October 25, 2018

VIA ELECTRONIC SUBMISSION

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 "Healthy Michigan."

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 Kentuckians from ages 50 to 64 and Kentuckians with functional limitations and chronic conditions of all ages who are not administratively classified as "disabled."

Washington, DC Office:
1444 I Street NW, Suite 1105
Washington, DC 20006
202.637.0961

www.medicarerights.org www.medicareinteractive.org

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. The elimination of Medicaid mandated retroactive benefits and the imposition of harsh lock-out provisions would create particular risks for this population, especially for those with chronic conditions and/or functional limitations. Similarly, eliminating non-emergency transportation would have detrimental effects on persons aged 50–64 and on people of all ages who are living with a chronic condition or functional limitation.

This waiver would undermine access to health care coverage and services for low-income people who are not yet eligible for Medicare including older adults and people with functional limitations and/or chronic conditions. Accordingly, this waiver fails to "assist in promoting the objectives" of the Michigan Medicaid program. (*See* 42 U.S.C. § 1315(a).) To the contrary, the Michigan waiver would terminate or reduce Medicaid coverage for tens of thousands of low-income Michigan residents. The terms of the waiver are punitive, and they do nothing to improve health care coverage for Michigan's current and future Medicaid beneficiaries.

Work Requirements

Michigan proposes to institute a work requirement that would apply only to the adult group. 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 Michigan's non-elderly Medicaid population not receiving Supplemental Security Income due to disability, 39% cited being ill or disabled as the reason for not being

employed (Rachel Garfield *et al.*, Understanding the Intersection of Medicaid and Work 10 (Appendix Table 2), KAISER FAMILY FOUNDATION (Jan. 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 or early 60s 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. And if they successfully find employment, their struggles will continue because of administrative hurdles and lock outs that appear to be designed to be punitive.

We anticipate dramatic coverage losses for Medicaid beneficiaries, which could include coverage for working adults, people with medical conditions who cannot work but do not qualify for SSI disability, and family caregivers. For these reasons, CMS should not approve a waiver to institute a work requirement for the adult group.

Administrative Hurdles, Premiums, "Healthy Behaviors" requirements, and Lock Outs

Michigan requests permission to institute aggressive paperwork requirements, premiums, and punitive lock-outs for failure to comply. 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. Enrollees who are already working would need to document hours worked at regular intervals. Those exempt from the work requirement would need to prove that they are exempt. Those not currently working would need to document hours in community service, job training, or hours spent applying for jobs. All would stand to lose coverage if they don't keep up with the paperwork requirements.

Michigan requests to disenroll individuals for failure to pay premiums and lock them out of coverage. This will cause people to drop coverage, which will increase the number of uninsured in the state. Numerous studies have found that premium payments in Medicaid reduce enrollment, increase disenrollment, and increase the number of uninsured in a state. States' implementation of Medicaid premiums has been associated with an increased in uninsured patients, and increases in emergency department use by the uninsured. A program that will increase the uninsured in a state is inconsistent with Medicaid's objective of furnishing medical assistance.

In order to maintain eligibility, enrollees with incomes 100 to 138% of poverty with 48 months cumulative eligibility must complete or actively engage in specified health behaviors (not listed in the waiver, just noted that they will get "incrementally more challenging" over time) and pay a premium of 5% of their income. Individuals who do not comply with these requirements will be disenrolled until they come into compliance. Individuals who are medically frail are exempt and the state will consider hardship exemptions

for premiums. Applying unspecified and undefined "healthy behaviors" requirements to Medicaid beneficiaries is unacceptable. This appears to give Michigan a blank check to dub any behaviors "healthy" and penalize beneficiaries for not complying. Importantly, kicking people off Medicaid for not being healthy will not make them healthier. It will make it more difficult for them to keep or attain the best health possible.

When states make the Medicaid program more complicated, either through eligibility rules or paperwork, fewer people can gain or keep coverage, despite their eligibility. This would likely be true in Michigan, as the waiver would create significant burdens for people with Medicaid. The similar Kentucky program has similar pitfalls:

> The Kentucky program won't just create a work requirement for some beneficiaries; it will set up a broader obstacle course of administrative rules. Many beneficiaries will be asked to pay monthly premiums to the state to retain their coverage, as little as $1 a month for some very poor families, who are unlikely to have bank accounts.
>
> They will be asked to notify Medicaid officials any time their income changes. Their benefits could rise or fall depending on whether they get an annual checkup, or take a financial literacy course. Beneficiaries who fail to renew their coverage promptly at the end of a year will be locked out for as long as six months. Beneficiaries who are "medically frail" can get an exemption from the work requirement, but they will need to submit a doctor's note….
>
> Kentucky now will ask its beneficiaries to interact with the state monthly, both to pay premiums and to document the time they've worked or pursued work. A few missed premiums or work filings could cost them their coverage, even if they continue to work the required number of hours (Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning in It," NEW YORK TIMES (January 18, 2018), https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html).

Michigan estimates that the changes sought would affect 400,000 of the program's current 655,000 enrollees—over 60 percent of the program. This means thousands of people, at a minimum, are likely to lose coverage, and sadly, there is reason to believe these initial estimates are low. Arkansas, for example, has fewer people affected, but huge losses of coverage: "Of the 25,815 Medicaid adults who were required to meet (or be designated exempt from) Arkansas' 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 Michigan's experience to be better. Importantly, the Arkansas work requirement applies to a younger population than the Michigan waiver, topping out at age 49. Individuals between those ages are more likely to have internet access or to use the internet regularly—making compliance reporting more accessible—than are individuals between 50 and 62 (*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/).

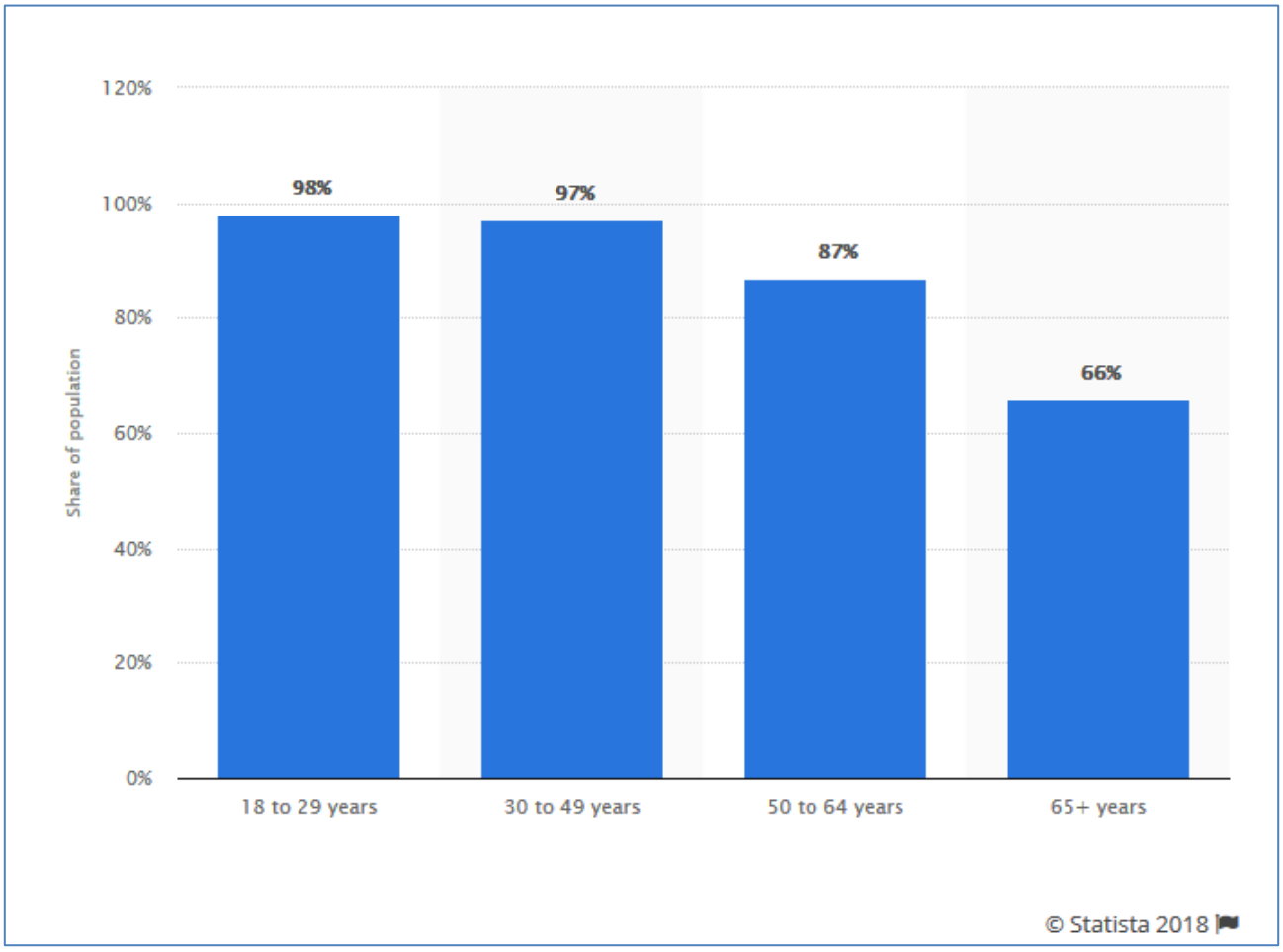

Figure 1: Share of adults in the United States who use the internet in 2018, by age group

This suggests we can anticipate even steeper declines in compliance in Michigan, and a more devastating loss of health insurance coverage.

By increasing administrative hurdles, including premiums, "Healthy Behaviors" requirements, and paperwork, Michigan will increase "churn," where people lose coverage, often briefly, then re-enroll in the

[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.

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%. Lock-outs tied to failure to renew eligibility will result in huge coverage losses which will dramatically increase the number of uninsured state residents—just as such a policy would if it were applied to Medicare coverage, which does not require renewal.

People with low incomes can face multiple challenges in completing the sometimes-lengthy redetermination processes, including difficulty receiving mail, lack of a fixed address, and chronic or intermittent homelessness. 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 a lock out is especially troubling for people currently being treated for chronic illness, mental illness, or substance use disorder.

Lock outs 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 Michigan residents. The vast majority of Medicaid enrollees locked out of coverage would likely become uninsured, with those below 100% of the poverty level particularly at risk, because they do not have access to marketplace coverage. 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 Michigan's lowest-income residents.

For these reasons, CMS should not approve a waiver to allow such administrative hurdles, premiums, "healthy behaviors" requirements, and lock-out periods.

Conclusion

Thank you again for this opportunity to comment on the proposed Michigan Medicaid waiver. This is an important moment to protect the coverage gains the Medicaid expansion has made possible in Michigan. 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