October 19, 2018

The Honorable Alexander Azar, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

SUBMITTED ELECTRONICALLY VIA MEDICAID.GOV

Dear Secretary Azar:

The Medicare Rights Center (Medicare Rights) appreciates the opportunity to comment on the Alabama Medicaid Workforce Initiative.

Medicare Rights is a national, nonprofit organization that works to ensure access to affordable health care for older adults and people with disabilities through counseling and advocacy, educational programs, and public policy initiatives. Medicare Rights provides services and resources to three million people with Medicare, family caregivers, and professionals each year. Our experiences helping people of all income levels access high-quality health care through Medicare and Medicaid inform our comments below.

General Comments

The Medicaid program, now in its 53rd year, is a success story. Through Medicaid, millions of low-income Americans have built well-being and gained greater economic security via access to health insurance coverage. This coverage has guaranteed health care to those who are unable to find work, whose employers or job types do not grant access to health insurance, or who are caregivers, students, or who have disabling conditions that interfere with regular work.

As an organization that focuses on the health coverage and well-being of older Americans and people with disabilities, we have a particular interest in how this waiver would harm Alabamans from ages 50 to 60 and Alabamans with functional limitations and chronic conditions of all ages who are not administratively classified as "disabled."

Alabama's proposal contains all the core flaws of the work requirements approach as seen in other states. In the recent Stewart v. Azar decision (Civil Action No. 18-152 (JEB), 2 (D.D.C. Apr. 10, 2018) rejecting federal approval of Kentucky's work requirements waiver, the judge stated that the administration "never

adequately considered whether Kentucky HEALTH would, in fact, help the state furnish medical assistance to its citizens, a central objective of Medicaid," with medical assistance (the statutory term for Medicaid) defined as "payment of part or all of the cost of medical care and services."

As individuals approach Medicare eligibility, their health is often compromised. This is especially true for those who have unmet health care needs from a lack of insurance coverage. This lack of quality coverage can lead to reduced well-being for entire families (Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, Chapter 5 (2002), *see attached*, "Davidoff and colleagues (2002) analyzed the NSAF 1999 data set and found that having an uninsured parent decreased the likelihood that a child would have any medical provider visit by 6.5 percentage points and the likelihood of a well-child visit by 6.7 percentage points, compared with having an insured parent. In addition, this analysis found that a parent without health insurance is less likely to have confidence in the family's ability to get medical care when needed. As would be expected, the effects of having uninsured parents are smaller than the effects of the children themselves being uninsured. Still, they add to the mounting body of evidence that links parents' well-being to that of their children"; "The weight of the studies just discussed suggest that neglecting financial access to care for adults may have the unintended effect of diminishing the impact of targeted health insurance programs for children"); poorer health (David W Baker, Joseph Feinglass, Ramon Durazo-Arvizu, Whitney P Witt, Joseph J Sudano, & Jason A Thompson, "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J Gen Intern Med. 2006 Nov; 21(11): 1144–1149 (2006), *see attached*, "Adults in late middle age may be particularly vulnerable to adverse health consequences that result from lack of health insurance and impaired access to care because of their higher prevalence of chronic disease and higher chance of suffering major, debilitating illnesses such as heart attack and stroke. Previous studies have shown that adults age 51 to 61 years old who lack health insurance have higher risk-adjusted rates of decline in their overall health and physical functioning and higher risk-adjusted mortality…."); lack of access to care (Committee on the Consequences of Uninsurance, Board on Health Care Services, "Health Insurance is a Family Matter," INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, pp 91-106 (2002), *see attached*, "Uninsured adults in poor health are especially likely to encounter access problems in obtaining care for themselves; they are two to three times as likely to go without needed care and are twice as likely to lack a regular source of care as healthier uninsured adults (Schoen and Puleo, 1998; Duchon et al., 2001). Uninsured adults in fair or poor health are more likely to have experienced a time without needed care than are continuously insured adults of comparable health status. Schoen and Puleo (1998) find that the worse the health status, the greater is the likelihood of access problems when insurance status is controlled in the analysis."); economic devastation (Rohan Khera, Jonathan C. Hong, Anshul Saxena, Alejandro Arrieta, Salim S. Virani, Ron Blankstein, James A. de Lemos, Harlan M. Krumholz, & Khurram Nasir, "Burden of Catastrophic Health Expenditures for Acute Myocardial Infarction and Stroke Among Uninsured in the United States," CIRCULATION, 2018;137:00–00 (2018), *see attached*, "In summary, before the Affordable Care Act, >1 in 8 AMI and stroke hospitalizations among nonelderly adults occurred among those without insurance. In this vulnerable group of patients, in-hospital expenditures alone would be expected to cross the threshold to define a catastrophic expense in the large majority. Because many of these patients will have additional hospitalizations and health expenditures, they may easily exceed their annual income while being deprived of work during the illness. The potentially devastating financial impact of these events on the uninsured is considerable."); and higher Medicare costs when they are ultimately eligible (David W

Baker, Joseph Feinglass, Ramon Durazo-Arvizu, Whitney P Witt, Joseph J Sudano, & Jason A Thompson, "Changes in Health for the Uninsured After Reaching Age-eligibility for Medicare," J GEN INTERN MED, 2006 Nov; 21(11): 1144–1149 (2006), *see attached*, "Because of their higher risk-adjusted rates of health decline, many uninsured adults who reach age 65 and enroll in Medicare enter the program in worse health than they would have if they had continuous health insurance coverage before gaining Medicare. As a result, lack of health insurance during the preretirement years could lead to higher Medicare costs."; Jack Hadley and Timothy Waidmann, "Health Insurance and Health at Age 65: Implications for Medical Care Spending on New Medicare Beneficiaries," HEALTH SERV RES, 2006 Apr; 41(2): 429–451 (2006), *see attached*, "Continuous insurance coverage is associated with significantly fewer deaths prior to age 65 and, among those who survive, a significant upward shift in the distribution of health states from fair and poor health with disabilities to good to excellent health. Treating insurance coverage as endogenous increases the magnitude of the estimated effect of having insurance on improved health prior to age 65. The medical spending simulations suggest that if the near-elderly had continuous insurance coverage, average annual medical spending per capita for new Medicare beneficiaries in their first few years of coverage would be slightly lower because of the improvement in health status. In addition, total Medicare and Medicaid spending for new beneficiaries over their first few years of coverage would be about the same or slightly lower, even though more people survive to age 65.").

As these resources demonstrate, the stakes are very high for those approaching Medicare eligibility. We are concerned that this waiver would undermine their access to health care coverage and services. In so doing, the waiver fails to "assist in promoting the objectives" of the Medicaid program. (*See* 42 U.S.C. § 1315(a).) To the contrary, the Alabama's waiver would terminate or reduce Medicaid coverage for many low-income Alabamans. The terms of the waiver are punitive, and they do nothing to improve health care coverage for Alabama's current and future Medicaid beneficiaries.

Work Requirements

Alabama proposes to institute a work requirement on parents and caretakers despite not expanding Medicaid coverage to the adult group. We oppose this change. Alabama's income limits are already among the most restrictive in the country at 18% of the federal poverty level. This extreme limit, coupled with a work requirement, would lead parents and caretakers into a shocking Catch-22 where they would have to work to keep coverage, but would be ineligible for coverage if they worked. This means people with Medicaid would still lose coverage, despite having extremely low incomes and no way to afford other coverage. Administrative sleight of hand that creates temporary coverage for these individuals does not fix the underlying problem.

Although Medicaid eligibility rules may classify a person only as "disabled" or "not disabled," disability is a continuum. A person may not be administratively classified as "disabled," but may face significant health challenges that drive un- or underemployment.

Data from the National Center for Health Statistics show approximately 40% of working-age Medicaid beneficiaries "have broadly defined disabilities, most of whom are not readily identified as such through administrative records" (H. Stephen Kaye, "How do disability and poor health impact proposed Medicaid work requirements?," COMMUNITY LIVING POLICY CENTER, UNIVERSITY OF CALIFORNIA SAN FRANCISCO (February 12,

2018), *see attached*). Similarly, data from the March 2017 Current Population Survey (reflecting 2016 health insurance coverage) show that, among Alabama's non-elderly Medicaid population not receiving Supplemental Security Income due to disability, 41% cited being ill or disabled as the reason for not being employed (Rachel Garfield *et al.*, "Understanding the Intersection of Medicaid and Work," KAISER FAMILY FOUNDATION, Appendix Table 2 (January 2018), *see attached*).

While beneficiaries under 65 are not classified as "aged," beneficiaries of all ages can face the same health-related challenges. Those in their 50s commonly deal with health problems, chronic conditions, and functional limitations that are often related to aging and can be hidden by the use of the term "able-bodied."

For example, the likelihood of having a pre-existing health condition increases with age. According to the Office of the Assistant Secretary for Planning and Evaluation, "[U]p to 84 percent of those ages 55 to 64—31 million individuals—have at least one pre-existing condition" (Office of the Assistant Secretary for Planning and Evaluation, "Health Insurance Coverage for Americans with Pre-Existing Conditions: The Impact of the Affordable Care Act," DEPARTMENT OF HEALTH AND HUMAN SERVICES (January 5, 2017), *see attached*).

Prevalence of chronic conditions, including both physical and mental health conditions, also increases significantly with age. Based on health care expense data, the Agency for Healthcare Research and Quality found that over 75% of people ages 55 through 64 have at least one chronic condition, with the majority (57%) having two or more. (Steven Machlin, Joel W. Cohen & Karen Beauregard, "Statistical Brief #203: Health Care Expenses for Adults with Chronic Conditions, 2005," Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality (May 2008), *see attached*). AARP came to similar conclusions in an analysis of data for the age 50–64 population, finding that 72.5% have at least one chronic condition, and almost 20% suffer from some sort of mental illness (AARP Public Policy Institute, "Chronic Care: A Call to Action for Health Reform" (2009), *see attached*).

This partly explains why older adults can struggle to find and keep employment. In addition, ageism in hiring affects workers as they enter middle age, then more and more as they approach retirement age. Women are especially penalized (David Neumark, Ian Burn, & Patrick Button, "FRBSF Economic Letter: Age Discrimination and Hiring of Older Workers," FEDERAL RESERVE BANK OF SAN FRANCISCO (February 27, 2017), *see attached*, "Our study contains a number of other analyses, but they coalesce around the same three messages. First, there is evidence of age discrimination in hiring, for both women and men. Second, while both middle-aged and older applicants experience discrimination relative to younger applicants, older applicants—those near the age of retirement—experience more age discrimination. And third, women experience more age discrimination than men do"; Hila Axelrad, Miki Malul & Israel Luski, "Unemployment among younger and older individuals: does conventional data about unemployment tell us the whole story?" J Labour Mark Res. 2018; 52(1): 3 (2018), *see attached*, "On average, throughout the OECD, the hiring rate of workers aged 50 and over is less than half the rate for workers aged 25–49. The low re-employment rates among older job seekers reflect, among other things, the reluctance of employers to hire older workers. Lahey (2005) found evidence of age discrimination against older workers in labor markets. Older job applicants (aged 50 or older), are treated differently than younger applicants. A younger worker is more than 40% more likely to be called back for an interview compared to an older worker. Age

discrimination is also reflected in the time it takes for older adults to find a job. Many workers aged 45 or 50 and older who have lost their jobs often encounter difficulties in finding a new job, even if they are physically and intellectually fit (Hendels 2008; Malul 2009)").

The combination of health and social factors, including the time spent unemployed, act as a drag on further opportunities (Christina Smith FitzPatrick, "Discrimination against the Unemployed," AARP Public Policy Institute (September 2014), *see attached*, "Studies have found that job applicants with long spells of unemployment are significantly less likely than other applicants to be called for a job interview, regardless of their qualifications and experience. The call-back rate declines substantially after 6 months of unemployment, even for workers with relevant work experience. After 9 months, the probability of being called for an interview is about the same for a worker with relevant work experience as for someone with no relevant work experience"), especially for older workers ("In 2013, about 48 percent of jobseekers ages 55 or older had been unemployed for 6 months or longer, compared with 36 percent of jobseekers under age 55. This disparity between older and younger jobseekers increases as the duration of unemployment increases. (See exhibit 3.)"). This means those who are nearing retirement age are at great risk of not being able to find suitable employment to meet an arbitrary deadline. Even if they do successfully find employment, their struggles would likely continue, as the waiver's income and administrative hurdles could drive them off the program.

For these reasons, CMS should not approve a waiver to institute a work requirement for the parent and caretaker group.

Administrative Hurdles

Alabama requests permission to institute aggressive paperwork requirements. We object to this change as it would harm Medicaid beneficiary access to needed health insurance coverage and medical assistance.

These new bureaucratic hurdles would affect a broad swath of adults with Medicaid. When states make the Medicaid program more complicated, either through eligibility rules or paperwork, fewer people can gain or keep coverage, despite their eligibility.

Enrollees who are already working would need to document hours worked at regular intervals. Those who are exempt from the work requirement would need to prove that they are exempt. All would stand to lose coverage if they failed to keep up with the paperwork requirement.

The state estimates that 75,000 individuals will be subject to the work requirement or will have to prove eligibility for an exemption. The state also estimates the program will result in a 20% drop in member months over 5 years. That means thousands of very low-income Alabamans going without Medicaid coverage.

Sadly, there is reason to believe even these high initial estimates are low, and that administrative hurdles may end up playing an outsized role. In Arkansas, for example, "Of the 25,815 Medicaid adults who were required to meet (or be designated exempt from) Arkansas's work requirement in the first month, the state reported that 7,464 people—more than one-quarter (29%) of the targeted population—did not meet the requirements. As detailed below, the 25,815 individuals are Medicaid expansion beneficiaries aged 30 to

49, including those who received exemptions from the requirement" (Erin Brantley & Leighton Ku, "A First Glance At Medicaid Work Requirements In Arkansas: More Than One-Quarter Did Not Meet Requirement," HEALTH AFFAIRS (August 13, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180812.221535/full/) and only "445 (1.7%) reported that they met the work requirement" (*Id.*). Since implementation, over 8000 vulnerable Arkansans have lost Medicaid coverage and nearly 5000 more are expected to lose coverage next month.[1]

There is little reason to expect Alabama's experience to be better and many reasons to expect people between 50 and 60 would make up a disproportionate number of those losing coverage. For example, individuals between those ages are less likely to have internet access or to use the internet regularly, likely making compliance reporting more difficult (*see* Figure 1, Statista, Share of adults in the United States who use the internet in 2018, by age group, https://www.statista.com/statistics/266587/percentage-of-internet-users-by-age-groups-in-the-us/).

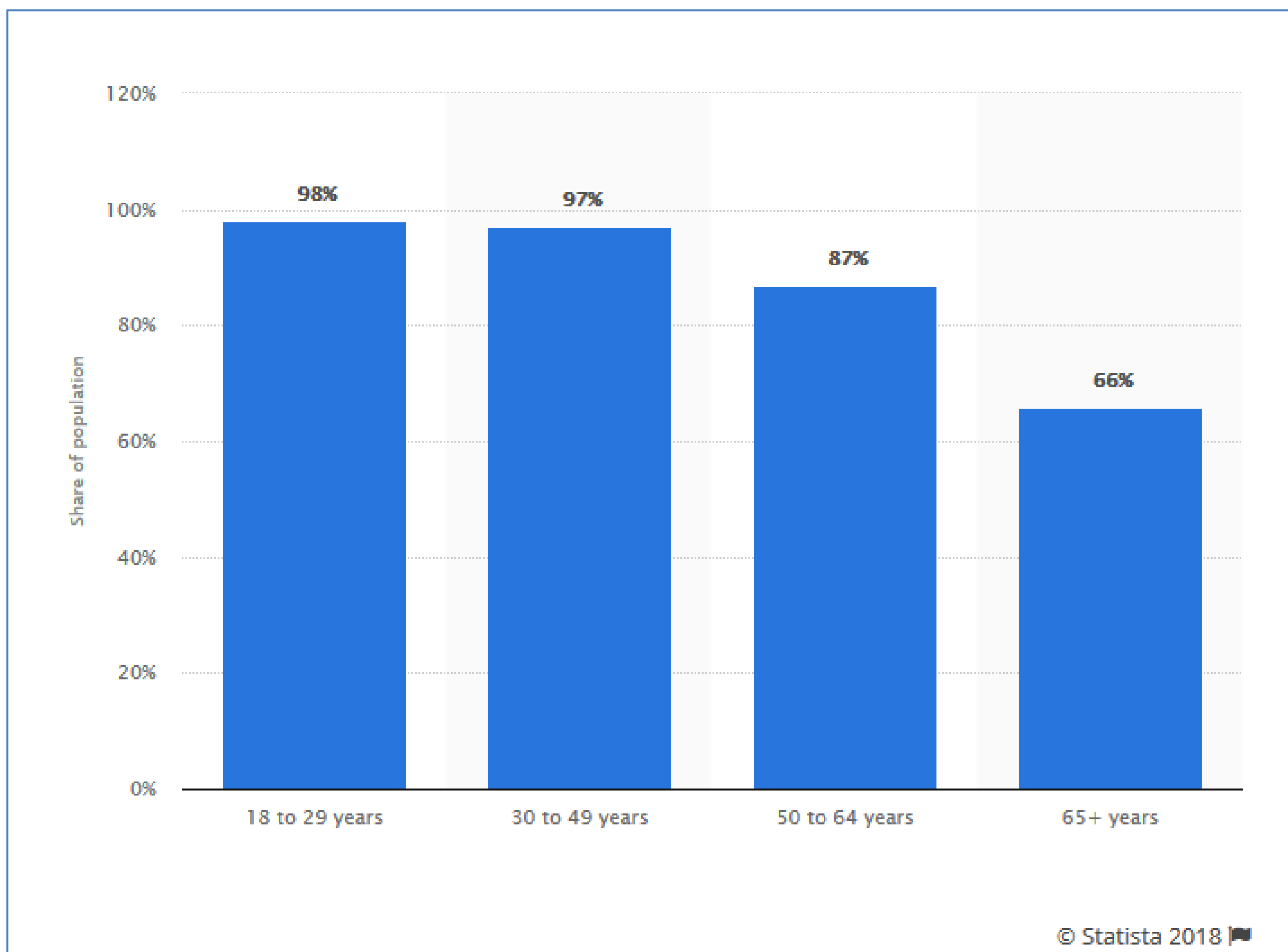

Figure 1: Share of adults in the United States who use the internet in 2018, by age group

[1] Andrew DeMillo, "Arkansas drops 4,100 more from Medicaid over work rule," Associated Press (October 15, 2018), https://abcnews.go.com/Health/wireStory/arkansas-drops-4100-medicaid-work-rule-58509297.

This suggests we can anticipate even steeper declines in compliance for older enrollees in Alabama than the state acknowledges and a more devastating loss of health insurance coverage.

By increasing administrative hurdles and paperwork, Alabama will increase "churn," where people lose coverage, often briefly, then re-enroll in the program after resolving documentation or mailing address issues. Already, percentages of people churning on and off Medicaid at renewal generally range from 25% to as high as 50%, which results in coverage losses.

People with low incomes can face multiple challenges in completing burdensome paperwork, and these problems—such as difficulty receiving mail, lack of a fixed address, and chronic or intermittent homelessness—are emphasized when the incomes are extremely low. Adding the stress of a risk of loss of coverage to an already complex or harrowing situation is a mistake. For example, a beneficiary may be suffering from an acute illness and unable to fill out paperwork to maintain coverage precisely when coverage is the most important. The risk of losing coverage is especially troubling for people currently being treated for chronic illness, mental illness, or substance use disorder.

These paperwork proposals serve no other purpose than to cut people off Medicaid, making it even more difficult for them to get back on their feet. In the meantime, the lack of coverage would create disruptions in care, leading to poorer health outcomes and increased costs for Alabama residents. The vast majority of Medicaid enrollees locked out of coverage would likely become uninsured, because they do not have access to other affordable coverage, including the marketplace. Multiple studies have found that regular and ongoing access to health care reduces preventable hospitalizations for people with chronic diseases such as diabetes and heart disease. The direct, foreseeable consequence of this policy will be worse health for Alabama's lowest-income residents.

For these reasons, CMS should not approve a waiver to allow such administrative hurdles and drive thousands of Alabamans out of the Medicaid program.

Conclusion

Thank you again for this opportunity to comment on the proposed Alabama Medicaid waiver. This is an important moment to protect the Medicaid program's guarantee of coverage for the most vulnerable Alabama parents and caretaker relatives. This proposed waiver is an attack on the fundamental purposes of the Medicaid statute which is meant to provide medical assistance to low-income beneficiaries throughout the state.

If you have questions, please contact Lindsey Copeland, Federal Policy Director, at lcopeland@medicarerights.org or Julie Carter, Senior Federal Policy Associate, at jcarter@medicarerights.org. Thank you.

Sincerely,

Joe Baker
President
Medicare Rights Center