October 26, 2018

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

Re: Michigan's Extension Application Amendment for its Healthy Michigan Plan Section 1115 Demonstration (No. 11-W-00245/5)

Submitted electronically via Medicaid.gov

Dear Secretary Azar:

Families USA appreciates the opportunity to provide comments on Michigan's request to extend and amend its Healthy Michigan Plan 1115 Demonstration Waiver. We request that these comments and all supporting citations be incorporated into the administrative record.

Families USA is a national health care advocacy organization that supports policies and programs at the state and federal levels to expand access to quality, affordable health care, with a particular focus on policies that affect lower-income individuals.

Michigan is proposing to:

- Add a work requirement to its Healthy Michigan Plan that would take coverage away from non-exempt enrollees under age 62 who do not engage in work or specified work-related activities for at least 80 hours/month or who fail to document compliance with the program requirements for more than three months in a year;
- Disenroll individuals with incomes above poverty who have been enrolled in Healthy Michigan for 48 cumulative months if they do not meet healthy behavior requirements, with coverage reinstatement only upon coming into compliance with the requirement (with an effort given to making the requirements incrementally more challenging over time); and,
- Raise premiums to 5 percent of income for enrollees with incomes above the poverty level who have been enrolled in Healthy Michigan for more than 48 cumulative months, with disenrollment for nonpayment and coverage reinstatement only when the individual comes into compliance with premium requirements.

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Healthy Michigan has extended health coverage to over a million low-income Michigan residents, with over 650,000 currently enrolled in the program.[1] Program evaluations have found that the current waiver has been instrumental in cutting the state's uninsured rate in half, has improved the physical and financial health of enrollees, improved enrollees' access to health services, and helped enrollees look for and maintain employment.[2] These considerable gains have been accomplished without a work requirement or other punitive disenrollment penalties.

The requested changes would, without doubt, result in many individuals losing health insurance and becoming uninsured. That outcome, an increase in the uninsured, is inconsistent with the statutory requirements for approval of an 1115 waiver request, and therefore this request must be denied.

Framework for the Analysis

Statutory Requirements for 1115 Waivers

Section 1115 of the Social Security Act (the Act) gives the Secretary broad authority to approve state waiver requests. However, that authority is not unlimited. The Act places specific limits on what the Secretary can and cannot waive.

Section 1115 gives the Secretary the authority to "**waive** compliance with any of the requirements of section …..1902" of the Social Security Act for any experimental, pilot, or demonstration project which, in the judgment of the Secretary, "is likely to **assist in promoting the objectives of title….XIX** [Medicaid]."[3] [Emphasis added.]

The Secretary is bound by law to review waiver requests within the parameters of the Act.[4]

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[1] Michigan, Healthy Michigan Plan 1115 Waiver Extension Application Amendment.

[2] See: Jesse Cross-Call, "Michigan Medicaid Proposal Would Harm People in All Parts of the State," Center on Budget and Policy Priorities, May 21, 2018, https://www.cbpp.org/blog/michigan-medicaid-proposal-would-harm-people-in-all-parts-of-the-state; State of Michigan, "Section 1115 Demonstration Extension Application: Healthy Michigan Plan (Project No. 11-W-00245/5)," https://www.michigan.gov/documents/mdhhs/Amended_Section_1115_Demonstration_Extension_Application_-_Clean-Web_Posting_632189_7.pdf ; Renuka Tipirneni, Susan D. Goold, John Z. Ayanian, "Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan," *Journal of the American Medical Association,* April 2018, https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2664514?redirect=true; Institute for Healthcare Policy & Innovation, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan, June 27, 2017, http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches.

[3] Social Security Act, section 1115 [42 U.S.C. 1315].

[4] CMS has made changes to the Medicaid.gov website and issued guidance that includes language expanding the objectives of the Medicaid program. However, it is the statute, not website language or agency guidance that governs the limits on the Secretary's authority.

Medicaid's Objectives

The objectives of the Medicaid program are set forth in section 1901 of the Social Security Act, "Appropriations." That section states that federal Medicaid funds are for the purpose of enabling states "to furnish (1) medical assistance on behalf of [statutorily eligible individuals], and (2) rehabilitation and other services to help such [individuals] attain or retain capability for independence or self-care…."[5] In the context of the statute, it is absolutely clear that "independence or self-care" refers to federal funding enabling states to provide care that can help individuals attain or retain independence that has been compromised because of *health related* conditions.

The Secretary Must Consider the Waiver's Coverage Impact

In evaluating waivers affecting any population covered through the Medicaid program, the Secretary must analyze whether it promotes those objectives. In the recent *Stewart v. Azar* decision, which vacated HHS' approval of Kentucky's waiver proposal to take coverage away from adults who did not meet a work requirement, pay premiums, or renew their coverage or report changes on time, the court found that Medicaid's primary objective is to provide coverage to people who otherwise wouldn't have it. The court also stated that, at a minimum, the Secretary must adequately analyze the coverage impacts of waiver approvals: would the project cause recipients to lose coverage and would the project help promote coverage.[6]

The program proposed would reduce coverage.

There is no analysis under which Michigan's proposal would promote coverage of low-income individuals eligible for Healthy Michigan.

While Michigan's waiver application failed to include an adequate assessment of the coverage impact that this proposal would have on enrollment, a Michigan House Legislative Agency Fiscal Analysis estimated that coverage losses would range from 5 to 10 percent of non-exempt, able-bodied program recipients.[7] Actual coverage losses would almost certainly be much higher.

Paperwork/work documentation requirements will make it harder for all enrollees to keep Medicaid.

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[5] Social Security Act Sec. 1901. **[**42 U.S.C. 1396**].**

[6] Memorandum in Support of Federal Defendants' Motion to Dismiss or, in the Alternative, for Summary Judgment, *Stewart v. Azar,* Civil Action No. 1:18-cv-152 (JEB), District Court for the District of Columbia, filed April 25, 2018.

[7] House Fiscal Agency Legislative Analysis, Healthy Michigan Plan Work Requirements and Premium Payment Requirements, SB 897 (H-2), completed 6-6-18 online at http://www.legislature.mi.gov/documents/2017-2018/billanalysis/House/pdf/2017-HLA-0897-5CEEF80A.pdf. Based on enrollment at the time of the analysis, coverage losses reported ranged from 27,000 to 54,000.

Experience shows that when programs add reporting requirements, which Michigan's work requirement would, enrollment falls across the board, not just among the population subject to the requirement.[8] Coverage losses will not be confined to able-bodied adults who are not working the requisite 80 hours per month. It is inevitable that Michigan's program will result in disenrollment among individuals who meet the work requirement but fail to fulfill all the reporting requirements, and those who are unable to work but fail to report or adequately document their exemption.

The recent experience in Arkansas provides a vivid example of how work requirements effect Medicaid enrollment. In Arkansas, over 8,000 people have lost coverage in the first months of implementation of the state's work requirement, with most disenrollment being for failure to report rather than failure to meet the required work hours.[9]

When enrollment reporting requirements are added to a program, unintended coverage losses are unavoidable and Michigan will not be an exception.

***The program will affect a large percent of Healthy Michigan enrollees*.**

While Michigan did not adequately analyze the coverage impact of its proposed program in its request, it did note that 400,000 of Healthy Michigan enrollees would be "impacted" by the changes—roughly 60 percent of all enrollees. Not all of those enrollees would lose coverage, but since all of the program changes requested have disenrollment as the penalty for non-compliance, the request essentially places 60 percent of enrollees *at risk* of losing coverage.

As a program that will, by design, promote coverage losses (particularly when those coverage losses could be substantial) rather than increase coverage, Michigan's waiver request is inconsistent with Medicaid's objectives and therefore outside of the Secretary's authority to approve under 1115 authority.

Coverage losses and coverage lock-outs are inevitable and would undercut Healthy Michigan's success in covering low-income Michigan residents.

Michigan asserts that it will make all efforts to ensure that enrollment is not negatively affected by the proposed programs. However, a hallmark of the requested work, healthy behavior and premium requirements is disenrollment of individuals who do not meet those requirements, coupled with onerous enrollee reporting requirements. Given that, and the large number of enrollees the state says will be "impacted" by the proposal, it is likely the result will be

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[8] Margot Sanger Katz, "Hate Paperwork? Medicaid Recipients will be Drowning in it," New York Times, January 18, 2018 online at https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html

[9] Jennifer Wagner, "4,109 More Arkansans Lost Medicaid in October for Not Meeting Rigid Work Requirements," Center on Budget and Policy Priorities, October 16, 2018, https://www.cbpp.org/blog/4109-more-arkansans-lost-medicaid-in-october-for-not-meeting-rigid-work-requirements

substantial coverage losses.

Those predictable coverage losses will worsen health outcomes.

By cutting people off coverage and increasing the uninsured in the state, the proposed program is the opposite of "furnishing medical assistance." It will reduce access to care and worsen health outcomes.[10]

Requiring Work is Not among Medicaid's Objectives

We support programs that improve employment among low-income individuals. In fact, the experience in Michigan is that Healthy Michigan is one such program. Enrollees have reported that health coverage through the program has made it easier for them to look for and maintain employment.[11]

It is not unexpected that access to medical care, associated health improvements, and relief from the financial stress of being uninsured would make it easier for individuals to gain and keep employment. While a welcomed and logical benefit of Medicaid coverage, employment is not an objective of the Medicaid program: *Medicaid is a health insurance program and its objective is furnishing medical care.*

In its application, Michigan states that the program's workforce engagement requirement is:

> "designed to assist, encourage, and prepare an able-bodied adult for a life of self-sufficiency and independence from governmental interference. Studies provide evidence of the correlation between income and health; as income increases overall health status improves…… studies indicate that employment and community engagement are beneficial for health, particularly depression, general mental health, life satisfaction, and wellbeing."

While we do not dispute that increased income is associated with better health, there is no evidence that a program that takes health care away from individuals who do not meet a work requirement will promote health or increase income; quite the opposite is likely.

[10] Hannah Katch, et al., *Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families Access to Care and Worsen Health Outcomes* (Washington, DC: Center on Budget and Policy Priorities, August 2018) online at https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce; *Access to Health Care for Low-Income Adults in States with and without Expanded Eligibility,* (Washington, DC: Government Accountability Office, September 2018) GAO-18-607 online at https://www.gao.gov/products/GAO-18-607; and, Julia Paradise, *Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid* (Washington, DC: Kaiser Family Foundation, March 2017) online at https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/.

[11] Institute for Health Care Policy & Innovation, *op cit.*

Furthermore, the connection between health and employment is not firmly established, particularly for employees in low-wage jobs, which are by definition the jobs that Medicaid enrollees would have. And finally, and critical to the analysis of whether or not the Secretary has the legal authority to approve Michigan's request, a work requirement is not related to Medicaid's role as health insurance and its objective of furnishing medical care.

Taking Medicaid coverage away from enrollees will worsen, not improve their financial security.

Studies of the impact of Medicaid expansion on financial health have found that Medicaid expansion is associated with a significant reduction in unpaid medical bills, a decline in credit card debt, and a decline in debts sent to collections—in other words, improved financial health.[12] Health coverage through Medicaid is also associated with reduced medical debt and improved finances among enrollees.[13] Providers in the Health Michigan Plan report that the current program has improved enrollees' financial stability and sense of dignity.[14]

By cutting people off coverage and increasing the uninsured in the state, the work requirement is the opposite of "furnishing medical assistance" and will deepen individuals' poverty,[15] increase their financial strain,[16] worsen health outcomes[17] and ultimately make it harder for people to stay healthy so that they can work.

Social science data does not conclusively show a positive association between work and health.

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[12] Dee Mahan, "Medicaid Expansion Improves People's Financial Stability," Families USA, September 8, 2016 online at https://familiesusa.org/blog/2016/09/medicaid-expansion-improves-people%E2%80%99s-financial-stability.

[13] Karina Wagnerman, "Medicaid Expansion Reduced Unpaid Medical Debt, Improved Financial Well-Being for Families," Georgetown University Center for Children and Families, August 2, 2017 https://familiesusa.org/blog/2016/09/medicaid-expansion-improves-people%E2%80%99s-financial-stability.

[14] Michigan waiver application, Primary Care Practitioners' Views of the Impact of the Healthy Michigan Plan, in Section IV, Evaluation Report, in the application, online at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/mi-healthy-michigan-pa3.pdf.

[15] Karina Wagnerman, "Research Update: Medicaid Pulls Americans Out of Poverty, Updated Edition, *"Say Ahh!,* Georgetown Center for Children and Families, March 8, 2018 online at https://ccf.georgetown.edu/2018/03/08/research-update-medicaid-pulls-americans-out-of-poverty-updated-edition/

[16]National Health Care for the Homeless Council, "Oregon Study Shows Obtaining Medicaid Improves Financial Security," online at https://www.nhchc.org/2013/05/oregon-study-shows-obtaining-medicaid-improves-financial-security/

[17] Hannah Katch, et al., *Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families Access to Care and Worsen Health Outcomes* (Washington, DC: Center on Budget and Policy Priorities, August 2018) online at https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce

A survey of the literature finds that while some studies show a positive connection between work and health, others show no relationship.[18] Most studies note major limitations in drawing conclusions on the relationship between health and work.

Whether work has a positive impact on health is significantly affected by the quality and stability of that work.[19] Low-wage jobs, the type that Medicaid enrollees will by definition be engaged in, are less stable and therefore less likely to promote health.[20] Low-wage jobs often have associated and documented health risks, such as: erratic shift-work; exposure to toxic chemicals; non-standard or part-time working relationships (which are associated with higher job related stress); and, risks of physical injury associated with manual labor.[21] A significant body of research has found that when it comes to showing a positive relationship between employment and health, not all jobs are equal.

The Secretary does not have the authority to add eligibility requirements to Medicaid because an activity might be related to health.

Medicaid's purpose is to ***furnish medical assistance***; it is not to require enrollees to engage in any activity that might improve health. If that were the purpose of the program, there are numerous activities that are far more conclusively linked to improved health than work: diet[22]; exercise[23]; marital status[24]; social engagement and having friendships[25], to list only a few of the near endless activities that have been shown to have a more conclusive positive impact on health than work. *It is regulatory overreach for this or any other administration to start adding required activities to Medicaid eligibility because there is some data showing that the activity might improve health*.

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[18] Larisa Antonisse, et al., *The Relationship Between Work and Health: Findings form a Literature Review* (Washington, DC: Kaiser Family Foundation, August 2018) online at https://www.kff.org/medicaid/issue-brief/the-relationship-between-work-and-health-findings-from-a-literature-review/.

[19] Sarah Burgard, et al., "Perceived job insecurity and worker health in the United States,"Soc Sci Med. 2009 Sep; 69(5): 777–785, online at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2757283/ and JG Grzywacz, et al., "Good jobs to bad jobs:replicated evidence of an employment continuum from two large surveys," Soc Sci Med. 2003 Apr;56(8):1749-60. Online at https://www.ncbi.nlm.nih.gov/pubmed/12639591.

[20] Robert Roy Britt, "Job Insecurity Worse for Your Health than Unemployment," Live Science, August 2009, online at https://www.livescience.com/7856-job-insecurity-worse-health-unemployment.html.

[21]Jeanette Zeockler, *Mapping the Landscape of Low-Wage Work and Health in Syracuse*, (SUNY Upstate Medical University, The Low-Wage Workers' Health Project, Syracuse, NY, 2017) online at http://ohccupstate.org/pdfs/LWWHP%202017.pdf.

[22] For one of the myriad articles and studies on the connection between diet and health, see U.S. Department of Health and Human Services and U.S. Department of Agriculture, *2015–2020 Dietary Guidelines for Americans 8th Edition*. December 2015. Available at http://health.gov/dietaryguidelines/2015/guidelines/.

[23] US Office of Disease Prevention and Health Promotion, *Physical Activity Guidelines,* online at https://health.gov/paguidelines/.

[24] Office for the Assistance Secretary for Planning and Evaluation, *The Effects of Marriage on Health: A Synthesis of Recent Research Evidence. Research Brief* (Washington, DC: Department of Health and Human Services, 2007) online at https://aspe.hhs.gov/report/effects-marriage-health-synthesis-recent-research-evidence-research-brief.

[25] Jane Brody, "The Surprising Effects of Loneliness on Health," New York Times December 11, 2017 online at https://www.nytimes.com/2017/12/11/well/mind/how-loneliness-affects-our-health.html.

Section 1115 of the Social Security Act gives the Secretary the authority to waive Medicaid requirements, not to add new requirements unrelated to the program's objective of furnishing medical care.[26] Adding eligibility requirements, such as a work requirement, to Medicaid because of an arguable connection to health stretches Medicaid's objectives far beyond statutory limits, is outside the Secretary's approval authority, and sets the stage for using the program to orchestrate unending government interference in the lives of low-income people.

The community engagement program may violate other federal laws.

In addition to a work requirement, Michigan is proposing a community engagement, unpaid, work program could be used to satisfy the requirement. Programs that require individuals to work without pay for Medicaid coverage may violate the Fair Labor Standards Act in addition to the Medicaid statute. The community service provisions are essentially requiring individuals to work for health insurance, not wages.

Health insurance, which Medicaid is, is nothing like wages. It is a non-cash benefit. Whether and how much someone uses it (i.e., its monetary value) in any given time period is unpredictable. When it is used, payments are made to health providers, not the covered individual. In areas of high unemployment in the state, individuals may have no viable employment options and if they want to keep coverage, they may have no option other than to work for free in order keep health insurance.

Cutting Enrollees off of Coverage Because They Do Not Meet Healthy Behaviors is Inconsistent with Medicaid's Objectives

The existing Healthy Michigan Plan has been successful in helping enrollees to access care, reduce emergency room use for non-emergency care, and engage in healthy behaviors like smoking cessation.[27] The proposed change—disenrolling individuals with incomes above poverty who do not complete assigned health behaviors (which will be designed to become more challenging over time)—is inconsistent with the state's ostensible goal of improving enrollee health.

Cutting people off of health coverage because they do not meet "healthy behavior" requirements will not make them healthier—it will make it more difficult for them to access medical care and maintain their health. The objective of Medicaid is to furnish medical assistance, not take medical assistance away from enrollees who are not doing enough to improve their health.

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[26] Section 1115 of the Social Security Act gives the Secretary the authority to *waive* compliance with section 1902 of the Act. It does not give the Secretary authority to add new requirements to section 1902.
[27] Michigan waiver application, report on program evaluation, provider and enrollee survey results.

The program proposed is intrusive, and designed to be progressively so. It is government micro-management of the lives of Medicaid enrollees, masquerading as a health improvement program. That is not consistent with the objective of furnishing medical assistance.

Disenrolling Individuals Who Do Not Pay Premiums 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.[28] States' implementation of Medicaid premiums has been associated with an increase in uninsured patients.[29]

The Secretary must consider coverage impacts as part of any analysis of 1115 waiver approval.[30] While the state fails to include an analysis of the coverage impact of this proposal in its waiver application, as noted above, the negative impact of premiums on coverage is well documented. Coupling the hardship that premium payments place on low-income people with a disenrollment penalty and lock-out until premiums are paid will only compound that negative impact, is inconsistent with Medicaid's objectives, and must be denied.

Healthy Michigan is an extremely successful program that has given health care access to hundreds of thousands of Michigan residents. The proposed changes not only undercut that success, but, for the reasons outlined above, are inconsistent with the requirement of section 1115 of the Act and outside of the Secretary's authority to approve. Therefore, the request must be denied.

Thank you for the opportunity to submit these comments. If you have any questions, please contact Dee Mahan at Families USA, 202-628-3030 or at dmahan@familiesusa.org.

Respectfully submitted,

Dee Mahan
Director Medicaid Initiatives

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[28] David Machledt, et al., *Medicaid Premiums and Cost Sharing*,(Washington, D.C.: National Health Law Program, 2014) online at http://www.healthlaw.org/about/staff/david-machledt/all-publications/Medicaid-Premiums-Cost-Sharing#.W9N5JNVKgdU; Brendan Saloner, et al., "Medicaid and CHIP Premiums Increase Disenrollment," *Pediatrics,* March 2016, online at http://www.pnhp.org/news/2016/march/medicaid-and-chip-premiums-increase-disenrollment.

[29] Samatha Artiga, et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations* (Washington, D.C.: Kaiser Family Foundation, June 2017) online at https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/print/.

[30] Stewart –v- Azar*, op cit.*