providers to work collaboratively with individuals to submit a full Medicaid application for ongoing coverage."[182] If that remains a goal, there are a number of policy options available to the State. Eliminating presumptive eligibility is not an appropriate response. It ignores that presumptive eligibility is acting as an avenue to permanent Medicaid coverage for many individuals in Utah, and there is simply no basis for permitting Utah to block that avenue.[183]

E. "Flexibility" to Reduce Coverage Further

Utah is requesting the ability implement several additional changes to eligibility and benefits through its state administrative rulemaking process.[184] We interpret this request to

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[178] Pub. L. 111-148, 124 Stat. 119, 291, § 2202 (2010) (codified at 42 U.S.C. § 1396a(a)(47)(B)).
[179] *See* Ctrs. For Medicare & Medicaid Servs., *Medicaid & CHIP FAQs: Implementing Hospital Presumptive Eligibility Programs* (2014), https://www.medicaid.gov/state-resource-center/faq-medicaid-and-chip-affordable-care-act-implementation/downloads/faqs-by-topic-hospital-pe-01-23-14.pdf.
[180] Application at 84.
[181] Application at 20.
[182] Utah Dep't of Health, *Utah 1115 Demonstration Waiver Application Per Capita Cap*, 97 (2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-per-capita-cap-pa.pdf.
[183] *See* Application at 18 (noting that more than one-half of individuals approved for presumptive eligibility continue on to receive Medicaid).
[184] *Id*. at 20.

mean that the State is seeking these waivers now, but could ultimately decide not to implement them.

We are particularly concerned by Utah's request to eliminate retroactive eligibility and to delay enrollment until the first day of the month after application for individuals with incomes above 100% of FPL. Cutting eligibility does not serve a valid experimental purpose. In fact, Utah admits that the only goal of the waivers is to save money.[185] In addition, theses waivers are not likely to promote the objectives of the Medicaid Act. As Utah admits, they will reduce access to coverage among low-income individuals.[186] This will lead to an increase in unmet health needs and a decrease in financial security. Evidence from other states is telling. For example, Iowa estimated that waiving retroactive coverage in its Medicaid program would decrease coverage by 3,344 people every month and over 40,000 people every year.[187] When Indiana received permission to waive retroactive coverage in 2015, CMS required the State to continue to provide some retroactive coverage to parents. The State reported to CMS that 13.9% of parents who enrolled in Medicaid needed retroactive coverage, with their costs incurred averaging $1,561 per person.[188] In addition, data from New Hampshire show that between August 2014 and November 2015, 4,657 individuals in the Medicaid expansion population benefited from retroactive coverage, which paid for more than $5 million in medical expenses.[189] These figures confirm that the lack of retroactive coverage and the delay in enrollment will cause financial hardship to many Medicaid enrollees in Utah.

In addition, these waivers will result in increased uncompensated care costs for hospitals.[190] When Ohio requested a waiver of retroactive coverage, one report estimated that the waiver would result in roughly $2.5 billion more in uncompensated costs for

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[185] *Id*. at 25.
[186] *Id*. at 20 (estimating the percent reduction in total covered months for the population subject to the coverage restrictions).
[187] *See* Iowa Dep't of Human Servs., *Section 1115 Demonstration Amendment, Iowa Wellness Plan*, at Attachment A (2017), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/ia-wellness-plan-pa4.pdf.
[188] MaryBeth Musumeci & Robin Rudowitz, Kaiser Family Found., *Medicaid Retroactive Coverage Waivers: Implications for Beneficiaries, Providers, and States* 4 (2017), https://www.kff.org/medicaid/issue-brief/medicaid-retroactive-coverage-waivers-implications-for-beneficiaries-providers-and-states/ (citing Letter from Vikki Wachino, Dir., Ctr. for Medicaid & CHIP Services, to Tyler Ann McGuffee, Insurance & Healthcare Policy Dir., Office of Governor Michael R. Pence (July 29, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf).
[189] *See* N. H. Dep't of Health & Human Servs., *Retroactive Coverage Waiver Submission* (2015), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-retro-cov-waiver-submission-12212015.pdf.
[190] *See, e.g.*, Jessica Schubel, Ctr. on Budget & Policy Priorities, *Ending Medicaid's Retroactive Coverage Harms Iowa's Medicaid Beneficiaries and Providers* OFF THE CHARTS (Nov. 9, 2017), https://www.cbpp.org/blog/ending-medicaids-retroactive-coverage-harms-iowas-medicaidbeneficiaries-and-providers.

hospitals over a five year period.[191] Iowa's waiver was opposed on similar grounds, with the Iowa Hospital Association warning that the waiver would "place a significant financial burden on hospitals and safety-net providers and reduce their ability to serve Medicaid patients . . . translate into increased bad debt and charity care for Iowa's hospitals and . . . affect the financial stability of Iowa's hospitals, especially in rural communities."[192]

Ultimately, many providers will likely stop providing care to individuals who are eligible for Medicaid but have not enrolled, meaning that low-income individuals will experience a substantial delay in receiving medically necessary care. Notably, Congress passed the retroactive coverage requirement in part to avoid this very problem.[193]

Paradoxically, CMS has waived retroactive eligibility in other states on the grounds that it will promote continuous coverage by encouraging individuals to enroll in Medicaid even when they are healthy. However, low-income individuals do not actively delay seeking Medicaid coverage until they become sick or injured. Medicaid eligibility rules are complicated, and individuals often do not know that they qualify for Medicaid coverage, much less understand that Medicaid has a retroactive coverage policy and what that means.[194] In fact, Congress passed the retroactive coverage requirement with this in mind, describing the purpose of the requirement as "protecting persons who are eligible for Medicaid but do not apply for assistance until after they have received care, either because they did not know about the Medicaid eligibility requirements, or because the sudden nature of their illness prevented their applying."[195] Imagine, for example, a man who recently suffered a pay cut from his employer, is eligible for Medicaid, but is not aware of his eligibility. He is in a serious car accident on the 30th of the month and receives emergency treatment in a hospital. His condition is severe enough that he cannot apply for Medicaid until the 1st of the following month. Without retroactive coverage in place, he will be responsible for the costs of the services he received in the previous month. And, with the one-month delay in enrollment Utah is seeking, he will also be responsible for the costs he incurs during the month of application.

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[191] Virgil Dickson, *Ohio Medicaid Waiver could cost hospitals $2.5 billion*, MODERN HEALTHCARE (April 22, 2016(, http://www.modernhealthcare.com/article/20160422/NEWS/160429965.
[192] Virgil Dickson, *Hospitals balk at Iowa's proposed $37 million Medicaid cuts*, MODERN HEALTHCARE (August 8, 2017), http://www.modernhealthcare.com/article/20170808/NEWS/170809906.
[193] Amends. to the Soc. Sec. Act 1969-1972: Hrg. on H.R. 17550 Before the S. Comm. on Fin., 91st Cong. 1262 (1970) (stmt. of Elliot L. Richardson, Sec'y, Dep't of Health, Educ., & Welfare) (noting that Congress wanted to encourage providers to "furnish necessary medical assistance and ensure financial protection to otherwise eligible persons during the retroactive period").
[194] *See* Alexia Fernandez Campbell, *These 2 Medicaid provisions prevent medical debts from ruining people's lives*, VOX, July 19, 2017, https://www.vox.com/policy-and-politics/2017/7/19/15949250/medicaid-medical-bankruptcy (highlighting the story of a man who did not realize he was eligible for Medicaid until after he faced $500,000 in medical bills and a family friend informed him that Medicaid may be able to help); Harris Meyer, *New Medicaid barrier: Waivers ending retrospective eligibility shift costs to providers, patients*, MODERN HEALTHCARE, Feb. 11, 2019 (attached).
[195] *Cohen by Cohen v. Quern*, 608 F. Supp. 1324, 1332 (N.D. Ill. 1984) (quoting H. Rep. No. 92-231, 92d Cong., 2d Sess., reprinted in [1972] U.S. Code Cong. & Ad. News 4989, 5099).

In short, eliminating retroactive coverage and requiring individuals to wait an extra month for coverage will harm low-income people as well as health care providers. These waivers will not only fail to advance the objectives of the Medicaid program, but they will actively undermine the goals of providing coverage, care, and related financial protection to low-income individuals. They will inevitably saddle some low-income individuals with medical debt, increase financial strains on hospitals and providers, and increase the likelihood that hospitals and providers are no longer able to provide quality care to people who need it.[196] The effect of the waivers will be even more pronounced due to the other features of the proposed project, which will cause individuals to churn on and off of Medicaid coverage.

F. Imposing Lockout Period for Intentional Program Violation

Utah is currently implementing an "overpayment" policy that violates federal law. The State emphasizes that it is charging individuals who have committed an intentional program violation (IPV) for any claims "as well as any capitation payment" paid on their behalf during months in which they were not actually eligible for medical assistance.[197] The Social Security Act does not permit Utah to collect this kind of "overpayment" from Medicaid enrollees.[198]

Now, Utah is seeking permission to add a six-month lockout period on individuals who commit an IPV. The application makes clear that Utah is targeting fraudulent conduct.[199] The application's focus on enrollee fraud is misplaced, as estimates suggest that enrollees commit only 10% of all health care fraud.[200] In addition, existing federal law already gives Utah and other states comprehensive authority and extensive flexibility to address fraud among Medicaid enrollees. States must refer cases of suspected fraud to law enforcement officials.[201] Individuals convicted of fraud face substantial fines and imprisonment, and states have the authority to prohibit them from enrolling in Medicaid for up to one year.[202] There is no basis for allowing Utah to impose a lockout penalty on otherwise eligible enrollees who have not been convicted of any wrongdoing. What is more, if Utah is concerned about enrollees (intentionally or unintentionally) not reporting changes in

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

[197] Application at 81.

[198] *See* 42 U.S.C. § 1320a-7k(d)(4) (defining "overpayment" as "any funds that a person receives or retains under title XVIII or XIX to which the person, after applicable reconciliation, is not entitled under such title" and making clear that the term "person" "does not include a beneficiary").

[199] Application at 9; *see also id*. at 10 (noting that an IPV finding requires "clear and convincing evidence that the individual knowingly, willingly, or recklessly provided false or misleading information with an intent to receive benefits to which he or she was not eligible to receive").

[200] Sara Rosenbaum et al., George Washington Univ. Dep't of Health Policy, *Health Care Fraud*: *An Overview* 2 (2009), https://publichealth.gwu.edu/departments/healthpolicy/DHP_Publications/pub_uploads/dhpPublication_EFDAD1BC-5056-9D20-3D3D36632A4F2163.pdf.

[201] 42 C.F.R. §§ 455.15.

[202] 42 U.S.C. § 1320a-7b(a).

income or other circumstances that affect their eligibility, it may implement periodic data matching to proactively detect such changes.[203]

More importantly, simply imposing an additional penalty on individuals found to commit an IPV is not likely to promote the objectives of the Medicaid Act and is not experimental. Utah admits that the policy will cause 750 individuals to lose coverage for a six-month period every year. As described below, these individuals will suffer serious health and financial consequences. Utah claims that it is testing whether the lockout penalty will discourage enrollees from committing an IPV.[204] However, there is simply no evidence to suggest that the lockout penalty is more likely than the existing consequences – fines, imprisonment, and a twelve-month lockout – to discourage fraudulent conduct.

G. Consequences of Coverage Loss

As established above, the proposed project would leave thousands of low-income adults without coverage for some period of time. Not surprisingly, gaps in coverage lead to worse health outcomes, including premature mortality.[205] 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.[206] 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.[207]

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[203] *See, e.g.*, Ctrs. for Medicare & Medicaid Servs., Notice of Opportunity for Hearing on Compliance of Alabama State Plan Provisions Concerning Provision of Terminating Coverage and Denying Reenrollment to Otherwise Eligible Individuals Based on a Determination of Fraud or Abuse With Titles XI and XIX (Medicaid) of the Social Security Act, 82 Fed. Reg. 11034, 11036 (Feb. 17, 2017).

[204] Application at 11, 23.

[205] Benjamin D. Sommers *et al.*, *Health Insurance Coverage and Health—What the Recent Evidence Tells Us*, 377 N. Eng. J. Med. 586 (2017), http://www.nejm.org/doi/full/10.1056/NEJMsb1706645; Benjamin D. Sommers, *State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis*, 3 AM. J. OF HEALTH ECONOMICS 392 (2017), https://www.mitpressjournals.org/doi/full/10.1162/ajhe_a_00080; Allyson G. Hall *et al., Lapses in Medicaid Coverage: Impact on Cost and Utilization Among Individuals with Diabetes Enrolled in Medicaid*, 48 MEDIC. CARE 1219 (2008) (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 & 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 Policy 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; Sarah Miller et al., Nat'l Bureau of Economic Research, *Medicaid and Mortality: New Evidence From Linked Survey and Administrative Data*, *Working Paper 26081* (2019) (attached).

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

[207] Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage* at 1, 5-6; Julia Paradise & Rachel Garfield, Kaiser Family Found., *What is Medicaid's Impact on Access to Care, Health*

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.[208] Likewise, continuous insurance coverage is associated with earlier cancer identification and better outcomes.[209] Recent research also found that Medicaid expansion was associated with a reduction in preventable hospitalizations.[210]

Studies show that Medicaid expansion reduces medical debts and out-of-pocket expenses for enrollees.[211] For example, independent studies of the Healthy Michigan Plan have found that coverage significantly improves financial security.[212] Similarly, 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% and reduced the probability of having a medical debt collection by 25%.[213] 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

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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 [hereinafter Paradise & Garfield, *What is Medicaid's Impact on Access to Care*].

[208] Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage,* at 1, 5-6.

[209] *Id.* at 6.

[210] Hefei Wen et al., *Medicaid Expansion Associated With Reductions in Preventable Hospitalizations*, 38 HEALTH AFFAIRS 1845 (2019) (attached).

[211] *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 & Policy Priorities, *More Evidence Medicaid Expansion Boosts Health, Well-Being* (2018), https://www.cbpp.org/blog/more-evidence-medicaid-expansion-boosts-health-well-being (highlighting data showing that health coverage reduces poverty and Medicaid expansion improves financial security); Louija 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 [hereinafter Louija Hu]; 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, *What is Medicaid's Impact on Access to Care*, 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, Ohio Medicaid Group VII Assessment, at 39-40; Naomi Zwede & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions Over Time,* 38 HEALTH AFFAIRS 132-138 (2019) (attached) (finding that Medicaid significantly reduces poverty and that the impact has increased over the past decade).

[212] *See, e.g.,* Sarah Miller et al., *The ACA Medicaid Expansion in Michigan and Financial Health* (2018), http://www.nber.org/papers/w25053; Aaron E. Carroll, *Medicaid as a Safeguard for Financial Health*, 321 JAMA 135 (2019), https://jamanetwork.com/journals/jama/fullarticle/2720716?guestAccessKey=8a4329f5-c92a-4aee-a143-2d44b8138da2&utm_source=silverchair&utm_medium=email&utm_campaign=article_alert-jama&utm_content=etoc&utm_term=011519.

[213] 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.

and in the amount of non-medical debt sent to third-party collection agencies.[214] A national study found that medical debt fell by almost twice as much in expansion states (13%) compared to non-expansion states (7%).[215] Together, this data contradicts any suggestion that the work requirement will improve individuals' financial well-being. Rather, causing major coverage losses in a program proven to improve financial security is likely to worsen outcomes for enrollees.

Evidence also demonstrates how improved financial security due to Medicaid correlates with 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 also reduced stress and severe psychological distress.[216] Along with dramatically reducing financial strain, Oregon's Medicaid experiment demonstrated significantly fewer positive screens for depression compared to a randomized control, amounting to a nearly 30% reduction.[217] A third study showed that Medicaid expansion reduced the incidence of newly-accrued medical debt by 30% to 40% and reduced the number of bankruptcies compared to non-expansion states.[218] 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.[219] Other studies have linked Medicaid expansion coverage in California to lower eviction rates and fewer payday loans.[220] Each of these studies bolsters the finding that Medicaid coverage itself improves enrollees' financial security and well-being.

III. The Proposed Project Will Reduce Access to Services

A. Eliminating EPSDT

The State proposes to waive the requirement to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, again targeting individuals in the partial expansion population who are ages 19 and 20.

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[214] 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.
[215] Aaron Sojourner & Ezra Golberstein, *Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction*, HEALTH AFFAIRS BLOG (July 24, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170724.061160/full/.
[216] Stacey McMorrow, et al, *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents*, 36 HEALTH AFFAIRS 808 (2017) (attached).
[217] Katherine Baicker et al., *The Oregon Experiment -- Effects of Medicaid on Clinical Outcomes*, 36 NEW ENG. J. MED. 1713 (2013) (attached).
[218] Kenneth Brevoort, Daniel Grodzixki, & Martin B. Hackmann, Nat'l Bureau of Economic Research, *Medicaid and Financial Health* 3 (2017) (attached).
[219] *Id.* at 3-4.
[220] Heidi L. Allen et al., *Can Medicaid Expansion Prevent Housing Evictions?* 38 HEALTH AFFAIRS 1451 (2019) (attached); Heidi Allen et al., *Early Medicaid Expansion Associated with Reduced Payday Borrowing in California*, 36 HEALTH AFFAIRS 1769 (2017) (attached).

Since adding EPSDT to the Medicaid Act in 1967, Congress has amended the EPSDT provisions on numerous occasions, each time adding more detail as to how it expects EPSDT to be covered by the states and consistently requiring EPSDT coverage for all individuals under age 21. Most recently, in 2010 Congress provided that coverage for the expansion population would consist of the coverage listed in 42 U.S.C. § 1396u-7. Notably, 42 U.S.C. § 1396u-7(a)(1)(A)(ii) – a provision outside of § 1396a – requires this coverage to consist of EPSDT for individuals under the age of 21. Because Congress placed the EPSDT coverage requirement outside of 1396a and also repeatedly made its intent with respect to EPSDT coverage abundantly clear, the Secretary does not have the authority to waive the requirement.

In addition, eliminating EPSDT is inconsistent with the objectives of the Medicaid Act. As noted above, Congress has included EPSDT in the Medicaid Act as a detailed, comprehensive program to cover preventive and treatment services for individuals under age 21. EPSDT entitles these individuals to receive comprehensive screening services, as well as any of the services listed in the Medicaid Act when necessary to "correct or ameliorate" illnesses and conditions discovered during a screening.[221] Since 1967, Congress has targeted the EPSDT coverage standards to meet the particular health care needs that face low-income individuals under age 21.

Research confirms that individuals ages 19 and 20 face unique and significant health challenges. For example, this population experiences high rates of mental illness and substance use disorder. Approximately 21% of 19 year-olds and 24% of 20 year-olds have had a diagnosable mental illness other than a developmental or substance use disorder in the past year.[222] In addition, approximately 15% of individuals ages 18 to 25 have met the criteria for illicit drug or alcohol dependence or abuse in the past year.[223] This population also experiences high rates of sexually transmitted infections. According to the Centers for Disease Control and Prevention (CDC), individuals ages 15 to 24 face the highest risk of acquiring STIs "for a combination of behavioral, biological, and cultural reasons."[224] CDC data show that individuals ages 15 to 24 account for 25% of the sexually active population, but 50% of new STIs.[225] In 2017, young people ages 13 to 24 accounted for more than 1

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[221] 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
[222] Substance Abuse and Mental Health Servs. Admin., *Results from the 2016 National Survey on Drug Use and Health: Mental Health Detailed Tables, Adult Mental Health Tables, Table 8.1B*, https://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs-2016/NSDUH-DetTabs-2016.htm#lotsect9pe.
[223] *Id* at *Table 8.24B*. The percentages are much lower for adults: 9.4% of individuals ages 26 to 49 and 4.1% of individuals 50 or older.
[224] Ctrs. for Disease Control and Prevention, Div. of STD Prevention, *Sexually Transmitted Disease Surveillance 2016* at 43 (2016), https://www.cdc.gov/std/stats16/CDC_2016_STDS_Report-for508WebSep21_2017_1644.pdf.
[225] Ctrs. for Disease Control and Prevention, *Fact Sheet: Incidence, Prevalence, and Cost of Sexually Transmitted Infections in the United States* (2013), http://www.cdc.gov/std/stats/sti-estimates-fact-sheet-feb-2013.pdf.

in 5 new HIV diagnoses.[226] Young people with HIV are the least likely out of any age group to be linked to care (36%) and to have a suppressed viral load (25%).[227]

Eliminating EPSDT will make it less likely that these serious health conditions will be prevented or detected early through screening services, which should include screening for mental illness, substance use, and STIs for 19 and 20 year-olds.[228] Notably, research shows that early diagnosis and treatment of many of these conditions can dramatically improve health outcomes.[229]

In addition, eliminating ESPDT will leave all individuals ages 19 and 20 without access to dental services, which will lead to worse overall health outcomes.[230] As a U.S. Surgeon General report explains, oral health is essential to overall health.[231] In addition, untreated oral health problems often lead individuals to seek care in the emergency room. In 2009, preventable dental conditions were the cause of 830,000 emergency room visits nationwide, and hospital care for dental conditions is nearly ten times as expensive as preventive dental care.[232] Emergency room visits for dental conditions cost about $1.6 billion nationwide.[233]

What is more, as a result of the EPSDT waiver, 19- and 20-year-olds who have dependent children will not have access to necessary vision and hearing services, including glasses and hearing aids.[234] The CDC has declared vision loss a serious public health problem, as "people with vision loss are more likely to report depression, diabetes, hearing impairment, stroke, falls, cognitive decline, and premature death," as well as "substantially

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[226] Ctrs. for Disease Control and Prevention, *HIV Among Youth*, http://www.cdc.gov/hiv/risk/age/youth/index.html?s_cid=tw_drmermin-00186 (last reviewed Nov. 12, 2019).
[227] *Id*.
[228] Am. Acad. of Pediatrics & Bright Futures, *Recommendations for Preventive Pediatric Health Care* (2019), https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.
[229] *See, e.g.*, Ctrs. for Disease Control and Prevention, *2015 STDs Treatment Guidelines, HIV Infection: Detection, Counseling, and Referral*, https://www.cdc.gov/std/tg2015/hiv.htm ("Early diagnosis of HIV infection and linkage to care are essential not only for the patients' own health but also to reduce the risk for transmitting HIV to others. As of March 2012, U.S. guidelines recommend all persons with HIV infection diagnoses be offered effective antiretroviral therapy."); Nat'l Institute of Mental Health, *Recovery After an Initial Schizophrenia Episode*: *What is RAISE?* (2017), https://www.nimh.nih.gov/health/topics/schizophrenia/raise/what-is-raise.shtml (describing research findings that coordinated specialty care (CSC) is more effective than usual treatment approaches to schizophrenia and that CSC is most effective when received early).
[230] *See* Application at 26-28.
[231] Dep't of Health & Human Servs., U.S. Pub. Health Serv., *Oral Health in America: A Report of the Surgeon General* (2000), https://www.nidcr.nih.gov/sites/default/files/2017-10/hck1ocv.%40www.surgeon.fullrpt.pdf.
[232] Pew Ctr. on the States, *A Costly Dental Destination: Hospital Care Means States Pay Dearly* 1, 3 (2012), http://www.pewtrusts.org/-/media/assets/2012/01/16/a-costly-dental-destination.pdf.
[233] Cassandra Yarbrough et al., *Estimating the Cost of Introducing a Medicaid Adult Dental Benefit in 22 States*, Am. Dental Ass'n 2 (2016), http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0316_1.ashx.
[234] *See* Application at 28-29.

compromis[ed] quality of life."[235] Further, the cost of vision loss is estimated to exceed $35 billion.[236]

Notably, untreated dental, vision, or hearing problems can make it more difficult for individuals to get and/or keep a job. With respect to dental services, nearly 30% of low-income adults say the appearance of their mouth and teeth affects their ability to interview for a job.[237] Thus, by restricting access to these critical services, Utah is directly undermining its own stated goal of promoting employment among individuals in the partial expansion population.

Finally, eliminating EPSDT has no valid experimental purpose. The policy is nothing more than a cut in benefits. The State will not test an innovative approach to health care delivery by preventing individuals ages 19 and 20 from receiving medically necessary services. What is more, HHS has been permitting Utah to waive EPSDT since 2002. Even assuming that the waiver was experimental at that time (which it was not), it is impossible to continue to construe it as experimental.

B. Providing Fewer Services for Parents

Utah proposes to provide a reduced benefits package ("non-traditional benefits") to adults who are in the expansion population but happen to have dependent children.[238] This distinction between parents and non-parents in the same Medicaid eligibility category is nonsensical.[239]

One of the benefits that Utah seeks to withhold from parents is non-emergency medical transportation (NEMT).[240] The Medicaid Act requires states to provide necessary NEMT to and from Medicaid services.[241] However, Utah did not explicitly request a waiver to allow it to eliminate NEMT, which raises serious transparency concerns.[242] In any event, such a waiver is not approvable under Section 1115. Eliminating NEMT is a simple cut in benefits with no experimental or demonstration purpose. In addition, it runs counter to the objectives of the Medicaid Act, as it will reduce access to medically necessary services for adults with dependent children.

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[235] Ctrs. for Disease Control & Prevention, *Why is Vision Loss a Public Health Problem?* (2015), https://www.cdc.gov/visionhealth/basic_information/vision_loss.htm.
[236] *Id.*
[237] Am. Dental Ass'n, Health Policy Inst., *Oral Health and Well-Being in the United States* (2015), https://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/OralHealthWell-Being-StateFacts/US-Oral-Health-Well-Being.pdf?la=en.
[238] Application at 26-28.
[239] *See id*. at 87 (responding to a comment questioning the distinction by stating that Utah is currently offering different benefits packages to individuals with and without children).
[240] Application at 28.
[241] *See* 42 U.S.C. § 1396a(a)(4); 42 C.F.R. § 431.53.
[242] *See* Application at 36 (listing waivers requested). *See also* 42 C.F.R. §§ 431.408(a)(1)(i)(E), 431.412(a)(1)(vi).

We have been working with state Medicaid advocates and directly with Medicaid beneficiaries for five decades. In our experience, NEMT is essential Medicaid coverage. Many people who live in poverty simply do not have the means to access medically necessary services on their own. Access to private vehicles is lower and transportation barriers are higher among lower-income populations, and Medicaid beneficiaries in particular.[243] Public transportation (if available) is often too expensive, too limited, and/or too infrequent to use. Friends or family may be unable or unwilling to take off work to drive an enrollee to an appointment. In addition, domestic violence survivors or young adults may need confidential access to a provider and depend on NEMT to help get them to the appointment. In one study, more than 7% of Medicaid beneficiaries reported that transportation was a primary barrier to accessing timely primary care. In contrast, less than 1% of privately insured individuals reported the same problem.[244]

Data from Indiana and Iowa, which received permission to eliminate NEMT for the expansion population, further demonstrate that many enrollees cannot access care without NEMT.[245] It must be noted that Iowa's and Indiana's evaluations were deeply flawed, principally because they: (1) used inappropriate and dissimilar comparison groups; and (2) had poor survey response rates (in Indiana) and potential response bias. However, even with these limitations, Iowa's evaluation shows that a significant subset (13%) of Medicaid expansion adults reported an unmet health care need due to lack of adequate transportation.[246] The percentage was higher (15%) among enrollees with income below 100% of FPL.[247] Roughly one-quarter of all Iowa Medicaid enrollees worried some or a lot about the cost of transportation to providers, and again, enrollees with lower incomes reported significantly more concerns.[248] Indiana's most recent evaluation likewise shows

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

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

[245] Suzanne Bentler et al., Univ. of Iowa Pub. Policy Ctr., *Evaluation of the Iowa Health and Wellness Plan: Member Experiences in the First Year*, 27 (April 2015), http://ppc.uiowa.edu/sites/default/files/ihawp_survey_interactive.pdf.

[246] *Id*.

[247] *Id*.

[248] *Id.*

that lack of transportation caused enrollees in the expansion population to forgo medically necessary care.[249]

Notably, data from Iowa also indicate that women, people of color, and younger people are significantly more likely to report a transportation barrier.[250] The same is true for people in relatively poorer health (58% higher odds), with multiple physical ailments (63%), or who have any functional deficit (245%).[251] Eliminating NEMT for adults with dependent children will disproportionately harm these populations, likely exacerbating existing health care disparities.

Significantly, evaluators in Indiana and Iowa found ongoing unmet transportation needs among enrollees that on paper had access to NEMT. The persistence of those unmet needs suggests an ineffective or poorly publicized NEMT benefit in those states. In fact, Indiana's most recent survey revealed that the overwhelming majority of Medicaid enrollees did not know if they had access to NEMT services or incorrectly identified whether or not their plan provided NEMT.[252] Iowa's evaluators did call for further research to understand "the causes of unmet NEMT need, how to better promote access to NEMT, and how barriers to transportation affect access to needed health care services."[253] However, Utah is not proposing to investigate these legitimate research questions. Its application does not even so much as mention a waiver of NEMT.[254]

Not surprisingly, research demonstrates that effective NEMT services improve access to health care. For example, research shows that transportation barriers can reduce

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

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

[251] Suzanne Bentler et al., Univ. of Iowa Pub. Policy Ctr., *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 26 (Mar. 2016), https://ir.uiowa.edu/cgi/viewcontent.cgi?article=1131&context=ppc_health.

[252]The Lewin Group, *Indiana HIP 2.0: Evaluation of Non-Emergency Medical Transportation (NEMT) Waiver*, 28-31 (Nov. 2016).

[253] Suzanne Bentler et al, Univ. of Iowa Pub. Policy Ctr., *Report in Brief: Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 1 (Aug. 2016), http://ppc.uiowa.edu/sites/default/files/nemt_brief.pdf.

[254] *See* Application at 21-26 (listing hypotheses for the project).

adherence to medications.[255] Studies also indicate that individuals with common chronic conditions like asthma or diabetes are more likely to complete the recommended care management visits when they have access to effective NEMT.[256] Better adherence to medications and care management visits can improve control of chronic conditions, reducing costly hospitalizations or emergency department visits. In fact, research shows that NEMT is cost effective for states.[257]

In sum, there is simply no basis to conclude that eliminating NEMT for a portion of the expansion population in Utah will yield any useful information or promote the objectives of the Medicaid program.[258] Instead, it will only reduce access to medically necessary care.

C. Managed Care "Flexibility"

Utah is also requesting permission to ignore several federal managed care requirements, affecting everything from network adequacy to availability of services.[259] We are simply not able to submit meaningful comments on this part of the proposal because it is not at all clear what Utah is seeking permission to do. Moreover, these requests are not approvable under § 1115. For example, the State is asking to implement its managed care contracts and rates without first receiving approval from HHS. Under § 1396b(m)(2)(A)(iii), HHS generally cannot reimburse a state for expenses paid to an MCO unless HHS provided prior approval of the MCO contract, which must include actuarially sound rates. The Secretary does not have the authority to waive that provision of the Medicaid Act. Similarly, the Secretary lacks the authority to waive HHS regulations regarding managed care.[260] In addition, Utah has not provided any indication as to how the requested flexibility is likely to promote the objectives of the Medicaid Act or serves an experimental purpose.

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

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

[257] P. Hughes-Cromwick et al.; J. Joseph Cronin, Jr., et al., Florida State Univ., *Florida Transportation Disadvantaged Programs Return on Investment Study* (2008); Medical Transportation Access Coalition, *Non-Emergency Medical Transportation: Findings from a Return on Investment Study* (2018), https://mtaccoalition.org/wp-content/uploads/2018/07/NEMT-ROI-Methodology-Paper.pdf; The Stephen Group, *Recommendations to the Ark. Health Reform Task Force* (2015).

[258] Notably, Utah is also requesting permission to provide the "non-traditional" benefits package, which does not include NEMT, to the entire expansion population at some point in the future, if necessary. Application at 20.

[259] *Id*. at 31-33.

[260] *See* 42 C.F.R. part 438.

Conclusion

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

We have included numerous citations to supporting research, including direct links to the research. We direct HHS to each of the studies we have cited and made available through active links, and we request that the full text of each of the studies cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these citations part of the record as we have requested here, we ask that you notify us and provide us an opportunity to submit copies of the studies into the record.

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

Sincerely,

Jane Perkins
Legal Director