Centers for Medicare and Medicaid Services

Re: Kentucky HEALTH – Application and CMS STCs; invitation to submit additional comments regarding KY HEALTH

August 14, 2018

Gentlepersons;

Forty-three public health and public policy deans, chairs, and scholars file these comments in response to CMS's invitation to present public views on KY HEALTH following the federal district court's decision in Stewart v Azar, No 18-152 (D.D.C. June 29, 2018). Specifically, and in accordance with CMS's request, we comment "on the issues raised in the litigation and in the court's decision."[1] The signatories present these comments on behalf of themselves, not their institutions. Among this group are many of the nation's leading authorities on health policy for the poor and underserved, including experts in public and private health insurance, population health, and health care for disadvantaged populations.

We welcome the opportunity to supplement the already-extensive administrative record before the Secretary and pertaining to KY HEALTH. Under the terms of § 1115, an experimental law, the Secretary's approval powers hinge on an evidentiary record sufficient to support his judgment that the proposed demonstration is "likely to assist in promoting the objectives of"[2] the Social Security Act program that is the focus of the demonstration. In this case, the question is whether the evidence reasonably shows that KY HEALTH is likely to assist in promoting Medicaid's objectives.

In its notice reopening the administrative record, CMS does not provide commenters with guidance regarding Medicaid's objectives. Nor does CMS indicate the type of evidence it seeks. But because the agency references the *Stewart* decision and the issues it raises, we begin by discussing *Stewart's* holding. We then present evidence relevant to the issues that lie at the heart of the court's decision.

The *Stewart* Decision

Stewart held that in approving KY HEALTH, the HHS Secretary violated the Administrative Procedure Act's prohibition against arbitrary and capricious agency action. The court based its conclusion on its central finding, namely, that the Secretary had "entirely" failed to consider the principal issue in § 1115 Medicaid demonstrations: whether and how a particular demonstration proposal is likely to assist in promoting Medicaid's objective. In describing this objective, and quoting directly from plaintiffs' briefs, Judge Boasberg framed Medicaid's essential purpose as "'to provide coverage and care to the most vulnerable' and, more precisely, 'to provide that care generally free of charge.'"[3]

To act lawfully, therefore, the HHS Secretary must squarely address Medicaid's coverage objective; furthermore, in accordance with the court's holding, he must do so for all Medicaid-eligible people,

[1] CMS Solicitation, available at https://public.medicaid.gov/connect.ti/public.comments/viewQuestionnaire?qid=1897699 (Accessed online August 9, 2018)

[2] 42 U.S.C. § 1315(a)

[3] *Stewart v Azar,* Slip op. p. 32

whether traditionally or newly eligible. The statute draws no distinctions in terms of the protections accorded Medicaid-eligible populations, and therefore neither can the Secretary.

As the court noted, in weighing the evidence relevant to Kentucky's proposal, basic principles of administrative law give the Secretary latitude. Nonetheless, the Secretary must demonstrate reasoned decision-making based on the fundamental requirement that the "agency adequately explain itself."[4]

Thus, the gravamen of KY HEALTH is whether it is likely to assist in promoting Medicaid's objective of covering the poor and vulnerable with coverage so comprehensive that, in keeping with the poverty level among the Medicaid-eligible population, coverage is essentially free in terms of both enrollment and cost-sharing at the point of care. The Secretary's review must lead to a reasonable conclusion that the people affected by the demonstration – both current beneficiaries and those who might qualify for medical assistance in the future, during the duration of the experiment, will realize sufficient gains in the form of equally comprehensive coverage – either through employer plans or through the individual insurance market – to offset the massive Medicaid coverage losses that – by the state's own admission – the demonstration appears to be designed to produce. (As we explained in our amicus brief in *Stewart,* the state's estimates likely severely understate the magnitude of KY HEALTH's impact, both immediately and over time).[5] In other words, the question is whether there are compensating effects – in the form of coverage of equal accessibility and value – that warrant pursuit of a demonstration that, by its very terms, has been designed to produce major Medicaid coverage losses.

In addition, by its very terms, the court's decisions compel the Secretary to weigh the risks and benefits of allowing a demonstration that is calculated to sever the relationship between Medicaid and the poor for a vast number of people for years to come – not only those who lose coverage in the near-term, but also those who will face barriers to regaining coverage or never will be able to gain initial coverage. By definition, § 1115 is an experimental statute; as a result, weighing benefits and risks is an inherent element of the Secretary's deliberation process. The need to carefully weigh the effects of withdrawing coverage from thousands of people is underscored by the Affordable Care Act amendments to § 1115,[6] which underscore the Secretary's obligation to create the meaningful administrative record on which his reasoned decision-making rests.

To this end, we believe that it is essential that the Secretary focus expressly on the health and health care risks posed by the experiment for hundreds of thousands of working-age adults and their children under an experiment that essentially lacks a factually credible hypothesis, a reasonable demonstration design, a carefully-designed evaluation plan, or safeguards commensurate with the dangers posed by this experiment that likely will create steep barriers to coverage, and as a result, to affordable care. Indeed, these barriers, by the state's own admission, have been built directly into its experimental design and the enrollment reductions it is intended to produce. For this reason, weighing the health risks posed by the demonstration becomes central to reasoned decision-making.[7]

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[4] *Stewart v Azar,* Slip op. p. 31

[5] *Stewart v Azar,* Brief for Deans, Chairs and Scholars as *Amici Curiae* in Support of Plaintiffs, available at https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Kentucky%20Medicaid%20Proposed%20Amici%20Curiae%20Brief.pdf

[6] 42 U.S.C. § 1315(d) as added by Pub. L. 111-148

[7] Unlike other federally-supported experiments involving human subjects, HHS has expressly declined to place 1115 demonstrations under the protective umbrella of the Common Rule, which exempts from its terms human subject research involving public benefit programs such as Medicaid. 45 C.F.R. §46.101(b)(5). But this does not excuse the Secretary from this fundamental responsibility to consider the effects of the demonstration on people.

The Secretary failed to consider the scope and magnitude of the individual and community-level health and health care risks posed by KY HEALTH's threat to Medicaid coverage

For working-age Americans and their children, health insurance coverage is not a static phenomenon; coverage status shifts as circumstances change over time.[8] Jobs are gained and lost; employers vary in the extent to which they provide health insurance, with smaller employers much less likely to do so. Marriage, divorce, death, and aging into adulthood all can affect insurance coverage.

In the case of Medicaid, all of these factors are magnified by the fact that Medicaid is an income-sensitive program, where even a few dollars can affect financial eligibility. In addition, administrative requirements applicable to enrolling and renewing Medicaid can affect eligibility; although the Affordable Care Act made great strides in expanding financial eligibility standards and in simplifying the enrollment and renewal process, barriers remain. According to federal statistics, among children, the average length of Medicaid enrollment is slightly longer than two years.[9] Research suggests that enrollment periods may be shorter for adults, lasting among the expansion population about 18 months on average.[10] In other words, Medicaid is characterized by churning eligibility, meaning continuous enrollment, loss of coverage, and re-enrollment.[11]

Medicaid's basic character is as a dynamic program that enrolls people as health needs and family, social, and economic circumstances change. This means that in assessing the impact of KY HEALTH – that by the state's own admission has been designed to reduce eligibility through work requirements, premiums of unprecedented size, and additional reporting requirements – the HHS Secretary must weigh evidence not only regarding the size of the population that initially risk loss of coverage because they are unable to meet new requirements, but also the demonstration's likely effects on populations that will initially gain coverage in the future or that will seek to re-enroll in coverage at some future point because they need care. In other words, in considering demonstration impact, examining entry and exit over time represents a vital dimension of the Secretary's obligation to weigh evidence of harm. Furthermore, because

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Indeed, as a basic matter of administrative law, were the HHS Secretary to ignore the health and health care impact of the demonstration, his conduct would be arbitrary and capricious regardless of whether the specific provisions of the Common Rule apply. Indeed, weighing risks and benefits in any experiment and reducing exposure to unnecessary risks is the essence of reasoned decision-making

[8] Institute of Medicine, Coverage Matters: Insurance and Health Care (National Academy Press, 2001)

[9] United States Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, CHIPRA MANDATED EVALUATION OF THE CHILDREN'S HEALTH INSURANCE PROGRAM: FINAL FINDINGS. VI. LENGTH OF MEDICAID AND CHIP ENROLLMENT SPELLS AND COVERAGE EXPERIENCES AFTER DISENROLLMENT (2014), available at https://aspe.hhs.gov/report/chipra-mandated-evaluation-childrens-health-insurance-program-final-findings/vi-length-medicaid-and-chip-enrollment-spells-and-coverage-experiences-after-disenrollment

[10] Avalere Health, Profile of the Medicaid Expansion Population: Demographics, Enrollment, and Utilization (2018), available at https://www.antheminc.com/cs/groups/wellpoint/documents/wlp_assets/d19n/mzmw/~edisp/pw_g330411.pdf

[11] Leighton Ku and Erica Steinmetz, *Bridging the Gap: Continuity and Quality of Coverage in Medicaid*, Association for Community Affiliated Plans, Sept. 10, 2013, http://ccf.georgetown.edu/wp-content/uploads/2013/09/GW-Continuity-Report-9-10-13.pdf

children's Medicaid enrollment is sensitive to the coverage status of their parents,[12] weighing the potential pediatric spillover effects of tighter adult eligibility standards assumes major importance as well.

Extensive research has consistently drawn a strong association between Medicaid and access to care among the poor. This is true for the adult expansion population.[13] From Medicaid's original enactment, this association has been documented among traditional low income working-age adults as well, such as exceptionally poor parents.[14] Therefore, the Secretary must weigh the effects of KY HEALTH not only on people's ability to keep coverage but also on their access to coverage during the period of the demonstration and on their resulting access to health care.

In *Stewart,* the court pointed to the fatal flaw in CMS's approval of KY HEALTH – the absence of any evaluation of the demonstration's effect on Medicaid beneficiaries who likely would lose coverage under its terms. Kentucky itself projected that almost 15% of Medicaid beneficiaries (approximately 95,000 individuals) would lose coverage.[15] As amici noted in their brief, however, recent evidence from evaluations of the impact of work requirements under SNAP suggests that the actual number of coverage losses may be much higher and far more rapid; indeed, analysis suggests that reductions could range between 50 percent and 85 percent of the target population in the first year alone. Using those percentages, the actual coverage losses could fall between 175,000 and 297,500 people.[16] The likely loss of access to care flowing from coverage losses of this magnitude are profound, given the inability of the poor to afford care. Extensive literature examining the link between Medicaid and access to care has documented that reduced access to care will span all forms of health care, ranging from preventive care to care for conditions that affect life and health. [17] Furthermore, the relationship between access to health care through Medicaid and declining mortality rates has been documented, meaning that as Medicaid coverage is withdrawn or prevented, measurable mortality consequences can be expected.[18]

In sum, in light of the court's holding in *Stewart,* the Secretary is obligated to consider both the current and future effects of KY HEALTH on Medicaid enrollment and retention. Losses among currently eligible beneficiaries are simply the starting point for this determination. Also essential is consideration of the effects of the demonstration, as it continues, on future eligibility among working age adults who either

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[12] Lara Antonisse et al., The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review (Kaiser Family Foundation, 2018), available at https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-march-2018/

[13] Olena Mazurenko et al., The Effects of Medicaid Expansion Under the ACA: A Systematic Review," 37 *Health Affairs* 944 (March 2018);

[14] Karen Davis and Cathy Schoen, Health and the War on Poverty: A Ten Year Appraisal (Brookings Press, 1977)

[15] KY HEALTH disenrollment figures are based on the Commonwealth's projections in its July 2017 request to amend the August 24, 2016 demonstration application. *See* Table in Letter from Adam Meier, Deputy Chief of Staff for Policy, Kentucky Governor's Office, to Brian Neale, Director, Center for Medicaid & CHIP Services (Jul. 3, 2017) at 17.

[16] Erin Brantley and Leighton Ku, *Work Requirements: SNAP DATA Show Medicaid Losses Could be Much Faster and Deeper Than Projected*, Health Affairs Blog, April 12, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180412.310199/full/.

[17] Julia Paradise and Rachel Garfield, What is Medicaid's Impact on Access to Care, Health Outcomes, and Quality of Care? Setting the Record Straight on the Evidence (Kaiser Family Foundation, 2013) (reviewing nearly 5 dozen studies), available at https://kaiserfamilyfoundation.files.wordpress.com/2013/08/8467-what-is-medicaids-impact-on-access-to-care1.pdf

[18] Benjamin D. Sommers, State Medicaid Expansions and Mortality, Revisited: A Cost-Benefit Analysis, 3 American Journal of Health Economics 392 (2017)

fail to qualify for an exemption or else lose their exemption over time (e.g., pregnant women who give birth, young adults no longer in school or in a transitional status, working adults who lose hours of employment and cannot find alternative sources of work sufficient to meet minimum work expectations, people who cannot pay premiums, people who cannot navigate new reporting requirements, and people who, being unable to pay premiums or report in a timely fashion, experience periods of being completely locked out of coverage, even though they regain eligibility). Under the decision, the Secretary's review will necessarily need to consider all aspects of the demonstration as they interact with one another. Additionally, evidence from the Medicaid coverage literature means that the Secretary will need to consider the spillover effects of the requirements on children living in households with affected parents or caregivers.

In addition, in order to satisfy the court's expectation of reasoned decision-making, the Secretary's review will need to take into account the demonstration's broader, community-wide effects. Poor people tend to live in communities that experience concentrated poverty. This fact therefore magnifies the effects of individual poverty and elevates the potential for system-wide impact on the stability of health care institutions serving entire communities.[19] Therefore, as part of a reasoned review, the Secretary must weigh the spillover effects of widespread Medicaid losses on community health systems, in particular, the hospitals and clinics that treat disproportionate numbers of low income patients. These effects, as we pointed out in our brief, are likely to include significant revenue reductions, increased levels of uncompensated care, reduced services and staffing and a reduction in the number of patients served. [20] For example, sharply decreasing the Medicaid rolls would have particularly egregious effects on community health centers. In 2016, 23 health centers furnished primary and preventive care to more than 423,000 Kentucky residents – 10% of state residents – in 232 sites.[21] Medicaid is the single largest source of health insurance coverage for health center patients. Federal data show that in 2016, 48.5% of Kentucky health center patients were insured through Medicaid, up from 32% in 2013. Because health centers serve poor patients, the Medicaid expansion had an enormous impact. Between 2013 (one year prior to implementation of the ACA in Kentucky) and 2016 (two years after expansion went into effect), health centers experienced a 46% decline in the number of uninsured patients. Applying the data on enrollment loss cited previously, researchers project that 14% to 24% of health center Medicaid patients – between 28,900 and 49,200 beneficiaries – will lose coverage in the first year alone. This decline translates into approximately $22 million to $37 million in lost revenue, leading to an estimated decline of between 400 and 700 lost staff. This loss results in a reduction in capacity of 60,000 to 102,000 patients served, nearly 25% of current capacity. [22]

In sum, in reasoned decision-making the Secretary would consider the effects of widespread dis-insurance on the health and well-being of communities experiencing concentrated poverty, including population health measures sensitive to loss of access on a community-wide basis. In addition, the Secretary would consider the effects of widespread coverage loss on health care institutions serving communities as a whole.

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[19] Institute of Medicine, *A Shared Destiny* (National Academy Press, 2003)

[20] Peter Shin, Jessica Sharac and Sara Rosenbaum, *Kentucky's Medicaid Work Requirements: The Potential Effects on Community Health Centers*, Health Affairs Blog, April 12, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180412.955253/full/

[21] U.S. DEPT. OF H.H.S., Health Resources and Services Administration, Bureau of Primary Health Care, 2016 Health Center Data: Kentucky Data (2017).

[22] Peter Shin, Jessica Sharac and Sara Rosenbaum, *Kentucky's Medicaid Work Requirements: The Potential Effects on Community Health Centers, Health Affairs Blog, April 12, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180412.955253/full/*

The evidence shows that, at best, only a modest fraction of the people who lose, or who are unable to qualify for, Medicaid coverage, likely will gain access to other sources of insurance, much less equally comprehensive coverage

The association between insurance coverage and access to and use of health care is one of the most well-established facts in the health services research literature. Countless studies have documented the relationship between the ability to pay for care and access to services. Because Medicaid's impact on health care access and utilization also is well established, as we already have noted, the second central issue the HHS Secretary must weigh is the likelihood that people losing Medicaid or being barred from the program under KY HEALTH will gain alternative, and equally effective, forms of coverage.

In fact the evidence points in the opposite direction. Poor Kentucky Medicaid beneficiaries who lose coverage, as well as those prevented from qualifying for it, are unlikely to move to employment carrying affordable workplace health insurance coverage. Furthermore, as the *Stewart* court pointed out, school or job training participation or community volunteer work sanctioned as a form of allowable "community engagement" are unlikely to create pathways to other forms of health insurance coverage. Moreover, as people transition into low-wage employment owing to lack of jobs and a lack of the type of education and training that leads to higher paying positions, wages remain low. This means that they will not attain the level of income necessary to cross the health insurance Marketplace threshold and thereby qualify for premium tax subsidies and cost sharing reduction assistance that becomes available under the ACA once household income surpasses 138 percent of the federal poverty level.

Extensive evidence belies the notion that other forms of coverage could mitigate the loss of Medicaid. A review by the Medicaid and CHIP Payment and Access Commission ("MACPAC"), a special Congressionally appointed committee that advises lawmakers on national Medicaid policy, examined work patterns under the Temporary Assistance for Needy Families ("TANF") program. The Committee found that: (1) only one third of people losing TANF benefits found jobs that included employer-sponsored coverage; (2) almost half of the jobs held by Medicaid beneficiaries were at small firms not required under the ACA to provide health insurance; and (3) 40% worked in the agriculture and service industries, known for their low employer-sponsored insurance offer rates."[23]

Thus, the assertion that a work requirement will lead to a significant increase in employer-sponsored insurance for current Medicaid recipients is not supported by the evidence. It overlooks the fact that most working Medicaid beneficiaries are employed by small firms and in industries with historically low rates of employer-based coverage, with offer rates as low as 30 percent for workers with family incomes below

[23] *Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF*, MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, October 2017, https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf; *see also* MaryBeth Musumeci and Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons from the TANF Experience*, Kaiser Family Foundation, August 2017, https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/.

the federal poverty level.[24] Similarly, among employed Medicaid beneficiaries, only one-third work for an employer who offers coverage (which may not meet affordability requirements under the ACA).[25]

The situation in Kentucky is even more glaring, with employer-sponsored health insurance declining and generally unavailable to low-income workers. Prior to implementation of the Medicaid expansion, only 16% of poor Kentucky adults were covered by employer insurance; this figure briefly rose to 18% in the year following full Medicaid expansion implementation, but fell back to 12% in 2016.[26]

A more recent study of employer-sponsored insurance patterns prepared by the Urban Institute examined employer insurance patterns among low wage workers generally and Kentucky workers in particular. Among part-time private sector workers (the level of work required under KY HEALTH), only 13.3 percent had employer coverage.[27] This figure does not take into account the proportion of insured workers who may have been enrolled in high-deductible plans with higher premiums, more limited benefits and far higher cost-sharing than that found in Medicaid. Indeed, in Kentucky, according to the researchers, the average annual premium for employer coverage for a single individual would surpass 20 percent of family income among part-time workers. Nor does this figure take into account possible health care access differentials across measures of utilization for preventive care, acute care, and treatment of serious and chronic health conditions such as hypertension, depression, or diabetes.

The reality of course is that most poor adults, including Kentucky's poor, already work at jobs offering no employer coverage, and their incomes fall below the Marketplace threshold. As a result, the absence of a pathway to coverage among the working poor already is an established fact in the state. The Secretary therefore, under *Stewart's* "reasoned decision-making" test, will need to explain how, in the face of this evidence, Medicaid's objectives are likely to be promoted by further jeopardizing coverage through premiums, reporting requirements, and lock-out periods. Also well-established is the fact that among low-wage workers, income fluctuates frequently, catching people in an endless cycle of wage fluctuation.[28] Given the premium and reporting requirements, as well as the lock-out periods for non-compliance, the Secretary will need to present a reasoned decision as to why, given these facts, imposing what amount to penalties for unstable incomes that preclude constant premium payments and that demand relentless reporting of changes will promote Medicaid's objectives.

Although the state may argue that most non-exempt poor adults already work and therefore are protected, this overlooks both the nature of employment for low-income Americans and the impact of the demonstration's administrative requirements, which also must be factored in. As noted, many

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[24] Michelle Long et al., *Trends in Employer-sponsored Insurance Offer and Coverage Rates, 1999-2014 (* Kaiser Family Foundation, 2014), available at https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/

[25] Rachel Garfield, Robin Rudowitz, MaryBeth Musumeci and Anthony Damico, *Implications of Work Requirements in Medicaid: What Does the Data Say?*, Kaiser Family Foundation, June 12, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/view/footnotes/#footnote-258830-10.

[26] *Health Insurance Coverage of the Total Population*, Kaiser Family Foundation (2016).

[27] Anuj Gangopadhyaya et al., *Kentucky Medicaid Work Requirements: What Are the Coverage Risks for Enrollees Who Are Working?* (Urban Institute, 2018), available at https://www.urban.org/research/publication/kentucky-medicaid-work-requirements-what-are-coverage-risks-working-enrollees

[28] See, e.g., Brynne Keith-Jennigs and Raheem Chaudhry, Most Working-Age SNAP Participants Work, but Often in Unstable Jobs. (Center on Budget and Policy Priorities, 2018) available at https://www.cbpp.org/research/food-assistance/most-working-age-snap-participants-work-but-often-in-unstable-jobs

Medicaid recipients work in low-wage service jobs with unpredictable hours. One study found that among Medicaid beneficiaries who worked at least 1,000 hours a year – which averages out to over 80 hours per month – one in four was at risk of failing to meet the work requirement, and thus lose Medicaid coverage, because they did not meet 80 hours every month.[29] Another study focused on 165,000 Kentucky Medicaid recipients (25 percent of working-age adult beneficiaries) who were likely to meet the work requirement, but only sporadically.[30] These individuals worked 36 hours per week on average, but 36 percent would not meet the minimum threshold of year-round work required by Kentucky HEALTH (defined as at least 80 hours a month for each month of coverage). Because of heavy work fluctuation and periodic layoffs, a reality of the job market for low-income Americans, this group of recipients would be at risk of experiencing gaps in their Medicaid coverage.

The Secretary must show why *this* demonstration will promote Medicaid's objectives given the early troubling results from a similar, less onerous, Medicaid work demonstration now in an initial implementation phase

Finally, the Secretary needs to show that he has weighed the fact that at least one other Medicaid demonstration, now in its initial implementation phase, already is showing evidence of substantial potential coverage losses. Early implementation of Arkansas Medicaid work demonstration (whose demonstration elements exempt people ages 50 and older and thus are less onerous than those proposed by Kentucky) suggests that some 7,464 Medicaid beneficiaries – more than one-quarter of the target population – already have been initially determined not to satisfy experimental requirements.[31] Although it is not yet possible to know whether this group ultimately will lose their coverage, this figure portends the possible dimensions of the impact of work requirements on access to Medicaid. Early research suggests that ultimately, losses in Arkansas could climb as high in the end as one-sixth of that state's expansion population.

In light of the fact that early stages of a highly similar, but not as severe, demonstration appear to be producing heavy potential losses, it is essential that the Secretary weigh the reasonableness of launching yet another demonstration whose terms are even more far-reaching and whose impact magnitude therefore is potentially greater. The Secretary must explain how it would be reasonable to proceed in a second state even as coverage losses mount in the first demonstration state, the underlying causes of these losses remain unclear, and the impact of coverage loss on access, utilization, health, and communities is not yet known. The Secretary must explain the basis for his conclusion that, in the midst of these results from Arkansas, which carry such far-reaching health implications, a second, even harsher experiment is warranted at this time.

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[29] Aviva Aron-Dine, Raheem Chaudhry, and Matt Broaddus, *Many Working People Could Lose Health Coverage Due to Medicaid Work Requirements*, Center on Budget and Policy Priorities, April 11, 2018, https://www.cbpp.org/research/health/many-working-people-could-lose-health-coverage-due-to-medicaid-work-requirements.

[30] Anuj Gangopadhyaya and Genevieve M. Kenney, *Updated: Who Could be Affected by Kentucky's Medicaid Work requirements, and What Do We Know About Them?*, URBAN INSTITUTE, Feb. 2018, updated Mar. 2018, https://www.urban.org/sites/default/files/publication/96576/3.26-ky-updates_finalized_1.pdf.

[31] Erin Brantley and Leighton Ku, A First Glance At Medicaid Work Requirements In Arkansas: More Than One-Quarter Did Not Meet Requirement, Health Affairs Blog, August 13, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180812.221535/full/

Other demonstrations, already well underway, also provide ample evidence of the effects of other aspects of KY HEALTH, such as premiums. The HHS Secretary will need to provide a reasoned decision as to why, given these other demonstrations, KY HEALTH meets the standard required under law – that is, that the experiment is "likely yield useful information or demonstrate a novel approach to program administration."[32] Here, the program sought to be enacted by Kentucky serves no demonstration value and does not seek to experiment a "novel approach" to program administration. Many of the components of Kentucky HEALTH either have already been tested or are currently being tested in other states, and their impact has been documented. For example, premiums have been tested widely and their negative impact has been documented. Specifically, Indiana's HIP 2.0, that required low-income Medicaid beneficiaries to pay monthly premiums and copays at the risk of disqualification of the program, led to coverage losses.[33] Similarly, Indiana beneficiaries subjected to heightened cost-sharing (an added feature of KY HEALTH) were more likely to use the emergency room, both in general and for non-emergency reasons.[34] Research into other state's efforts to implement premiums show that such efforts significantly reduced low-income people's participation in health coverage programs.[35] How this furthers the purpose providing medical assistance to low-income individuals is beyond comprehension.

a. Work Requirements

Kentucky is not the only state seeking to incorporate work requirements into the Medicaid program. CMS also approved Arkansas' 1115 waiver, which contains a work requirement similar to Kentucky, and the results from the Arkansas program's first month are indicative of the practical shortcomings of this type of endeavor. In June, the target population for the work requirements consisted of 25,815 adults aged 30-49 who either met, received an exemption from, or did not meet the requirement. Of these 25,815 Medicaid adults, the state reported that 7,464 people – *more than one-quarter* (29%) of the targeted population – did not meet the requirements. [36] Only 445 (1.7%) reported they met the work requirement through qualifying hours. If this trend continues, of the 125,000 adults who will be in the work requirement target population by this September, up to 36,000 may not meet the requirement.[37]

Furthermore, of the 171,000 who will be in the work requirement target population once the requirements are fully phased in, up to 50,000 are at risk of not meeting the requirement, and losing their Medicaid coverage.[38] And to reinforce the point, these individuals are not unemployed. In fact, according

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[32] Beno v. Shalala, 30 F.3d, 1057, 1069 (9th Cir. 1994).
[33] Robin Rudowitz, MaryBeth Musumeci and Elizabeth Hinton, *Digging Into the Data: What Can We Learn from the State Evaluation of Health Indiana (HIP 2.0) Premiums*, Kaiser Family Foundation, http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums
[34] Judith Solomon, *Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved*, Center on Budget and Policy Priorities, *Aug. 1, 2016,* https://www.cbpp.org/research/health/indiana-medicaid-waiver-evaluation-shows-why-kentuckys-medicaid-proposal-shouldnt-be
[35] Laura Snyder and Robin Rudowitz, *Premiums and Cost-Sharing in Medicaid*, Kaiser Commission on Medicaid and the Uninsured, February 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8416.pdf.
[36] Arkansas Department of Human Services. *Arkansas Works Program*. June 2018 Report.
[37] Erin Brantley and Leighton Ku, A First Glance At Medicaid Work Requirements In Arkansas: More Than One-Quarter Did Not Meet Requirement, Health Affairs Blog, August 13, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180812.221535/full/
[38] Erin Brantley and Leighton Ku, A First Glance At Medicaid Work Requirements In Arkansas: More Than One-Quarter Did Not Meet Requirement, Health Affairs Blog, August 13, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180812.221535/full/

to the Urban Institute, 32% of Arkansans who are already working and may be subject to the work requirement potentially are at risk of losing coverage because of the nature of their employment.[39] Moreover, many Medicaid recipients will not meet the requirement, not because they are unemployed, but because of the administrative hurdles associated with reporting their employment.[40] And as mentioned above, because these policies may also deter other eligible individuals from applying in the first place, the potential future effect could be must larger.

The above estimates appear problematic for Arkansas, but given the structure of KY HEALTH, they can spell disaster for Medicaid recipients in Kentucky. Arkansas' work requirement is less onerous than that of other states seeking to implement this type of program. In order to have one's Medicaid benefits suspended in Arkansas, a Medicaid recipient must fail to comply with the work requirement for three months. Under Kentucky's program, however, a Medicaid recipient can have their benefits suspended after only one month of noncompliance. As such, because there is practically no opportunity to correct or learn the system without losing benefits, the risk of losing coverage in Kentucky is much more likely.

This risk of substantial coverage losses stemming from work requirements has been further documented in evaluations of past attempts at incorporating work requirements into social programs, such as the Supplemental Nutrition Assistance Program ("SNAP") and TANF. Work requirements in SNAP caused 50% to 85% of the recipients not exempt from the work requirements to lose benefits.[41] Furthermore, declines in enrollment also occurred after work requirements were added to the TANF program as part of welfare reform in the 1990s.[42] What is more egregious is studies have also shown that TANF recipients who were cut from the rolls for not meeting the work requirement actually had significantly higher rates of disability than those who were not.[43]

Taking into account the above information, it is clear that there is hardly anything "novel" to be learned from KY HEALTH. Indeed, the "experiment" becomes little more than an exercise in repetition. As part of reasoned decision making, the Secretary will need to explain why launching another program of eligibility restrictions furthers Medicaid objectives.

The Secretary must provide updated, clearly explained estimates regarding the impact of the Kentucky demonstration on the state's existing and future Medicaid caseload, including detailed information on

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[39] Anuj Gangopadhyaya, Genevieve M. Kenney, Rachel A. Burton and Jeremy Marks, *Medicaid Work Requirements in Arkansas, Who Could Be Affected, and What Do We Know about Them?*, URBAN INSTITUTE, May 2018, https://www.urban.org/research/publication/medicaid-work-requirements-arkansas

[40] Margot Sanger-Katz, *Hate Paperwork? Medicaid Recipients Will Be Drowning in It*, The New York Times, Jan 18, 2018, https://www.nytimes.com/2018/01/18/upshot/medicaid-enrollment-obstacles-kentucky-work-requirement.html

[41] Erin Brantley and Leighton Ku, *Work Requirements: SNAP DATA Show Medicaid Losses Could be Much Faster and Deeper Than Projected*, Health Affairs Blog, April 12, 2018, https://www.healthaffairs.org/do/10.1377/hblog20180412.310199/full/.

[42] Jeffrey Grogger, Steven J. Haider and Jacob Klerman, *Why Did the Welfare Rolls Fall During the 1990's? The Importance of Entry*, American Economic Review, https://pubs.aeaweb.org/doi/pdfplus/10.1257/000282803321947218

[43] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, *Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments*, Mathematica Policy Research, Inc., February 2008, https://www.acf.hhs.gov/opre/resource/assisting-tanf-recipients-living-with-disabilities-to-obtain-and-maintain

who will lose or be denied coverage, as well as detailed cost impact estimates that include both medical assistance and related administrative costs.

Critical to lawful reviews under § 1115 is the quality and completeness of the administrative record. This is the essence of the post –ACA requirements. There can be no complete administrative record on which to base the decision if clear impact estimates – both coverage and costs – are absent. Yet this is the situation in which those directly affected by the demonstration find themselves, not to mention the concerned public that seeks to provide meaningful comments.

Central to Judge Boasberg's decision was CMS' failure to consider the potential magnitude or effects of lost Medicaid coverage under the proposed demonstration project. Kentucky's application indicated that it expected relatively small losses in the first year, gradually increasing over time. Arkansas' application did not provide any estimates of caseload reductions, nor did the application from New Hampshire. Indiana's application also projected relatively low caseload reductions. The data from experiences with SNAP and from the first month of data from Arkansas indicate that Medicaid losses are likely to be much larger and to occur much more rapidly than indicated from the applications.

The administrative record simply is not complete in any demonstration proposal without these estimates, which must be made public – both their bottom line and their underlying assumptions, which must be clearly explained as part of the creation of the record. Information is available to permit more realistic estimates of the effects, which would offer the Secretary better information on which to make decisions, as well as providing greater transparency regarding the potential effects of these programs. Furthermore, any decision by the Secretary to proceed with Kentucky or any other demonstration must independently estimate coverage, cost, and care estimates, as well as estimates of health impact, along with the assumptions that underlie the estimates and the Secretary's reasoning as to how, exactly, major Medicaid coverage losses nonetheless will be offset by gains and the nature of those gains.

The Secretary must provide evidence that there is no other, less harmful approach to helping low income people find employment and realize gains from work

The Secretary has predicated his approval on the notion that work improves health. Putting aside the lack of evidence showing that such a causal relationship exists,[44] it is also clear that Medicaid has been shown to be positively associated with work and greater employment gains. Indeed, Medicaid eases work entry for people in poor health, who need stable insurance in order to work. One study found that states that expanded Medicaid eligibility experienced more workers who were sufficiently mobile to leave lower-paying jobs in favor of higher-paying work. [45] Furthermore, studies of expansion populations in Ohio[46] and Michigan[47] found that a majority of respondents reported that having Medicaid actually made it easier to look for a job.

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[44] Larisa Antonisse and Rachel Garfied, *The Relationship Between Work and Health: Findings from a Literature Review*, Kaiser Family Foundation, Aug 2018, http://files.kff.org/attachment/Issue-Brief-The-Relationship-Between-Work-and-Health-Findings-from-a-Literature%20Review

[45] Ammar Farooq and Adriana Kugler, *Beyond Job Lock: Impacts of Public Health Insurance on Occupational and Industrial Mobility*, IZA: Discussion Paper Series, March 2016, http://ftp.iza.org/dp9832.pdf

[46] Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly, The Ohio Department of Medicaid, http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[47] *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, University of Michigan Institute For Healthcare Policy & Innovation, June 27, 2017, http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches

In the wake of the court's decision, it is clear that the Secretary must engage in reasoned decision-making showing why this nexus between safeguarding Medicaid coverage and work opportunities does not apply in Kentucky.

There is also evidence that voluntary work programs that do not threaten coverage can accomplish the goal of encouraging work. For example, Montana's Health and Economic Livelihood Partnership Link (HELP-Link) program targets Medicaid enrollees who do not have disabilities but are not working due to common challenges such as limited skills, lack of transportation, childcare and other work supports.[48] Montana's program is voluntary and does not condition receipt of Medicaid benefits on participation in the program. It instead targets Medicaid enrollees looking for work or a better job, and provides assistance in the form of career counseling, on-the-job-training programs and subsidized employment.

Three years after the program's implementation, a total of 22,000 Montanans have enrolled and received employment services through the program. Furthermore, a report by the University of Montana's Bureau of Business and Economic Research, Montana Healthcare Foundation and Headwaters Foundation titled "The Economic Impact of Medicaid Expansion in Montana" found that HELP-Link helped increase labor force participation among low-income Montanans by 6%-9%. The report also found that "similar gains in labor force participation did not occur among low-income populations in other states."[49]

The Secretary must provide a reasoned decision to support the notion that encouraging the growth of voluntary work programs that offer employment supports cannot accomplish the same goal as a demonstration that visits harmful punishment on the poor.

Signed by,

Ayman El-Mohandes, MBBCh, MD, MPH, Dean of the Graduate School of Public Health & Health Policy, the City University of New York (CUNY)

Linda P. Fried, MD, MPH, Dean and DeLamar Professor of Public Health Practice at the Mailman School of Public Health, Columbia University

Sandro Galea, MD, MPH, DrPH, Dean and Robert A. Knox Professor at the School of Public Health at Boston University

Sherry Glied, PhD, Dean and Professor of Public Service at the Robert F. Wagner Graduate School of Public Service, New York University

Lynn R. Goldman, MD, MS, MPH, Michael and Lori Milken Dean of the Milken Institute School of Public Health, George Washington University

Jody Heymann, MD, PhD, Dean of the Fielding School of Public Health, University of California, Los Angeles

[48] Hannah Katch, *Promising Montana Program Offers Services to Help Medicaid Enrollees Succeed in the Workforce*, April 25, 2018, https://www.cbpp.org/sites/default/files/atoms/files/4-20-18health.pdf.
[49] *The Economic Impact of Medicaid Expansion in Montana*, April 2018, https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf

Paula Lantz, PhD, Associate Dean of Academic Affairs and Professor of Public Policy at the Gerald R. Ford School of Public Policy, University of Michigan

Thomas LaVeist, PhD, Dean of the School of Public Health and Tropical Medicine at Tulane University

Sten H. Vermund, MD, PhD, Dean and Anna M.R. Lauder Professor of Public Health at the School of Public Health at Yale University

Jonathan Oberlander, PhD, MA, Professor and Chair, Department of Social Medicine; Professor of Health Policy and Management, University of North Carolina-Chapel Hill

Michael Sparer, PhD, JD, Chair and Professor, Department of Health Policy and Management, Mailman School of Public Health, Columbia University

Julia Zoë Beckerman, JD, MPH, Adjunct Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Andrew Bindman, MD, Professor of Medicine, University of California San Francisco

Claire Brindis, DrPH, Professor of Pediatrics, Obstetrics, Gynecology and Reproductive Sciences, University of California, San Francisco

Maureen Byrnes, MPA, Lead Research Scientist and Lecturer, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Lara Cartwright-Smith, JD, MPH, Associate Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Alan B. Cohen, ScD, Professor of Health Law, Policy and Management, School of Public Health, Boston University

Judith Feder, PhD, Professor of Public Policy, McCourt School of Public Policy, Georgetown University

David M. Frankford, JD, Professor of Law, Rutgers Law School, Rutgers University

Abbe R. Gluck, JD, Professor of Law, Yale Law School, Yale University

Janet Heinrich, DrPH, RN, FAAN, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Katherine Horton, RN, MPH, JD, Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Nicole Huberfeld, JD, Professor of Health Law, Ethics, and Human Rights, School of Public Health, Boston University; Professor of Law, School of Law, Boston University

Leighton Ku, PhD, MPH, Professor of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Sylvia Law, JD, Elizabeth K. Dollard Professor of Law, Medicine and Psychiatry, School of Law, New York University

Jeffrey Levi, PhD, Professor of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Anne Markus, PhD, MHS, JD, Associate Professor of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Wendy K. Mariner, JD, LLM, MPH, Edward R. Utley Professor of Health Law, School of Public Health, Boston University; Professor of Law, School of Law, Boston University; Professor of Medicine, School of Medicine, Boston University

Melissa McCarthy, ScD, MS, Professor of Health Policy and of Emergency Medicine, Milken Institute School of Public Health, George Washington University

Wendy E. Parmet, JD, Matthews Distinguished University Professor of Law, Professor of Public Policy and Urban Affairs, Northeastern University School of Public Policy and Urban Affairs

James M. Perrin, MD, Professor of Pediatrics, Harvard Medical School, Harvard University

Marsha Regenstein, PhD, Professor of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Sara Rosenbaum, JD, Harold and Jane Hirsh Professor of Health Law and Policy, Milken Institute School of Public Health, George Washington University

Rand E. Rosenblatt, JD, Professor of Law, Rutgers Law School, Rutgers University

Andy Schneider, JD, Research Professor of the Practice, McCourt School of Public Policy, Georgetown University

Naomi Seiler, JD, Associate Research Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Peter Shin, PhD, MPH, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Katherine Swartz, PhD, Professor of Health Policy and Economics, Harvard T.H. Chan School of Public Health, Harvard University

Joel Teitelbaum, JD, LLM, Associate Professor, Department of Health Policy and Management, Milken Institute School of Public Health, George Washington University

Sidney Watson, JD, Jane and Bruce Robert Professor of Law, School of Law, Saint Louis University

Timothy M. Westmoreland, JD, Professor from Practice, Georgetown Law, Georgetown University

Paul H. Wise, MD, MPH, Richard E. Behrman Professor in Child Health, Department of Pediatrics – Neonatology and Developmental Medicine, Stanford University

Susan F. Wood, PhD, Professor of Health Policy and management and Environmental and Occupational Health, Milken Institute School of Public Health, George Washington University