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February 3, 2021

VIA ELECTRONIC SUBMISSION

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

**Re: Arizona 1115 Demonstration Extension**

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 underserved people. We appreciate the opportunity to provide these comments on Arizona's requested extension.

Arizona's Health Care Cost Containment System (AHCCCS) extension raises concerns about the use of § 1115 authority and includes features that do not comply with the requirements of the Social Security Act. These features will block, rather than facilitate, access to Medicaid coverage and services. The Department of Health and Human Services (HHS) should deny the extension request in whole or in part. At a minimum, the extension requests for work requirements and waiver of retroactive coverage should be denied.

**I. Procedural Concerns**

Arizona's application raises numerous procedural concerns.

First, as the Arizona Governor notes in his letter accompanying the extension request, Arizona has been operating a Section 1115 managed care demonstration since 1982 – over 38 years. Section 1115 can only be used for “experimental, pilot, or demonstration” projects “for the period ... necessary to enable ... States to carry out such project.”<sup>1</sup> The Arizona “experiment” was to test use of a managed care delivery system for Medicaid enrollees and was one of a handful of such experiments approved around

the time. Using information provided from these experiments, Congress added two statutory provisions to make managed care a state plan option, with some exceptions. See 42 U.S.C. §§ 1396u-2, 1396n(b). Thus, Congress has spoken to the implementation of managed care in Medicaid. Arizona’s managed care demonstration, now in its fourth decade, should not be approvable under section 1115. (We note that the previous administration began approving waivers for 10-year periods. Section 1115 does not authorize such an action.)<sup>2</sup>

Second, Arizona’s application does not meet the federal requirements for a complete application. First, 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 to provide comment.”<sup>3</sup> While Arizona conducted public events, these events were all “held via webinar.”<sup>4</sup> Sixteen percent of Arizona households do not have internet access.<sup>5</sup> Research confirms that the problem is particularly acute for low-income individuals.<sup>6</sup> Thus, moving from in-person to virtual hearings disproportionately prevented the very people affected by the AHCCCS project from offering comment.

CMS has issued 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.<sup>7</sup> 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.<sup>8</sup> 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, Arizona does not meet the criteria for an exemption from the public notice and comment process, and any exemption given to Arizona by CMS was improper.<sup>9</sup>

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<sup>1</sup> 42 U.S.C. § 1315(a).

<sup>2</sup> 42 U.S.C. § 1315 (e)(2).

<sup>3</sup> 42 C.F.R. § 431.408(a)(3).

<sup>4</sup> State of Arizona Office of the Governor, *Arizona Health Care Cost Containment System: Arizona Demonstration Renewal Proposal 47* (December 21, 2020), <https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-hccc-pa8.pdf> [hereinafter Application].

<sup>5</sup> U.S. Census Bureau, *Quick Facts: Arizona* (2020), <https://www.census.gov/quickfacts/AZ> (last visited January 25, 2021).

<sup>6</sup> 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).

<sup>7</sup> 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>.

<sup>8</sup> 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).

<sup>9</sup> 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”).



Third, Arizona has not provided a sufficient level of detail to “ensure a meaningful level of public input” on various aspects of the AHCCCS project.<sup>10</sup> For example:

- There are also no “with waiver” budget neutrality Member Month estimates, meaning commenters cannot evaluate the coverage impact or the assumptions underlying the budget neutrality estimates;
- More alarmingly, if the estimated member months are calculated from the PMPM and cost estimates that *are* provided, the results indicate the State made no “with waiver” member month estimates (or did not adjust current estimates to account for the work requirement). For example, the DY2 with waiver calculation using the application data table would compute to an estimate of 4,523,040 member months for “expansion state adults,” compared to a without waiver estimate of 4,523,063 provided by the State. This data suggests, preposterously, that only 23 member months would be lost as a result of this demonstration, or more likely, this difference is due to normal rounding errors using such large numbers and the State actually made no changes to its member month assumptions between its with and without waiver calculations.
- The State has provided no estimates on the coverage impacts of either the work requirement or retroactive coverage waiver policies.
- Numerous other features of the work requirement policy are unclear. For example, there is no specificity about the documentation individuals will need to provide to secure the various exemptions, nor what criteria will be used to evaluate the exemptions (such as who is a “designated” caretaker) — making it impossible to evaluate the full extent of the harm the policy will cause.

Fourth, portions of Arizona’s application are not accessible to individuals with a disability. An Adobe accessibility test (report attached) shows the approval document fails on twelve different parameters, including needing alternative text for figures and elements. As a result, individuals with visual impairments 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.

## II. HHS Authority and § 1115

For the Secretary to approve Arizona’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

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<sup>10</sup> 42 U.S.C. § 1315(d)(2)(A), (C); 42 C.F.R. §§ 431.408(a), 431.412(a).



- waive compliance only “to the extent and for the period necessary” to carry out the experiment.<sup>11</sup>

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.<sup>12</sup> As explained in detail below, Arizona’s proposal is inconsistent with the provisions of § 1115.

### III. The Project Will Reduce Medicaid Coverage

On January 28, 2021, President Biden signed Executive Order 14009, requiring DHHS and all executive agencies to re-examine “demonstrations and waivers, as well as demonstration and waiver policies, that may reduce coverage under or otherwise undermine Medicaid.”<sup>13</sup> This includes work requirements (see White House Fact Sheet on the Executive Order).<sup>14</sup> As President Biden stated, the purpose of the Executive Order is to “restor[e] the Medicaid [program] to the way it was before Trump became President.”<sup>15</sup>

Arizona seeks to implement a number of policy changes that will unquestionably reduce Medicaid coverage and, thus, should not be approved. The retroactive coverage waiver applies to the large majority of Medicaid enrollees, and the State predicts about 120,000 individuals will be subject to the work requirements.<sup>16</sup> Although Arizona has provided no estimates of how many people will lose coverage under these policies, the evidence cited below indicates there will be substantial coverage losses. Arizona’s requests to impose work requirements and waive retroactive eligibility should be denied.

#### A. Imposing Work Requirements

Arizona proposes to require enrollees between the ages of 19 and 49 to complete 80 hours per month of specified work or work-related activities and to report their participation to the State each month.<sup>17</sup> After the orientation period, individuals who do not meet the

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<sup>11</sup> 42 U.S.C. § 1315(a).

<sup>12</sup> *Id.* § 1396-1.

<sup>13</sup> Exec. Order No. 14,009, 86 Fed. Reg. 7793 (Feb. 2, 2021), <https://www.whitehouse.gov/briefing-room/presidential-actions/2021/01/28/executive-order-on-strengthening-medicaid-and-the-affordable-care-act/>.

<sup>14</sup> Press Release, The White House, *Fact Sheet: President Biden to Sign Executive Orders Strengthening Americans’ Access to Quality, Affordable Health Care* (Jan. 28, 2021), <https://www.whitehouse.gov/briefing-room/statements-releases/2021/01/28/fact-sheet-president-biden-to-sign-executive-orders-strengthening-americans-access-to-quality-affordable-health-care/>.

<sup>15</sup> Press Release, The White House, *Remarks by President Biden at Signing of Executive Orders Strengthening Americans’ Access to Quality, Affordable Healthcare* (Jan. 28, 2021), <https://www.whitehouse.gov/briefing-room/speeches-remarks/2021/01/28/remarks-by-president-biden-at-signing-of-executive-orders-strengthening-americans-access-to-quality-affordable-healthcare/>.

<sup>16</sup> Application at 19.

<sup>17</sup> See Application at 19.



work requirements in a particular month will have their Medicaid coverage suspended for two months and unless they: (1) qualify for an exemption from the work requirements; (2) obtain a good cause exemption; or (3) file an appeal.<sup>18</sup> Thus, some portion of individuals who are not able to meet the work requirements will lose Medicaid coverage. Some individuals will repeatedly lose coverage for two months throughout the year; they will be suspended for two months, re-enrolled, suspended again, re-enrolled again, etc., losing Medicaid coverage for half of the year and struggling with discontinuous care during the other half of the year.

The Medicaid Act does not authorize HHS to approve any waiver permitting Arizona to condition Medicaid coverage on compliance with these work requirements. Unlike some other public benefits programs, Medicaid is not a work program; it is a medical assistance program. The Medicaid Act does not reference work as a purpose of the program nor does it include participation in work activities in 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 coverage requirements is illegal.<sup>19</sup>

Section 1115 cannot be used to short-circuit these Medicaid protections. There is no basis for finding that the work requirements Arizona describes are likely to assist in promoting the objectives of the Medicaid Act.<sup>20</sup> Put simply, conditioning Medicaid coverage on completion of work activities blocks access to medical assistance.

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

Although Arizona provides no estimates of coverage losses, all evidence indicates that the work requirement will lead to substantial numbers of individuals losing Medicaid coverage.<sup>21</sup>

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<sup>18</sup> *Id.* at 18-19.

<sup>19</sup> 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).

<sup>20</sup> 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>.

<sup>21</sup> See, e.g., Leighton Ku et al., *Medicaid Work Requirements: Who’s At Risk?*, HEALTH AFFAIRS BLOG (Apr. 12, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170412.059575/full/>; 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*



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.<sup>22</sup> 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.<sup>23</sup>

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.<sup>24</sup> 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.<sup>25</sup> Researchers have estimated coverage loss rates of up to 41% when

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*Unemployed Gain Jobs or Improve Health?*, 1 (2018), [https://www.commonwealthfund.org/sites/default/files/2018-11/Ku\\_Medicaid\\_work\\_requirements\\_ib.pdf](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.”).

<sup>22</sup> 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>.

<sup>23</sup> 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>.

<sup>24</sup> 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>.

<sup>25</sup> Letter from Meyers (noting that otherwise New Hampshire would experience the “unintended loss of coverage for thousands of beneficiaries.”)



valuating similar work requirements in other states.<sup>26</sup> Nearly 80,000 people in Michigan were facing termination before a federal court halted implementation.<sup>27</sup>

There is no reason to expect a different outcome in Arizona. So far as we can tell, the work requirements that they propose are like those in these states.

To be sure, 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 many individuals who are working or should be exempt.

Those who lose Medicaid coverage will have few alternative coverage options, and evidence shows that many will become uninsured over long periods of time. As described in detail in Section III.C 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 86% of adult Medicaid enrollees in Arizona who do not receive Social Security disability benefits (SSI) live in families with at least one worker and 66% work themselves.<sup>28</sup> 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

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<sup>26</sup> 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>.

<sup>27</sup> See Press Release, Office of Governor Gretchen Whitmer, *State Asks Lower Court to Declare Healthy Michigan Plan Work Requirements Unlawful, as Required by Higher Court Ruling* (Feb. 25, 2021), <https://www.michigan.gov/whitmer/0,9309,7-387-90487-520194--,00.html>.

<sup>28</sup> 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*].



one of these occupations.<sup>29</sup> 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.<sup>30</sup> In total, 83% of part-time workers report having unstable work schedules, and 41% of hourly workers between ages 26 and 32 receive one week or less notice of their schedules.<sup>31</sup>

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.<sup>32</sup> 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.<sup>33</sup> 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.<sup>34</sup>

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 Arizona is nearly 8%.<sup>35</sup> Industries on which Medicaid enrollees rely for work, such as leisure and

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<sup>29</sup> 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].

<sup>30</sup> Susan J. Lambert et al., *Precarious Work Schedules among Early-Career Employees in the US: A National Snapshot* (2014) (attached); Stephanie Luce et al., City Univ. of N.Y. and Retail Action Project, *Short Shifted*, (2014) [http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted\\_report\\_FINAL.pdf](http://retailactionproject.org/wp-content/uploads/2014/09/ShortShifted_report_FINAL.pdf); Liz Ben-Ishai, CLASP, *Volatile Job Schedules and Access to Public Benefits* (2015), <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>; Bivens & Fremstad; 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](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/precarius\\_work\\_schedules\\_could\\_jeopardize\\_access\\_to\\_safety\\_net\\_programs.pdf](https://www.urban.org/sites/default/files/publication/100352/precarius_work_schedules_could_jeopardize_access_to_safety_net_programs.pdf).

<sup>31</sup> Goldman, *The Struggles of Low Wage Work*.

<sup>32</sup> Bivens & Fremstad; Goldman, *The Struggles of Low Wage Work*.

<sup>33</sup> 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/>.

<sup>34</sup> 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>.

<sup>35</sup> U.S. Dep't of Labor, Bureau of Labor Statistics, Local Area Unemployment Statistics, <https://www.bls.gov/web/laus/lausthl.htm> (last visited January 25, 2021).





hospitality, have been hit particularly hard.<sup>36</sup> Experts cannot predict precisely when or how the economy will recover, as that depends on the course of the pandemic.<sup>37</sup> 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”<sup>38</sup>

Nor will volunteering or other un-paid activities be a viable solution for Medicaid enrollees. To begin with, they do not come with offers of private insurance coverage. Moreover, many individuals whose hours fluctuate regularly will struggle to complete other activities 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 sixteen percent of households in Arizona do not have a broadband internet subscription.<sup>39</sup> The State ranks 29th in internet connectivity.<sup>40</sup> And, research confirms that low-income people do not have access to the internet to the same extent as the non-poor.<sup>41</sup> 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.<sup>42</sup> 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.

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<sup>36</sup> 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>.

<sup>37</sup> See Interview by Rachel Martin, Nat'l Pub. Radio with David Wessel, Dir., Hutchins Ctr. at Brookings Inst. (June 9, 2020), <https://www.npr.org/2020/06/09/872710984/u-s-recession-began-in-february-national-bureau-of-economic-research-says>.

<sup>38</sup> 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>.

<sup>39</sup> U.S. Census Bureau, *Quick Facts: Arizona* (2020), <https://www.census.gov/quickfacts/AZ> (last visited January 25, 2021).

<sup>40</sup> 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>.

<sup>41</sup> 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?*].

<sup>42</sup> 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).



Moreover, conditioning Medicaid on unpaid work could run afoul of other laws the Secretary is not permitted to waive, such as the Fair Labor Standards Act (FLSA), which requires that all individuals be compensated in an amount equal to at least the minimum wage in exchange for hours they work.<sup>43</sup> FLSA concerns will also limit the number of recurring, stable volunteer opportunities that are available to AHCCCS enrollees.<sup>44</sup>

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.<sup>45</sup> 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.<sup>46</sup> Twenty-one percent reported serious problems concentrating, remembering, or making decisions, and 26% reported serious problems walking or climbing stairs.<sup>47</sup>

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.<sup>48</sup> 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.<sup>49</sup> 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.<sup>50</sup>

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<sup>43</sup> 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>.

<sup>44</sup> 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>.

<sup>45</sup> Garfield et al., *Understanding the Intersection of Medicaid and Work* at 8.

<sup>46</sup> 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>.

<sup>47</sup> *Id.*

<sup>48</sup> 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](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2663198).

<sup>49</sup> 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>.

<sup>50</sup> 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).



Providing an exemption for enrollees who are medically frail or have disability cannot resolve these concerns.<sup>51</sup> The experience in Arkansas demonstrated that individuals with chronic conditions lost their coverage due to confusion about the work requirements.<sup>52</sup> 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.<sup>53</sup> These coverage losses occurred despite Arkansas taking steps to avoid the problem, such as “using existing data sources when possible” to confirm disability status.<sup>54</sup> 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.”<sup>55</sup>

Evidence from other programs confirms that, in practice, individuals with disabilities are often not exempted as they should be.<sup>56</sup> They are, in fact, more likely to lose benefits due to noncompliance.<sup>57</sup> Numerous studies of state Temporary Assistance for Needy Families (TANF) programs already found that participants with physical or mental health conditions

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<sup>51</sup> Application at 18-19.

<sup>52</sup> 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>.

<sup>53</sup> 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/>.

<sup>54</sup> 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*].

<sup>55</sup> 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).

<sup>56</sup> 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>.

<sup>57</sup> 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*].



are disproportionately sanctioned for not completing the work requirement or related work activities.<sup>58</sup>

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.<sup>59</sup> 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.<sup>60</sup> 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.<sup>61</sup> State officials acknowledged that hundreds of enrollees had been wrongly classified as “able-bodied” when they were actually unable to work.<sup>62</sup>

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.<sup>63</sup> Several

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<sup>58</sup> See, e.g., Yehekel 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](http://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers); Lens, *Welfare and Work Sanctions*; MaryBeth Musumeci & Julia Zur, Kaiser Family Found., *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience* (Aug. 18, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/> [hereinafter Musumeci & Zur, *Medicaid Enrollees and Work Requirements*]; Mathematica 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](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>.

<sup>59</sup> 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>.

<sup>60</sup> Ohio Association of Foodbanks, *Comprehensive Report: Able-Bodied Adults without Dependents* (2015), <https://cfpa.net/CalFresh/ExternalPublications/OAFB-WEP-ABAWD-report-2015.pdf>.

<sup>61</sup> *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>.

<sup>62</sup> *Id.*

<sup>63</sup> 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](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



beneficiaries reported being denied disability-related extensions even though they were in the process of applying for – and ultimately received – SSI benefits.<sup>64</sup> Beneficiaries also reported being discouraged from applying for extensions by TANF caseworkers and confusion about the process for applying for hardship extensions.<sup>65</sup>

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.<sup>66</sup> 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.<sup>67</sup>

Likewise, the work requirements will disproportionately harm individuals with prior arrests or convictions, who face significant barriers to employment.<sup>68</sup> 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.<sup>69</sup> 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.<sup>70</sup> In Arizona, which has the fifth highest imprisonment rate in the country, the imprisonment rate for Black people is 4.8 times the imprisonment rate for White people.<sup>71</sup> What is more, research suggests that the

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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](https://mail.maineequaljustice.org/site/assets/files/1525/tanf-time-limits-march2014_0.pdf).

<sup>64</sup> McLaughlin & Butler, *Lessons from a 2010 Survey of Maine TANF Families*.

<sup>65</sup> McLaughlin & Butler. *Lessons from a 2010 Survey of Maine TANF Families*.

<sup>66</sup> 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).

<sup>67</sup> See *Burns-Vidlak v. Chandler*, 939 F. Supp. 765, 772 (D. Haw. 1996).

<sup>68</sup> 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](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](https://www.nelp.org/wp-content/uploads/2015/03/65_Million_Need_Not_Apply.pdf)

<sup>69</sup> 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>.

<sup>70</sup> The Sentencing Project, *Criminal Justice Facts*, <https://www.sentencingproject.org/criminal-justice-facts/> (last visited June 3, 2020).

<sup>71</sup> 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 Arizona*, <https://www.sentencingproject.org/the-facts/#detail?state1Option=Arizona&state2Option=0> (last visited January 25, 2021).



employment prospects of Black individuals are more strongly affected by a criminal record.<sup>72</sup>

Additional evidence shows that Arizona'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.<sup>73</sup> 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 Arizona. 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 those who are already working or who fall within an exemption – will lose coverage due to the administrative burden associated with the work requirements.<sup>74</sup> Research has repeatedly established that adding new administrative requirements for Medicaid enrollees decreases enrollment.<sup>75</sup> 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.<sup>76</sup> Similarly, when Washington State increased documentation requirements, moved from a 12- to 6-month renewal period, and ended continuous eligibility for children

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<sup>72</sup> 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>

<sup>73</sup> 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).

<sup>74</sup> 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>.

<sup>75</sup> 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*].

<sup>76</sup> 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/>).



in Medicaid and CHIP in 2003, enrollment dropped sharply.<sup>77</sup> Enrollment quickly rebounded when the State reinstated the 12-month renewal period and continuous eligibility.<sup>78</sup>

There are several reasons for this. First, states and their contractors inevitably make mistakes implementing the requirement, causing some erroneous coverage losses.<sup>79</sup> In Arkansas, programming glitches created widespread problems accessing the State's work requirement reporting website.<sup>80</sup>

Second, many enrollees fail to receive adequate notice of or simply do not understand the requirements, and as a result, do not comply.<sup>81</sup> 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.<sup>82</sup> 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.<sup>83</sup> 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.<sup>84</sup>

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<sup>77</sup> 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>; 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>).

<sup>78</sup> Kaiser Family Found., *Implications of Emerging Waivers*.

<sup>79</sup> See Wagner & Solomon, *States' Complex Medicaid Waivers*, at 13-14.

<sup>80</sup> 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/>.

<sup>81</sup> 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.").

<sup>82</sup> Jessica Greene, *Medicaid Recipients' Early Experience With the Arkansas Medicaid Work Requirement*, HEALTH AFFAIRS BLOG, Sept. 5, 2018, <https://www.healthaffairs.org/doi/10.1377/hblog20180904.979085/full/>.

<sup>83</sup> 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*].

<sup>84</sup> Sommers et al., *Medicaid Work Requirements – Results from the First Year in Arkansas*, at 1077.



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.<sup>85</sup> Although New Hampshire claimed that its outreach and reporting would differ from the approach in Arkansas, the result of the work requirements was very similar.<sup>86</sup>

Third, even individuals who know their obligations under the work requirement face challenges to show they qualify for an exemption or good cause exemption.<sup>87</sup> The application is silent as to how individuals will need to document their basis for exemption, such as by providing a medical certification from a health care provider. Reports from New Hampshire show how difficult and time-consuming it can be to get that kind of documentation.<sup>88</sup>

Similarly, “designated caretakers” of children under age eighteen can be exempt.<sup>89</sup> However, it is not clear how one qualifies to be a “designated” caretaker, how broadly that exemption will apply, nor how individuals will verify their eligibility. How many hours of caretaking is required, and how must this be documented?

Additional structural barriers will prevent individuals from reporting their hours or seeking an exemption or good cause exemption. Arizona will allow individuals to report their hours or seek an exemption online, over the phone, in person, or through the mail.<sup>90</sup> 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

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<sup>85</sup> Ethan DeWitt, “New Hampshire Medicaid work requirement faces crucial test,” CONCORD MONITOR (July 6, 2019), <https://www.concordmonitor.com/New-Hampshire-Medicaid-work-requirement-faces-crucial-test-26791579>; Gary Rayno, “Progress Made on NH Medicaid work requirement deal,” EAGLE TRIBUNE (Jun. 18, 2019), [https://www.eagletribune.com/news/progress-made-on-nh-medicaid-work-requirement-deal/article\\_fd8bc5df-4375-5e2d-a694-a3dc6c2b73f9.html](https://www.eagletribune.com/news/progress-made-on-nh-medicaid-work-requirement-deal/article_fd8bc5df-4375-5e2d-a694-a3dc6c2b73f9.html)

<sup>86</sup> 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>.

<sup>87</sup> 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>.

<sup>88</sup> 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](https://www.concordmonitor.com/Penacook-NH-medical-frailty-exemption-difficulties-26880774?utm_source=HeadlineAlerts&utm_medium=DailyNewsletter&utm_campaign=HeadlineAlerts)

<sup>89</sup> Application at 18. 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](https://www.urban.org/sites/default/files/publication/101094/medicaid_work_reqs_child_care_0.pdf).

<sup>90</sup> Application at 8.





on a regular or semi-regular basis.<sup>91</sup> These kinds of logistical barriers to reporting have been documented in the SNAP program; research shows that otherwise eligible individuals lose coverage due to reporting requirements at recertification.<sup>92</sup>

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.<sup>93</sup> 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.<sup>94</sup>

Navigating the work requirements could be especially challenging for individuals with substance use disorders and/or with mental illness that affects their cognitive function.<sup>95</sup> 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.<sup>96</sup> Forty-three million U.S. adults have low English literacy skills, and at least 8.4 million of these individuals are functionally illiterate.<sup>97</sup> In this way, the work requirement is likely to exacerbate health disparities within Arizona.<sup>98</sup>

Fourth and finally, research indicates that the complexity of the work requirements could dissuade individuals from enrolling in AHCCCS in the first place.<sup>99</sup> In 2000, a survey of

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<sup>91</sup> 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).

<sup>92</sup> 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](http://research.upjohn.org/cgi/viewcontent.cgi?article=1306&context=up_workingpapers).

<sup>93</sup> 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>.

<sup>94</sup> 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.

<sup>95</sup> 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>.

<sup>96</sup> Musumeci, *Medicaid Work Requirements in Arkansas*, at 6.

<sup>97</sup> Nat'l Ctr. for Education Statistics, *Data Point: Adult Literacy in the United States* (2019), <https://nces.ed.gov/datapoints/2019179.asp>.

<sup>98</sup> See Perry et al., *Medicaid and Children*.

<sup>99</sup> 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>.



parents revealed that the perceived red tape, the complexity of rules and regulations, and confusion about how to apply were all significant factors that prevented parents from even trying to enroll their children in Medicaid.<sup>100</sup>

In short, abundant evidence shows that reducing enrollees' administrative burdens increases coverage.<sup>101</sup> 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.<sup>102</sup>

Arizona's proposed work requirement, which requires perpetual 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.<sup>103</sup> 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.<sup>104</sup> 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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<sup>100</sup> Perry et al., *Medicaid and Children*, at 10-12.

<sup>101</sup> 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>.

<sup>102</sup> 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*.

<sup>103</sup> See Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*.

<sup>104</sup> 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.<sup>105</sup> 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.<sup>106</sup> 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.<sup>107</sup> 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).<sup>108</sup> 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.<sup>109</sup>

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.<sup>110</sup> 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.<sup>111</sup> 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.<sup>112</sup>

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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<sup>105</sup> 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*"].

<sup>106</sup> *Trends in Employer-Sponsored Insurance*, at 4.

<sup>107</sup> Bivens & Fremstad.

<sup>108</sup> Goldman et al.

<sup>109</sup> 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>.

<sup>110</sup> Musumeci, *Medicaid Work Requirements in Arkansas*, at 3.

<sup>111</sup> 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>.

<sup>112</sup> 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. 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.<sup>113</sup> 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).<sup>114</sup> 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).<sup>115</sup>

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.<sup>116</sup> 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.<sup>117</sup> 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.<sup>118</sup>

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<sup>113</sup> 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).

<sup>114</sup> *Id.* at 304-305.

<sup>115</sup> *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*”].

<sup>116</sup> Kids Forward, *The Wisconsin Approach to Medicaid Expansion* (2017), <http://kidsforward.net/assets/Medicaid-Approach.pdf>.

<sup>117</sup> 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>.

<sup>118</sup> 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 Arizona’s proposed work requirement are highly unlikely to find affordable, alternative health coverage. And, as detailed in Section III.C, 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.

Arizona argues that imposing a work requirement on Medicaid enrollees “will increase employment, employment opportunities, and activities to enhance employability, [and] increase financial independence.”<sup>119</sup> Redundant research refutes this claim.<sup>120</sup> 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.”<sup>121</sup> In fact, the number of individuals working more than 20 hours a week declined after implementation of the work requirement.<sup>122</sup> Notably, the study did detect a rise in the rate of uninsured individuals.<sup>123</sup> 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.<sup>124</sup> In fact, imposing work

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<sup>119</sup> Application at 8, 37.

<sup>120</sup> 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*].

<sup>121</sup> Sommers et al., *Medicaid Work Requirements – Results from First Year in Arkansas*, at 1079.

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> 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](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.<sup>125</sup> 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.<sup>126</sup>

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.<sup>127</sup> More rigorous, and long-term analyses indicate that individuals who left TANF due to increased earnings did not typically experience lasting income increases.<sup>128</sup> 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](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 Support 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*.

<sup>125</sup> 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>.

<sup>126</sup> 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>.

<sup>127</sup> 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/doi/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>.

<sup>128</sup> 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).<sup>129</sup> 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.<sup>130</sup> Four years later, the numbers had not budged.<sup>131</sup> Parents terminated from TANF due to time limits earned even less, a median of just \$1,370 annually (7% FPL).<sup>132</sup> 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.<sup>133</sup>

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.<sup>134</sup> 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.<sup>135</sup> In fact, those who had substantial work one year were likely to experience drops in their income, hours, and wages in the next.<sup>136</sup> 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.”<sup>137</sup>

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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](https://usm.maine.edu/sites/default/files/food-studies/CHastedt_Work-Requirements.pdf).  
<sup>129</sup> 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>.

<sup>130</sup> Mitchell & Pavetti, *Life after TANF in Kansas*.

<sup>131</sup> *Id.*

<sup>132</sup> *Id.*

<sup>133</sup> 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](https://www.cbpp.org/sites/default/files/atoms/files/tanf_trends_ks.pdf).

<sup>134</sup> See Butcher & Whitmore Schanzenbach.

<sup>135</sup> *Id.*

<sup>136</sup> *Id.*

<sup>137</sup> 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.<sup>138</sup> 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.<sup>139</sup> 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.<sup>140</sup> 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.<sup>141</sup>

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.<sup>142</sup> 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.<sup>143</sup> 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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<sup>138</sup> 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*"].

<sup>139</sup> *Id.*

<sup>140</sup> 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>.

<sup>141</sup> 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).

<sup>142</sup> 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>.

<sup>143</sup> 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.<sup>144</sup> 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.<sup>145</sup> During HELP-Link's first three years, over 25,000 Medicaid enrollees received services.<sup>146</sup> The State has reported that program participants have high employment rates, and the majority of participants had higher wages after completing the program.<sup>147</sup>

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

Arizona suggests that the work requirement will lead to positive health outcomes for Medicaid enrollees.<sup>148</sup> 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.<sup>149</sup> 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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<sup>144</sup> 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>.

<sup>145</sup> 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>.

<sup>146</sup> 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](http://lmi.mt.gov/Portals/193/Publications/LMI-Pubs/Special%20Reports%20and%20Studies/HELP-Link_2018Report.pdf).

<sup>147</sup> *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](https://dphhs.mt.gov/Portals/85/Documents/healthcare/March%202018%20HELP_Link_Fact_Sheet.pdf).

<sup>148</sup> Application at 3, 6.

<sup>149</sup> Letter from Jane Perkins, Nat'l Health Law Program, to Brian Neale, Dir. Ctrs. for Medicare & Medicaid Servs. (Jan. 11, 2018) (attached).



detrimental.<sup>150</sup> For one, job quality matters.<sup>151</sup> 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.”<sup>152</sup> “High strain” jobs, or jobs with little reward or recognition, can increase poor health outcomes, such as high blood pressure and cardiovascular disease.<sup>153</sup> This is a key finding mentioned in two meta-analyses cited in the DSMD, but the letter never mentions it.<sup>154</sup>

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 that looked at the relationship between health and employment, only 11 are US-based.<sup>155</sup> 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.”<sup>156</sup> In short, translating findings from mostly European studies to this Medicaid project in Arizona 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.”<sup>157</sup> CMS should use these findings, published in 2017, to reverse and withdraw its ill-considered position on mandatory work requirements and to reject the Arizona 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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<sup>150</sup> 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*.

<sup>151</sup> 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>.

<sup>152</sup> *Id.*

<sup>153</sup> Douglas Jacobs, *The Social Determinants Speak: Medicaid Work Requirements Will Worsen Health*, HEALTH AFFAIRS BLOG (Aug. 6, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180730.371424/full/>.

<sup>154</sup> 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.

<sup>155</sup> Waddell & Burton, at 110-132.

<sup>156</sup> *Id.* at 112, 123.

<sup>157</sup> 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.”<sup>158</sup> 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.<sup>159</sup> 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].”<sup>160</sup> Rather than grapple with this important factor, the DSMD misrepresents complex correlation as simple causation.

Under Arizona’s proposal, individuals will be able to satisfy the work requirement by participating in community service. Studies that find positive benefits from volunteering also suggest that the benefits diminished or disappeared when volunteering was perceived as obligatory.<sup>161</sup> 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.<sup>162</sup> 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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<sup>158</sup> Raj Chetty et al., *The Association between Income and Life Expectancy in the United States*, 315 JAMA 1750, 1759 (2016).

<sup>159</sup> 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.”).

<sup>160</sup> Van der Noordt at 735.

<sup>161</sup> 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*.

<sup>162</sup> See Jens Detollenaere, Sara Willems & Stijn Baert, *Volunteering, Income and Health*, 12 PLOS ONE e0173139 (2017); Thoits & Hewitt.



younger adults.<sup>163</sup> Again, the literature on the link between volunteering and health does not support the policy that Arizona 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.<sup>164</sup> Ten of those studies noted that involvement in the welfare to work programs actually “exacerbated ill health.”<sup>165</sup> 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.”<sup>166</sup>

Even if it were true that work and/or volunteering leads to better health, Arizona 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.C 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.<sup>167</sup> 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.”<sup>168</sup> The evidence is clear that Medicaid expansion coverage itself is what improves the health of low-income individuals in states.<sup>169</sup> States expanding Medicaid (without added conditions of eligibility) have seen improvements in care utilization, financial well-being, and health metrics.<sup>170</sup> Medicaid

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<sup>163</sup> Grimm, Jr. et al.

<sup>164</sup> 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).

<sup>165</sup> *Id.* at 195.

<sup>166</sup> *Id.* at 197.

<sup>167</sup> Waddell & Burton, Table 2A, at 123, (citing Halvorsen 1998).

<sup>168</sup> 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).

<sup>169</sup> 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).

<sup>170</sup> 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>.



expansion coverage gains nationally have strongly benefitted individuals in small towns and rural areas.<sup>171</sup> In addition, Medicaid expansion has been widely experienced as a financial boon to participating states.<sup>172</sup> And yet, Arizona 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.

Arizona's application acknowledges that state commenters were concerned about "the increase in programmatic administrative costs due to reporting requirements" related to the work requirement.<sup>173</sup> However, in the application the State neither responded to that concern nor provided an estimate of the expected administrative costs for implementing work requirements. All available evidence indicates that these costs will be high.<sup>174</sup> 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.<sup>175</sup> These figures, which were provided by the states themselves, did not even include all planned costs.<sup>176</sup> Other states have likewise estimated that the costs of implementing a work requirement would be substantial.<sup>177</sup> For example, Michigan estimated that a work requirement would cost the State \$15 to \$30 million every year.<sup>178</sup> Minnesota projected implementing a work requirement would cost local governments \$121 million in 2020 and \$163 million in 2021.<sup>179</sup> New Hampshire spent \$130,000 on outreach alone—*prior to*

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<sup>171</sup> 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](https://ccf.georgetown.edu/wp-content/uploads/2018/09/FINALHealthInsuranceCoverage_Rural_2018.pdf).

<sup>172</sup> 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/>

<sup>173</sup> Application at 48.

<sup>174</sup> 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).

<sup>175</sup> 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).

<sup>176</sup> U.S. Gov't Accountability Office, *Medicaid Demonstrations: Actions Needed to Address Weaknesses in Oversight of Costs to Administer Work Requirements* 19 (Oct. 2019).

<sup>177</sup> See Wagner & Solomon, *States' Complex Medicaid Waivers*, at 15-16.

<sup>178</sup> *Id.*

<sup>179</sup> *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](http://www.governing.com/topics/health-human-services/gov-medicaid-work-requirements-states-cost-implement.html).



deciding to pause implementation of its work requirement to prevent thousands of people from losing coverage.<sup>180</sup>

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 related to exemptions; requests for good cause exceptions; inquiries regarding suspensions; an increased volume of re-applications (after suspended individuals attempt to reapply); and an increased volume of administrative appeals for individuals who are suspended due to the work requirements.<sup>181</sup> Alaska estimated the added cost of work requirement-related appeals alone would exceed \$500,000, and its Medicaid program is far smaller than Arizona's.<sup>182</sup>

Individuals who have lose their Medicaid coverage will experience discontinuous care and create administrative costs to repeatedly turn coverage on and off. Because the work requirements will result in increased churning between enrollment and suspension, Arizona may incur substantially higher administrative costs per-beneficiary than continuous coverage—as happens with eligibility churn.<sup>183</sup> 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.<sup>184</sup> 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.<sup>185</sup>

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<sup>180</sup> 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>.

<sup>181</sup> 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>).

<sup>182</sup> 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>.

<sup>183</sup> Ku et al., *Improving Medicaid's Continuity of Coverage*, at 1.

<sup>184</sup> 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).

<sup>185</sup> See, e.g., Jessica Sharac et al., The George Washington Univ., *How Would Medicaid Losses in Approved Section 1115 Medicaid Work Experiment States Affect Community Health Centers?* (June 2019), <https://www.rchnfoundation.org/wp-content/uploads/2019/06/Draft-GG-IB-59-6.19-FINAL.pdf>; Randy Haught et al., The Commonwealth Fund, *How Will Medicaid Work Requirements Affect Hospitals' Finances?*, (Mar. 14, 2019), <https://www.commonwealthfund.org/publications/issue-briefs/2019/mar/how-will-medicaid-work-requirements-affect-hospitals-finances>; Jessica Schubel & Matt Broaddus, Ctr. on Budget & Policy Priorities, *Uncompensated Care Costs Fell in Nearly Every State as ACA's Major Coverage Provisions Took Effect: Medicaid Waivers That Create Barriers to Coverage Jeopardize Gains* (2018), <https://www.cbpp.org/research/health/uncompensated-care-costs-fell-in-nearly-every-state-as-acas-major-coverage>.



Notably, Arizona 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.<sup>186</sup> 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. Eliminating Retroactive Coverage

Arizona seeks to once again renew its waiver of retroactive coverage for all but a few groups of Medicaid enrollees. 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. The application includes no significant demonstration lessons since the policy was implemented in July 2019.<sup>187</sup> Meanwhile, the Health System Alliance of Arizona commented that this policy has “represented a cost-shift of [State] savings onto hospitals who have been burdened with increased uncompensated care costs from patients who have been uninsured and unable to consistently remain enrolled in the Medicaid program due to part-time or seasonal employment.”<sup>188</sup> This problem will be exacerbated by work requirements.

Arizona’s application does not provide an estimate of the number of people who will lose coverage and face medical costs due to the waiver or the average amount of those costs. Nor does it estimate the financial losses that will be suffered by providers. Evidence from other states shows the policy will harm consumers and providers. 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.<sup>189</sup> 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.<sup>190</sup> In addition, data from New Hampshire show that between August

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<sup>186</sup> 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).

<sup>187</sup> The application includes a September 2020 AHCCCS evaluation which includes only baseline calculations based on data from 2017 and 2018, and no data from 2019 when the policy began. Application at 158.

<sup>188</sup> Application at 812.

<sup>189</sup> 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>.

<sup>190</sup> 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



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.<sup>191</sup> These figures confirm that the lack of retroactive coverage will cause financial hardship to many Medicaid enrollees in Arizona.

In addition, eliminating retroactive coverage will result in increased uncompensated care costs for hospitals.<sup>192</sup> A health system association representing over 80 hospitals in Arizona directly raised this point in comments to the State.<sup>193</sup> When Ohio requested a waiver of retroactive coverage, one report estimated that the waiver would result in roughly \$2.5 billion more in uncompensated costs for hospitals over a five year period.<sup>194</sup> 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."<sup>195</sup>

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.<sup>196</sup>

Arizona justifies eliminating retroactive coverage by claiming that it will encourage individuals to enroll in Medicaid even when they are healthy.<sup>197</sup> 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

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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> ).

<sup>191</sup> 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>.

<sup>192</sup> 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>.

<sup>193</sup> See *supra* note 188.

<sup>194</sup> Virgil Dickson, *Ohio Medicaid Waiver could cost hospitals \$2.5 billion*, MODERN HEALTHCARE (April 22, 2016), <http://www.modernhealthcare.com/article/20160422/NEWS/160429965>.

<sup>195</sup> 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>.

<sup>196</sup> 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").

<sup>197</sup> Application at 3, 57.





they qualify for Medicaid coverage, much less understand that Medicaid has a retroactive coverage policy and what that means.<sup>198</sup> 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.”<sup>199</sup> 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 Arizona is seeking to eliminate – he will be responsible for the costs of the services he received prior to filing his application.

What is more, there is nothing experimental about eliminating retroactive coverage. CMS has permitted Arizona and various other states to “test” the effects of waiving retroactive coverage over the past 25 years, and yet Arizona cites to no evidence supporting the policy from any state’s project, including its own.<sup>200</sup>

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.<sup>201</sup> 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.

### C. Consequences of Coverage Loss

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<sup>198</sup> 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).

<sup>199</sup> *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).

<sup>200</sup> See e.g., OHCA, *SoonerCare Choice and Insure Oklahoma §1115(a) Demonstration Application for Extension of the Demonstration, 2013-2015*, 38 (2011)(indicating the Oklahoma retroactive coverage waiver was first approved in October 1995), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ok/SoonerCare/ok-soonercare-demo-ext-app-12302011.pdf>.

<sup>201</sup> 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/>



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.<sup>202</sup> 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.<sup>203</sup> 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.<sup>204</sup> 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.<sup>205</sup> Likewise, continuous insurance coverage is associated with earlier cancer identification and better outcomes.<sup>206</sup> Recent research also found that Medicaid expansion was associated with a reduction in preventable hospitalizations.<sup>207</sup>

Continuous coverage is also essential for financial security. Studies show that Medicaid expansion reduces medical debts and out-of-pocket expenses for enrollees.<sup>208</sup> For

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<sup>202</sup> 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).

<sup>203</sup> 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>.

<sup>204</sup> 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).

<sup>205</sup> Ku, Ass'n for Community Affiliated Plans, *Improving Medicaid's Continuity of Coverage*, at 1, 5-6.

<sup>206</sup> *Id.* at 6.

<sup>207</sup> Hefei Wen *et al.*, *Medicaid Expansion Associated With Reductions in Preventable Hospitalizations*, 38 HEALTH AFFAIRS 1845 (2019) (attached).

<sup>208</sup> 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-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),



example, independent studies of the Healthy Michigan Plan have found that coverage significantly improves financial security.<sup>209</sup> 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%.<sup>210</sup> 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.<sup>211</sup> A national study found that medical debt fell by almost twice as much in expansion states (13%) compared to non-expansion states (7%).<sup>212</sup> 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.<sup>213</sup> Along with dramatically reducing financial strain, Oregon's Medicaid experiment demonstrated significantly fewer positive screens for depression compared to a randomized control,

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<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).

<sup>209</sup> 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](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).

<sup>210</sup> 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>.

<sup>211</sup> 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>.

<sup>212</sup> Aaron Sojourner & Ezra Golberstein, *Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction*, HEALTH AFFAIRS BLOG (July 24, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170724.061160/full/>.

<sup>213</sup> Stacey McMorro, et al, *Medicaid Expansion Increased Coverage, Improved Affordability, and Reduced Psychological Distress for Low-Income Parents*, 36 HEALTH AFFAIRS 808 (2017) (attached).



amounting to a nearly 30% reduction.<sup>214</sup> 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.<sup>215</sup> 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.<sup>216</sup> Other studies have linked Medicaid expansion coverage in California to lower eviction rates and fewer payday loans.<sup>217</sup> Each of these studies bolsters the finding that Medicaid coverage itself improves enrollees' financial security and well-being.

Of significance, Arizona's work requirement design will have a disparate impact on Medicaid enrollees based on race, color, or nationality and will lead to worsened health disparities for individuals who are black, indigenous, and people of color (BIPOC). The State has announced a phased in rollout out for the work requirements.<sup>218</sup> The Arizona county with the largest proportion of black residents (Maricopa, about 6.4% black) is among three targeted in the first phase (along with Yuma, a large county that is almost two-thirds Latinx).<sup>219</sup> Meanwhile, the six counties (Apache, Gila, Graham, Greenlee, La Paz, and Navajo) targeted for the third phase are .6%, .8%, 1.9%, 2.1%, 1.2%, and 1.0% black and have a total population that is much less than one-tenth of Maricopa County.<sup>220</sup> In its application, the State suggests these counties are less likely to have "sufficient community engagement resources," yet the unemployment rate in Maricopa County as of November 2020 was 7.2%, while in Graham, Greenlee, and La Paz counties had 6.3%, 5.9%, and 6.3% rates, respectively.<sup>221</sup> The other two phase one counties, Pima and Yuma, had unemployment rates of 7.6% and 14% respectively.<sup>222</sup> Arizona's "phases" are discriminatory and will worsen health disparities. Nor does the phasing make any sense as an effort to gradually implement the administrative complexity of work requirements – the

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<sup>214</sup> Katherine Baicker et al., *The Oregon Experiment -- Effects of Medicaid on Clinical Outcomes*, 36 NEW ENG. J. MED. 1713 (2013) (attached).

<sup>215</sup> Kenneth Brevoort, Daniel Grodzicki, & Martin B. Hackmann, Nat'l Bureau of Economic Research, *Medicaid and Financial Health* 3 (2017) (attached).

<sup>216</sup> *Id.* at 3-4.

<sup>217</sup> 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).

<sup>218</sup> Application at 20.

<sup>219</sup> U.S. Census Bureau, QuickFacts Race and Hispanic OriginTable, <https://www.census.gov/quickfacts/fact/table/yumacountyarizona.maricopacountyarizona/PST045219>.

<sup>220</sup> U.S. Census Bureau, QuickFacts Race and Hispanic OriginTable, <https://www.census.gov/quickfacts/fact/table/apachecountyarizona.gilacountyarizona.grahamcountyarizona.greenleecountyarizona.lapazcountyarizona.navajocountyarizona/PST045219>.

<sup>221</sup> University of Arizona Economic and Business Research Center, *Arizona Unemployment*, <https://www.azeconomy.org/arizona-unemployment-2/#Co>.

<sup>222</sup> Federal Reserve Bank of St. Louis, *Economic Research: Unemployment Rate in Pima County, AZ* (Nov. 2020), <https://fred.stlouisfed.org/series/AZPIMA9URN>; Federal Reserve Bank of St. Louis, *Economic Research: Unemployment Rate in Yuma County, AZ* (Nov. 2020), <https://fred.stlouisfed.org/series/AZYUMA0URN>.



first phase will include three counties that represent 79% of the State's entire population.<sup>223</sup>

Because Arizona's proposal would unquestionably lead to significant reductions in coverage, it cannot be approved consistent with the requirements of Section 1115.

#### **IV. The Proposed Project Will Reduce Access to Services.**

##### **A. Verbal Consent for HCBS Service Plans**

Pursuant to an emergency authority during the COVID-19 pandemic, Arizona currently allows verbal consent in lieu of written consent requirements for home and community based services (HCBS). In its AHCCCS extension application, Arizona has requested section 1115 authority to make this an on-going program policy. Verbal consent with signature required can help overcome barriers to service plan approval and delays in individuals receiving the services they need to stay in the community. While we generally support such a policy, it must have sufficient detail and protections in place to ensure that plans are not deemed as approved by the individual when the individual has not truly provided informed consent.

The importance of being presented with and understanding all of the options for services and making an informed choice was reflected in the 2014 HCBS rule changes to the person-centered planning process, and any consent process must reflect those principles. Therefore, informed consent in the context of a service plan means that individuals understand the services requested, the choices available about provider options for those services, how their needs will be met by those services or by assumptions of natural support, and the array of services available to them under AHCCCS programs.<sup>224</sup> In the 2014 rule changes, the role and importance of documenting informed choice was reiterated and any changes to the signature process must reflect the importance of documenting what the individual understands before any documentation of what was agreed to. Importantly, the verbal agreement process should include a step that clearly informs the individual that they maintain the right to appeal service changes even if the service plan is finalized and agreed to.<sup>225</sup>

In addition, conflict of interest protections should be in place to decrease the risk of service plan agreement being documented solely for the ease of the individual responsible for completing the service plan. The process for verbal consent with signature follow up should document what information was conveyed to an individual; how it was conveyed (including accessibility); how it was verified that the individual understood the decision

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<sup>223</sup> U.S. Census Bureau, Population Division, *Annual Estimates of the Resident Population for Counties in Arizona: April 1, 2010 to July 1, 2019*, <https://www2.census.gov/programs-surveys/popest/tables/2010-2019/counties/totals/co-est2019-annres-04.xlsx>.

<sup>224</sup> See, e.g., 42 C.F.R. § 441.301(c)(1)-(2).

<sup>225</sup> 79 Fed. Reg. 2948, 2991.



being requested; the individual's consent statement; and any concerns expressed about the sufficiency, type of services, or other issues. A signature follow-up is not enough in and of itself to ensure that individuals will not feel "trapped" into accepting and signing a service plan that is not fully faithful to their verbal consent. We recommend CMS require a specific protocol that addresses these issues.

## Conclusion

In summary, while NHeLP supports the use of § 1115 to implement true, time-limited experiments that are likely to promote the objectives of the Medicaid Act, we strongly object to this proposal. It uses § 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 a result, of Executive Order 14009, this application should be denied.

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](mailto:perkins@healthlaw.org)) or Leonardo Cuello ([cuello@healthlaw.org](mailto:cuello@healthlaw.org)).

Sincerely,



Jane Perkins  
Legal Director

