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June 26, 2020

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: Oklahoma 1115 Demonstration Application

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 Oklahoma's application.

NHeLP supports expanding Medicaid to low-income adults and hopes that Oklahoma decides to do so. However, we recommend 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 for the expansion population. SoonerCare 2.0 does not comply with the requirements of § 1115 of the Social Security Act. It will block, rather than facilitate, access to Medicaid coverage and services. In addition, Oklahoma has not proposed a valid experimental, pilot, or demonstration project. Instead, the State has done nothing more than label its various requests as an "experiment" in order to ignore federal Medicaid requirements and evade federal oversight of its program.

I. Procedural Problems

Oklahoma's application does not meet the federal requirements for a complete application. First, as explained in our April 23, 2020 letter, the State did not meet the federal requirement that it hold "two public hearings, on separate dates and at separate locations" that give members of the public "throughout the State the opportunity

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to provide comment."[1] With very little notice, Oklahoma cancelled the public hearings scheduled for March 18 and March 24, citing COVID-19, and held four "virtual" meetings instead. Lack of internet access is a serious problem for many people in Oklahoma.[2] Research confirms that the problem is particularly acute for low-income individuals.[3] Thus, moving from in-person to virtual hearings disproportionately prevented the very people affected by the SoonerCare 2.0 project from offering comment.

Oklahoma has pointed to CMS guidance indicating that, due to the public health emergency caused by the coronavirus, virtual hearings are sufficient to meet the public notice and comment requirements.[4] However, that guidance does not comport with the relevant federal regulation. The regulation permits CMS to waive the requirements to enable a state to implement a demonstration project quickly in order to respond to a disaster or public health emergency.[5] It does not allow a state to ignore the public participation requirements during a public health emergency in order to pursue a § 1115 project that has nothing to do with that emergency, as is the case here. As such, Oklahoma does not meet the criteria for an exemption from the public notice and comment process, and any exemption given to Oklahoma by CMS was improper.[6]

Second, Oklahoma has not provided a sufficient level of detail to "ensure a meaningful level of public input" on various aspects of the SoonerCare 2.0 project.[7] Oklahoma seeks to implement a per capita cap, but has not explained critical features of that funding transformation. The State presented flawed and/or incomplete enrollment and expenditure estimates. For example:

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[1] 42 C.F.R. § 431.408(a)(3). *See* Letter from Jane Perkins, Legal Dir., Nat'l Health Law Program to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (April 23, 2020), https://healthlaw.org/resource/letter-calls-on-seema-verma-to-reject-oklahomas-section-1115-request-as-incomplete/; Letter from Jane Perkins, Legal Dir., Nat'l Health Law Program to Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs. (March 17, 2020), https://healthlaw.org/wp-content/uploads/2020/03/CMS-Letter-OK.pdf.

[2] *See, e.g.*, Tyler Cooper, *States with the Best and Worst Internet Coverage 2018*, BroadbandNow, (Aug. 14, 2018), https://broadbandnow.com/report/us-states-internet-coverage-speed-2018 (ranking Oklahoma 47th in internet connectivity). *Cf.* U.S. News & World Report, U.S. Internet Rankings, https://www.usnews.com/news/best-states/rankings/infrastructure/internet-access (ranking Oklahoma 44th in internet access).

[3] *See, e.g.*, 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 (finding that nationwide, half of households with incomes under $25,000 have either no computer or no broadband at home).

[4] Ok. Health Care Auth., *SoonerCare 2.0 Healthy Adult Opportunity Section 1115 Demonstration Application* 61 (April 21, 2020) (citing Ctrs. for Medicare & Medicaid Servs., *COVID-19 Frequently Asked Questions (FAQs) for State Medicaid and Children's Health Insurance Program (CHIP) Agencies* (last updated May 5, 2020), https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf) [hereinafter Application].

[5] 42 C.F.R. § 431.416(g); Medicaid Program; Review and Approval Process for Section 1115 Demonstrations, 77 Fed. Reg. 11677, 11685 (Feb. 27, 2012).

[6] *See* 42 C.F.R. § 431.416(g)(3) (requiring the state to establish, among other things, that "delay would undermine or compromise the purpose of the demonstration and be contrary to the interest of beneficiaries").

[7] 42 U.S.C. § 1315(d)(2)(A), (C); 42 C.F.R. §§ 431.408(a), 431.412(a).

- The enrollment projections were based on Oklahoma implementing the Medicaid expansion on July 1, 2020 – one year before implementing the project. However, the State has now made clear that it will not begin covering the expansion population as planned.[8]
- The enrollment projections make "no assumptions on economic outlook," despite the fact that the U.S. is in the middle of an economic crisis, which will lead to a significant increase in Medicaid enrollment.[9] In fact, the Governor has acknowledged that the State's enrollment estimates are far too low given the economic conditions.[10]
- Oklahoma claims that the proposed eligibility restrictions will cause enrollment to drop by 5%. As described in detail below, the restrictions will result in far greater coverage loss.
- Nowhere does Oklahoma explain how it arrived at its per-member-per-month estimate.
- The State does not even attempt to estimate the extent to which inflation and increases in health care costs will result in higher expenditures over the course of the project.

What is more, in response to public comments about the per capita cap, Oklahoma states that the funding transformation will enable it to "to share in the savings" achieved.[11] But, it ignores that under CMS policy, shared savings will only be available if Oklahoma shifts from a per capita cap to block grant funding.[12] Nowhere in the application does Oklahoma indicate that it intends to pursue a block grant during the course of the project. Nor does Oklahoma: (1) estimate the amount of the shared savings; or (2) explain how it would spend the shared savings.

The public is entitled to full disclosure of the data on which Oklahoma relied in submitting its proposal, and on which CMS would rely if it were to approve that proposal. Without

[8] *See* Sean Murphy, *Gov. Stitt Scraps Plan to Expand Medicaid on July 1*, TULSA WORLD (May 29, 2020), https://www.tulsaworld.com/news/local/government-and-politics/gov-stitt-scraps-plan-to-expand-medicaid-on-july-1/article_40e606b3-f430-5cf7-a97c-32c36a263682.html; Letter from Melody Anthony, State Medicaid Dir. to James Scott, Ctrs. for Medicare & Medicaid Servs. (May 28, 2020) (rescinding the state plan amendments needed to cover the expansion population) (attached).

[9] Application at 47, 50. *See* Joseph Benitez et al., *Medicaid Access During Economic Distress: Lessons Learned From the Great Recession*, MED. CARE RES. & AND REV. (2020), https://journals.sagepub.com/doi/pdf/10.1177/1077558720909237; Joan Alker & Laurne Roygardner, Georgetown Univ. Health Policy Inst. Ctr. for Children & Families, *Medicaid as First Responder: Enrollment is on the Rise* (2020), https://ccf.georgetown.edu/wp-content/uploads/2020/05/Medicaid-and-COVID-final.pdf.

[10] *See* Sean Murphy, *Gov. Stitt Scraps Plan to Expand Medicaid on July 1*, TULSA WORLD (May 29, 2020), https://www.tulsaworld.com/news/local/government-and-politics/gov-stitt-scraps-plan-to-expand-medicaid-on-july-1/article_40e606b3-f430-5cf7-a97c-32c36a263682.html.

[11] *See* Application at Attachment F.

[12] *See* Ctrs. for Medicare & Medicaid Servs., Dear State Medicaid Director Letter #20-001, at 17, 23 (Jan. 30, 2020), https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf.

accurate information about the financial consequences of shifting to a per capita cap, the public cannot offer meaningful comment on the application. The State repeatedly claims that it will refine the enrollment and expenditure estimates once it starts covering the expansion population. Even if the State were following through with its stated plan to expand on July 1, 2020, members of the public would not be able to comment on estimates developed behind closed doors after the comment period has closed.

Other aspects of the SoonerCare 2.0 proposal are also vague or misleading. The State asks for "flexibility to develop a unique managed care solution to deliver coordinated, timely, high-quality care" to enrollees.[13] But, the application does not say a thing about what this "solution" might actually be, making it impossible for the public to evaluate the proposal and submit meaningful comment. Moreover, managed care is no longer experimental, as Congress, following a series of § 1115 experiments, made extensive amendments to the Medicaid Act to allow states to implement capitated managed care through state plan amendments.[14] Similarly, Oklahoma asks for "flexibility to make changes to our prescription drug benefit" in the future without having to amend the SoonerCare 2.0 project.[15] However, the State does not offer enough information about those changes for the public to provide meaningful comment on them now.[16]

Third, portions of Oklahoma's application are not accessible to individuals with a disability. Specifically, the attachments describing the Alternative Benefit Plan and summarizing the comments received are not screen-readable. As a result, individuals with visual impairment do not have equal opportunity to evaluate and comment on the proposal.

Given these deficiencies, the application is not complete. We ask CMS to require the State to submit an application that adheres to the federal transparency requirements and to provide a public comment period for that proposal.

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[13] Application at 43.

[14] *See* 42 U.S.C. § 1396u-2.

[15] Application at 27, Attachment F.

[16] To the extent that Oklahoma is asking to use a closed formulary, that request is not approvable. The Secretary does not have the authority to waive the outpatient prescription drug coverage requirements, which are outside of § 1396a. *See* 42 U.S.C. § 1396r-8. In addition, there is nothing experimental about a closed formulary (which is a standard part of commercial insurance plans). Research confirms that they cause significant harm to enrollees and do not lower costs. *See, .e.g.*, Laura E. Happe et al., *A Systematic Literature Review Assessing the Directional Impact of Managed Care Formulary Restrictions on Medication Adherence, Clinical Outcomes, Economic Outcomes, and Health Care Resource Utilization,* 20 J. MANAGED CARE & SPECIALTY PHARM. 677 (2014), https://www.jmcp.org/doi/10.18553/jmcp.2014.20.7.677; James Baumgardner et al., *Modeling the Impacts of Restrictive Formularies on Patients With HIV,* 24 AM. J. MANAGED CARE (Special Issue NO. 8) SP322, SP325 (2018),https://www.researchgate.net/publication/326491815_Modeling_the_impacts_of_restrictive_formularies_on_patients_with_HIV; Yujin Park et al., *The Effect of Formulary Restrictions on Patient and Payer Outcomes: A Systematic Literature Review,* 23 J. MANAGED CARE & SPECIALTY PHARM. 893, 898 (2017), https://www.jmcp.org/doi/10.18553/jmcp.2017.23.8.893 (reviewing 59 unique studies and observing that the majority of "studies that included total or medical costs (in addition to pharmacy costs)… showed either negative effect on total, medical, or pharmacy costs or no effect on pharmacy costs").

II. HHS Authority and § 1115

For the Secretary to approve Oklahoma'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.[17]

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.[18] As explained in detail below, Oklahoma's proposal is inconsistent with the provisions of § 1115.

III. The Project Will Reduce Medicaid Coverage

Oklahoma 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 (and as described below, these estimates are unreasonably low).[19] As such, the project runs directly counter to the "one primary purpose" of the Medicaid program, which is "providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage." *Gresham v. Azar*, 950 F.3d 93, 102 (D.C. Cir. 2020). The fact that Oklahoma seeks to cover the expansion population through the project (using the purported "expenditure authority"), as opposed to through the state plan, does not change the outcome.[20] That illegal maneuver does not make the project coverage-promoting. What is more, the requested policy changes do not have any experimental value.

A. Imposing Work Requirements

Oklahoma proposes to require enrollees to complete 80 hours per month of specified work or work-related activities and to report their participation to the State each month.[21] Individuals who do not meet the work requirements in a particular month will lose their Medicaid coverage and will not be able to regain coverage unless and until they: (1) complete the required hours for one month; (2) participate in and comply with the requirements of a state workfare program; (3) qualify for an exemption from the work

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[17] 42 U.S.C. § 1315(a).
[18] *Id.* § 1396-1.
[19] *See* Application at 17-18.
[20] *See id.* at 51.
[21] *Id.* at 11.

requirements; or (4) become pregnant.[22] Thus, some portion of individuals who are not able to meet the work requirements will never regain Medicaid coverage.

Under § 1115 and other relevant law, HHS has no authority to approve any waiver permitting Oklahoma 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.[23]

Section 1115 cannot be used to short-circuit these Medicaid protections. There is no basis for finding that the work requirements Oklahoma describes are likely to assist in promoting the objectives of the Medicaid Act.[24] Put simply, conditioning Medicaid eligibility on completion of work activities blocks access to medical assistance.

1. The Work Requirement Will Lead to Substantial Coverage Losses.

All evidence indicates that the work requirement will lead to substantial numbers of individuals losing Medicaid coverage.[25] In its application, Oklahoma estimates that the work requirements and premiums *combined* will cause 5% of the expansion population to lose coverage every year. This means that over the course of the project, 39,500 individuals will lose coverage for failure to comply with the work requirements and

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[22] *Id.* at 13.

[23] *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).

[24] 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.

[25] *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/; Rachel 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.").

premiums.[26] As troubling as that estimate is, evidence from other states with similar work requirements reveals that it is far too low.

For example, Arkansas began implementing a work requirement for the Medicaid expansion population in June 2018, and by the end of 2018, roughly 23% of Medicaid enrollees subject to the requirement – 18,164 individuals – lost coverage for failure to comply.[27] The dramatic losses led the federal Medicaid and CHIP Payment and Access Commission (MACPAC), an advisory body for Congress, to write to Secretary Azar and call for a "pause" in implementation.[28]

In New Hampshire, data showed even higher rates of non-compliance with work requirements. Of the approximately 25,000 individuals who needed to report activities, two thirds – nearly 17,000 people – did not report sufficient hours and were at risk of losing coverage.[29] Given the potential for this substantial coverage loss, New Hampshire paused the implementation of the work requirements before a court invalidated CMS's approval of the project.[30] Researchers have estimated coverage loss rates of up to 41% when evaluating similar work requirements in other states.[31]

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[26] Application at 17-18, 21.

[27] *See* Ark. Dep't of Human Servs., *Arkansas Works Program December 2018 Report*, 10 (attached). *See also*, Robin Rudowitz et al., Kaiser Family Found., *A Look at November State Data for Medicaid Work Requirements in Arkansas* (December 2018), http://files.kff.org/attachment/Issue-Brief-A-Look-at-November-State-Data-for-Medicaid-Work-Requirements-in-Arkansas; Jennifer Wagner, Ctr. on Budget and Policy Priorities, *Medicaid Coverage Losses Mounting in Arkansas from Work Requirement* (Jan. 17, 2019), https://www.cbpp.org/blog/medicaid-coverage-losses-mounting-in-arkansas-from-work-requirement.

[28] Penny Thompson, Medicaid & CHIP Payment & Access Comm'n, *MACPAC letter to HHS Secretary Regarding Work Requirements Implementation* (Nov. 8, 2018), https://www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf.

[29] 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 [hereinafter "Letter from Meyers"]; 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.

[30] Letter from Meyers (noting that otherwise New Hampshire would experience the ""unintended loss of coverage for thousands of beneficiaries.")

[31] Leighton Ku & Erin Brantley, The Commonwealth Fund, *Medicaid Work Requirements in Nine States Could Cause 600,000 to 800,000 Adults to Lose Medicaid Coverage* (June 21, 2019), https://www.commonwealthfund.org/blog/2019/medicaid-work-requirements-nine-states-could-cause-600000-800000-adults-lose-coverage [hereinafter Ku & Brantley, *Medicaid Work Requirements in Nine States*]; *see also* Sara R. Collins et al., THE COMMONWEALTH FUND, *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky* (2018), https://www.commonwealthfund.org/publications/2018/oct/kentucky-medicaid-work-requirements; Aviva Aron-Dine, Ctr. on Budget & Policy Priorities, *Eligibility Restrictions in Recent Medicaid Waivers Would Cause Many Thousands of People to Become Uninsured* (2018), https://www.cbpp.org/research/health/eligibility-restrictions-in-recent-medicaid-waivers-would-cause-many-thousands-of.

There is no reason to expect a different outcome in Oklahoma. Individuals will lose coverage for various reasons. First, many individuals simply will not be able to consistently complete the required number of hours. Second, the administrative burdens of reporting compliance or proving an exemption will cause a significant decline in enrollment, even for those who are working or should be exempt.

Those who lose Medicaid coverage will have few alternative coverage options and many will remain uninsured, likely for a significant amount of time. Fewer than one in four Arkansans terminated for failure to meet the work requirements had reenrolled five months after their lockout period ended.[32] And, unlike Oklahoma's proposal, Arkansas did not require compliance with the work requirements prior to reenrollment. As described in detail in Section III.E below, people without health insurance have poorer access to medically necessary services, increased financial insecurity, and worse health outcomes.

a) Individuals will not be able to complete the required work hours.

Data show that Medicaid enrollees are already working. About 84% of adult Medicaid enrollees in Oklahoma who do not receive Social Security disability benefits (SSI) live in families with at least one worker and 66% work themselves.[33] But many do not work consistent hours every month due to the volatile nature of the low-wage labor market. Between 2002 and 2017, the ten most common jobs among Medicaid and SNAP recipients were: nursing aides, orderlies, and attendants; cashiers; cooks; truck, delivery, and tractor drivers; retail sales clerks; janitors; laborers outside construction; waiter/waitresses; supervisors and proprietors of sales jobs; and housekeepers, maids, butlers, and stewards. Approximately one third of SNAP and Medicaid recipients worked in one of these occupations.[34] These jobs do not provide consistent, predictable hours each month. They have variable schedules, often set by employers with no possibility for changes, making it difficult (or impossible) for individuals to make up for a loss of hours in a given month.[35] In total, 83% of part-time workers report having unstable work schedules,

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[32] Harris Meyer, *More Arkansans Uninsured, Unemployed Post-Medicaid Work Requirement*, MODERN HEALTHCARE (June 19, 2019), https://www.modernhealthcare.com/medicaid/more-arkansans-uninsured-unemployed-post-medicaid-work-requirement.

[33] Rachel Garfield et al., Kaiser Family Found., *Understanding the Intersection of Medicaid and Work, Kaiser Family Foundation*, Appendix at table 1 (Aug. 8, 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*].

[34] *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 percent) [hereinafter Butcher & Whitmore Schanzenbach]; *see also* Josh Bivens & Shawn Fremstad, Economic Pol. Inst., *Why Punitive Work-Hours Tests in SNAP and Medicaid Would Harm Workers and Do Nothing to Raise Employment* (July 26, 2018), https://www.epi.org/publication/why-punitive-work-hours-tests-in-snap-and-medicaid-would-harm-workers-and-do-nothing-to-raise-employment/ (reporting data from 2016 listing the most common occupations for workers receiving SNAP or Medicaid) [hereinafter Bivens & Fremstad].

[35] 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_

and 41% of hourly workers between ages 26 and 32 receive one week or less notice of their schedules.[36]

Moreover, these occupations experience high rates of *involuntary* part-time employment—meaning workers wanted full-time hours but were only offered part-time hours—with the retail, trade, and leisure and hospitality industries ranking highest.[37] Thus, even when workers do work a substantial number of hours throughout the year, they are likely to experience periods with less or no work.[38] As a result of the churn and volatility in the low-wage labor market, almost half of low-income workers would fail a work-hours test in at least one month over the course of the year.[39]

The economic crisis sparked by the coronavirus pandemic will make it even more difficult for Medicaid enrollees to find consistent work. Currently, the unemployment rate in Oklahoma is nearly 13%.[40] Industries on which Medicaid enrollees rely for work, such as leisure and hospitality, have been hit particularly hard.[41] Experts cannot predict precisely when or how the economy will recover, as that depends on the course of the pandemic.[42] However, the Federal Reserve Bank anticipates that the unemployment rate will remain elevated for years, and that millions of people will not "get to go back to their old job, and, in fact, there may not be a job in that industry for them for some time"[43]

Nor will volunteering or other un-paid activities be a viable solution for Medicaid enrollees. Many individuals whose hours fluctuate regularly will struggle to complete other activities

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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; Tanya L. Goldman et al., Ctr. for Law & Social Policy, *The Struggles of Low Wage Work* (2018), https://www.clasp.org/sites/default/files/publications/2018/05/2018_lowwagework.pdf [hereinafter Goldman, Urban Inst., *The Struggles of Low Wage Work*]; Michael Karpman et al., *Precarious Work Schedules Could Jeopardize Access to Safety Net Programs Targeted by Work Requirements* (2019), https://www.urban.org/sites/default/files/publication/100352/precarious_work_schedules_could_jeopardize_access_to_safety_net_programs.pdf.

[36] Goldman, *The Struggles of Low Wage Work*.

[37] Bivens & Fremstad; Goldman, *The Struggles of Low Wage Work*.

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

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

[40] U.S. Dep't of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, https://www.bls.gov/web/laus/lauhsthl.htm (modified June 19, 2020).

[41] Thomas Frank, *Hardest Hit Industries, Nearly Half the leisure and hospitality jobs were lost in April*, CNBC (May 8, 2020), https://www.cnbc.com/2020/05/08/these-industries-suffered-the-biggest-job-losses-in-april-2020.html.

[42] *See* Interview by Rachel Martin, Nat'l Pub. Radio with David Wessel, Dir., Hutchins Ctr. at Brooking Inst. (June 9, 2020), https://www.npr.org/2020/06/09/872710984/u-s-recession-began-in-february-national-bureau-of-economic-research-says.

[43] Jeanna Smialek & Alan Rappeport, *Fed Leaves Rates Unchanged and Projects Years of High Unemployment*, N.Y. TIMES (June 10, 2020), https://www.nytimes.com/2020/06/10/business/economy/federal-reserve-rates-unemployment.html.

at the last minute in a month when their work hours fall short. Thus, the variation and volatility of the low-wage market will make it difficult for individuals to complete any of the non-work activities. In addition, obstacles that prevent people from finding and maintaining work, such as lack of internet access and lack of transportation, will prevent people from completing volunteer activities. Almost a quarter of households in Oklahoma do not have a broadband internet subscription.[44] The State ranks 47th in internet connectivity.[45] And, research confirms that low-income people do not have access to the internet to the same extent as the non-poor.[46] Further, low-income people are less likely to own a car than their middle- or upper-income peers, and many low-income families do not have access to affordable transportation, particularly in rural areas.[47] Thousands of workers in Oklahoma do not have any access to a car.[48] Four counties in the State have no public transportation service at all, and many other counties report that they are not fully meeting local transportation needs.[49] In addition, concerns about coronavirus transmission will likely prevent: (1) organizations from offering volunteer opportunities; and (2) Medicaid enrollees, particularly those who are at higher risk of severe illness or live with someone who is at higher risk, from participating in volunteer activities.

Moreover, conditioning Medicaid on unpaid work could run afoul of other laws the Secretary is not permitted to waive, such as the Fair Labor Standards Act (FLSA), which requires that all individuals be compensated in an amount equal to at least the minimum

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[44] U.S. Census Bureau, *Quick Facts: Oklahoma* (2019), https://www.census.gov/quickfacts/OK (last visited May 28, 2020).

[45] Tyler Cooper, *States with the Best and Worst Internet Coverage 2018*, BroadbandNow, (Aug. 14, 2018), https://broadbandnow.com/report/us-states-internet-coverage-speed-2018. *Cf.* U.S. News & World Report, U.S. Internet Rankings, https://www.usnews.com/news/best-states/rankings/infrastructure/internet-access (ranking Oklahoma 44th in internet access).

[46] *See, e.g.*, 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 (finding that nationwide, half of households with incomes under $25,000 have either no computer or no broadband at home); 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?*].

[47] Federal Highway Admin., *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).

[48] Dilip Mistry et al., Small Urban and Rural Transit Ctr. Upper Great Plains Transp. Inst., North Dakota State Univ., Fargo, *Statewide Personal Mobility Needs for Oklahoma 2018-2028*, at 13-14 (2018), https://www.ok.gov/odot/documents/2018-2028%20OK%20Transit%20Mobility%20Needs.pdf.

[49] *Id.* at 44, 91, 86. *See also id.* at 77 (finding that 90% of county transit agencies reported needing to provide for more services to allow people to get to work).

wage in exchange for hours they work.[50] FLSA concerns will also limit the number of recurring, stable volunteer opportunities that are available to SoonerCare enrollees.[51]

The work requirements will hit individuals with chronic and disabling conditions particularly hard. Many individuals in the expansion population have chronic or disabling conditions that prevent them from working. The Kaiser Family Foundation estimates that nationwide, 34% of adult Medicaid enrollees who were not receiving disability benefits and were not working live with multiple chronic medical conditions, and 51% have a functional limitation that could affect their ability to work.[52] A separate study found that among unemployed Kentucky Medicaid enrollees who would have been likely subject to its work requirement, 41% reported one or more serious health limitations.[53] Twenty-one percent reported serious problems concentrating, remembering, or making decisions, and 26% reported serious problems walking or climbing stairs.[54]

Individuals with disabilities also face structural barriers to employment. People with disabilities experience discrimination at various stages of employment, including at hiring, resulting in low employment rates and wage levels. For example, employees with disabilities that would not affect their job performance are 26% less likely to be considered for employment.[55] In addition, compared to people without a disability, people with a disability are nearly twice as likely to be employed part time because they cannot find a job with more hours or their hours have been cut back.[56] Individuals with disabilities also experience difficulties obtaining necessary work supports or reasonable accommodations from their employer. All told, people with disabilities actually saw their labor force participation drop from 1980 to 2015 and remain more than twice as likely to not have employment.[57]

Providing an exemption for enrollees who are "medically certified as physically or mentally unfit for employment" or who have a disability cannot resolve these concerns.[58] News accounts from Arkansas demonstrated how individuals with chronic conditions lost their

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[50] *See* 29 U.S.C. § 206(a)(1)(C); Dep't of Labor, *How Workplace Laws Apply to Welfare Recipients* 2 (1997), http://nclej.org/wp-content/uploads/2015/11/LaborProtectionsAndWelfareReform.pdf.
[51] *See e.g.*, Dep't of Labor, Wage and Hour Division, *Fact Sheet #14A: Non-Profit Organizations and the Fair Labor Standards Act* 2 (2015), https://www.dol.gov/whd/regs/compliance/whdfs14a.pdf.
[52] Garfield et al., *Understanding the Intersection of Medicaid and Work* at 8.
[53] Anuj Gangopadhyaya and Genevieve M. Kenney, Urban Inst., *Who Could Be Affected by Kentucky's Medicaid Work Requirements, and What Do We Know about Them?* 3 (2018), https://www.urban.org/research/publication/updated-who-could-be-affected-kentuckys-medicaid-work-requirements-and-what-do-we-know-about-them.
[54] *Id.*
[55] Mason Ameri et al., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior* (2015) https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2663198.
[56] U.S. Bureau of Labor Statistics, *Persons with a Disability: Labor Force Characteristics—2016* (June 21, 2017), https://www.bls.gov/news.release/pdf/disabl.pdf.
[57] Grace Donnelly, *See How Your State Ranks in Employment among Works with Disabilities*, FORTUNE (Feb. 28, 2017), http://fortune.com/2017/02/28/disability-employment-rank/ (citing the Annual Disability Statistics Compendium).
[58] Application at 14.

coverage due to confusion about the work requirements.[59] A recent Kaiser Family Foundation study similarly found that despite the purported exemptions and safeguards in place, significant numbers of individuals with a disability still lost coverage. The study notes that safeguards were themselves complex and difficult to navigate and resulted in very few enrollees actually utilizing the exemptions.[60] These coverage losses occurred despite Arkansas taking steps to avoid the problem, such as "using existing data sources when possible" to confirm disability status.[61] Another recent study examined data from Arkansas, Indiana, Michigan, and New Hampshire and found that of the individuals subject to work requirements, those who did not meet them "were disproportionately sicker than those fulfilling them and often reported health-related barriers to work." Thus, the authors concluded that exemptions commonly used by states "may incompletely identify medical inability to work."[62]

Evidence from other programs confirms that, in practice, individuals with disabilities are often not exempted as they should be.[63] They are, in fact, more likely to lose benefits due to noncompliance.[64] Numerous studies of state Temporary Assistance for Needy Families (TANF) programs already found that participants with physical or mental health conditions are disproportionately sanctioned for not completing the work requirement or related work activities.[65]

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[59] 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://www.arktimes.com/arkansas/when-arkansas-works-doesnt/Content?oid=25890378.

[60] 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/.

[61] Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas,* 381 N. ENG. J. MED. 1073, 1080 (Sept. 2019), https://www.nejm.org/doi/pdf/10.1056/NEJMsr1901772?articleTools=true [hereinafter Sommers et al., *Medicaid Work Requirements – Results from the First Year in Arkansas*].

[62] David M. Silvestri et al., *Research Letter: Assessment of Health Status and Barriers to Employment Among Medicaid Beneficiaries Not Meeting Work Requirements After Accounting for State Medical Frailty Exemptions*, JAMA INTERNAL MED. (2020) (attached).

[63] *See* Anna Bailey & Judy Solomon, *Medicaid Work Requirements Don't Protect People with Disabilities: Yet Another Way Requirements Are at Odds with Medicaid's Objectives* (Nov. 14, 2018), https://www.cbpp.org/research/health/medicaid-work-requirements-dont-protect-people-with-disabilities.

[64] *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*].

[65] *See, e.g.*, Yeheskel Hasenfeld et al., Univ. of Pennsylvania School of Social Policy and Practice, *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment* (2004), 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*

There is similar evidence from the SNAP program. Researchers have expressed concern that states might incorrectly determine that many SNAP participants who have a disability are subject to the work requirement.[66] 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.[67] And without question, individuals in this group experience significant coverage loss for failure to comply with work requirements. 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 had lost benefits after only three months.[68] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when they were actually unable to work.[69]

Likewise, "hardship" protections in Maine's TANF program did not protect people with disabilities. The Maine Department of Health and Human Services (DHHS) reported that though nearly 90 percent of parents receiving TANF for five years or longer have a disability themselves or are caring for a family member with a disability, only 17 percent of families terminated due to the time limits received a disability-related extension.[70] Several beneficiaries reported being denied disability-related extensions even though they were in the process of applying for – and ultimately received – SSI benefits.[71] Beneficiaries also reported being discouraged from applying for extensions by TANF caseworkers and confusion about the process for applying for hardship extensions.[72]

Requirements]; Mathematica Policy Research, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments (2008)* https://www.acf.hhs.gov/sites/default/files/opre/conducting_in_depth.pdf; Pamela Loprest, Urban Inst., *Disconnected Welfare Leavers Face Serious Risks* (2002), http://www.urban.org/sites/default/files/publication/59036/310839-Disconnected-Welfare-Leavers-Face-Serious-Risks.PDF.

[66] *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.

[67] Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults without Dependents* (2015), https://cfpa.net/CalFresh/ExternalPublications/OAFB-WEP-ABAWD-report-2015.pdf.

[68] *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.

[69] *Id.*

[70] Thomas Chalmers McLaughlin & Sandra S. Butler, Maine Equal Justice Partners & Maine Women's Lobby, *Families in Focus: Moving Beyond Anecdotes: Lessons from a 2010 Survey of Maine TANF Families* (2011), http://www.mainewomen.org/assets/files/Families_in_Focus_Final%20Report.pdf [hereinafter McLaughlin & Butler, *Lessons from a 2010 Survey of Maine TANF Families*]; Sandra S. Butler, Maine Equal Justice Partners, *TANF Time Limits, One Year Later: How Families are Faring*, https://mail.maineequaljustice.org/site/assets/files/1525/tanf-time-limits-march2014_0.pdf.

[71] McLaughlin & Butler, *Lessons from a 2010 Survey of Maine TANF Families.*

[72] McLaughlin & Butler. *Lessons from a 2010 Survey of Maine TANF Families.*

Because conditioning Medicaid eligibility on completion of the work requirement would 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.[73] 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.[74]

Likewise, the work requirements will disproportionately harm individuals with prior arrests or convictions, who face significant barriers to employment.[75] Oklahoma's proposal to give individuals recently released from incarceration a nine-month grace period before they must comply with the work requirements will not prevent substantial coverage loss. Research shows that prior arrests (including those that did not result in a conviction) and convictions continue to inhibit individuals' job prospects for many years.[76] The problem is particularly acute for Black individuals. Due to racial bias, Black people are more likely to be arrested, convicted, and incarcerated than White people.[77] In Oklahoma, which has the second highest imprisonment rate in the country, the imprisonment rate for Black people is more than 4.5 times the imprisonment rate for White people.[78] What is more, research suggests that the employment prospects of Black individuals are more strongly affected by a criminal record.[79]

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[73] 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).
[74] See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).
[75] *See, e.g.*, Devah Pager, *The Mark of a Criminal Record*, 108 AJS 937 (2003), https://scholar.harvard.edu/files/pager/files/pager_ajs.pdf [hereinafter Pager, *The Mark of a Criminal Record*]; Harry J. Holzer et al., *Perceived Criminality, Criminal Background Checks, and the Racial Hiring Practices of Employers,* 49 J. LAW & ECON. 451, 453-454 (2006), https://pdfs.semanticscholar.org/10d4/d3352ec2c282647f696b8bbd7adc59fafd02.pdf (finding the majority of employers report they would "probably" or "definitely" not be willing to hire someone with a criminal record); Michelle N. Rodriguez & Maurice Emsellem, Nat'l Employment Law Project, *65 Million 'Need Not Apply': The Case for Reforming Criminal Background Checks for Employment* (2011), https://www.nelp.org/wp-content/uploads/2015/03/65_Million_Need_Not_Apply.pdf
[76] Simone Ispa-Landa & Charles E. Loeffler*, Indefinite Punishment and the Criminal Record: Stigma Reports Among Expungement-seekers in Illinois*, 54 CRIMINOLOGY 387 (2006), https://www.sesp.northwestern.edu/docs/publications/279299815a1452bc75a5b.pdf; Lucius Couloute & Daniel Kopf, Prison Policy Initiative, *Out of Prison & Out of Work: Unemployment among formerly incarcerated people* (2018), https://www.prisonpolicy.org/reports/outofwork.html.
[77] The Sentencing Project, Criminal Justice Facts, https://www.sentencingproject.org/criminal-justice-facts/ (last visited June 3, 2020).
[78] The Sentencing Project, State-by-State Data, State Rankings, https://www.sentencingproject.org/the-facts/#rankings?dataset-option=SIR; The Sentencing Project, State-by-State Data for Oklahoma, https://www.sentencingproject.org/the-facts/#detail?state1Option=Oklahoma&state2Option=0 (last visited June 3, 2020).
[79] Pager, *The Mark of a Criminal Record*, at 961; Lucius Couloute & Daniel Kopf, Prison Policy Initiative, *Out of Prison & Out of Work: Unemployment among formerly incarcerated people* (2018), https://www.prisonpolicy.org/reports/outofwork.html

Additional evidence shows that Oklahoma's work requirements are likely to disproportionately harm Black individuals. One study found that caseworkers are more likely to sanction African American (as opposed to White) TANF participants for noncompliance with program requirements.[80] The study raises serious concerns that People of Color would be disparately impacted by the project. The evidence shows they will be more likely to lose Medicaid coverage due to the work requirement, further increasing racial disparities in Oklahoma. The application should be denied so as to avoid a situation where federal funds are being used to operate a program that violates Title VI of the Civil Right Act.

b) Administrative burden will result in coverage loss.

Many individuals – including many individuals who are already working or who fall within an exemption – will lose coverage due to the administrative burden associated with the work requirements.[81] Repeated research has established that adding new administrative requirements for Medicaid enrollees decreases enrollment.[82] For example, in 2003 Texas experienced a nearly 30 percent drop in enrollment after it increased premiums, established a waiting period, and moved from a 12- to 6-month renewal period for children in CHIP.[83] Similarly, when Washington State increased documentation requirements, moved from a 12- to 6-month renewal period, and ended continuous eligibility for children in Medicaid and CHIP in 2003, enrollment dropped sharply.[84] Enrollment quickly

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

[81] *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.

[82] *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 et al., Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage and Quality of Care,* 12-16 (2009) http://www.communityplans.net/Portals/0/ACAP%20Docs/Improving%20Medicaid%20Final%20070209.pdf, [hereinafter Ku et al., *Improving Medicaid's Continuity of Coverage*].

[83] 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/ [hereinafter Kaiser Family Found., *Implications of Emerging Waivers*] (citing Kaiser Family Found., *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act*, (June 4, 2013), https://www.kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/).

[84] Kaiser Family Found., *Implications of Emerging Waivers*, at 59 (citing Donna Cohen Ross and Laura Cox, Kaiser Family Found., *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, A 50 State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and CHIP* (Oct. 2004), https://www.kff.org/wp-content/uploads/2013/01/beneath-the-surface-barriers-threaten-to-slow-progress-on-expanding-health-coverage-of-children-and-families-pdf.pdf;

rebounded when the State reinstated the 12-month renewal period and continuous eligibility.[85]

There are several reasons for this. First, states and their contractors inevitably make mistakes implementing the requirement, causing some erroneous coverage losses.[86] In Arkansas, programming glitches created widespread problems accessing the State's work requirement reporting website.[87]

Second, many enrollees fail to receive adequate notice of or simply do not understand the requirements, and as a result, do not comply.[88] In-depth interviews with 18 adult Medicaid enrollees in Arkansas in September 2019 revealed "a profound lack of awareness" about the work requirements, with two-thirds of the enrollees having not even heard of them.[89] Later focus groups conducted with 31 Medicaid enrollees in Arkansas showed many were still unaware of or confused by the new requirements in November 2019, a full six months after they went into effect.[90] And, in a recent study published in the New England Journal of Medicine, Harvard researchers found that 44% of people subject to the work requirements in Arkansas had never heard of them.[91]

Early evidence from New Hampshire revealed similar problems. 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.[92] Although New

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and Laura Summer and Cindy Mann, Commonwealth Fund, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies* (June 2006), http://www.commonwealthfund.org/publications/fund-reports/2006/jun/instability-of-public-health-insurance-coverage-for-children-and-their-families--causes--consequence).

[85] Kaiser Family Found., *Implications of Emerging Waivers*.

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

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

[88] *See, e.g.*, *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 et al., *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.").

[89] 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/.

[90] MaryBeth Musumeci et al., Kaiser Family Found., *Medicaid Work Requirements in Arkansas: Experience and Perspectives of Enrollees* (December 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*].

[91] Sommers et al., *Medicaid Work Requirements – Results from the First Year in Arkansas*, at 1077.

[92] 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-

Hampshire claimed that its outreach and reporting would differ from the approach in Arkansas, the result of the work requirements was very similar.[93]

Third, even individuals who know their obligations under the work requirement face challenges to show they qualify for an exemption or good cause exemption.[94] For example, if someone is physically or mentally unable to work, they must provide medical certification, presumably from a health care provider.[95] Reports from New Hampshire show how difficult and time-consuming it can be to get that kind of documentation.[96]

Similarly, parents of children over age six will be entitled to a good cause exemption only if they are not able to fulfill the work requirements "due to childcare responsibilities."[97] It is not clear how broadly that exemption will apply or how individuals will verify their eligibility. Will they have to collect and submit documentation every month showing that they could not secure affordable, quality childcare or that their car broke down, leaving them with childcare responsibilities?

Additional structural barriers will prevent individuals from reporting their hours or seeking an exemption or good cause exemption. Oklahoma will allow individuals to report their hours or seek an exemption online, over the phone, or through the mail.[98] As explained above, many low-income people do have access to the internet, which will make reporting more difficult. In addition, research indicates that many low-income individuals rely on cell phones as opposed to landlines, and they have their cell phones disconnected on a regular or semi-regular basis.[99] These kinds of logistical barriers to reporting have been

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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

[93] 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.

[94] *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.

[95] Application at 14.

[96] *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

[97] Application at 15. A large number of caretakers could find themselves in that position. Not only is childcare too expensive for many low-wage workers, it is also in short supply. 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.

[98] Application at 13.

[99] *See, e.g.*, Amy L Gonzales et al., *Cell Phone Disconnection Disrupts Access to Healthcare and Health Resources: A Technology Maintenance Perspective*, 18 NEW MEDIA & SOCIETY 1422 (2014) (attached).

documented in the SNAP program; research shows that otherwise eligible individuals lose coverage due to reporting requirements at recertification.[100]

In addition, evidence from Arkansas shows that the good cause exemptions will have little to no effect on the number of enrollees who lose coverage due to the work requirements.[101] 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 requirements.[102]

Navigating the work requirements could be especially challenging for individuals with substance use disorders and/or with mental illness that affects their cognitive function.[103] In addition, safety net providers in Arkansas observed that individuals with limited English proficiency or limited reading skills would struggle to comprehend notices and other information written at a high reading level in English.[104] Forty-three million U.S. adults have low English literacy skills, and at least 8.4 million of these individuals are functionally illiterate.[105] In this way, the work requirement is likely to exacerbate health disparities within Oklahoma.[106]

Fourth and finally, research indicates that the complexity of the work requirements could dissuade individuals from enrolling in SoonerCare in the first place.[107] In 2000, a survey of parents revealed that the perceived red tape, the complexity of rules and regulations, and

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[100] 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.

[101] 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 & Policy Priorities, *Medicaid Work Requirements Can't Be Fixed* (2019), https://www.cbpp.org/research/health/medicaid-work-requirements-cant-be-fixed.

[102] 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.

[103] 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.

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

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

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

[107] Perry et al., *Medicaid and Children*; 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.

confusion about how to apply were all significant factors that prevented parents from even trying to enroll their children in Medicaid.[108]

In short, abundant evidence shows that reducing enrollees' administrative burdens increases coverage.[109] Congress recognized this relationship, drafting the Affordable Care Act to:

- create a single-streamlined application process for both Medicaid and Marketplace coverage; prohibit states from requiring an in-person interview for Medicaid applicants;
- eliminate asset tests for most Medicaid eligibility groups; require states to rely on electronic data matches to verify eligibility to the greatest extent possible before requesting documentation from applicants; and
- require states to conduct annual eligibility redeterminations without requesting information from beneficiaries if eligibility can be determined using electronic data.[110]

Oklahoma's proposed work requirement, which requires monthly reporting by enrollees who are already working or qualify for an exemption, undercuts or violates these provisions (a number of which are not waivable under § 1115) and will decrease enrollment.

c) Most individuals who lose coverage will remain uninsured.

Individuals who lose coverage for failure to comply with the work requirements are extremely likely to remain uninsured. [111] First, individuals who are working but nevertheless lose coverage for failure to comply with the work requirements are not likely to have access to affordable insurance through their employer.[112] According to the Kaiser Family Foundation, only 30% of workers in households with income below the federal poverty level (FPL) had access to insurance through their employer, compared to nearly

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[108] Perry et al., *Medicaid and Children*, at 10-12.

[109] Kaiser Family Found., *Implications of Emerging Waivers*; Ashley M. Fox et al., *Administrative Easing: Rule Reduction and Medicaid Enrollment*, 80 PUBLIC ADMIN. REV. 104 (2020), https://onlinelibrary.wiley.com/doi/epdf/10.1111/puar.13131.

[110] *See* 42 U.S.C. §§ 1396a(e)(14)(C), 1396w-3, 18083. *See also* Wagner & Solomon, *States' Complex Medicaid Waivers*, at 12; Kaiser Family Found., *Implications of Emerging Waivers*.

[111] *See* Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*.

[112] *See, e.g.*, Sara R. Collins et al., The Commonwealth Fund, *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky* (2018), https://www.commonwealthfund.org/publications/2018/oct/kentucky-medicaid-work-requirements (reporting data showing that nearly three-quarters of individuals who churn off of Medicaid remain uninsured or experience a coverage gap before regaining insurance and that individuals who experience a gap in coverage report barriers to accessing care at nearly the same rate as those who are uninsured).

80% of workers in households with income above 400% of FPL.[113] Nationally, among part-time workers, only 13% of those with incomes below poverty and 20% of those with incomes between 100% and 125% of FPL had an offer of insurance from their employer.[114] Another study found that among private-sector workers in the bottom fourth of the wage distribution, two-thirds lacked access to health care benefits from their employer.[115] A report based on 2017 data found that 78% of very low-wage workers (bottom 10% of earners) did not have health care through their jobs, leaving just 22% with access to employer sponsored insurance (ESI).[116] 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 like temporary work and independent contractors.[117]

And even where ESI is offered, it is often unaffordable. In focus groups, Arkansas Medicaid enrollees subject to work requirements repeatedly explained that ESI was neither available nor affordable.[118] According to the United States Bureau of Labor Statistics, private-sector workers in the lowest 25% of wages are still responsible for an average of 24% of their premium costs, equaling $133.75 each month.[119] That does not include cost sharing or other out-of-pocket expenses. Meanwhile, workers in organizations with a relatively large share of low-wage workers (with at least one third of workers earning $25,000 or less per year – well above the $22,000 median earnings for Medicaid enrollees) have to contribute *more* for their individual and family coverage than their peers in organizations with fewer low-wage workers.[120]

Second, Marketplace coverage is not an adequate substitute for Medicaid coverage. Individuals with incomes below 100% of FPL will not have access to Marketplace

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[113] Michelle Long et al., Kaiser Family Found., *Trends in Employer-Sponsored Insurance Offer and Coverage Rates: 1999-2014*, 3 (2016) http://files.kff.org/attachment/issue-brief-trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-2 [hereinafter "*Trends in Employer-Sponsored Insurance*"].
[114] *Trends in Employer-Sponsored Insurance*, at 4.
[115] Bivens & Fremstad.
[116] Goldman et al.
[117] Thomas C. Buchmueller & Robert G. Valletta, *Work, Health, and Insurance: A Shifting Landscape for Employers and Workers Alike,* 36 HEALTH AFFAIRS 214 (2017), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.1200.
[118] Musumeci, *Medicaid Work Requirements in Arkansas*, at 3.
[119] U.S. Bureau of Labor Statistics, Employee Benefits Survey, Healthcare Benefits, March 2016, *Table 10: Medical Care Benefits: Share of Premiums Paid by Employer and Employee, Private Industry Workers, March 2016*, https://www.bls.gov/ncs/ebs/benefits/2016/ownership/private/table10a.pdf (percentage of premium); U.S. Bureau of Labor Statistics, Employee Benefits Survey, Healthcare Benefits, March 2016, *Table 11: Medical Care Benefits, Single Coverage: Employer and Employee Premiums By Employee Contribution Requirement, Private Industry Workers, March 2016*, https://www.bls.gov/ncs/ebs/benefits/2016/ownership/private/table11a.pdf.
[120] Kaiser Family Found., *Employer Health Benefits: 2018 Annual Survey*, 9 (2018), http://files.kff.org/attachment/Report-Employer-Health-Benefits-Annual-Survey-2018; Kristin F. Butcher & Diane W. Schanzenbach, Ctr. on Budget & Policy Priorities, *Most Workers in Low-Wage Labor Market Work Substantial Hours, in Volatile Jobs* (2018), https://www.cbpp.org/sites/default/files/atoms/files/7-24-18pov.pdf.

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 lowers coverage rates and increases out-of-pocket expenses.[121] 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).[122] 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).[123]

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%) remained uninsured or their insurance status was unknown—despite access to subsidized insurance on the Marketplace.[124] Rural areas, where Marketplace premiums are typically higher, may experience even greater differences in out-of-pocket spending between Medicaid and the Marketplace. This may result in a higher number of rural individuals remaining uninsured.[125] 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.[126]

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[121] 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).
[122] *Id.* at 304-305.
[123] *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, &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/, [hereinafter "Artiga et al., *The Effects of Premiums and Cost Sharing*"].
[124] Kids Forward, *The Wisconsin Approach to Medicaid Expansion* (2017), http://kidsforward.net/assets/Medicaid-Approach.pdf.
[125] 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.
[126] Larisa Antonisse & Rachel Garfield, Kaiser Family Found., *The Relationship between Work and Health: Findings from a Literature Review* (2018), https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/ [hereinafter Antonisse & Garfield, *The Relationship between Work and Health*]. *See also* Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*.

All these statistics point to an obvious conclusion: people who lose Medicaid coverage due to Oklahoma's proposed work requirement are highly unlikely to find affordable, alternative health coverage. And, as detailed in Section III.E., people without health coverage face reduced access to health care and, consequently, poorer health outcomes.

2. The Literature Does Not Support Imposing a Work Requirement to Increase Employment and Financial Independence.

Oklahoma argues that imposing a work requirement on Medicaid enrollees will lead to "upward mobility" and greater financial independence.[127] Redundant research refutes this claim.[128] The Harvard researchers found that the Arkansas work requirements were associated with "significant losses in health insurance coverage in the initial 6 months of the policy but no significant change in employment."[129] In fact, the number of individuals working more than 20 hours a week declined after implementation of the work requirement.[130] Notably, the study did detect a rise in the rate of uninsured individuals.[131] 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 remain uninsured.

Duplicative and rigorous studies of other public benefits programs show that work requirements do not increase stable, long-term employment.[132] In fact, imposing work

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[127] Application at 6, 57.

[128] Sommers et al, *Medicaid Work Requirements - Results from First Year in Arkansas*, at 1078-81; 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 [hereinafter Wagner, *New Arkansas Data*].

[129] Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 1079.

[130] *Id.*

[131] *Id.*

[132] *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), 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*

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.[133] 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.[134]

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.[135] More rigorous, and long-term analyses indicate that individuals who left TANF due to increased earnings did not typically experience lasting income increases.[136] For instance, Kansas parents who reported having a job when they

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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*.

[133] 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.

[134] 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.

[135] *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://gwhpmmatters.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.

[136] *See* Rebecca Thiess, Economic Policy 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 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

left TANF in 2014 earned only $1,107 per month, or $13,284 annually (80% FPL for a family of two).[137] 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.[138] Four years later, the numbers had not budged.[139] Parents terminated from TANF due to time limits earned even less, a median of just $1,370 annually (7% FPL).[140] 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 ten percent of Kansas families with children in poverty receive TANF assistance.[141]

Labor market data underscore why work requirements will not promote long-term employment or increases in income. Medicaid enrollees face low wages, stagnant wage growth, and few prospects for advancement.[142] Even when individuals in the low-wage market work a substantial amount in one year, they may not see opportunities for advancement, increased work, or increased wages in the following year.[143] In fact, those who had substantial work one year were likely to experience drops in their income, hours, and wages in the next.[144] A 2019 report that examined work requirements for programs including Medicaid within the context of broader factors found that Medicaid work requirements are "ill-informed" and that "[d]etermining eligibility or benefits for these programs by requiring ongoing demonstration of formal work or work-related activities will tend to compound disadvantage, trapping rather than empowering people when they are struggling the most."[145]

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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) https://www.cbpp.org/sites/default/files/atoms/files/12-14-16fa.pdf; Maine Equal Justice Partners, *Work Requirements Do Not Work and Have Harmful Consequences* 5 (2017) https://usm.maine.edu/sites/default/files/food-studies/CHastedt_Work-Requirements.pdf.

[137] Meg Wingerter, Kansas Health Institute, *Do 'Welfare to Work' Numbers Add Up?* (Apr. 14, 2016), http://www.khi.org/news/article/numbers-dont-support-welfare-to-work-claim.

[138] Mitchell & Pavetti, *Life after TANF in Kansas*.

[139] *Id.*

[140] *Id.*

[141] 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.

[142] *See* Butcher & Whitmore Schanzenbach.

[143] *Id.*

[144] *Id.*

[145] Kali Grant, et al., Georgetown Ctr. Poverty & Inequality: Economic Security & Opportunity Initiative, *Conditioning Access to Program that Ensure a Basic Foundation for Families on Work Requirements*, 19-21 (2019), http://www.georgetownpoverty.org/wp-content/uploads/2019/02/Unworkable-Unwise-20190201.pdf.

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.[146] For example, more than half of Ohio Medicaid expansion enrollees surveyed reported that Medicaid coverage has made it easier to continue working. Among respondents who did not have a job, three-quarters reported that Medicaid coverage made it easier for them to look for one.[147] In a 2018 follow-up survey, more than four in five working Medicaid expansion enrollees (83.5 percent) reported that Medicaid made it easier to work, and 60 percent of the unemployed expansion population said that Medicaid made it easier to look for work.[148] Similarly, Michigan's 2016 expansion enrollee survey showed 69 percent of working enrollees reported Medicaid helped them do a better job and 40 percent 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.[149]

On the other hand, a study following Tennessee's decision in 2005 to end Medicaid coverage for approximately 170,000 low-income adults revealed no increase in the work rate, though there was a shift from full-time to part-time work following the disenrollment. Simultaneously, the State's Medicaid coverage rate dropped by more than 5 percent and the uninsured rate rose by approximately 5 percent.[150] Adults' private coverage rates did not change meaningfully. In other words, taking Medicaid away from low-income adults did not increase employment, or increase access to commercial insurance. Instead, it increased uninsurance, and associated negative health outcomes.

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.[151] 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

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[146] 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 VIII Assessment*"].
[147] *Id.*
[148] Ohio Dep't of Medicaid, *2018 Ohio Medicaid Group VIII Assessment: A Follow-Up to the 2016 Medicaid Group VIII Assessment*, 21-22 (Aug. 2018), https://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf.
[149] 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).
[150] 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.
[151] The State also has the option to offer supportive employment services under § 1915(i) of the Social Security Act.

produced substantial and sustained gains in earnings when fully implemented.[152] 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.[153] During HELP-Link's first three years, over 25,000 Medicaid enrollees received services.[154] The State has reported that program participants have high employment rates, and the majority of participants had higher wages after completing the program.[155]

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

Oklahoma suggests that the work requirement will lead to positive health outcomes for Medicaid enrollees.[156] 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.[157] 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 the relationship to be "very complex" and suggests that a work requirement will be

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[152] 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.
[153] *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.
[154] 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.
[155] *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.
[156] Application at 3, 6.
[157] Letter from Jane Perkins, Nat'l Health Law Program, to Brian Neale, Dir. Ctrs. for Medicare & Medicaid Servs. (Jan. 11, 2018) (attached).

detrimental.[158] For one, job quality matters.[159] 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."[160] "High strain" jobs, or jobs with little reward or recognition, can increase poor health outcomes, such as high blood pressure and cardiovascular disease.[161] This is a key finding mentioned in two meta-analyses cited in the DSMD, but the letter never mentions it.[162]

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 (ages 19 to 50—notably lower than Oklahoma's proposed age 60) that looked at the relationship between health and employment, only 11 are US-based.[163] 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."[164] In short, translating findings from mostly European studies to this Medicaid project in Oklahoma can be misleading. A more relevant meta-analysis used 12 high-quality welfare-to-work interventions involving 27,482 individuals to examine their effects on the health of single parents. Eleven of these studies used 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."[165] CMS should use these findings, published in 2017, to reverse its ill-considered position on mandatory work requirements and to reject the Oklahoma project.

What is more, broad-based population studies that suggest employment is linked to better health and that higher earnings are associated with longer life are not necessarily

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[158] 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*.

[159] *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.

[160] *Id.*

[161] 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/.

[162] Gordon Waddell & A. Kim Burton, *Is Work Good For Your Health & Well-Being?* EurErg Centre for Health and Social Care Research, University of Huddersfield, U.K. (2006) at 34 [hereinafter "Waddell & Burton"]; van der Noordt, at 735.

[163] Waddell & Burton, at 110-132.

[164] *Id.* at 112, 123.

[165] 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.

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."[166] Other research explains that access to health insurance that comes with stable employment explains a substantial part of the correlation between employment and longer life in the United States.[167] 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 or volunteering is the key distinction between causation and correlation, another issue that the DSMD ignores. Van der Noordt et al., another meta-analysis cited in the letter, 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. Similar selection effects are also described in the literature on volunteering. 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]."[168] Rather than grapple with this important factor, the DSMD misrepresents complex correlation as simple causation.

Under Oklahoma's proposal, individuals will be able to satisfy the work requirement by participating in volunteer activities. Studies that find positive benefits from volunteering also suggest that the benefits diminished or disappeared when volunteering was perceived as obligatory.[169] Moreover, the existing studies of the relationship between volunteering and health have significant limitations. For example, two studies cited in the DSMD acknowledge that they do not distinguish between correlation and causation. People already in better health and with strong social ties were more likely to volunteer, signaling a self-selection bias.[170] Another report found health benefits for an older adult population (over age 65), but noted a weaker correlation between health and volunteering among

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[166] Raj Chetty et al., *The Association between Income and Life Expectancy in the United States*, 315 JAMA 1750, 1759 (2016).
[167] Robert Wood Johnson Found., *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; *see also* HEALTH AFFAIRS, *Workforce Health and Productivity* (2017), https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1580 ("Policies and benefits such as paid sick leave and unemployment compensation are associated with improved health outcomes.").
[168] Van der Noordt at 735.
[169] *See, e.g.*, Robert Grimm, Jr., Kimberly Spring & Nathan Dietz, *The Health Benefits of Volunteering: A Review of Recent Research* (2007) [hereinafter Grimm, Jr. et al.]; Peggy A. Thoits & Lyndi N. Hewitt, *Volunteer Work and Well-Being*, 42 J. HEALTH & SOCIAL BEHAVIOR 115 (2001) [hereinafter Thoits & Hewitt]. *See also* Antonisse & Garfield, *The Relationship Between Work and Health*.
[170] *See* Jens Detollenaere, Sara Willems & Stijn Baert, *Volunteering, Income and Health,* 12 PLOS ONE e0173139 (2017); Thoits & Hewitt.

younger adults.[171] Again, the literature on the link between volunteering and health does not support the policy that Oklahoma seeks to implement.

In fact, more relevant studies suggest that work requirements have no benefit, or are even harmful to health. For example, 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.[172] Ten of those studies noted that involvement in the welfare to work programs actually "exacerbated ill health."[173] The review concluded that "[t]his synthesis of the experiences of lone parents in mandatory [welfare to work programs] suggests that . . . participation may do little to improve lone parents' health and wellbeing or economic circumstances, often only leading to low paid, precarious employment."[174]

Even if it were true that work and/or volunteering leads to better health, Oklahoma 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 III.F. 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.[175] That financial stress and resulting psychological distress would be recreated when individuals lose their health coverage.

Ultimately, expert researchers who have studied work requirements in public benefits programs and have reviewed the assertions regarding work and health have warned, "[t]he available evidence strongly supports the conclusion that Medicaid work requirements harm human health and offer little to no economic benefits."[176] If Oklahoma 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.[177] Other states that expanded Medicaid without added conditions of

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[171] Grimm, Jr. et al.
[172] 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).
[173] *Id.* at 195.
[174] *Id.* at 197.
[175] Waddell & Burton, Table 2A, at 123, (citing Halvorsen 1998).
[176] Erin Brantley & Leighton Ku, *Critique of a Flawed Analysis about Medicaid Work Requirements*, GW HEALTH POLICY MATTERS BLOG (Jan. 14, 2019), http://gwhpmmatters.com/blog-critique-flawed-analysis-about-medicaid-work-requirements (analyzing and finding significant flaws in the report by the Buckeye Institute that asserts requiring Medicaid beneficiaries to work will increase their income).
[177] *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).

eligibility saw improvements in care utilization, financial well-being, and health metrics.[178] Medicaid expansion coverage gains nationally have strongly benefitted individuals in small towns and rural areas.[179] In addition, Medicaid expansion has been widely experienced as a financial boon to participating states.[180] And yet, Oklahoma proposes to undercut the positive impact of its Medicaid expansion by implementing mandatory work requirements that will harm the health of low-income individuals.

4. The Work Requirement Will Be Expensive to Administer

In its application, Oklahoma did not estimate the administrative costs associated with implementing the work requirements, but stated that it intends to keep those costs low.[181] However, all available evidence indicates that these costs will be high.[182] 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.[183] These figures, which were provided by the states themselves, did not even include all planned costs.[184] Other states have likewise estimated that the costs of implementing a work requirement would be substantial.[185] For example, Michigan estimated that a work requirement would cost the State $15 to $30 million every year.[186] Minnesota projected implementing a work requirement would cost local governments $121 million in 2020 and $163 million in

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[178] *See* Sommers et al., *Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance* 176 JAMA INTERNAL MED. 1501 (2016), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2542420.

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

[180] 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/

[181] Application at Attachment F.

[182] *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).

[183] U.S. Gov't 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. *See also* 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 (noting that Medicaid administrative costs in Kentucky increased by more than 40% after preparing to implement the Kentucky HEALTH project, which included a work requirement).

[184] U.S. Gov't Accountability Office, *Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements* 19 (Oct. 2019).

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

[186] *Id.*

2021.[187] 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.[188]

Many of the administrative expenses will be ongoing. And, the State will incur new administrative costs as individuals begin to lose coverage for failure to comply with the work requirements. The State must process: requests for good cause exceptions; requests to end a suspension; an increased volume of re-applications (after individuals lose coverage for failure to meet the work requirement); and an increased volume of administrative appeals for individuals who are terminated due to the work requirements.[189] Alaska estimated the added cost of work requirement-related appeals alone would exceed $500,000, and its Medicaid program is far smaller than Oklahoma's.[190]

Evidence shows that churn on and off Medicaid increases both administrative and medical costs. Because the work requirements will result in increased churning between enrollment and disenrollment, Oklahoma will incur substantially higher administrative costs per-beneficiary than continuous enrollment.[191] Studies show that enrollment costs can be hundreds of dollars per person enrolled in a program, and those costs—both expenses and time—increase with documentation requirements.[192] These estimates do not take into account the increased uncompensated care costs that hospitals and community health centers will face when individuals who do not comply with the work requirement lose coverage.[193]

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[187] *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.

[188] 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.

[189] Wagner & Solomon, *States' Complex Medicaid Waivers*, at 4-6 (providing a list of added administrative burdens for states that implement a Medicaid work requirement); MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (2017) https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience (citing Government Accountability Office, *Temporary Assistance for Needy Families: Potential Options to Improve Performance and Oversight* (2013), http://www.gao.gov/assets/660/654614.pdf.)

[190] 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.

[191] Ku et al., *Improving Medicaid's Continuity of Coverage*, at 1.

[192] *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).

[193] *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:*

Notably, Oklahoma is requesting to incur these expenses to target a very small portion of individuals. As noted above, the vast majority of individuals enrolled in Medicaid already work or have good reason for not working.[194] Spending significantly more money on work requirements 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

Oklahoma proposes to require individuals to pay monthly premiums to maintain their Medicaid eligibility. Specifically, individuals with incomes between the parent/caretaker level and 100% of FPL will initially pay $5 ($7.50 for a family), and individuals with incomes above 100% of FPL will initially pay $10 ($15 for a family) every month.[195] Oklahoma requests permission to increase the amount of the monthly premiums up to 5% of household income. Individuals will not receive coverage until they pay their initial premium, and those who do not pay within three months will have their application denied.[196] Individuals who manage to enroll but are unable to pay a subsequent premium within three months of the due date will be terminated from Medicaid.[197]

The Secretary does not have the authority to allow Oklahoma 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.[198] These limits exist outside of § 1396a and as a result, cannot be waived 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.[199] 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.[200]

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.

[194] 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).

[195] Application at 8-9.

[196] *Id.* at 9-10.

[197] *Id.* at 10.

[198] 42 U.S.C. §§ 1396o(a)(1), (c)(1), 1396o-1(b)(1).

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

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

Second, the proposed premiums are not experimental, and research has confirmed that they conflict with the objectives of the Medicaid Act. Redundant research proves that premiums deter and reduce enrollment among low-income individuals.[201] Numerous studies, conducted over the course of almost two decades, have examined the effects of imposing premiums in Medicaid and CHIP. These studies show the same patterns – people facing premiums are less likely to enroll, more likely to drop coverage, and more likely to become uninsured.[202] These effects become more pronounced as income decreases, and they can be dramatic.[203]

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[201] *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.

[202] *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/sites/default/files/atoms/files/5-31-05health2.pdf (compiling existing research and concluding "[e]vidence indicates that premiums reduce Medicaid participation and make it harder for individuals to maintain stable and continuous enrollment" and noting that at least four states reconsidered, abandoned, or discontinued policies to implement premiums in Medicaid or CHIP due to concerns about declining enrollment and adverse health consequences); Genevieve Kenney et al., *Effects of Premium Increases on Enrollment in SCHIP: Findings from Three States*, 43 INQUIRY 378, 380 (2006) (finding that imposing premiums on CHIP enrollees reduced initial enrollment and led to substantial disenrollment, and in some states disproportionately affected non-white individuals) (attached); Margo Rosenbach et al, Mathematica Policy Research, Inc., *National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access* (2007), https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/rosenbach9-19-07.pdf (noting that premiums and lockout provisions have been found to reduce retention in CHIP and that lockout provisions have been associated with both an increase in disenrollment and substantial decrease in reenrollment among individuals who lost coverage); Laura Dague, *The effect of Medicaid premiums on enrollment: A regression discontinuity approach* 37 J. HEALTH ECONOMICS 1 (2014), https://ccf.georgetown.edu/wp-content/uploads/2012/03/Dague-Premiums.pdf (finding that an increase in premiums from $0 to $10 each month reduced the likelihood of individuals remaining enrolled in Medicaid/CHIP for a full year by 12%).

[203] *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 Policy 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

For example, after Oregon imposed premiums ranging from $6 to $20 on Medicaid enrollees below 100% of FPL, nearly half of the affected enrollees lost coverage within the first six months. Of those who lost coverage, 40% identified the increase in premiums as the main reason for their disenrollment, and the percentage was much higher (68%) for individuals with income below 25% of FPL.[204] Further research examined the impact of the premiums after thirty months and found that only 33% of enrollees required to pay premiums remained continuously enrolled over the thirty months (compared with 69% of enrollees not subject to premiums), and 32% of enrollees required to pay premiums who lost Medicaid coverage remained uninsured.[205]

The research reaches uniform conclusions. Recent data gathered from several states that have imposed premiums on the expansion population find the same coverage barriers: 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.[206]

For example, evaluations of Indiana's § 1115 project found that premiums created barriers to both enrollment and continuous coverage. From February 2015 through November 2016, 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.[207] In those 22 months, nearly 7% of people who successfully enrolled and were required to pay premiums to maintain their eligibility lost coverage for

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Boylston Herndon et al.,*The Effect of Premium Changes on SCHIP Enrollment Duration*, 43 HEALTH SERVS. RES. 458 (2008), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2442374/ (finding that increasing premiums from $15 to $20 for children in families from 151-200% of FPL decreased length of enrollment, with a greater decrease among lower income children).

[204] 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.

[205] 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.

[206] *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).

[207] 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.

failure to pay.[208] In total, premiums impeded 29% of all individuals required to pay premiums as a condition of eligibility from obtaining or maintaining coverage during that period.[209] Overall, 55% of those found eligible for the program did not pay at least one monthly premium, meaning they never received coverage, were terminated from the program, or were shifted to a plan with fewer benefits and higher cost sharing.[210] Data from Indiana's most recent evaluation paint an even darker picture.[211]

These findings add to the volume of research noted above showing that the premiums Oklahoma is seeking to impose will deter and reduce enrollment. They also undercut the State's estimate that the work requirements and premiums *combined* will lead to a 5% reduction in coverage every year. In fact, the coverage loss for failure to pay premiums is likely to be much higher in Oklahoma than it has been in Indiana, given that Oklahoma would require individuals with income below 100% of FPL and individuals who are medically frail (due to a condition other than HIV/AIDS, SUD, or SMI) to pay premiums to enroll and maintain their coverage.

Oklahoma makes the hackneyed claim that the premiums will make individuals "more engaged" in their health care and will improve their health outcomes, pointing to data from Indiana's § 1115 project as support.[212] However, there is no evidence to support Oklahoma's assertion. 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

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[208] *Id.* at ii. In Indiana, only individuals with income above 100% FPL who are not pregnant, Native American, or medically frail may be disenrolled for nonpayment.

[209] *Id.*

[210] *Id.* at 8-11.

[211] *See* Lewin Group, *Healthy Indiana Plan Interim Evaluation Report, Final for CMS Review* (2019), http://www.state.in.us/fssa/hip/files/IN_HIP_Interim_Evaluation_Report_Final.pdf. During 2017 and 2018, 26,037 enrollees lost coverage for failure to pay their monthly premiums. *Id.* at 150. The latest evaluation does not update the disturbing data regarding the fate of "conditional enrollees" – applicants who did not pay their initial premiums and as a result were not enrolled in coverage – despite the major red flag from its 2017 study of Indiana's premiums. Nor does the 2019 report include an appropriate denominator comprising all individuals required to pay premiums to become or remain eligible, so there is no way to accurately estimate the proportion of individuals who lost access to coverage due to HIP's premium policies, as the 2017 report did. While the 2019 evaluation mentions a decline in disenrollments for nonpayment, the decline is small in absolute terms and may be explained by compounding factors, like the overall increase in medical frailty determinations. The evaluation also shows a marked decline in the share of HIP Plus members who remained continuously enrolled through the calendar year (from 76.2% in 2015 to 60.5% in 2018), suggesting a possible increase in churn over time, which is exactly what other research on Medicaid premiums has shown. *See, e.g.,* 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.

[212] Application at 8.

showed better use of generic medications over brand name drugs.[213] Oklahoma 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.[214]

Oklahoma also justifies the premiums by claiming they will prepare members to transition to private coverage, ultimately ensuring "long-term access to coverage."[215] Familiarizing individuals with common features of commercial insurance is not an objective of the Medicaid Act. In addition, the very premise of the claim is flawed – many individuals in the expansion population have already had significant experience with private insurance. Most (if not all) enrollees have already had significant experience with paying bills. As described in detail above, the evidence shows that the proposed premiums will simply prevent or delay Medicaid coverage or interrupt continuous coverage, leaving many individuals uninsured.

While Oklahoma expresses a need to contain costs, it ignores the costs of implementing the premiums and associated consequences for failure to pay. 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 ($15.8 million) to implement and administer the policy.[216] Thus, any money Oklahoma expects to save by implementing the proposed premiums will come from reduced enrollment in Medicaid.

Finally, while Oklahoma proposes to allow providers and provider groups to pay premiums on behalf of enrollees, providers that do so could well be subject to civil monetary penalties. The providers could be seen as improperly inducing enrollees to receive Medicaid services from them, in violation of the Social Security Act and implementing regulations.[217]

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[213] The Lewin Group, *Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report* 83 (2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf.
[214] The Lewin Group, *HIP 2.0: Power Account Contribution Assessment*, at 21-22.
[215] Application at 6.
[216] 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).
[217] *See* 42 U.S.C. § 1320a-7a(a)(5); 42 C.F.R. §§ 1003.110, 1003.1000.

C. Eliminating Retroactive Coverage

Oklahoma seeks to eliminate retroactive coverage for the expansion population. The waiver is not experimental and is not likely to promote the objectives of the Medicaid Act. It will reduce access to coverage among low-income individuals, leading to an increase in unmet health needs and a decrease in financial security.

Oklahoma did not estimate the number of people who will lose coverage and face medical costs due to the waiver or the average amount of those costs. It does make the declaratory statement that the waiver will not have a "significant impact" on the SoonerCare 2.0 population.[218] Evidence from other states shows this statement to lack foundation. 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.[219] When Indiana received permission to waive retroactive coverage in 2015, CMS required the State to continue to provide some retroactive coverage to parents and caretaker relatives. The State reported to CMS that 13.9% of the people in that eligibility category who enrolled in Medicaid needed retroactive coverage, with their costs incurred averaging $1,561 per person.[220] 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.[221] These figures confirm that the lack of retroactive coverage will cause financial hardship to many Medicaid enrollees in Oklahoma.

In addition, eliminating retroactive coverage will result in increased uncompensated care costs for hospitals.[222] 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

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[218] Application at Attachment F.

[219] *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.

[220] 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).

[221] *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.

[222] *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.

for hospitals over a five year period.[223] 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."[224]

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.[225]

Oklahoma justifies eliminating retroactive coverage by claiming that it will encourage individuals to enroll in Medicaid even when they are healthy.[226] 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.[227] 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."[228] Imagine, for example, a man who recently suffered a pay cut, is eligible for Medicaid, but is not aware of his eligibility. He is in a serious car accident on the 30th of the month and receives emergency treatment in a hospital. His condition is severe enough that he is unable to apply for Medicaid for nearly a month. Without retroactive coverage in place – and without hospital presumptive eligibility, which Oklahoma is seeking to eliminate – he will be responsible for the costs of the services he received prior to filing his application.

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[223] Virgil Dickson, *Ohio Medicaid Waiver could cost hospitals $2.5 billion*, MODERN HEALTHCARE (April 22, 2016(, http://www.modernhealthcare.com/article/20160422/NEWS/160429965.

[224] 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.

[225] 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").

[226] Application at 3, 57.

[227] *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).

[228] *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).

Oklahoma also justifies the waiver by arguing that it is necessary to help familiarize Medicaid enrollees with private insurance coverage.[229] As noted above, this is not an objective of the Medicaid Act. Simply put, imposing a potentially devastating financial penalty on low-income individuals is a particularly cruel and ineffective method of education that cannot be squared with the objectives of the statute.

What is more, there is nothing experimental about eliminating retroactive coverage. CMS has permitted Oklahoma to "test" the effects of waiving retroactive coverage for nearly 25 years.[230] Notably, Oklahoma is only now preparing to formally evaluate those effects.[231]

In short, eliminating retroactive coverage will harm low-income people as well as health care providers. The waiver will not only fail to advance the objectives of the Medicaid program but will actively undermine the goals of providing coverage and affordable care to low-income individuals. It will inevitably saddle 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.[232] The effect of the waiver will be even more pronounced due to the other features of the proposed project, including the elimination of hospital presumptive eligibility, as well as the monthly premiums and work requirements, which will cause individuals to churn on and off of Medicaid coverage.

D. Eliminating Hospital Presumptive Eligibility

Oklahoma 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.[233] Even if it were, eliminating hospital presumptive eligibility (HPE) will demonstrate nothing. The Affordable Care Act amended the Medicaid Act to require states to allow hospitals to make presumptive eligibility determinations, effective January 1, 2014.[234] The State cannot possibly demonstrate something new by returning to the status quo ante, particularly in a situation such as this where the State's actions have prevented hospitals from taking up the option in the first place.

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[229] Application at 5.
[230] OHCA, *SoonerCare Choice and Insure Oklahoma §1115(a) Demonstration Application for Extension of the Demonstration, 2013-2015*, 38 (2011), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/SoonerCare/ok-soonercare-demo-ext-app-12302011.pdf.
[231] See OHCA, *Evaluation Design for the SoonerCare § 1115(a) Waiver Demonstration* (2019), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/soonercare/ok-soonercare-appvd-eval-design-20190926.pdf. Notably, the evaluation design is fatally flawed and will not yield any useful information about the effect of the waiver.
[232] *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/
[233] *See* 42 U.S.C. § 1396a(a)(47)(B).
[234] Pub. L. 111-148, 124 Stat. 119, 291, § 2202 (2010) (codified at 42 U.S.C. § 1396a(a)(47)(B)).

In addition, precluding hospitals from making presumptive eligibility determinations is not likely to promote the objectives of Medicaid. The purpose of HPE is to give individuals immediate Medicaid coverage and access to care until a final eligibility determination can be made. Presumptive eligibility also leads to permanent coverage by providing individuals with an additional way to apply for Medicaid.[235] Eliminating the protection will simply reduce coverage and access to necessary services.

Oklahoma suggests that the waiver will not actually harm low-income individuals because: (1) hospitals in the State have not opted to use presumptive eligibility; and (2) the Notification of Date of Service process will remain in place.[236] As for the first argument, the fact that hospitals have not yet implemented presumptive eligibility is not a valid reason to eliminate it. State policy has prevented hospitals from adopting presumptive eligibility.[237] Instead of allowing Oklahoma to now formalize its unwillingness to meaningfully implement the federal law, CMS should ensure that hospitals are able to use presumptive eligibility as Congress intended. As for the second argument, the NODOS process conflicts with the process Congress has set forth and is not an adequate substitute for HPE. For example, compared with HPE, NODOS gives individuals much less time to file an application after they begin receiving services at the hospital. In addition, hospitals that file a NODOS are not guaranteed reimbursement for services provided.

Oklahoma also speaks out of the other side of its mouth to justify the proposed waiver by claiming it is necessary to protect program integrity and save money.[238] But Congress already enacted the law in a way that gives states sufficient flexibility to ensure that hospitals are making accurate and appropriate presumptive eligibility determinations.[239] And, having failed to implement presumptive eligibility, the State has absolutely no evidence that it poses a threat to program integrity or causes excessive spending. To the extent that Oklahoma objects to providing temporary coverage to even one person whose application is ultimately denied, it objects to a policy decision made by Congress.[240] That disagreement is not grounds for a waiver under § 1115. Finally, "testing" whether eliminating HPE will save money is not a valid experiment under § 1115.

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[235] *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.

[236] Application at 6.

[237] *See* CMS, SPA #14-007 MM7 Approval Letter (2014), https://www.medicaid.gov/sites/default/files/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/OK/OK-14-0007.pdf (expressing concern about Oklahoma's high threshold performance standards and explaining CMS would continue monitor the program to ensure that Oklahoma "can provide a program for those hospital that want to serve as qualified entities").

[238] Application at 6, 57.

[239] *See* 42 C.F.R. § 435.1110; 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.

[240] *See* Application at 6 (noting that Oklahoma hopes to "ensure that *all* covered members have been verified to meet the eligibility criteria") (emphasis added).

E. 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.[241] 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.[242] 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.[243] 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.[244] Likewise, continuous insurance coverage is associated with earlier cancer identification and better outcomes.[245] Recent research also found that Medicaid expansion was associated with a reduction in preventable hospitalizations.[246]

Continuous coverage is also essential for financial security. Studies show that Medicaid expansion reduces medical debts and out-of-pocket expenses for enrollees.[247] For

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[241] 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) (attached); 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).

[242] 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.

[243] 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 Outcomes, and Quality of Care? Setting the Record Straight on the Evidence* 4-5 (2013) https://www.kff.org/medicaid/issue-brief/what-is-medicaids-impact-on-access-to-care-health-outcomes-and-quality-of-care-setting-the-record-straight-on-the-evidence/ [hereinafter Paradise & Garfield, *What is Medicaid's Impact on Access to Care*]. *See also* Rebecca Myerson *et al.*, *Medicaid Eligibility Expansions May Address Gaps In Access to Diabetes Medications*, 37 HEALTH AFFAIRS 1200 (2018) (attached).

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

[245] *Id.* at 6.

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

[247] *See, e.g.*, Georgetown Univ. Health Policy Inst., Ctr. for Children and Families, *Medicaid: How Does it Provide Economic Security for Families*, OFF THE CHARTS, (Jan. 8, 2017), http://ccf.georgetown.edu/wp-

example, independent studies of the Healthy Michigan Plan have found that coverage significantly improves financial security.[248] 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%.[249] Another study of credit report data found that when compared to low-income areas in non-expansion states, low-income areas in expansion states experienced significant reductions in unpaid non-medical bills and in the amount of non-medical debt sent to third-party collection agencies.[250] A national study found that medical debt fell by almost twice as much in expansion states (13%) compared to non-expansion states (7%).[251] Together, this data contradicts any suggestion that the project 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.[252] Along

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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).

[248] *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.

[249] 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.

[250] 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.

[251] 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/.

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

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.[253] 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.[254] 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.[255] Other studies have linked Medicaid expansion coverage in California to lower eviction rates and fewer payday loans.[256] Each of these studies bolsters the finding that Medicaid coverage itself improves enrollees' financial security and well-being.

Because Oklahoma's proposal would unquestionably lead to significant reductions in coverage, it cannot be approved consistent with the requirements of Section 1115. Moreover, for the same reason, HHS should not even proceed to approve the proposal during the current COVID-19 pandemic, as Oklahoma is foreclosed from adopting more restrictive eligibility standards, methodologies, or procedures so long as the emergency remains in effect. *See* Pub. L. No. 116-127, § 6008(b), 134 Stat. 178, 208 (2020).

IV. The Proposed Project Will Reduce Access to Services

A. Eliminating EPSDT

Oklahoma proposes to waive the requirement to cover Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for 19- and 20-year-olds.[257]

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.

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[253] Katherine Baicker et al., *The Oregon Experiment -- Effects of Medicaid on Clinical Outcomes*, 36 NEW ENG. J. MED. 1713 (2013) (attached).
[254] Kenneth Brevoort, Daniel Grodzixki, & Martin B. Hackmann, Nat'l Bureau of Economic Research, *Medicaid and Financial Health* 3 (2017) (attached).
[255] *Id.* at 3-4.
[256] 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).
[257] Application at 6, 26.

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.[258] 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.[259] 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.[260] 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."[261] CDC data show that individuals ages 15 to 24 account for 25% of the sexually active population, but 50% of new STIs.[262] In 2018, young people ages 13 to 24 accounted for more than 1 in 5 new HIV diagnoses.[263] Young people with HIV are the least likely out of any age group to be retained in care (31%) and to have a suppressed viral load (30%).[264]

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.[265] Notably, research shows that early diagnosis and treatment of many of these conditions will dramatically

[258] 42 U.S.C. §§ 1396a(a)(43), 1396d(a)(4)(B), 1396d(r).
[259] 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.
[260] *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.
[261] 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.
[262] 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.
[263] 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 May 18, 2020).
[264] *Id.*
[265] Am. Acad. of Pediatrics & Bright Futures, *Recommendations for Preventive Pediatric Health Care* (2020), https://www.aap.org/en-us/Documents/periodicity_schedule.pdf.

improve health outcomes.[266] In addition, without EPSDT, individuals will simply not have access to medically necessary treatment services. For example, Oklahoma proposes to place hard limits on a number of services, including occupational therapy, physical therapy, speech therapy, home health, and nutritional services.[267] Without EPSDT, limits like these will prevent many 19- and 20-year-olds from receiving necessary care, a situation that will inevitably cause health conditions to worsen over time.

What is more, eliminating EPSDT will cause young adults to lose coverage for routine dental and vision care. Lack of coverage for dental services will lead to worse overall health outcomes. As a U.S. Surgeon General report explains, oral health is essential to overall health.[268] 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.[269] Emergency room visits for dental conditions cost about $1.6 billion nationwide.[270]

As for the lack of coverage for vision services, the CDC has declared vision loss a serious public health problem, as "people with vision loss are more likely to report depression, diabetes, hearing impairment, stroke, falls, cognitive decline, and premature death," as well as "substantially compromis[ed] quality of life."[271] Further, the cost of vision loss is estimated to exceed $35 billion.[272]

Notably, untreated dental and vision problems can make it more difficult for individuals to get and/or keep a job. Nearly 30% of low-income adults say the appearance of their mouth

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[266] *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).

[267] Application at Attachment B, pg. 14, 19.

[268] 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.

[269] 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.

[270] 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.

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

[272] *Id.*

and teeth affects their ability to interview for a job.[273] Thus, by restricting access to these critical services, Oklahoma is directly undermining its own stated goal of promoting employment among individuals in the 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 permitted Oklahoma to waive EPSDT for some individuals in this age range for at least a decade.[274] Even assuming the waiver was experimental when it was first granted (which it was not), it is impossible to continue to construe it as such.

B. Eliminating NEMT

Oklahoma is requesting a waiver to eliminate NEMT for the Medicaid expansion population. This is nothing more than a cut in benefits – it has no experimental or demonstration purpose. In addition, eliminating NEMT runs counter to the objectives of the Medicaid Act, as it will reduce access to medically necessary services for SoonerCare 2.0 enrollees.

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.[275] 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

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[273] 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.

[274] *See* Ctrs. for Medicare & Medicaid Servs., *Waiver and Expenditure Authority for SoonerCare, 1/1/2010 – 12/31/2012*, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/SoonerCare/ok-soonercare-waiver-expnditure-auth-01012010-12312012.pdf. CMS has also permitted Utah to waive EPSDT for individuals ages 19 and 20 since 2002.

[275] 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), https://pdfs.semanticscholar.org/d52d/a6f9d42378ec756aaba36f670f5826d02188.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).

transportation was a primary barrier to accessing timely primary care. In contrast, less than 1% of privately insured individuals reported the same problem.[276]

Data from Indiana and Iowa, which received permission to eliminate NEMT for the expansion population, have already "demonstrated" that many enrollees will not access care without NEMT.[277] 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.[278] The percentage was higher (15%) among enrollees with income below 100% of FPL.[279] 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.[280] Indiana's most recent evaluation likewise shows that lack of transportation caused enrollees in the expansion population to forgo medically necessary care.[281]

Notably, data from Iowa also indicate that women, People of Color, and younger people are significantly more likely to report a transportation barrier.[282] In addition, people in relatively poorer health (58% higher odds), with multiple physical ailments (63%), or who have any functional deficit (245%) were all much more likely to report unmet transportation

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[276] 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.

[277] 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.

[278] *Id.*

[279] *Id.*

[280] *Id.*

[281] 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).

[282] 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://www.kff.org/womens-health-policy/report/women-and-health-care-in-the-early-years-of-the-aca-key-findings-from-the-2013-kaiser-womens-health-survey/ (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).

needs.[283] Eliminating NEMT will disproportionately harm these populations, likely exacerbating existing health care disparities in Oklahoma.

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.[284] 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."[285] However, Oklahoma is not proposing to investigate these legitimate research questions.[286]

Not surprisingly, research demonstrates that effective NEMT services improve access to health care. For example, research shows that transportation barriers can reduce adherence to medications.[287] 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.[288] 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.[289]

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[283] 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.

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

[285] 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.

[286] *See* Application at 57.

[287] 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).

[288] *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.]

[289] 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).

Oklahoma suggests that it could choose to cover NEMT "in limited cases based on an individualized assessment of need and in accordance with a care coordination plan."[290] That single sentence does not provide enough detail to determine the extent to which (if at all) this potential exception could mitigate the harm that the waiver will cause, raising serious transparency concerns.[291] Likewise, "reimbursing for a wide range of telehealth services" will not prevent the harm caused by the waiver of NEMT.[292] As described in detail above, many low-income individuals in Oklahoma do not have reliable access to the internet.[293] In addition, as Oklahoma recognizes, many services, including critical preventive services such as vaccines and cancer screening, cannot be provided through telehealth.

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

C. Not Covering Long-Term Services and Supports (LTSS)

For individuals with disabilities and chronic-health conditions, long-term care services are absolutely critical to health and well-being. Medicaid expansion has allowed millions of Americans with chronic health conditions and disabilities, who do not qualify for Medicaid through a disability pathway, to gain coverage and access to state plan LTSS. While the Alternative Benefit Package that applies to most expansion enrollees can differ from state plan services, the Medicaid Act requires that Medicaid expansion enrollees who are medically frail have the option to select state plan coverage.[294] In Oklahoma, that encompasses an array of important LTSS, including state plan personal care services.

Most states avoid having to identify medically frail expansion enrollees by fully aligning the expansion benefit package with state plan benefits.[295] But Oklahoma proposes to not provide LTSS through SoonerCare 2.0, meaning it would have to develop a process to target expansion enrollees who are medically frail. The project proposal does not explain how the State will target applicants and enrollees who are medically frail; how people with disabilities will be notified about the medically frail pathway and the state plan alternative;

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290 Application at 26.

291 *See* 42 U.S.C. § 1315(d); 42 C.F.R. § 431.408(a)(i) (requiring the application to include "a sufficient level of detail to ensure meaningful input from the public").

292 *See* Application at Attachment F.

293 *See* Jennifer Palmer, *In Oklahoma, Shift to Distance Learning Highlights Stark Inequity in Students' Internet Connection*, PBS FRONTLINE (May 5, 2020) (noting that less than half of rural residents in the State have access to high-speed internet).

294 42 U.S.C. § 1396u-7(a)(2)(B)(vi)

295 *See* MaryBeth Musumeci et al., Kaiser Family Found., *Key State Policy Choices About Medical Frailty Determinations for Medicaid Expansion Adults (2019)*, https://www.kff.org/report-section/key-state-policy-choices-about-medical-frailty-determinations-for-medicaid-expansion-adults-issue-brief/.

how they will be screened and verified; and whether such a screening will exempt them from certain conditions of eligibility. Aside from the questionable legality of the proposal, without these details, we cannot provide meaningful comment on whether the State will effectively identify individuals who are medically frail and need state plan LTSS.

If, alternatively, the Oklahoma intends simply to exclude access to state plan LTSS for all expansion enrollees, including individuals who are medically frail, that would require a waiver that amounts to no more than a simple benefit cut for expansion enrollees with disabilities and chronic conditions who need state plan LTSS. Such a benefit cut would be inconsistent with the purpose of the Medicaid Act and would not be approvable.

D. Imposing Copayments for Non-emergency Use of the Emergency Room

Medicaid regulations permit states to charge enrollees with household incomes below 150% of FPL up to $8 for non-emergency use of the emergency room.[296] Oklahoma seeks indefinite, anticipatory approval of an unspecified adjustment in this copayment amount at some unidentified time in the future.[297] This request should be denied.

Under the Medicaid Act, the Secretary may only approve Oklahoma's proposal if five tightly circumscribed criteria are met.[298] After providing notice and comment, the Secretary must find that the waiver is for a demonstration project that:

> (1) will test a unique and previously untested use of copayments,
> (2) is limited to a period of not more than two years,
> (3) will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients,
> (4) is based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and
> (5) is voluntary, or makes provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.[299]

Oklahoma's proposed policy does not comply with any of these criteria. First and foremost, the proposed policy does not describe a unique or previously untested use of copayments. In fact, existing, peer-reviewed research has found that imposing cost sharing for non-

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[296] 42 C.F.R. § 447.54(b).
[297] Application at 35.
[298] 42 U.S.C. § 1396o(f)(1)-(5).
[299] *Id.*

emergency use of the emergency department does not reduce emergency room use among Medicaid and CHIP enrollees.[300]

Second, Oklahoma has not indicated that it will limit the heightened 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.[301]

Fourth, the proposed cost sharing is not based on a reasonable hypothesis. According to Oklahoma, the purpose of the cost sharing is to discourage inappropriate use of the emergency room.[302] However, research shows that very few Medicaid enrollees use the emergency room for non-urgent conditions.[303] More importantly, as described above, existing research disproves the hypothesis Oklahoma 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

[300] *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).

[301] *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.

[302] Application at 3, 56.

[303] 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).

enrollees.[304] 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."[305] In addition, Oklahoma 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 Oklahoma 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 Oklahoma to implement its undefined 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.

V. Oklahoma's Request to Implement a Per Capita Cap Is Not Approvable Under § 1115.

A. The Secretary Does Not Have the Authority to Approve the Request

In § 1396b, the Medicaid Act sets forth how the federal government is to reimburse states for a portion of their Medicaid expenditures. HHS must cover 90% of Oklahoma's spending on the expansion population, with no limit on the amount of federal funding provided.[306] In requesting a per capita cap, Oklahoma is asking HHS to deviate from that formula. However, § 1115 only permits the Secretary to waive requirements located in 42 U.S.C. § 1396a, meaning the Secretary does not have the authority to allow the State to implement a per capita cap. We recognize that HHS has asserted that it may approve demonstration projects without limitation as an exercise of its purported "expenditure authority" under 42 U.S.C. § 1315(a)(2), but this plainly misreads the statute. Section 1115 places limits on the agency's ability to waive the requirements of the Medicaid statute, and

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[304] 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.
[305] *Id.* at 7-8 (citing Wash. State Health Care Auth., *Emergency Department Utilization: Assumed Savings from Best Practices Implementation* (2013)).
[306] 42 U.S.C. §§ 1396b(a)(1), 1396d(b), 1396d(y).

the expenditure authority under § 1115(a)(2) does not erase those limits. Indeed, the contrary theory that HHS has put forth, under which it could approve alternative state programs entirely unconstrained by any provision in the Medicaid statute, would raise serious questions under the non-delegation doctrine. *See Gundy v. United States*, 139 S. Ct. 2116, 2131 (2019) (Gorsuch, J., dissenting).

In fact, CMS confirmed the legal limits in a recent letter to North Carolina, stating:

> Section 1115(a)(i) waiver authority extends only to provisions of section 1902 of the Act, and does not extend to provisions of section 1905 of the Act, such as section 1905(b). Nor is CMS able to grant the state's request by providing expenditure authority under section 1115(a)(2)(A) of the Act. Section 1115(a)(2)(A) only permits state expenditures to be regarded as federally matchable. It does not allow applicable federal match rates to be altered.[307]

Thus, CMS has recognized that it cannot: (1) waive the financing requirements in 42 U.S.C. §§ 1396b and 1396d; or (2) change the *way* states are paid. Section 1115 does not allow the Secretary to permit Oklahoma to implement a per capita cap.

B. A Per Capita Cap Runs Counter to the Objectives of Medicaid and Is Not Experimental.

As described in Section I above, Oklahoma provided flawed and incomplete information about its proposed per capita cap, making it difficult to offer comments on this aspect of the application. However, by its very nature, a per capita cap funding structure puts Oklahoma at serious risk of losing federal funding. If Oklahoma does exceed its cap (and lose federal funding) it will have no choice but to reduce access to coverage and care.

Under a per capita cap, Oklahoma would have full responsibility for any increase in per capita costs, meaning that if those cost rise, it could lose millions or billions in federal funding. Oklahoma could see an increase in per capita costs and sustain large federal funding losses for numerous reasons. New medical technologies could dramatically increase the per capita costs of providing care. For example, two CAR-T immunotherapies

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[307] Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Dave Richard, Deputy Sec'y for Med. Assistance, N.C. Dep't of Health & Human Servs. (Oct. 19, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nc/Medicaid-Reform/nc-medicaid-reform-demo-demo-appvl-20181019.pdf.

were approved for certain types of cancer in 2017, at costs that range from an estimated $160,000 to almost $800,000, depending on complications.[308]

Per person costs could also increase because of health epidemics.[309] For example, opioid misuse is a serious issue in Oklahoma and could drive up per capita costs.[310] One study showed that per capita Medicaid expenditures in 2013 for patients with opioid use disorder (OUD) averaged twice that of a matched comparison group without OUD.[311] As another example, further spread of the Zika virus could add significant costs.[312] Treatment, care, and services for an infant born with microcephaly may be well over $4 million dollars and may reach as much as $10 million over their lifetime.[313] Over 4,800 pregnancies in the U.S. territories had a lab result showing confirmed or possible Zika from 2016-2018 and about 1 in 7 of those babies had birth defects or neurodevelopmental abnormalities potentially caused by Zika.[314]

Public health crises and acts of nature may also increase per capita spending, including after the immediate emergency has subsided. For example, research shows that severe weather events have caused a significant increase in per-capita costs for Medicaid enrollees over the long-term.[315] In 2016, flooding in Baton Rouge led to an increase in

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[308] Jeffrey A. Tice et al., Institute for Clinical and Economic Review, *Chimeric Antigen Receptor T-Cell Therapy for B-Cell Cancers: Effectiveness and Value* 179 (Mar. 2018), https://icer-review.org/wp-content/uploads/2017/07/ICER_CAR_T_Final_Evidence_Report_032318.pdf.

[309] Candace Gibson, Nat'l Health Law Program, *How Per Capita Caps Harm the Prevention and Treatment of New Viruses* (2017), https://healthlaw.org/resource/how-per-capita-caps-harm-the-prevention-and-treatment-of-new-viruses/.

[310] *See, e.g.*, Ok. Attorney General, *News Release: Attorney General Hunter Files Lawsuit against Three Leading Opioid Distributors for Fueling Opioid Epidemic* (Jan. 13, 2020), http://www.oag.ok.gov/attorney-general-hunter-files-lawsuit-against-three-leading-opioid-distributors-for-fueling-opioid-epidemic (noting that "Oklahoma leads the nation in non-medical use of painkillers, with nearly 5% of the population ages 12 and older abusing or misusing painkillers).

[311] Douglas Leslie et al., *The Economic Burden of the Opioid Epidemic on States: the Case of Medicaid*, 25 AM. J. MANAGED CARE S243 (July 2019), https://www.ncbi.nlm.nih.gov/pubmed/31361426.

[312] *See* Enbal Chacham et al., *Potential High-Risk Areas for Zika Virus Transmission in the Contiguous United States*, 107 AM. J. PUBLIC HEALTH 724 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5388944/ (finding a number of counties in Oklahoma at high risk of Zika transmission).

[313] Transcript for CDC Telebriefing, Centers for Disease Control and Prevention, Zika Summit Press Conference, (Apr. 1, 2016), https://www.cdc.gov/media/releases/2016/t0404-zika-summit.html; Daniel Chang, *One in 10 Pregnant Women With Zika Had Fetus or Baby with Birth Defects, CDC Says*, MIAMI HERALD, Apr. 4, 2017, http://www.miamiherald.com/news/health-care/article142594664.html.

[314] Centers for Disease Control and Prevention, *Vital Signs: Zika-Associated Birth Defects and Neurodevelopmental Abnormalities Possibly Associated with Congenital Zika Virus Infection — U.S. Territories and Freely Associated States, 2018* (2018), https://www.cdc.gov/mmwr/volumes/67/wr/mm6731e1.htm?s_cid=mm6731e1_w.

[315] Marisa Elena Domino et al., *Disasters and the Public Health Safety Net: Hurricane Floyd Hits the North Carolina Medicaid Program*, 93 AM. J. PUBLIC HEALTH 1127 (2003), https://ajph.aphapublications.org/doi/pdfplus/10.2105/AJPH.93.7.1122.

behavioral health claims for at least 10 months.[316] Similarly, while we are still learning about COVID-19, it appears that the infection can cause health complications that require long-term treatment.

Some of the drivers of increased per capita costs, such as natural disasters or health epidemics, will have negative economic impacts on a state. This means that at the same time that state costs increase, revenues to pay for health care costs decrease. This "countercyclical" risk is a well-known aspect of the Medicaid program.[317] Congress's matching structure for Medicaid is designed to provide some insulation for this countercyclical nature of the program; when state costs increase, federal funding does as well. Under a per capita cap, however, the State is fully exposed to the countercyclical risk: so, after the flood, the State has more costs and fewer state dollars, and federal funding stops (at the cap).

Even under the existing financing structure, countercyclical risk is a serious problem for states in Medicaid. Congress has temporarily increased federal matching rates during recessions on two occasions to prop up state Medicaid programs (and economies).[318] The GAO has recommended more, not less, countercyclical protection for states.[319] A per capita cap does the opposite, putting states at greater financial risk exactly when they need assistance the most.

Once the per capita cap is in place, when spending nears the cap Oklahoma will have no choice but to cut eligibility, covered services, and/or provider rates. MACPAC has noted that in "responding to changing economic conditions, states … decide whether to cover optional eligibility groups and services, determine provider payment methods and rates, define coverage parameters for covered services, and adopt strategies to address the volume and intensity of services."[320] In response to the 2009 recession, which left states with significant budget constraints, at least 20 states reduced or restricted Medicaid

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[316] Stephen W. Phillippi et al., *Medicaid Utilization Before and After a Natural Disaster in the 2016 Baton Rouge–Area Flood*,109 AM. J. PUBLIC HEALTH S316 (2019), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2019.305193.
[317] Laura Snyder and Robin Rudowitz, Kaiser Family Found., *Medicaid Financing: How Does it Work and What are the Implications?* (2015),https://www.kff.org/medicaid/issue-brief/medicaid-financing-how-does-it-work-and-what-are-the-implications/.
[318] *Id.*
[319] Government Accountability Office, *Medicaid: Key Issues Facing the Program* (2015), https://www.gao.gov/assets/680/671761.pdf.
[320] Medicaid and CHIP Payment and Access Comm'n, *Report to Congress on Medicaid and CHIP* 24 (June 2016), https://www.macpac.gov/wp-content/uploads/2016/06/June-2016-Report-to-Congress-on-Medicaid-and-CHIP.pdf.

benefits, and 39 froze or cut provider reimbursement rates.[321] Cuts to eligibility and/or services directly harm low-income individuals. Cuts to provider rates also harm Medicaid enrollees by decreasing provider participation in the program, making it harder for patients to access covered services.[322]

In response to comments expressing concerns about a per capita cap, Oklahoma suggests that the new funding structure will not affect low-income individuals in the State because OHCA is "accustomed to managing the SoonerCare program" under a funding cap – the money appropriated by the state legislature.[323] However, that is the situation faced by the single state Medicaid agency in every state. And that management does not prepare Oklahoma to operate its program with a cap on federal funding. What Oklahoma fails to acknowledge is that in the past, when the state legislature has appeared poised to reduce SoonerCare funding, OHCA has not devised innovative solutions to lower its expenditures without harming enrollees and providers. Rather, the agency has responded to reduced funding by proposing – and sometimes following through with – reductions in provider rates and/or cuts to covered services.[324]

Finally, there is nothing experimental about implementing a per capita cap. In fact, Oklahoma appears to admit that a per capita cap has no research value at all.[325]

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[321] Phil Galewitz, *States Cutting Medicaid Benefits As They Stagger Under Economic Downturn*, KAISER HEALTH NEWS (Sept. 30, 2010), https://khn.org/news/medicaid-cutbacks/.

[322] Diane Alexander and Molly Schnell, *Closing the Gap: The Impact of the Medicaid Primary Care Rate Increase on Access and Health* (2018), https://economics.stanford.edu/sites/g/files/sbiybj9386/f/alexander_schnell_2018.pdf; Suk-fong S. Tang et al., *Increased Medicaid Payment and Participation by Office-Based Primary Care Pediatricians*, 141 PEDIATRICS (2018), https://pediatrics.aappublications.org/content/pediatrics/141/1/e20172570.full.pdf.

[323] Application at Attachment F.

[324] *See, e.g.*, OHCA, *Press Release: OHCA eyes provider rates and elimination of benefits and services to balance budget* (April 10, 2017), http://www.okhca.org/about.aspx?id=20445 (in anticipation of fiscal year 2018 appropriation, explaining the agency is exploring reducing provider rates by up to 25%, eliminating or reducing benefits, and eliminating eligibility for certain optional populations, and recognizing the cuts would "threaten our health care infrastructure for Oklahoma's neediest citizens" and put[] people's lives at stake"); OHCA, *Press Release: OHCA to propose provider rate cuts* (March 29, 2016), https://www.okhca.org/about.aspx?id=18904#:~:text=The%20Oklahoma%20Health%20Care%20Authority,state%20fiscal%20year%202017%20appropriation (providing notice of proposal to reduce provider rates by 25% "in anticipation of the state fiscal year 2017 appropriation" and acknowledging the cuts could cause many providers "to close their doors to our patients"); Barbara Hoberock, *Oklahoma Health Care Authority cuts Medicaid provider rates*, TULSA WORLD, July 2, 2014, https://www.tulsaworld.com/news/local/government-and-politics/oklahoma-health-care-authority-cuts-medicaid-provider-rates/article_98c235e5-13ed-5718-8183-b9a8ebebcda7.html (reporting that due to budget shortfall, OHCA voted to cut provider rates by 7.75%).

[325] *See* Application at 55-57 (listing research hypotheses, none of which reference the per capita cap).

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, Oklahoma'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 me (perkins@healthlaw.org) or Catherine McKee (mckee@healthlaw.org).

Sincerely,

Jane Perkins
Legal Director