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August 10, 2018

Mr. Timothy Hill
Center for Medicare and Medicaid Services
Children and Adults Health Programs Group
75000 Security Boulevard
Baltimore, MD 21244

Re: South Dakota Career Connector 1115 Waiver Application

Dear Mr. Hill:

In accordance with the Centers for Medicare and Medicaid Services 1115 Community Engagement Initiative, South Dakota proposes to implement the South Dakota Career Connector program through the enclosed 1115 waiver application. The waiver proposes work requirements for adult Medicaid recipients who are parents age 19 to 59 enrolled in the parent and other caretaker relative's eligibility group living in Minnehaha and Pennington counties in South Dakota. Our program includes intensive employment and training services and skill building opportunities offered through the South Dakota Department of Labor and offers a variety of pathways for recipients to actively participate and maintain health care coverage. Key elements of South Dakota's proposal include:

- Focus on individualized employment and training plans instead of one-size fits all requirements.
- South Dakota's plan focuses on improving health and is structured to give individuals the resources necessary to succeed.
- Maintaining health care coverage is a key tenet of the plan. Promoting employment and employer-based coverage and Transitional Medical Benefits will help individuals maintain health care coverage.
- To avoid the "subsidy cliff", consistent with current eligibility standards South Dakota Career Connector participants will be eligible for Transitional Medical Benefits (TMB) if their income exceeds the income limit. TMB provides full Medicaid coverage for individuals who lose eligibility due to an increase in earnings for twelve calendar months.
- South Dakota's plan proposes premium assistance for individuals who lose Medicaid eligibility due to increased income, ensuring health care coverage for individuals as they enter into the workforce.
- Although not provided as a service funded through this demonstration, waiver participants that also receive child care subsidy will be eligible for co-payment assistance so that as family income increases, out of pocket costs for child care will be gradual and support the family as they transition.
- In addition to the explicit exemptions listed on pages 3-4 of the application, South Dakota Career Connector allows for participants to request a "good cause" exemption prior to losing coverage, due to events such as a death in the family or natural disaster.

- South Dakota's plan proposes to operate in select areas of the state where individuals have access to the employment and training resources needed to ensure success. The limited scope of the program means that approximately 1,300 individuals in the parent or other caretaker relative's eligibility group will be enrolled in the South Dakota Career Connector program annually.
- The plan includes a variety of activities that count toward the work requirement. With this approach, individuals that make a good faith effort and participate actively in qualifying activities outlined in their individualized plan will maintain coverage.
- South Dakota estimates that approximately 15% of participants will become ineligible annually due to increased income or individuals choosing to not participate. The State anticipates that the majority of these individual will become ineligible due to increased income and that they will be able to maintain coverage through TMB and premium assistance for two additional years. At the conclusion of the TMB and premium assistance period it is anticipated that these individual will have employer sponsored coverage or qualify for a subsidy through the Marketplace based on the program's emphasis on helping individuals find jobs with employer sponsored insurance and emphasis on lifting participants out of poverty. We believe this is likely based on a 2015 study that indicated that most major sectors provide employer-based coverage in South Dakota, as do most employers with at least 10 employees. The State anticipates a small number of individuals will lose coverage during the demonstration period as a result of choosing not to participate in the program.

The State conducted Tribal Consultation beginning with notification on May 21, 2018. We have enclosed a copy of the notification sent to the Tribes. Public notice was published in the South Dakota *REGISTER*, <http://sdlegislature.gov/docs/rules/Register/05212018-A.pdf>, on May 21, 2018. Additional information regarding the public notice process is provided in the waiver application.

Thank you for your consideration. If you have any questions regarding this waiver application, please contact Sarah Aker, Deputy Director of the Division of Medical Services via email at sarah.aker@state.sd.us or via telephone at (605) 773-3495.

Sincerely,



Lynne A. Valenti
Cabinet Secretary

CC: Brenda Tidball-Zeltinger, Deputy Secretary
William Snyder, Director Division of Medical Services
Carrie Johnson, Director Division of Economic Assistance
Sarah Aker, Deputy Director

Career Connector
A South Dakota 1115 Demonstration Proposal

Table of Contents

Program Summary	3
Eligibility	3
Program Details	4
Promoting Work	4
Non-compliance	6
Promoting Health	7
Demonstration Benefits and Cost Sharing Requirements	8
Support Services	8
Premium Assistance	8
Delivery System and Payment Rates for Services	9
Implementation of Demonstration	9
Demonstration Financing and Budget Neutrality	9
List of Proposed Waivers and Expenditure Authorities	11
Public Notice	11
Demonstration Administration	25
Appendix 1: Draft Evaluation Plan	26
Appendix 2: Budget Neutrality	30

Program Summary

The purpose of the Career Connector program is to improve the health and wellbeing of able-bodied adult Medicaid recipients while empowering them to obtain full-time meaningful work. South Dakotans value hard work and believe that work can add meaning and purpose to an individual's life. The State of South Dakota's (herein after, State) goals include:

- Improve participant's health and encourage the development of healthy habits; and
- Empower participants to be successful in today's workforce.

As noted in CMS's January 11, 2018 State Medicaid Director letter titled *Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries* studies have found a correlation between work and wellbeing. These include:

- Higher earnings being positively correlated with a longer lifespan;
- Unemployment being associated with higher mortality, poorer general health, poorer mental health, and higher medical consultation and admission rates; and
- Unemployment being associated with higher rates of depression.

South Dakota proposes to operate the Career Connector program as a pilot in Minnehaha and Pennington Counties. The two areas are the most populated counties in the state and were identified as pilot locations to operate the program based on population and access to employment and training resources. The Department of Labor and Regulation (DLR) will provide supports for individuals in the program through a contractual agreement with the Department of Social Services (DSS). It is estimated that 1,300 recipients in these areas will meet the eligibility criteria for the Career Connector program. The State is seeking to implement this demonstration for a five-year period. The State may seek to expand the program to other areas of the state through an amendment based on the initial outcomes of the pilot.

Maintaining health coverage is a key tenant of the program. Participants will be offered a range of services individualized to support employment goals and transitional Medicaid benefits and premium assistance will be available to avoid coverage gaps.

The State recognizes that certain individuals may have acute or chronic health conditions that prevent individuals from working, working full time, or participating in employment and training activities on either a temporary or long term basis. Individuals with disabilities and medically frail individuals with health care conditions that prevent or limit participation may be exempt from participation.

Eligibility

Adult recipients age 19 to 59 who are enrolled in the parent and other caretaker relatives eligibility group as described in 42 CFR 435.110 and reside in Minnehaha or Pennington County will be required to participate in the Career Connector program unless they qualify for an exemption. The following individuals will be exempt:

- Individuals who work 80 hours or more a month;

- Individuals age 18 or younger;
- Individuals age 60 or older;
- Full-time students;
- Pregnant women;
- Individuals whose eligibility has been determined on the basis of disability or who have been determined disabled by the Social Security Administration;
- Medically frail individuals (e.g. individuals unable to work due to cancer or other serious or terminal illness);
- Individuals already participating in a workforce participation program that the State has determined meets the objectives of the Career Connector program (e.g. SNAP, TANF or unemployment insurance);
- Nonparent caretaker relatives;
- Parents of dependent children under one year old living in the parent's residence; and
- Primary caregivers of elderly or disabled individuals living in the caretaker's residence.

The DSS, Division of Economic Assistance will determine whether a recipient is eligible for the Career Connector program. Recipients will be assessed for participation in the program at the time of their initial South Dakota Medicaid application. Individuals currently enrolled in South Dakota Medicaid will be assessed for participation at their next eligibility review. Exempt individuals may elect to participate in the program on a voluntary basis. Individuals participating on a voluntary basis will not be subject to the non-compliance remedies described in this application.

Consistent with current eligibility standards Career Connector participants will be eligible for Transitional Medical Benefits (TMB) if their income exceeds the income limit. TMB provides full Medicaid coverage for individuals who lose eligibility due to an increase in earnings for twelve calendar months.

Program Details

The Career Connector program is focused on the intertwined objectives of improving lives by helping individuals find meaningful work and improving the health and wellbeing of the individual. The key components of these objectives are an individualized employment and training plan and promoting healthy living. In addition, the Career Connector program will offer a pathway from Medicaid to private health insurance coverage through premium assistance. The demonstration will not affect or modify other components of the State's current Medicaid program other than as described in this application. The demonstration will have no effect on the State's CHIP program.

Promoting Work

The objective of the program is for an individual to obtain meaningful work. Meaningful work is considered a job in one of the participant's desired fields of employment commensurate with their qualifications and abilities. Participants must meet minimum training and/or work requirements. To meet the requirements of the program participants must either work at least 80

hours per month or achieve monthly milestones in their individualized plan. South Dakota will continue to work with individuals once they have met the requirements of the program until the individual:

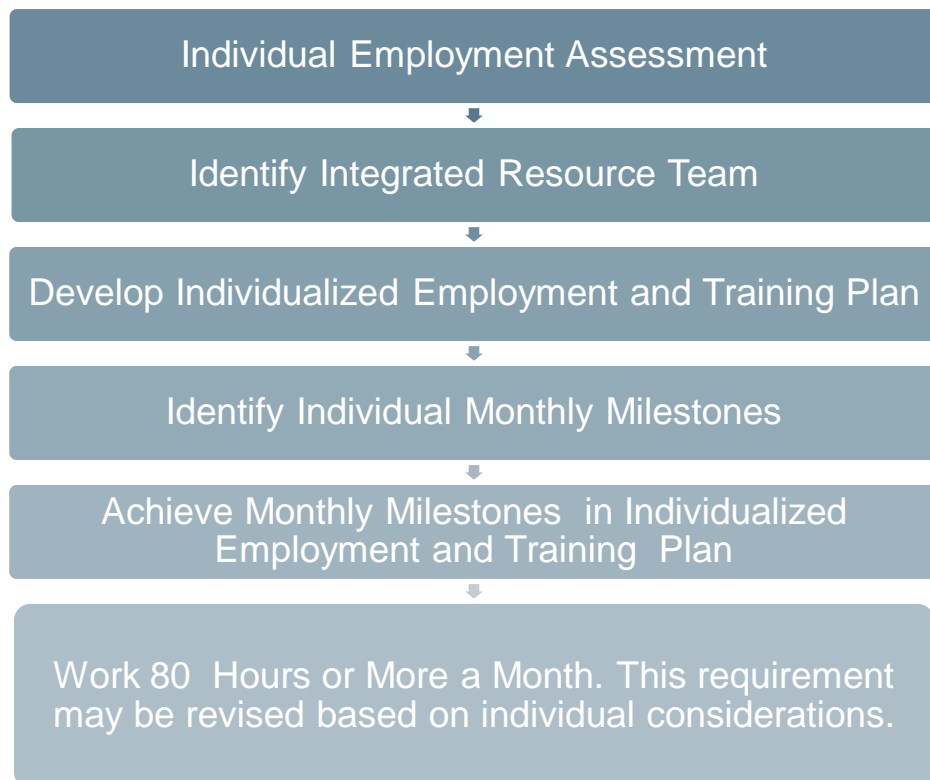
- Works 120 hours or more a month; or
- Has an income of at least 150 percent of the Federal Poverty Level; or
- Loses Medicaid eligibility and chooses to no longer pursue the objectives of their individualized plan.

Recipients enrolled in the Career Connector program will be notified by DSS. Newly enrolled recipients will be provided a three month period from their initial application month before they are required to begin achieving monthly milestones in their individualized plan. Individuals may meet with a DLR employment specialist at any point during the three month period to begin an initial employment assessment and creation of an individualized employment and training plan.

DSS will connect all program participants with a case manager. The case manager will aid participants to help ensure their success in the Career Connector program. Case managers' activities may include, but are not limited to, the following:

- Connecting individuals to support services;
- Promoting preventative health services available through Medicaid coverage; and
- Reminding individuals of important Career Connector program elements.

The program will follow the same process for all eligible individuals:



DLR will be responsible for conducting the employment assessment, identifying the integrated resource team, developing the employment and training plan, identifying monthly milestones, tracking achievement of monthly milestones, and tracking/verifying hours worked.

The individualized employment and training plan may include, but is not limited to:

- English as a second language;
- Health insurance literacy courses;
- Financial literacy courses;
- Disease management courses;
- Other healthy living courses;
- Treatment for chronic or behavioral health conditions;
- High school equivalency education;
- Post-secondary education and training;
- Volunteer work;
- Caregiving for an elderly or disabled individual;
- Resume writing and soft skills training; or
- Job search.

The components of the employment and training plan may be provided by DLR or by other entities.

As family income increase to address the “subsidy cliff” participants will be eligible for Transitional Medical Benefits for one year and for up to an additional twelve months of premium assistance. Although not provided as a service funded through this demonstration, waiver participants that also receive child care subsidy will be eligible for co-payment assistance so that as family income increases, out of pocket costs for child care will be gradual and support the family as they transition.

Non-compliance

Participants must meet the requirements in the Promoting Work section. Non-compliance with requirements will be handled in the following manner:

Instance	Remedy
First month of non-compliance	Participant must contact a DLR employment specialist within 30 days of the first notice of non-compliance to establish a corrective action plan.
Second month of non-compliance	Participant must contact a DLR employment specialist within 30 days of the second notice of non-compliance to establish a corrective action plan. DSS is notified of non-compliance.
Third month of non-compliance	Participant is sent 10 day timely notice of closure of his or her Medicaid eligibility.

DLR will notify the DSS case manager of a participant's non-compliance. DSS' Division of Economic Assistance will determine if a participant's non-compliance results in closure of his or her Medicaid eligibility. Closure of the participant's Medicaid eligibility will not affect the eligibility of a child, spouse, or other household member that is not required to participate. An individual who loses eligibility due to non-compliance may work with DLR to take corrective action within 30 days of coverage closure to reinstate coverage. Reinstatement of coverage will be determined by DSS. Failure to obtain reinstatement during this 30 day period will result in a 90-day ineligibility period of the participant's Medicaid coverage.

An individual who has been determined ineligible for Medicaid due to noncompliance with the Career Connector program and is subsequently determined to qualify for an exemption from the Career Connector program and is otherwise determined eligible for Medicaid will have their eligibility reinstated starting the month they qualify for the exemption.

Prior to disenrollment due to non-compliance, a participant may request a "good cause" exemption. The circumstance constituting good cause must have occurred during the month for which the participant is seeking a good cause exemption. Recognized good cause exemptions include, but are not limited to, the following verified circumstances:

- The participant has a family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to acting as the short-term caretaker of that family member;
- The participant experiences a hospitalization or serious illness or has an immediate family member who lives in the home with the participant that experiences a hospitalization or serious illness;
- The participant experiences the death of a family member living with the participant;
- The participant experiences severe inclement weather (including a natural disaster) that renders him or her unable to meet the requirements; or
- The participant has a family emergency or other life-changing event. Examples include a divorce or domestic violence.

DSS' Division of Economic Assistance is responsible for determining whether a "good cause" exemption is granted.

Promoting Health

The Career Connector program is designed to improve health outcomes for participants by helping them find meaningful work. As noted in the Program Summary section studies have identified a correlation between work and wellbeing. In addition, the Career Connector program will focus on improving health outcomes for participants by promoting the utilization of preventative services with the intent of helping participants develop healthy habits. The program will accomplish this objective through the following mechanisms:

1. Increasing identification and treatment of chronic or behavioral health conditions.
2. Promoting Well-Adult visits, immunizations, and preventative dental visits.

3. Requiring one Well-Adult visit and one preventative dental visit during the period an individual is eligible for TMB to qualify for premium assistance.

Increased identification of chronic or behavioral health conditions will be accomplished through DLR's initial assessment. Treatment of these conditions may count as achievement of a monthly milestone. DSS' Division of Medical Services and DSS case managers will be primarily responsible for promoting preventative care.

Demonstration Benefits and Cost Sharing Requirements

The benefits available under the demonstration are the same as those currently provided under the Medicaid state plan. In addition, the cost sharing requirements will be the same as currently required under the state plan with the exception of the premium assistance program.

The premium assistance program covers up to the previous year's TMB per member per month (PMPM) amount, which will assist participants in purchasing employer-sponsored health insurance or coverage through a Qualified Health Plan (QHP). Participants in the premium assistance program will be subject to the cost sharing terms and conditions of the plan they are enrolled in including any portion of premiums not covered by premium assistance and payment for any services not covered under employer-sponsored plan or the QHP.

Support Services

DLR will form an integrated resource team to facilitate referrals to community and support services including vocational rehabilitation services. Participants will also be evaluated by DLR for Workforce Innovation and Opportunity Act (WIOA) support services, including:

- Transportation;
- Clothing; and
- Rent assistance.

Career Connector participants will also be referred to the DSS' Division of Child Care, which provides assistance to low income families who need help with child care costs while parents work or attend school. Although not provided as a service funded through this demonstration, waiver participants that also receive child care subsidy will be eligible for co-payment assistance so that as family income increases, out of pocket costs for child care will be gradual and support the family as they transition.

Support services described above are not funded by Medicaid expenditures.

Premium Assistance

Following the expiration of TMB benefits, some individuals may qualify for premium assistance. To qualify an individual must meet the following criteria:

- The individual completed one Well-Adult visit and one preventative dental visit during the period the individual was enrolled in TMB coverage;

- The individual has an income above the LIF limit, but below 100 percent of the Federal Poverty Level; and
- The individual is in compliance with the training and work requirements of the program.

Eligibility for premium assistance will be determined by DSS' Division of Economic Assistance. DSS' Division of Medical Services will be responsible for administration related to premium assistance payments.

Premium assistance will be provided for a period of up to one year. Payment will be for the cost of the health insurance premium up to PMPM associated with TMB coverage in the previous federal fiscal year. Individuals who no longer meet the criteria during the one year period will no longer be eligible for premium assistance and will be referred to the Marketplace. The participant will be responsible for cost sharing amounts including co-payments, co-insurance, and deductibles. For individuals not utilizing the full premium assistance amount, the remaining amount may be used to assist them with co-payments, co-insurance, and deductibles.

Delivery System and Payment Rates for Services

The delivery system and payment rates for medical benefits provided to recipients in the Career Connector program will be the same as under the Medicaid state plan with the exception of the premium assistance program.

Implementation of Demonstration

The Career Connector program will begin operating on a voluntary basis beginning July 1, 2018. The State's intent is to begin operating the Career Connector program for individuals in accordance with the above-stated eligibility criteria within 90 days of CMS approving the demonstration.

Recipients will be reviewed for participation in the Career Connector program at their initial application if they are not currently enrolled in South Dakota Medicaid or at their next eligibility review if they are currently enrolled in South Dakota Medicaid. Applicants will be notified of participation in the Career Connector program in accordance with 42 CFR § 435.917.

Demonstration Financing and Budget Neutrality

The State proposes to finance the non-federal share of expenditures under the demonstration using state general funds. South Dakota proposes to demonstrate budget neutrality using the per capita method, which evaluates budget neutrality based on the PMPM cost. Statewide historical data was used to produce a more robust projection of the PMPM. As the demonstration project is limited to eligible individuals in Minnehaha County and Pennington County the eligible member months and total expenditures listed in the document are not reflective of actual member months and total expenditures that will be associated with the implementation of the demonstration.

The budget neutrality historical data and projections are included in Appendix 2. The historical expenditures were calculated using statewide historical data for the parent and other caretaker relatives and TMB populations. Data was limited to individuals age 19 to 59 as the demonstration is limited to individuals in this age range. The premium assistance without waiver projection is based on the projected cost of these individuals continuing in the parent and other caretaker relatives eligibility group. The with waiver premium assistance projection is based on TMB data as the maximum allowable premium assistance is the previous year's TMB per member per month.

The State estimates approximately 1,300 individuals in the parent or other caretaker relatives eligibility group will be enrolled in the Career Connector program annually. In Federal Fiscal Year 2017, the annual aggregate expenditures for 1,300 individuals in this eligibility group was approximately \$9,672,000. The State anticipates similar annual aggregate expenditures going forward. South Dakota's budget neutrality document is based on PMPM costs not annual aggregate expenditures.

South Dakota designed the Career Connector program to allow anyone making a good faith effort to comply with the program to not lose coverage due to non-compliance. The program allows a diverse set of activities to count toward complying with the program. For example, both GED and English as a second language classes are activities for compliance in the Career Connector program. The program is not operating statewide. Instead it is designed specifically for the state's largest population centers where the most resources and access to work are available focused in areas with access to work or job related training. The Career Connector also places an emphasis on individual success, utilizing individualized plans and goals as a measure of a participant's success instead of a one-size fits all compliance requirements. Career Connector participants will also benefit from additional case management.

The State anticipates approximately 15 percent of participants may become ineligible annually due to increased income or individuals choosing not to participate. The State anticipates the majority of these individuals will become ineligible due to increased income. Most of individuals whose income exceeds the income limit will maintain Medicaid coverage for up to two years through transitional Medicaid coverage and premium assistance offered as part of the program. At the conclusion of the TMB and premium assistance period it is anticipated that these individual will have employer sponsored coverage or qualify for a subsidy through the Marketplace based on the program's emphasis of helping individuals find jobs with employer sponsored insurance. In addition, a 2015 study indicated that most major sectors provide employer-based coverage in South Dakota, as do most employers with at least 10 employees.

The State anticipates a small number of individuals will lose coverage during the demonstration period as a result of choosing not to participate in the program.

List of Proposed Waivers and Expenditure Authorities

South Dakota is requesting section 1115(a)(2) expenditure authority to provide premium assistance for those transitioning from TMB to employer-sponsored health insurance or a QHP. South Dakota is requesting expenditures for premium assistance to assist individuals who found employment, but lack the means to purchase health insurance. Participation in the premium assistance program is contingent on participating in specific wellness activities.

South Dakota is requesting the following waivers of state plan requirements contained in section 1902 of the Act under the authority of section 1115(a)(1) of the Social Security Act (the Act):

1. Comparability, Section 1902(a)(10)(B)

To the extent necessary to enable the State to implement the premium assistance program, which includes participants paying the cost sharing amounts associated with their health insurance.

To enable the State to offer premium assistance to a subset of participants and implement the Career Connector program for a subset of Medicaid recipients.

2. Reasonable Promptness, Section 1902(a)(3)

To enable the State to prohibit re-enrollment for a period of three months for individuals who lose coverage due to continued non-compliance with the Career Connector program as described in the application.

3. Provision of Medical Assistance, Section 1902(a)(8) and 1902(a)(10)

To the extent necessary to enable the State to suspend eligibility for and not make medical assistance available to Career Connector participants due to continued non-compliance with the Career Connector program as described in the demonstration application.

4. Statewideness/Uniformity, Section 1902(a)(I)

To enable South Dakota to restrict the Career Connector program to certain geographical areas of the state, specifically Minnehaha and Pennington Counties.

Public Notice

Governor Dugaard announced intent to submit an 1115 waiver for work requirements during the 2018 State of the State Address on January 9, 2018. A transcript of the State of the State Address is available [online](#). Governor Dugaard additionally published a [column](#) on January 26, 2018 regarding South Dakota's intent to submit an 1115 wavier for work requirements.

In order to obtain public input in the development stage of the demonstration, the State formed the Medicaid Work Requirement & Employment and Training Stakeholder Workgroup. The work group met on the following dates to discuss and review components of the demonstration:

- February 14, 2018
- February 28, 2018
- April 4, 2018

A list of workgroup members and meeting minutes are available on the [DSS website](#). The group's membership included representatives from the Department of Social Services and the Department of Labor, Great Plains Tribal Chairman's Health Board, Indian Health Service, the Medicaid Advisory Committee, technical schools, community action agencies, and other stakeholders. The comments received from the workgroup were generally favorable. Concern regarding the effects of the demonstration on American Indians was expressed.

The demonstration project was announced at the January 4, 2018 Medicaid Tribal Consultation meeting and an overview of the demonstration was provided at the April 5, 2018 Medicaid Tribal Consultation meeting. Some of the tribes expressed concern or opposition to the demonstration and requested an exemption for American Indians. DSS indicated that the demonstration is a pilot and will operate in areas with employment and training opportunities. The counties included in the pilot do not include Indian reservations. In addition, the State's understanding is that CMS has determined that it cannot legally exempt American Indians.

Information regarding the demonstration was also presented to the DSS Advisory Board. Comments from the advisory board were favorable.

The State started the public notice period on May 21, 2018 and the last day to comment was June 19, 2018. The State certifies that it published the public notice in [South Dakota Register](#), which included a link to the [State's website](#). The notice was published more than 30 days prior to submission of the application to CMS.

The State certifies that two public hearings were held; both hearings included the ability to appear telephonically. One was held on May 24, 2018 in Sioux Falls, South Dakota which is located in Minnehaha County. Another was held on May 31 in Rapid City, South Dakota which is located in Pennington County. The hearings included introductory remarks regarding the proposed programs and allowed any individuals present to provide comments regarding the proposed demonstration. According to the State's sign-in sheets a total of thirty-two individuals were present at the first and second hearing. Two individuals present at the first hearing were present at the second hearing via telephone. A total of thirteen individuals provided oral comments at the two hearings. Oral comments were summarized and incorporated into the summary of comments below. Commenters appearing at the hearings were encouraged to also provide written comments.

The State certifies that the public notice was sent to the listserv DSS uses for notification of proposed administrative rule changes. In addition, the State certifies that tribal consultation was conducted in accordance with the consultation process outlined in the State's approved Medicaid State Plan. Tribal consultation started on May 21, 2018 and the last day to comment was June 19, 2018. The state provided email notification in addition to discussing the program at Tribal Consultation meetings prior to the comment period.

The State received 55 written comments during the comment period some of which were signed by more than one individual or organization. The oral and written comments were aggregated and summarized. A single comment or commenter often expressed multiple ideas. Similar ideas were grouped together for response. A copy of comments submitted on letterhead or on behalf of an organization are attached to the application. Comments by citizens often contain email addresses or physical addresses that they may wish not be published and as such are not attached. The State can provide copies of these comments to CMS upon request.

1. The majority of comments expressed general opposition to Medicaid work requirements.

The State understands and appreciates concerns expressed by individuals generally opposed to work requirements or who are concerned about individuals losing Medicaid coverage. The State has designed the Career Connector program with the intent of preventing anyone making a good faith effort to comply with the program from losing Medicaid coverage due to noncompliance. The foundation of the program is that individuals that are able to work will be healthier and better off if they are given assistance to rise out of poverty, are employed, and have health benefits than if they continue to live in poverty.

2. Multiple comments expressed concern about child care, the cost or availability of child care, a child care assistance subsidy cliff and increased child care copayments relative to increased income, or expressed support for exempting parents of children under age 6 from the program. One comment expressed that being a mother is the most important unpaid job and that individuals need all of the help they can get. One comment noted that it is important to keep mothers and babies together and that not all mothers can afford childcare.

The Career Connector program exempts individuals that are unable to participate due to a variety of circumstances, including pregnancy and parents of children under one year old. The State recognizes that childcare can be a barrier to employment. The Division of Child Care within the Department of Social Services has been involved throughout the development of the Career Connector program. The target population of the Career Connector program meet the income requirements for child care assistance. Individuals in the Career Connector Program will be referred for childcare assistance and other supports from the Division of Child Care, if assistance is needed. Some families have other arrangements for child care and therefore may not need assistance. To address the subsidy cliff, participants receiving childcare subsidy will be provided with co-payment assistance so as income increases, and child care out of pocket costs increase, the transition is gradual instead of immediate. The application has been updated to reflect the availability of childcare co-payment assistance.

The program also builds in flexibility that takes into account individual circumstances. For example, on an individual basis a person complying with the program may be able to have the number of hours of work required reduced to meet the individual needs of the person.

- 3. Multiple comments expressed concern about potential negative effects on participants' health due to the program, interruption to continuity of care, that the medically frail exemption may not capture all individuals with or at risk of serious or chronic condition that prevents them from working, and individuals becoming sick after losing coverage.**

The Career Connector program is designed to increase preventative care, increase identification and treatment of behavioral health and chronic conditions, and improve wellbeing. The State understands the concern expressed in these comments and designed the program to mitigate this issue. The State has designed the Career Connector program with the intent of preventing anyone making a good faith effort to comply with the program from losing Medicaid coverage due to noncompliance. The non-compliance section of the application has been updated to ensure all participants are provided sufficient opportunity to take corrective action.

The State also designed the program to allow coverage for individuals that exceed the Medicaid income limit through a year of transitional Medicaid coverage and up to a year of premium assistance. In addition, individuals that don't qualify for the medically frail exemption may qualify for a "good cause" exemption due to an illness. Treatment for chronic or behavioral health condition can also count toward complying with the program.

Several commenters raised concerns about individuals losing coverage due to noncompliance and subsequently becoming pregnant or medically frail during the 90 day period they are ineligible for Medicaid coverage. The State agrees with this concern. The application has been updated to reflect that anyone that loses coverage due to noncompliance with the Career Connector program, but is subsequently determined to qualify for a stated exemption and is otherwise eligible for Medicaid will have their eligibility reinstated starting the month they qualify for the exemption.

- 4. Multiple comments indicated the program would have a disproportionate impact on American Indians/Alaskan Natives, expressed concerns about the inclusion of American Indians in the program, the loss of IHS revenue, the federal government's treaty obligation to provide health care, concern about American Indians performing activities or services that benefit their community, but are often not counted as work, or concern that the program would be a barrier to enrollment for American Indians. A request was also made to exempt individuals already exempt from Medicaid cost sharing requirements or Individuals dually eligible for Indian Health Services.**

The Career Connector program is focused on individuals that are able to work. The proposed program is a pilot program and will only operate in Minnehaha and Pennington County, which do not include Indian reservations. These counties were chosen due to

the availability of jobs and employment and training services. The State believes the program will be beneficial to all individuals that are able to work. The program allows for flexibility regarding what activities count toward compliance. The list in the application is not all inclusive and nonpaid activities may count as a monthly milestone. The State does not anticipate a barrier to enrollment of American Indians eligible for Medicaid or a loss of revenue to IHS due to implementation of the waiver. The waiver will not impact IHS's ability to provide health care to American Indians.

The State is not adding the proposed exemptions to its list of exemptions. The demonstration application allows an exemption for individuals already participating in a workforce program that meets the objective of the Career Connector program. If a tribal entity develops a State-approved workforce development program, American Indians could participate in that program and obtain an exemption via participation in that program.

- 5. Multiple comments expressed concerns that the process for demonstrating compliance with or exemption from the program will be bureaucratic or burdensome; that the program will cause increased churn, and about participants' lack of incentive or motivation to meet requirements, as well as burden for physicians to provide documentation for exemptions.**

The State has designed the Career Connector program with the intent of preventing individuals making a good faith effort to comply with the program from losing Medicaid coverage due to noncompliance. Each participant will have a DSS case manager that will work with them to help them be successful and navigate the program. The program is designed to allow individuals multiple opportunities to take corrective action should they not meet a program requirement. Individuals are assessed for participation in the Career Connector program at the time of initial application or at their next eligibility review for individuals already on Medicaid. The benefits specialist will work with the individual to assess them for exemption. Individuals already participating in the program can obtain assistance from the DSS case manager to obtain an exemption. The State recognizes physicians may be asked to provide information when an individual is seeking a "medically frail" exemption. Due to the size of the population anticipating in this program, the State does not anticipate a given physician will receive a significant number of requests related to this exemption.

- 6. Multiple comments expressed concern about the effects on a child if a parent loses Medicaid coverage, concern about denying assistance to children, or a parent not having health insurance making it less likely a child has health insurance.**

A child's eligibility will not be affected if a parent becomes ineligible for Medicaid do not meeting a program requirement. If a parent's income increases, children are eligible for CHIP up to 204 percent of the Federal Poverty Level if the child has no other insurance

or up to 182 percent of the federal poverty level if the child has private health insurance. An individual that loses coverage can obtain coverage again in 90 days, if eligible for Medicaid.

- 7. Multiple comments expressed concern about the effects of work requirements associated with Supplemental Nutrition Assistance Program and Temporary Assistance to Needy Families including the program not being successful at finding individual's jobs or the work requirements in these programs resulting in people losing benefits or expressed concerns that the Career Connector program would be ineffective at helping people find jobs.**

Career Connector is a unique, individualized program that differs from SNAP and TANF in a variety of ways that are detailed throughout the application including the flexible and individualized nature of the program and emphasis on education and training. The Career Connector program also provides more ways to comply with the program.

- 8. Multiple comments expressed concern about a Medicaid "subsidy cliff" whereby the individual's income is too high to qualify for Medicaid, but not high enough to qualify for subsidies through the Health Insurance Marketplace or a catch 22 effect where an individual will lose Medicaid if they do not work or obtain a job and lose Medicaid benefits due to exceeding the Medicaid income limits.**

The State appreciates the commenters' concerns regarding a "subsidy cliff" or catch 22 effect. One of the goals of the program is to provide people the skills and supports to be successful. The State discussed these types of concerns with the stakeholder workgroup and has included strategies to address this. Regarding health care coverage, the program is designed to provide a bridge to health insurance. The program design allows individuals that exceed Medicaid income limits to qualify for a year of transitional Medicaid coverage. Additionally, the program provides the ability for individuals below 100 percent of the poverty level to qualify for premium assistance for up to one year. Regarding child care assistance, although not funded through Medicaid, in partnership with the Child Care Assistance Program, participants that also qualify for child care subsidy will be offered transitional co-payment assistance so that as income increases and out of pocket child care costs increase, the transition is gradual and not immediate.

The Career Connector program was designed to mitigate the issue of loss of coverage. First, the emphasis of the program is on education and training rather than immediate employment. The State believes it is important that participants obtain a job that will help the individual successfully rise out of poverty rather than a job that will leave them below the federal poverty line. DSS and DLR will work with each individual to help an individual obtain a job that puts them in a better financial position than they are currently in.

- 9. Multiple comments expressed concern about shifting costs elsewhere, individuals without coverage going to the ER, uncompensated costs, or loss of federal funds.**

As noted above, the Career Connector program is designed to prevent anyone making a good faith effort to comply with the program from losing Medicaid coverage due to noncompliance. The State has also updated the application to reflect that anyone that loses coverage due to noncompliance with the Career Connector program, but is subsequently determined to qualify for a stated exemption and is otherwise eligible for Medicaid will be immediately eligible for reinstatement of their coverage.

In addition, the program is designed to allow individuals that exceed the income limit to qualify for a year of transitional Medicaid coverage. The program also provides the ability for individuals below 100 percent of the poverty level to qualify for premium assistance for up to one year.

The State recognizes it will no longer receive federal funds for individuals ineligible for Medicaid. The program is designed to help individuals rise out of poverty and become healthier. As individuals rise out of poverty they may qualify for federal subsidies through the Health Insurance Marketplace.

10. Multiple comments expressed support for Career Connector on a voluntary basis.

The State believes the Career Connector program as designed will help more people succeed than a strictly voluntary program.

11. One comment requested that the state evaluate the success of the voluntary work requirements before moving forward with a mandatory implementation within 90 days following CMS approval of the waiver.

The State will monitor outcomes of the Career Connector program closely throughout both the voluntary program and mandatory implementation. The State will operate the program in Minnehaha and Pennington counties as a pilot program.

12. Multiple comments expressed concern about coercing people to work or negative consequences due to noncompliance creating resentment.

The Career Connector program is designed to help individuals be healthier, more successful, and rise out of poverty. The State understands the concern that some participants may have negative feelings toward the program but hopes individuals participating in the program recognize the benefits of the program.

13. Multiple comments expressed concern about administrative cost associated with the program, high administrative costs in other states, costs of associated supports, lack of funding appropriated in the budget, the program being used to resolve a DSS budget issue, increased bureaucracy, or insufficient staffing.

Career Connector is a pilot program operating in two counties. The framework for the program builds from existing infrastructure and services provided currently by the DLR and DSS. Based on the size of the population the state anticipates operating the program primarily using existing staff and resources when the program starts on a

voluntary basis on July 1, 2018. The program is designed to prevent anyone making a good faith effort from losing coverage due to noncompliance. DSS will evaluate staffing and resource needs throughout the demonstration.

14. Multiple comments expressed concern about potential barriers to success such as lack of transportation including help fixing a car or providing gas money, lack of supports for caregivers, and lack of affordable housing in Sioux Falls.

The Career Connector program is designed to address barriers that prevent work. DLR staff, DSS Case Managers, and the individual's integrated resource team will work with the individual to address barriers including transportation assistance, rent assistance, and clothing assistance. CMS prohibits Medicaid expenditures from being used to address the types of barriers noted above, but to the extent available individuals will be referred for other assistance that can address barriers as needed.

15. One comment indicated some individuals such as those with criminal records or those lacking technology skills may have trouble obtaining a job.

The program is designed to help individuals succeed. Individuals that struggle to find work may benefit from additional skills training or education. These activities count as monthly milestones and allow these individuals to comply with the program. DLR staff and DSS case managers can also act as an advocate for these individuals and may be able to provide a reference for individuals applying for a job.

16. One comment expressed concern about difficulty obtaining a job in Rapid City.

Pennington County was selected for the pilot program due to the relative availability of jobs. The program focuses on making sure individuals have necessary supports, skills, and education to succeed. Individuals can meet program requirements by completing monthly milestones in their individualized training and employment plan.

17. Several comments indicated the definition of disabled is critical or that some disabled individuals may not meet the exemption and be negatively impacted.

The Career Connector program exempts individuals whose Medicaid eligibility has been determined on the basis of disability or who have been determined disabled by the Social Security Administration. The State believes this is an appropriate standard. Individuals that do not meet this standard may qualify for a different exemption such as the medically frail exemption or the "good cause" exemption.

18. One comment requested an exemption for caregivers regardless of if the caregiver is residing with the individual. The commenter further requested that support services should be made available to individuals acting as family caregivers regardless of enrollment in the Career Connector program.

The waiver gives an exemption from the work requirement for individuals who care for an elderly or disabled individual living in their home. Individuals who care for loved ones

outside their home will be able to include this activity in their individualized plan as an activity that meets the requirements of the work requirement waiver. The State has updated the waiver to reflect this as an activity.

19. One comment expressed concern about the intent to move all adult Medicaid recipients in the parent/caregiver eligibility group including those aged 19-20 to employer sponsored or marketplace coverage and that those individuals would not receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) through employer sponsored or marketplace coverage.

The Career Connector program does not move all Medicaid recipients to employer sponsored or marketplace coverage. Individuals will receive all Medicaid benefits, including EPSDT if applicable for individuals age 19-20, while the individual remains eligible for full Medicaid coverage. Individuals who lose Medicaid eligibility due to increased income will be able to qualify for Transitional Medical Benefits which provides full Medicaid coverage, including EPSDT if applicable for individuals aged 19-20, for a period of 1 year. Following the Transitional Medical Benefits period, individuals may be eligible for premium assistance for employer sponsored or marketplace coverage under the waiver for another 1-year period. Premium assistance benefits will be those offered under the employer sponsored or marketplace coverage.

20. Multiple comments expressed support for the State expanding Medicaid.

The State is not considering Medicaid expansion nor does the demonstration waiver expand eligibility for Medicaid.

21. Multiple comments asked what happens if an individual works less than 80 hours or raised concerns regarding inconsistent hours resulting in an individual working less than 80 hours.

Career Connector is an individualized program. Participants can meet program requirements by completing monthly milestones in their individualized training and employment plan or working 80 hours or more a month. On an individualized basis the 80 hour requirement may be reduced to a lesser amount. In some instances the requirement may be reduced after the fact if participant made a good faith effort to meet his or her requirement. If the individual has not complied with the program it would be considered one month of non-compliance. The individual can remedy this by taking corrective action or requesting a "good cause" exemption.

22. One comment questioned the accuracy of the 1,300 estimated participants and expressed the belief the number was much higher.

The 1,300 estimated participants is based on historical trend data that identified targeted individuals who appear to meet the eligibility criteria and do not appear to be exempt based on the information we have at this time.

- 23. One comment asked the state to consider if the benefit of instituting a work requirement for a small population of individuals outweighs the risk of terminating coverage for patients and families relying on Medicaid.**

The Career Connector program is designed as a pilot in Minnehaha and Pennington counties where there is the greatest availability of employment and training resources. The Career Connector program will connect individuals to employment and training services to help ensure long-term success and the intent of the program is to prevent anyone making a good faith effort from losing Medicaid coverage due to noncompliance.

- 24. One comment noted that the Career Connector program would disproportionately affect women.**

The Career Connector program requirements apply to individuals regardless of gender.

- 25. One comment requested additional information about the individuals who served on the stakeholder workgroup.**

A list of workgroup members is available here:

http://dss.sd.gov/docs/medicaidworkgroup/work_group_members.pdf

Information about the workgroup's activities, including meeting minutes and handouts from the workgroup, are available here: <http://dss.sd.gov/medicaidworkgroup.aspx>

- 26. Multiple comments indicated that those on Medicaid that can work already do.**

The State agrees that many individuals that can work already do. As such the program exempts individuals that already work 80 or more hours a month from the program. These individuals may still participate in the program on a voluntary basis and obtain additional skills or education to further their career.

- 27. One comment indicated the upper age limit for inclusion in the program was too high and should be lowered to 50 years old.**

The State believes the upper age limit of individuals less than 60 years old is appropriate.

- 28. Several comments expressed concern about the potential for the program operating in rural areas or on Indian reservations.**

The State is only proposing to operate the pilot program in the two most populous counties in South Dakota neither of which have Indian reservations.

- 29. One comment expressed concern about the program's effects on grandparents that are taking care of their grandchildren.**

The State agrees that this program is not appropriate for grandparent caretakers. The State would like to clarify that nonparent caretakers of children are exempt from the program and the application was updated to reflect this.

30. Multiple comments expressed concern about the availability of jobs with benefits, paying for benefits, the ability to live on minimum wage, or the need for a living wage.

The program is focused on helping individuals rise out of poverty and earn a wage they can live on. The program is intended to help individuals obtain jobs with benefits or jobs that will allow them to qualify for a federal subsidy through the Health Insurance Marketplace. DLR staff will help people obtain jobs that result in them being better off than they are currently.

31. Multiple comments expressed concerns about the State satisfying the public comment process requirements regarding an enrollment estimate or asked about the number of individuals that may lose coverage.

The State included all required information in the abbreviated public notice document and long form public notice document. To ensure compliance with federal regulations the State shared a draft of the public notice documents with CMS. As required by federal regulation the long form public notice document posted on DSS' website contains the required estimate. The State verified with CMS that federal regulations indicate the abbreviated notice should be published in the *South Dakota Register*. In the application and the long form public notice, the state estimated approximately 1,300 individuals will be enrolled annually in the demonstration based on the assumption that increased and decreased enrollment will be approximately equivalent.

The State emphasized that enrollment may change due to increased income or due to non-participation in the program and also conveyed that this is an estimate and the exact change in enrollment that will occur is unclear due to the new, unique, and individualized nature of the program. To provide additional clarity the State updated the application to reflect that approximately 15 percent of participants may lose coverage due to exceeding the Medicaid income limit or choosing not to participate.

The State anticipates the majority of these individuals will become ineligible due to increased incomes. Most of individuals whose income exceeds the income limit will maintain Medicaid coverage for up to two years through transitional Medicaid coverage and premium assistance offered as part of the program. At the conclusion of the TMB period it is anticipated that these individual will have employer sponsored coverage or qualify for a subsidy through the Marketplace based on the program's emphasis of helping individuals find jobs with employer sponsored insurance and emphasis on lifting participants out of poverty.

The State anticipates a small number of individuals will lose coverage during the demonstration period as a result of choosing not to participate in the program. The state

anticipates many of these individuals will reapply and regain coverage after the 90 day ineligibility period expires. The state is updating the application to reflect that anyone that loses coverage due to noncompliance with the Career Connector program, but is subsequently determined to qualify for a stated exemption and is otherwise eligible for Medicaid will have their eligibility reinstated starting the month they qualify for the exemption. The non-compliance section of the application has been updated to ensure individuals that lose coverage due to non-compliance and subsequently participate in the program again have sufficient opportunity to take corrective action should the need arise.

The State anticipates coverage losses will be small during the 5 year demonstration period due to a number of factors including the time associated with implementation of the program, a focus on education and training over immediate employment, the availability of transitional Medical coverage and premium assistance, flexible hours requirements, multiple corrective action opportunities, the “good cause” exemptions process, and case managers assisting participants.

32. Multiple comments raised concerns regarding the budget neutrality calculations either being difficult to understand, insufficient, or not accounting for administrative costs.

CMS provides the option for states to demonstrate budget neutrality based on aggregate expenditures or per member per month costs. South Dakota’s budget neutrality document is based on a per member per month cost not aggregate expenditures. The State’s budget neutrality is not premised on or tied to individuals losing Medicaid coverage or on reducing aggregate expenditures. Rather the budget neutrality is tied to improving the health of the population as is the stated goal of the demonstration.

Statewide data was used to produce a more robust historical per member per month cost, which was projected forward using the trend rate in the budget neutrality template made available by CMS. The use of statewide numbers to produce a more robust projection is consistent with previous guidance that CMS provided the State during review of the Former Foster Care Youth demonstration. CMS indicated when dealing with small numbers a broader pool should be used to produce a per member per month cost. Administrative costs are not part of CMS budget neutrality calculation.

33. Multiple comments expressed concern that other parts of the demonstration application were too vague to such as qualifying for an exemption and reinstatement after a period of noncompliance.

The State believes the demonstration proposal provided sufficient detail to provide comment on. The State utilized a stakeholder workgroup with broad representation as well as other key stakeholder input to refine the waiver prior to posting for public comment. Additional changes have been made to the waiver based on comments provided during the public comment period to further clarify provisions of the waiver. In an effort to ensure the application meets federal regulation completeness requirements

and sufficient detail was provided, the State shared a draft application with CMS to evaluate for completeness prior to starting the public notice period.

34. One comment indicated everyone should be working or looking for work to enhance their own self-esteem and set an example for children.

The Career Connector program is designed to help individuals looking for work to find meaningful work in a field the individual is interested in working in.

35. Multiple comments expressed support general support for the Career Connector program.

Thank you for your comments.

36. Multiple comments indicated that the program was designed to or would help individuals obtain greater independence or improve their financial situation for a better future.

The State agrees with your comment.

37. Multiple comments indicated that the program contains supports to help individuals overcome barriers to employment.

The State agrees with your comment.

38. One comment indicated the program provides a plan for individuals to succeed.

The State agrees with your comment.

39. One comment expressed concern about the State's ability to adequately assess the health of program participants and make referrals for necessary treatment.

Department of Social Services and Department of Labor and Regulation staff are supported by clinical professionals who possess the necessary knowledge to assess the physical and mental health of individuals. Program participants will also be able to provide statements from medical professionals currently involved in their care. Further, the State will utilize standardized screening tools to assess participant health and make referrals as necessary.

40. One comment sought assurance that medically frail individuals would be exempt from cost sharing for services and expressed concern about the continuity of care for individuals transitioning from Medicaid to private health insurance.

Cost sharing assistance will not be provided for individuals receiving premium assistance under the waiver. However, medically frail individuals receiving premium assistance would be transitioned back to Medicaid coverage if they were no longer able to work and met the eligibility requirements for coverage.

The State appreciates the concerns raised relating to continuity of care. While enrollment in private health insurance when transitioning from Medicaid is ultimately the responsibility of the individual, the State is committed to assisting those who have questions about the process and making necessary referrals. Further, the State has existing methods of electronically transferring application information to the Federal Health Insurance Marketplace for individuals whose Medicaid coverage will be terminated.

41. Multiple comments raised concerns about the ability of participants to afford deductibles, copays and coinsurance for private health insurance plans purchased through the premium assistance option in the waiver.

The intent of the State is to assist participants in obtaining employer sponsored insurance or earn an income which qualifies for advance premium tax credits through individualized employment plans. Individuals receiving premium assistance will continue participating in the Career Connector program until the one year period has expired or they have obtained employment with a greater income. The application has been updated to reflect that individuals not utilizing the full premium assistance amount may be able to use the remaining amount to assist with co-payments, co-insurance, and deductibles.

42. One comment sought assurances that individuals participating in the Career Connector program would continue to receive adequate notice of decisions concerning eligibility and maintain the ability to appeal decision with which they do not agree.

The proposed waiver makes no changes to existing timely notice, appeal and fair hearing requirements. 42 CFR §431.210 requires that any notice of adverse action inform the individual of their right to request a fair hearing and the circumstances under which Medicaid coverage may continue pending resolution of the appeal. This information will continue to be provided to Medicaid enrollees, including those determined to be ineligible based upon the requirements of the proposed waiver.

43. One comment stated that program participants may have a physical or mental condition which prohibits them from obtaining employment.

While some individuals eligible under parent and other caretaker relative coverage group are dealing with physical and mental condition, eligibility for this coverage group is based solely on financial circumstances. Those who do have a physical or mental impairment which prohibits them from working entirely will be exempt from the Career Connector program and those whose ability to work is limited may have an individualized employment and training plan which corresponds to the amount of activity they are capable of engaging in.

Demonstration Administration

The State's point of contact for the demonstration application is the following:

Sarah Aker, Deputy Director
Division of Medical Services
South Dakota Department of Social Services
607.773.3495
Sarah.Aker@state.sd.us

Appendix 1: Draft Evaluation Plan

The table below provides an overview of the preliminary plan for how the State will evaluate the Career Connector program.

#	Hypothesis	Methodology	Data Source and Metrics
Goal 1: Improve participant's health and encourage the development of healthy habits.			
1.1	Career Connector will promote the use of preventative care.	Track preventative care utilization rates by Career Connector participants and compare to historical utilization rates.	Claims data: <ul style="list-style-type: none"> Number, type, and frequency of preventative care services used.
1.2	Increased utilization of preventative care by participants will result in a reduction of non-emergency use of emergency department services.	Track emergency department utilization and compare to historical utilization rates.	Claims data: <ul style="list-style-type: none"> Number of emergency department visits.
1.3	Career Connector will result in increased behavioral health treatment.	Track behavioral health treatment.	Claims data: <ul style="list-style-type: none"> Number of participants initiating behavioral health treatment. Number of participants who initiated treatment and received follow-up services for a behavioral health diagnosis.
1.4	Career Connector will increase the general health knowledge of participants.	Track participation in health related classes. Survey participants regarding whether their general health knowledge increased.	Administrative data: <ul style="list-style-type: none"> Number of participants completing a health related course as part of their training plan.
1.5	Work is positively correlated with improved wellbeing.	Survey participants regarding whether work improved their health and wellbeing.	Participant survey: <ul style="list-style-type: none"> Percentage of participants that rate their general health higher since obtaining

#	Hypothesis	Methodology	Data Source and Metrics
			employment. <ul style="list-style-type: none"> Percentage of participants that rate their mental health higher since obtaining employment.
Goal 2: Empower participants to be successful in today's workforce.			
2.1	Career Connector will encourage professional development.	Track participants actively working toward completion of their individualized training plan.	Administrative data: <ul style="list-style-type: none"> Monthly number of participants actively working toward completion of their individualized training plan. Participant survey: <ul style="list-style-type: none"> Percentage of participants who believe they are better prepared to obtain employment.
2.2	Career Connector will encourage participants to obtain their GED certification.	Track participants preparing for, taking, and passing the GED examination.	Administrative data: <ul style="list-style-type: none"> Number of participants working toward a GED. Number of participants taking the GED examination. Number of participants passing the GED examination.
2.3	Career Connector will encourage participants to obtain relevant post-secondary education.	Track participant working toward and completing post-secondary education.	Administrative data: <ul style="list-style-type: none"> Number of participants working toward a technical degree. Number of participants completing a

#	Hypothesis	Methodology	Data Source and Metrics
			technical degree. <ul style="list-style-type: none"> • Number of participants working toward a career certificate. • Number of participants completing a career certificate. • Number of participants working toward an associate's degree. • Number of participants completing an associate degree. • Number of participants working toward a bachelor degree. • Number of participants completing a bachelor degree. • Number of participants obtaining employment in a field related to their post-secondary education.
2.4	Career Connector will encourage participants to obtain meaningful employment.	Track participants that obtain employment.	Administrative data: <ul style="list-style-type: none"> • Number and percentage of individuals employed. • Number and percentage of individuals that work 80 hours or more a

#	Hypothesis	Methodology	Data Source and Metrics
			<p>month.</p> <ul style="list-style-type: none"> • Number and percentage of individuals that work 120 hours or more a month • Number and percentage of individuals that obtain employment in a desired field of interest. • Number and percentage of individuals whose income increases to 100% FPL or higher. • Number and percentage of individuals whose income increases to 150% FPL or higher.
2.5	Career Connector will help individuals obtain a job with health benefits.	Track the number of participants that obtain a job with health benefits.	<p>Administrative data:</p> <ul style="list-style-type: none"> • Number and percentage of participants who obtain a job that offers employer-sponsored health insurance. • Number and percentage of participants that enroll in employer-sponsored health insurance.

Appendix 2: Budget Neutrality Worksheets - Statewide Data

Table 1: 5 Years of Historical Data

LIF Population	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	5-YEARS
Total Expenditures	\$ 49,714,584	\$ 53,623,677	\$ 65,168,654	\$ 66,602,205	\$ 70,909,414	\$ 306,018,534
Eligible Member Months	97,569	105,405	121,430	116,989	114,257	
PMPM Cost	\$ 509.53	\$ 508.74	\$ 536.68	\$ 569.30	\$ 620.61	
Trend Rates						5-Year
Annual Change						Average
Total Expenditure		7.86%	21.53%	2.20%	6.47%	9.28%
Eligible Member Months		8.03%	15.20%	-3.66%	-2.34%	4.03%
PMPM Cost		-0.16%	5.49%	6.08%	9.01%	5.05%

TMB Population	FFY 13	FFY 14	FFY 15	FFY 16	FFY 17	5-YEARS
Total Expenditure	\$ 13,262,047	\$ 13,785,051	\$ 11,901,636	\$ 12,024,940	\$ 12,072,379	\$ 63,046,053
Eligible Member Months	36,740	32,434	31,320	32,270	30,802	
PMPM Cost	\$ 360.97	\$ 425.02	\$ 380.00	\$ 372.64	\$ 391.93	
Trend Rates						5-Year
Annual Change						Average
Total Expenditure		3.94%	-13.66%	1.04%	0.39%	-2.32%
Eligible Member Months		-11.72%	-3.43%	3.03%	-4.55%	-4.31%
PMPM Cost		17.74%	-10.59%	-1.94%	5.18%	2.08%

Notes

1. South Dakota used statewide historical data.
2. Statewide data is being used to establish a PMPM cost and trend projection.
3. The numbers above do not reflect the projected Career Connector eligible member months or total expenditures.

Table 2: Without Waiver Projection

Eligibility Group	Trend Rate 1	Months of Aging	Base Year FFY 18	Trend Rate 2	Demonstration Years					Total WOW
					FFY 19	FFY 20	FFY 21	FFY 22	FFY 23	
LIF Population										
Pop Type: Medicaid										
Eligible Member Months	4.0%	12	118,862	4.0%	123,652	128,635	133,819	139,212	144,822	
PMPM Cost	5.1%	12	\$ 651.95	5.1%	\$ 684.87	\$ 719.46	\$ 755.79	\$ 793.96	\$ 834.05	
Total Expenditure					\$ 84,685,327	\$ 92,547,625	\$ 101,138,932	\$ 110,528,542	\$ 120,788,755	\$ 509,689,181
TMB Population										
Pop Type: Medicaid										
Eligible Member Months	-4.3%	12	29,474	-4.3%	28,204	26,988	25,825	24,712	23,647	
PMPM Cost	2.1%	12	\$ 400.09	2.1%	\$ 408.41	\$ 416.90	\$ 425.57	\$ 434.42	\$ 443.46	
Total Expenditure					\$ 11,518,829	\$ 11,251,500	\$ 10,990,465	\$ 10,735,479	\$ 10,486,550	\$ 54,982,824
Premium Assistance										
Pop Type: Medicaid										
Eligible Member Months	4.0%	12	118,862	4.0%	123,652	128,635	133,819	139,212	144,822	
PMPM Cost	5.1%	12	\$ 651.95	5.1%	\$ 684.87	\$ 719.46	\$ 755.79	\$ 793.96	\$ 834.05	
Total Expenditure					\$ 84,685,327	\$ 92,547,625	\$ 101,138,932	\$ 110,528,542	\$ 120,788,755	\$ 509,689,181

Notes

1. South Dakota is using a per capita method, which evaluates budget neutrality on PMPM costs.
2. Statewide eligible member months and total expenditures were used to produce PMPM projections.
3. The numbers above do not reflect the projected Career Connector eligible member months or total expenditures.
4. The premium assistance projection without the waiver is based on parent and other caretaker relative data with the assumption that these individual would otherwise be eligible for coverage under this eligibility group.

Table 3: With Waiver Projection

Eligibility Group		Demo Trend Rate	Demonstration Years					Total WW
			FFY 19	FFY 20	FFY 21	FFY 22	FFY 23	
LIF Population								
Pop Type: Medicaid								
Eligible Member Months	118,862	4.0%	123,652	128,635	133,819	139,212	144,822	
PMPM Cost	\$ 651.95	5.1%	\$ 684.87	\$ 719.46	\$ 755.79	\$ 793.96	\$ 834.05	
Total Expenditure			\$ 84,685,327	\$ 92,547,625	\$ 101,138,932	\$ 110,528,542	\$ 120,788,755	\$ 509,689,181
TMB Population								
Pop Type: Medicaid								
Eligible Member Months	29,474	-4.3%	28,204	26,988	25,825	24,712	23,647	
PMPM Cost	\$ 400.09	2.1%	\$ 408.41	\$ 416.90	\$ 425.57	\$ 434.42	\$ 443.46	
Total Expenditure			\$ 11,518,829	\$ 11,251,500	\$ 10,990,465	\$ 10,735,479	\$ 10,486,550	\$ 54,982,824
Premium Assistance								
Pop Type: Medicaid								
Eligible Member Months	29,474	-4.3%	28,204	26,988	25,825	24,712	23,647	
PMPM Cost	\$ 400.09	2.1%	\$ 408.41	\$ 416.90	\$ 425.57	\$ 434.42	\$ 443.46	
Total Expenditure			\$ 11,518,829	\$ 11,251,500	\$ 10,990,465	\$ 10,735,479	\$ 10,486,550	\$ 54,982,824

Notes

1. South Dakota is using a per capita method, which evaluates budget neutrality on PMPM costs.
2. Statewide eligible member months and total expenditures were used to produce PMPM projections.
3. The numbers above do not reflect the projected Career Connector eligible member months or total expenditures.
4. The premium assistance projection with the waiver is based on TMB data as premium assistance is based on the previous year's TMB PMPM.

Attachment 1: Public Notice Documents

Compact; and update the rules for nurse practitioners and nurse midwives. The general authority for these rules, as cited by the board, is SDCL §§ 36-9-21, 36-9-91, 36-9A-26, and 36-9A-41.

A public hearing will be held in the conference room at the South Dakota Board of Nursing Office, 4305 South Louise Avenue, Suite 201, Sioux Falls, South Dakota, on June 28, 2018, at 1:00 p.m. CT. Copies of the proposed rules may be obtained without charge from and written comments sent to the South Dakota Board of Nursing, 4305 S. Louise Avenue, Suite 201, Sioux Falls, SD 57106. Materials sent by mail must reach the Board by June 20, 2018, to be considered. This hearing is being held in a physically accessible place. Persons who have special needs for which the Board can make arrangements are asked to call (605) 362-2760 at least 48 hours before the public hearing.

NOTICE:

The **Department of Social Services** intends to submit an 1115 demonstration application to the Center for Medicare and Medicaid Services to implement the Career Connector program. The Career Connector program goals and objectives are to empower participants to be successful in today's workforce, and improve participants' health and encourage the development of healthy habits. The demonstration is a pilot project that will operate in Minnehaha and Pennington Counties; these counties were selected due to employment opportunities and availability of employment and training resources. The program is limited to adult recipients age 19 to 59 who are enrolled in the parents and other caretaker relatives eligibility group. The following individuals are exempt from participation: individuals who work 80 hours or more a month; those 18 or younger or 60 or older; full-time students; pregnant women; individuals whose eligibility has been determined on the basis of disability or who have been determined disabled by the Social Security Administration; medically frail

individuals (e.g. unable to work due to cancer or other serious or terminal illness); those already participating in a workforce participation program that the State has determined meets the objective of the Career Connector program (e.g. SNAP, TANF or unemployment insurance); parents of dependent children under one year old living in the parent's residence; and primary caregivers of elderly or disabled individuals living in the caretaker's residence. Participation in the program will be determined at the time of initial application or during the renewal review for individuals currently enrolled in South Dakota Medicaid. Exempt individuals may elect to participate in the program on a voluntary basis. Participants in the program will have an individualized training plan. The individualized plan will help individuals develop skills and abilities to assist the individual in obtaining employment in his or her desired field. The plan will include monthly milestones or goals, such as job or skill training. Individuals must complete milestones each month or work 80 hours or more a month. The program also intends to improve participants' health. The program will promote preventative care and help increase identification and treatment of behavioral health and chronic conditions. Participants will be assisted by a DSS case manager who will help ensure participants are successful. In addition, participants will be referred to appropriate support services to address barriers to employment. Support services may include, but are not limited to, transportation, rent assistance, and child care assistance. Support services are not funded by Medicaid expenditures. Some participants' earned income may increase and exceed the Medicaid upper income limit. At the conclusion of their Medicaid coverage these individuals may be eligible for premium assistance to help pay for employer-sponsored health insurance or coverage through a Qualified Health Plan for up to one year. Individuals who do not accomplish their monthly milestones or work 80 or more hours a month will be provided the opportunity to take corrective action. Continual failure to take

corrective action may result in closure of an individual’s Medicaid eligibility. A 30 day comment period will be held from May 21, 2018 through June 19, 2018. The State will also conduct two public hearings: May 24, 2018, at 11:00 a.m. CT, at the Department of Social Services, 811 East 10th Street, Sioux Falls, South Dakota, and May 31, 2018, at 1:00 p.m. MT, at the Department of Labor and Regulation, 2330 North Maple Avenue, Suite 1, Rapid City, South Dakota. Individuals requiring assistive technology or other services in order to participate in a meeting should submit a request to Marilyn Kinsman at (605) 773-3165 or by email to Marilyn.kinsman@state.sd.us at least 48 hours prior to the meeting in order to make accommodations available. Commenters may appear telephonically at the hearings; to do so, dial (866) 410-8397 and enter conference code 8176972761. A more detailed public notice and the proposed demonstration application

are available for review and comment on the Department’s website at <https://dss.sd.gov/medicaid/1115waiver.aspx>. Comments may be emailed to dss.medicaid@state.sd.us. Include “Career Connector Public Comment” in the subject line. Written requests for a copy of the demonstration application, and corresponding comments, may also be sent to Division of Medical Services, Department of Social Services, 700 Governors Drive, Pierre, SD 57501.

Note: A copy of the rules may be obtained directly from the above agencies or at <https://rules.sd.gov>. Write to the agency at the address given under "Notices of Proposed Rules." There is no charge for proposed rules. The following agencies have permission from the Interim Rules Review Committee to charge for adopted rules: the Division of Insurance, the Cosmetology Commission, the State Board of Examiners in Optometry, the State Plumbing Commission, the Board of Nursing, the Department of Social Services, the State Electrical Commission, the South Dakota Board of Pharmacy, the Real Estate Commission, the Gaming Commission, the Department of Revenue, and the Department of Labor and Regulation for Article 47:03.

REMINDER OF HEARINGS SCHEDULED

5-24-2018	Department of Transportation: Amend rules to change the speed limit from 35 to 25 miles per hour on portions of U.S. Highway 14A in and around Lead and Deadwood; 44 SDR 165, May 7, 2018.
6-7-2018	Department of Game, Fish and Parks: Amend rules to eliminate the preference point forfeiture; eliminate age requirements for mentored youth hunters to hunt big game seasons; repeal the current size of party limit for hunting; replace the term “factory-rated” with “rated”; require that at least a .50 caliber bullet be used when using muzzleloading handguns; clarify that muzzleloading handguns are authorized for use in big game seasons; require deer that are harvested from Custer State Park to be submitted for chronic wasting disease; allow an individual to carry a firearm while archery hunting as long as they possess a firearms big game license valid for the same geographic area and time of year as the archery license; allow an individual to possess a firearm while accompanying an archery hunter so long as the individual has a valid big game license for the same geographic area and time of year as the licensed archery hunter; repeal the required bowhunter education requirement for certain archery hunters; move the start date for the archery deer hunting season from the fourth Saturday in September to September 1; ban the use of certain snares and extend the time period that all snares are prohibited on public lands and improved road rights-of-way to the end of pheasant season; require trappers to mark their traps to identify who the trap belongs to; and require all fur dealers to list employees/agents on their application who will purchase or contract to purchase fur-bearing animals; 44 SDR 171, May 21, 2018.

PUBLIC NOTICE

South Dakota Medicaid Program

Notice is hereby given that the South Dakota Department of Social Services (DSS) intends to submit an 1115 demonstration (demonstration) application to the Center for Medicare & Medicaid Services (CMS) to implement the Career Connector program. The Career Connector programs goals and objectives are to 1) empower participants to be successful in today's workforce and 2) improve participants' health and encourage the development of healthy habits.

The demonstration is a pilot project. It will operate in Minnehaha and Pennington Counties. These counties were selected due to employment opportunities and availability of employment and training resources. The program is limited to adult recipients age 19 to 59 who are enrolled in the parent and other caretaker relatives eligibility group and exempts the following individuals from participation:

- Individuals who work 80 hours or more a month;
- Individuals age 18 or younger;
- Individuals age 60 or older;
- Full-time students;
- Pregnant women;
- Individuals whose eligibility has been determined on the basis of disability or who have been determined disabled by the Social Security Administration;
- Medically frail individuals (e.g. individuals unable to work due to cancer or other serious or terminal illness);
- Individuals already participating in a workforce participation program that the State has determined meets the objectives of the Career Connector program (e.g. SNAP, TANF or unemployment insurance);
- Parents of dependent children under one year old living in the parent's residence; and
- Primary caregivers of elderly or disabled individuals living in the caretaker's residence.

Participation in the program will be determined at the time of initial application or during the renewal review for individuals currently enrolled in South Dakota Medicaid. Exempt individuals may elect to participate in the program on a voluntary basis.

Participants in the program will have an individualized training plan. The individualized plan will help individuals develop skills and abilities to assist the individual in obtaining employment in his or her desired field. The plan will include monthly milestones or goals, such as job or skill training. Individuals must complete milestones each month or work 80 hours or more a month.

The program also intends to improve participants' health. The program will promote preventative care and help increase identification and treatment of behavioral health and chronic conditions.

Participants will be assisted by a DSS case manager who will help ensure participants are successful. In addition, participants will be referred to appropriate support services to address barriers to employment. Support services may include, but are not limited to, transportation, rent assistance, and child care assistance. Support services are not funded by Medicaid expenditures.

Some participants' earned income may increase and exceed the Medicaid upper income limit. At the conclusion of their Medicaid coverage these individuals may be eligible for premium assistance to help pay for employer-sponsored health insurance or coverage through a Qualified Health Plan (QHP) for up to one year.

Participants in the demonstration will continue to have the same benefits, cost sharing, and delivery system as those with full coverage under the Medicaid state plan. Individuals receiving premium assistance will have the benefits, cost sharing, and delivery system associated with the employer-sponsored health insurance or QHP they are enrolled in.

Individuals who do not accomplish their monthly milestones or work 80 hours or more a month will be provided the opportunity to take corrective action. Continual failure to take corrective action may result in closure of an individual's Medicaid eligibility.

The State will conduct analysis on no less than an annual basis to determine the outcomes associated with this demonstration. This analysis will test the following hypotheses using claims data, administrative data, and participant surveys:

- Career Connector will promote the use of preventative care.
- Increased utilization of preventative care by participants will result in a reduction of non-emergency use of emergency department services.
- Career Connector will result in increased behavioral health treatment.
- Career Connector will increase the general health knowledge of participants.
- Work is positively correlated with improved wellbeing.
- Career Connector will encourage professional development.
- Career Connector will encourage participants to obtain their GED certification.
- Career Connector will encourage participants to obtain relevant post-secondary education.
- Career Connector will encourage participants to obtain meaningful employment.
- Career Connector will help individuals obtain a job with health benefits.

The State estimates approximately 1,300 individuals in the parent or other caretaker relatives eligibility group will be enrolled in the Career Connector program annually. In

Federal Fiscal Year 2017, the annual aggregate expenditures for 1,300 individuals in the parent and other caretaker relatives eligibility group was approximately \$9,672,000. The department anticipates similar annual aggregate expenditures going forward. Annual enrollment may decrease due to earned income increasing for some individuals. In addition, annual enrollment may decrease due to non-participation. At this time it is not clear how much annual enrollment will change. Decreases in annual enrollment would also likely result in decreases in annual expenditures.

The demonstration application requests 1115(a)(1) authority to waive the below provisions of Medicaid law and section 1115(a)(2) expenditure authority to provide premium assistance to eligible Career Connector participants, implement non-compliance measures, and to pilot the program in Minnehaha and Pennington Counties.

- Comparability, Section 1902(a)(10)(B)
- Reasonable promptness, Section 1902(a)(3)
- Provision of medical assistance, Section 1902(a)(8) and 1902(a)(10)
- Statewide/uniformity, Section 1902(a)(l)

The non-federal share of Medicaid expenditures for this population will continue to be financed through State general funds.

The State will conduct two public hearings at the following times and locations:

May 24, 2018
11:00 AM CT
Department of Social Services
811 East 10th Street
Sioux Falls, SD 57103-1650

May 31, 2018
1:00 PM MT
Department of Labor and Regulation
2330 North Maple Ave, Suite 1
Rapid City, SD 57701 -7898

Individuals requiring assistive technology or other services in order to participate in a meeting should submit a request to Marilyn Kinsman via telephone at 605.773.3165 or via email at Marilyn.Kinsman@state.sd.us at least 48 hours prior to the meeting in order to make accommodations available. Commenters are allowed to appear telephonically at these hearings. To appear telephonically please dial 866.410.8397 and enter conference code 8176972761.

A copy of the proposed demonstration is available on the Department's website at <https://dss.sd.gov/medicaid/1115waiver.aspx>. Comments may be emailed to dss.medicaid@state.sd.us. Please include "Career Connector Public Comment" in the

subject line. Written requests for a copy of the demonstration, and corresponding comments, may also be sent to:

DIVISION OF MEDICAL SERVICES
DEPARTMENT OF SOCIAL SERVICES
700 GOVERNORS DRIVE
PIERRE, SD 57501-2291

A copy of the proposed demonstration application is available for public review and comment at the above-referenced address. A 30 day comment period on the Career Connector demonstration application will begin May 21, 2018 and end June 19, 2018. All comments should be submitted during this time period.

DEPARTMENT OF SOCIAL SERVICES

DIVISION OF MEDICAL SERVICES

700 GOVERNORS DRIVE

PIERRE, SD 57501-2291

PHONE: 605-773-3495

FAX: 605-773-5246

WEB: dss.sd.gov



May 21, 2018

RE: South Dakota Medicaid 1115 Demonstration Waiver

The South Dakota Department of Social Services intends to submit an 1115 demonstration (demonstration) application to the Center for Medicare & Medicaid Services (CMS) to implement the Career Connector program. The Career Connector program goals and objectives are to empower participants to be successful in today's workforce and improve participants' health and encourage the development of healthy habits.

The demonstration is a pilot project. It will operate in Minnehaha and Pennington Counties. These counties were selected due to employment opportunities and the availability of employment and training resources. The program is limited to adult recipients age 19 to 59 enrolled in the parents and other caretaker relatives eligibility group and exempts the following individuals from participation:

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- Pregnant women;
- Individuals whose eligibility has been determined on the basis of disability or who have been determined disabled by the Social Security Administration;
- Medically frail individuals (e.g. individuals unable to work due to cancer or other serious or terminal illness);
- Individuals already participating in a workforce participation program that the State has determined meets the objectives of the Career Connector program (e.g. SNAP, TANF or unemployment insurance);
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Individuals who do not accomplish their monthly milestones or work 80 or more hours a month will be provided the opportunity to take corrective action. Continual failure to take corrective action may result in closure of an individual's Medicaid eligibility.

The State will hold a 30 day public comment period on this demonstration proposal from May 21, 2018 through June 19, 2018. The State will also conduct two public hearings at the following times and locations:

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A detailed public notice and a copy of the proposed demonstration application are available on the Department's website at <https://dss.sd.gov/medicaid/1115waiver.aspx>. Please contact me within 30 days of receipt of this message with any questions or comments.

Sincerely,

A solid black rectangular box redacting the signature of the sender.

Sarah Aker
Deputy Director
Division of Medical Services
South Dakota Department of Social Services

CC: Lynne A. Valenti, Cabinet Secretary
Brenda Tidball-Zeltinger, Deputy Secretary
William Snyder, Director, Division of Medical Services
Carrie Johnson, Director, Division of Economic Assistance

Medicaid 1115 Demonstration Waiver

Brief Description: The Career Connector program focuses on helping individuals obtain meaningful work and improve their health. The demonstration is a pilot and will only operate in Minnehaha and Pennington Counties.

Estimate of Fiscal Impact, if Any: FFY18: \$0.00
FFY19: \$0.00

Reason for the Demonstration: To empower participants to be successful in today's workforce as well as improve participant's health and encourage the development of healthy habits.

Attachment 2: Public Comments from Organizations or on Letterhead

Office Of
CODINGTON COUNTY WELFARE

14 1st Ave. SE • Watertown, SD 57201-3695 • (605) 882-6286 • FAX: (605) 882-5243



June, 14, 2018

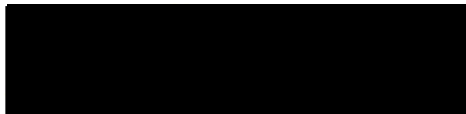
Bill Snyder, Director
Division of Medical Services
Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Dear Mr. Snyder,

It is the pleasure of the Codington County Welfare Office to write a letter in support for the South Dakota Department of Social Services 115 demonstration application to implement the Career Connector Program. We support a program that is designed to help people succeed and be healthy. By identifying barriers an individualized plan can be created to help a person take the next steps towards success. With the help of a supportive case manager, a person can work towards navigating these steps and challenges. The well-crafted program provides several essential wrap around supports, a key component to increase the likelihood of success. The program is designed to give a person time to economically transition and provides flexibility for life's unexpected situations. The overall design of the program is to ensure the individual is successful.

In conclusion, we fully support the efforts of the Department of Social Services as they seek a waiver to implement an innovative approach with the goal to help improve participants' health and welfare.

Sincerely,



Sarah Petersen
Director

**We oppose South Dakota's proposal
to take Medicaid away
from people who do not meet new work requirements**

Starting in Minnehaha and Pennington counties, South Dakota is proposing to take away Medicaid from parents who don't meet new work requirements. Low-income parents, even those with children as young as one year old, are the targets of this proposal, those with incomes less than approximately half the poverty line.

We oppose the plan for these reasons:

1. South Dakota's proposal will hurt families and children. Low-income parents, even with children age 12 months through 5 years, are at risk of having their health insurance taken away if they can't work enough hours each month. Losing coverage won't just affect parents— it harms children. When parents lack insurance, children are less likely to have regular doctor visits, more likely to become uninsured themselves, and more likely to experience financial insecurity. With this proposal, South Dakota is turning its back on a proud history of supporting children's health.

"As a single parent my schedule was often unpredictable. If my child got sick, I missed a shift and didn't get paid for those hours ... it became impossible to raise my son and earn a living wage ..." -Tina Keys

2. The proposal creates a CATCH-22 situation. If people try to keep their coverage by meeting the work requirement, they may lose coverage because their incomes would exceed South Dakota's very low income limits. It makes no sense to make people work to keep health coverage, only to take it away when they do.

Some in the program will be cut off Medicaid as they work more hours and income exceeds the limit. They'll get temporary help, but after that, unless a parent's job has benefits or income enough to qualify for subsidized insurance, that parent would have no coverage at all. Then costs for those individuals' catastrophic illnesses (that could possibly have been prevented) go to South Dakota citizens. [<https://www.cbpp.org/research/health/non-expansion-states-cant-fix-catch-22-in-their-proposals-to-take-medicaid-coverage>]

3. There are more ways people, including people with disabilities and working parents, will lose health coverage.

- **Red tape.** Documenting work-related activities makes it harder for everyone, especially people with physical disabilities or mental health needs, to stay covered, even if they are already working or if they qualify for exemptions.
- **Inconsistent job hours.** Some people could average over 80 hours a month over a year, but fall short in one or more months - for example, because their employer won't give them enough hours of work – and lose health care.

4. Native Americans will be disproportionately hurt by South Dakota's proposal. That's because Native Americans have very high levels of unemployment. Many also have significant health needs that make it especially dangerous to go without coverage.

Others who are opposed: *American Academy of Family Physicians, American Academy of Pediatrics, American Heart Association, Arthritis Foundation, Cystic Fibrosis Foundation, Leukemia & Lymphoma Society, National Multiple Sclerosis Society, National Alliance to End Homelessness, March of Dimes, American Diabetes Association, . . .*

5. Parents of young children should be exempted, not required.

States that now have Medicaid work requirements do not impose this requirement on parents of children as young as those in SD's proposal. They exempt parents caring for children younger than 6. Yet a large portion of those targeted in South Dakota are parents caring for children age 12 months to 6 years. The requirement is not appropriate for this group. It is widely recognized that (1) these parents have a lot on their plate already with small children and little money and (2) that the supports and case management that would be needed would not be cost effective for the state. Of course, any low-income parents should be offered the work supports, without any form of coercion.

6. Childcare

-- No funds for this additional childcare were included in the state budget. SD's childcare block grant is being fully used already.

-- Will the state workers be responsible for arranging for childcare at the odd and often variable hours of the jobs low-income people often find?

-- The childcare assistance cited in the proposal is not now available during volunteer assignments, or to part-time student parents, or to parents working fewer than 80 hours a month. What happens in these circumstances, such as when hours get cut?

-- SD has a "child care assistance cliff". Considering SD has the 4th lowest median hourly pay in the nation, it could take parents many years to rise up through the pay scale on the way to self sufficiency. On the way, parents will often encounter a "Child care assistance cliff." For example, For a mother of two earning \$1992 a month, a pay increase of \$86 will make her childcare assistance co-pay go up \$86 also. Why try to earn more?

7. Transportation

The proposal says the Dept. of Labor has funds to help with transportation. Will there be enough for car repairs and gas money, and not just bus passes? We hope so, but we do not know. 1300 families with incomes less than about half the poverty line would often have transportation needs, and the bus is not always the solution, especially when childcare is involved.

8. The lack of incentive to keep this group of young adults engaged.

National efforts to get young adults covered have noted the difficulty of inspiring 18-to-34-year-olds to sign up, even when subsidies are available and no work is required.

9. Staffing needs.

No staff hours or FTEs were included in the state budget for this program's intense management. South Dakota's caseworkers are overworked already.

10. Ability of staff to assess someone's health

Will caseworkers at Dept. of Social Services and Dept. of Labor have adequate ability to assess health conditions and recommend mental health or addiction treatments or other health measures?

11. Much of the help in the proposal is available already.

These are reasonable, even helpful, things people might do in order to better their situation. They should be available and encouraged without threat of losing Medicaid ie, without force.

12. The proposal's "Premium assistance" would leave people uninsured.

The proposal includes up to one year of assistance to buy full-price health insurance, if Medicaid is cut off and no other options are available. Paying for insurance with assistance of only about \$410 a

month (Unsubsidized insurance costs far more than that.), plus the deductibles and co-pays, would be impossible for parents with income less than 100% of poverty level.

13. This flawed proposal undermines the health promise of Medicaid and its core purpose. There are better incentives to connect people to work.

A better way: South Dakota should help with services - like health services, education opportunities, quality job training, child care - for anyone who needs help to find steady work, without taking away anyone's health coverage.

For all the above reasons, we ask that the proposal be withdrawn or rejected.

Signed,

South Dakota Chapter, National Association of Social Workers

Bread for the World-South Dakota, Cathy Brechtelsbauer, state coordinator, Sioux Falls

Nancy Olson, social worker, Sioux Falls

Jenn Folliard, nutritionist, Sioux Falls

Melanie Bliss, concerned citizen, retired Sioux Empire Homeless Coalition Coordinator, Sioux Falls

Peter Froelich, dad & student, Sioux Falls

Richard Fisher, United Methodist pastor, Deadwood

Donna Fisher, retired educator, community volunteer, Deadwood

Phyllis Arends, RN, community advocate, Sioux Falls

Legia L. Spicer, Watertown

Dianna Van Ravenswaay, Retired, Sioux Falls

Judith L Howard, Sioux Falls

Sister Ruth Geraets, Aberdeen

Rev. Mindy Ehrke, Clark

Rev. Christina Matson, Sioux Falls

Andrine Stricherz, Sioux Falls

Marilyn Teske, Pierre

Jerry Wilson PhD, Vermillion

Candace Grant, Sioux Falls

Sister Johanna Schumacher, Watertown

Sister Pat Prunty, Presentation Sisters Justice Coordinator, Aberdeen

Margaret Straley, concerned citizen, Sioux Falls

Jean rosenkranz, Degreed counselor, Rapid City

Sandra Ellingsen, Sioux Falls

Susan Torres, Retired teacher, Sioux Falls

Phyllis Cole-Dai, Brookings

Rev. Carl Kline, Brookings

Karen Brokenleg, Board Member of the Brain Injury Alliance of South Dakota, Sioux Falls

Norma Wilson, Doctor, Vermillion

Dave Mitchell, Mitchell

Fran Alberty, Bread for the World member, concerned citizen, Sioux Falls

Mary Kraljic, Brookings

Lorna Jost, Volga

Rick Jost, Volga

Diana Hane, Paraprofessionals Special Education, Watertown

Charlene Lund, Retired Nonprofit Program Manager, Pierre

Craig Spencer, College Professor, Sioux Falls
Connie Mogen, Sioux Falls
Mr. Lanny Stricherz, Sioux Falls
Sister JoAnn Sturzl, Sioux Falls
Michele Prestbo, Sioux Falls
Kevin Kolb, Sioux Falls
RozAnn Stricherz, Sioux Falls
Dan Varns, Sioux Falls
Andrew L'Amour, Brookings
Bryan Feuerhelm, Sioux Falls
Janet Blank-Libra, Sioux Falls
Sherry Nester, Sioux Falls
Sandra Bakker, Sioux Falls
Duane Bakker, Sioux Falls
Dr. Harriet Scott, Sioux Falls
Deb McIntyre, Valley Springs
Frank James, Toronto
Tama Backlund, Mitchell
James C Sorensen, Doctor, Sioux Falls
Harry Baltzer, Huron
Kathryn Hartigan, Sioux Falls
Paul and Pat Penn, Sioux Falls
Sister Pat Prunty, Aberdeen
Liz Bergstrom, Sioux Falls
Rich Lauer, Sioux Falls
Kerry Ruscitti, Sioux Falls
Ann McGovern, Sioux Falls
Constance Stock MD, Sturgis
Beth Walz Davis, Sioux Falls
David Kemp, Sioux Falls
Ann McLaughlin, Sioux Falls
Reynold F. Nesiba, State Senator, District 15, and Professor of Economics, Sioux Falls
Dale Nordlie, Sioux Falls
Nancy Everist, Brandon
Sister Gabriella Crowley, Aberdeen
Sharon Schulz-Elsing, Sioux Falls
Dr. Arley K. Fadness, Lutheran minister, Custer
David Wegner, Sioux Falls
Sheila Wood, Sioux Falls
Karin Lindell, Sioux Falls
Sister Theresa Hoffman, Watertown
Norma Knigge, Sioux falls
Cynthia and Glenn Wika, Sioux Falls
Nic Brokenleg, Social Worker, Sioux Falls
Rev. Cheryl Matthews, Sioux Falls
Pamela Naessig, Sioux Falls
Janine Scott, Sioux Falls
Scott Moeller, Sioux Falls
Denise Douthit, Sioux Falls
Carol Peterson, Sioux Falls
Deborah Billion, Sioux Falls

Shireen Ranschau, Social Worker, retired social services administrator, Sioux Falls
James Wassom, Sioux Falls
Gloria Houle, Retired social worker, Sioux Falls
Michelle Loseke, Sioux Falls
Karyn Veenis, Sioux Falls
Sister Eileen Brick, Watertown
Sister Francene Evans, Ph.D, Aberdeen
Mary Delaney, Mother and grandmother, Sioux Falls
Tom Houle, Retired college professor, Sioux Falls
Dorothy and John Brewick, Rapid City
Sister Mary Jo Polak, Yankton
Virginia Harrington, Sioux Falls
Chris Laughlin, Sioux Falls
Nancy Kusters, Sioux Falls
Ronald Rossing, MD, Sioux Falls
Martha Rossing, Sioux Falls
Jodi Schwab, Educator, mother, grandmother, Sioux Falls
Rebecca Clinton, Sioux Falls
Sister Pegge Boehm, Sioux Falls

A Supplement to the letter from NASW and BFW and many individuals

These comments are supplementary to the letter from National Association of Social Workers South Dakota Chapter and Bread for the World -South Dakota and a long list of individual signers.

South Dakotans value hard work. We also are aware of how work can promote health and well being. We endorse the goals of this proposal that aim to promote the health, health habits and, inasmuch as work is supported by good health, success in the workforce for Medicaid participants. Implicit in this proposal are flaws in its design that would actually lead to participants' loss of healthcare coverage with harm to parents, children and communities.

In general, my concerns are that this proposal:

- fails to provide adequate provisions for its implementation and
- fails to address how it could adversely affect those it intends to serve.

→ The proposal should include a budget to accompany its step-by-step protocol for its proposed support of Medicaid participants' entry into the work force. It has projections about premium assistance but not an estimate of other state costs. A projected budget should also include:

Staff hours
Staff training
Childcare
Transportation

Also, a budget should show how the proposal is revenue neutral. as written, the proposal does not give the reader enough information to show that this requirement is met.

→ Staff hours.

Upon asking the Dept. of Social Services about additional staff hours or FTE's, the response was: "Allocation of FTE will be based on participation. The Department plans to have two case managers available during the voluntary phase of the program."

Yet a significant increase in staff time would be required. Carrying out the proposal requires many tasks for state staffers: Develop "monthly milestones," track achievement, and verify hours worked; Make referrals (page 8) to community services, voc rehab, and assure WIOA supports (transportation, clothing) which also have reporting requirements; Assure (page 8) referrals to Child Care Assistance. In addition, the program's evaluation plan (pages 13-16) asks for data such as these that must be tracked and/or verified: number, type, frequency of preventive care services used; number of emergency room visits; behavioral health treatment usage; health course completions; clients' ratings of their health and mental state; clients' beliefs about their employability; GED participation and pass rate; Post-secondary ed participation and pass rate; employment hours and incomes; the benefits provided by the jobs.

Without staff hours or FTEs for these tasks, the capacity of South Dakota to do the required tracking and verifications will be severely hampered if not completely unworkable.

Additional staff hours would also be needed the Division of Child Care.

→ Staff training, liability

Caseworkers are not generally medically trained, yet they must assess and monitor mental and physical health. We note and appreciate that health is one of the goals of the program. However, it is a grave concern that the waiver request has no indication of the training that would be needed to enable caseworkers to assess, monitor and evaluate a parent's physical need for medical care, mental health services or addiction treatment. We think it would be rare indeed that the caseworkers would have the expertise or would want the liability that comes with these expectations of the program.

→ Childcare. From the Dept. of Social Services we have learned that about half of the projected group of participants have children in the age group 12 months through 5 years. This helps to inform the need for a vast array of childcare that will be required as parents attempt to meet the new requirements.

It should also be noted that the plan lacks clarity regarding who would be responsible for arranging for this childcare, but ascertaining these services would be a time burden for both parents and state employees.

→ Transportation. The additional information obtained on this critical need unfortunately does not relieve doubts about the availability of sufficient funds. The plan cites Workforce Innovation and Opportunity Act funds (WIOA) funds, which are administered by the Dept of Labor and Regulation (DLR). A request to the Dept of Labor for a report showing how much is used for transportation and whether some of these funds are available for a new program was answered by a reference showing which programs use the funds, not how much funding remains available. Without sufficient accounting of the WIOA funds, there is no way to tell if enough funds would be available for the transportation needs.

[<http://www.sdjobs.org/publications/documents/annrpt17.pdf> pages 4-12]

It should also be noted that buses do not often solve transportation needs, especially for situations that involve childcare. The Sioux Falls bus service reaches only part of the city, reaches none of the rest of Minnehaha county, and its routes have limited schedules. In Rapid city, the bus system covers more of the area, but the hours of operation are only 6:20am-5:50pm M-F and 9:50am-4:40pm on Saturdays.

→ Underperformance of current programs.

It should be instructive to take a look at South Dakota's current work programs for SNAP and TANF, which are administered by the same staff as the Career Connector would. For example, a brief report on the TANF work program in 2107 showed only 640 job entries among 3,331 TANF applicants. Only 21% of the job entries had medical benefits. The average starting wage was \$10.39, which does not sustain a family and which also means many jobs paid even less. This report does not show whether any pursued post-secondary education. [<http://www.sdjobs.org/publications/documents/annrpt17.pdf> on page 10]

This low level of success gives concern about the readiness of South Dakota to begin a new work program.

→ The "Coverage Cliff".

In South Dakota, the only Medicaid available to adults is for certain elderly and people with disabilities and for parents with extremely low incomes. The first two groups would be exempt from the Career Connector program, leaving parents with very low incomes as the only group that would be affected, the group in the states Medicaid Low Income Families program (LIF).

The upper income limit for LIF's Medicaid eligibility is approximately half the federal poverty line (FPL). (family of 2, 56%. Family of 3, 51%; family of 4, 47%; family of 5, 45%; family of 6, 43%; family of 7, 42%). Thus, there is a big income gap between the cut off for LIF Medicaid and 100% FPL, where subsidized insurance eligibility begins. Many more parents in the Career Connector would lose coverage, unless the Career Connector job placements are all jobs with incomes over 100% FPL, which is highly unlikely in South Dakota, which has the 4th lowest median hourly wage in the nation.

There is no assurance in the plan that parents who take jobs will be able to skip over the income gap in which they lose health coverage.

→ The unworkability of Premium Assistance.

This example illustrates the problem: A mother whose income cut her off of Medicaid found insurance for \$560 a month and is trying to pay this out of her limited budget. But she cannot actually use the insurance she purchased to visit a physician even though she is working and helping to pay premiums, because her deductible is \$7,000 and there would be co-pays.

Thus, for all practical purposes, there is only one year, the year with TMB, not two, in which the parent actually has healthcare after reaching the cut-off for LIF. With South Dakota's low wages, parents could work for a number of years before reaching an income (100% FPL) that provides eligibility to purchase subsidized insurance.

→ Red tape.

It is known that adding paperwork and appointments will cause some parents to drop off the rolls. Submitting paystubs, timesheets, or other documents, potentially from multiple employers, will be challenging for parent employees and create many chances for them to lose coverage due to inadvertent paperwork mistakes, whether their own or their employer's or the state's.

[www.cbpp.org/research/health/medicaid-work-requirements-will-harm-families-including-workers]

Not every family is able to function efficiently, especially given the combined demands of small children and deep poverty. These may be the states' most vulnerable families. Their loss of Medicaid can trigger a loss of health, against one of the stated goals of the plan.

→ Inconsistent job hours.

Variable work hours, seasonal work, hours are cut short without advance notice: any of these could mean Medicaid could be taken away even though people have jobs. [www.epi.org/files/pdf/114028.pdf]

This Medicaid work requirement puts parents who have outside-the-home jobs at risk of losing their health coverage, with potential to lose health also, or even life.

→ The lack of incentive.

It is a concern that there is not enough incentive to keep this group of young adults engaged in following the program's requirements. Some parents may think they can go to the community clinic with sliding-scale fees when they need healthcare, not realizing there are numerous parts of healthcare (like various tests, surgeries, medications) that are not available there. These losses, like the others, go against the goal of Medicaid to assure that the lowest income Americans have coverage when they need it. It is too big a risk for our state to take, even more so for families with single parents.

→ Harm to parents, children and communities, impeding the goal of promoting health.

The addition of a work requirement can add to the toxic stress that is experienced in too many low-income homes already. [http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf]

While some parents would benefit from the encouragement and direction from staff and some even from the threat of losing coverage, the proposal appears to assume that some parents will lose coverage. Why would we want anyone to lose health coverage?

In a 90-day sanction or after losing Medicaid completely, a parent could have a serious health condition. Without coverage she/he may delay checking some ailment or suspicion and could incur health problems and/or huge health bills before she/he could get back to DSS for Medicaid re-instatement.

In a 90-day sanction or a loss of Medicaid, a mother with no Medicaid could be pregnant. But South Dakota has a major emphasis on reducing child mortality, so it is critical that as many women as possible in childbearing years have optimal health coverage. In the long run, coverage benefits not only themselves but also the next generation of citizens and the budgets of the state and public schools.

The loss of health coverage could bring health crises and financial crises on these families with health detriments for the whole family.

When health expenses are sent to county government or written off, the public ultimately pays.

Bread for the World -South Dakota is and has been encouraging South Dakota to take Medicaid expansion, because we realize that adults not having health coverage can create both health crises and financial havoc impeding their efforts to provide for their families. If this proposal simply encouraged and supported efforts to help families achieve more family-sustaining income, it would have our wholehearted support. But the potential for loss of coverage is great enough to override the benefit of the work support. **For this and all the above reasons, please withdraw or reject this waiver proposal.**

The adults in this plan are caretakers of children, and these in particular have little money to work with. Taking away their Medicaid if they do not report enough work-related hours seems both unnecessary and harsh. Rather, parents should be offered the work supports and moral support, without a requirement to participate in a program that may at times appear to them more a threat than a help.

It is merciless for those of us with medical coverage to take it away from some poor soul who cannot afford it. Sure, that person may end up getting help for some major problem, with a big bill that is then paid by all of us anyway. Wouldn't it be better for that person's health condition to be found, treated and monitored before it takes the person's health - and maybe her life. I wouldn't want that on my conscience.

Sincerely,

Cathy Brechtelsbauer
2900 Poplar Dr, Sioux Falls SD 57105



**National
Multiple Sclerosis
Society**

June 18, 2018

Sarah Aker
Deputy Director
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Re: Section 1115 Demonstration Proposal for Career Connector

Dear Ms. Aker:

The National Multiple Sclerosis Society appreciates the opportunity to submit comments on South Dakota's Section 1115 Demonstration Proposal for the Career Connector program.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system. MS interrupts the flow of information within the brain, and between the brain and body. There is currently no cure for MS and since the disease is not fatal, a person can live with the disease their entire life. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted. Because of this unpredictability in symptoms, the ability to work can also become unpredictable.

The Society believes everyone should have access to quality and affordable healthcare coverage. Unfortunately, the proposed waiver will jeopardize access to healthcare by requiring certain people enrolled in the state's Medicaid program to either prove they work at least 80 hours per month or meet exemptions. This requirement would apply to parents and caregivers ages 19-59 with incomes below 51 percent of the federal poverty level (\$866 per month for a family of three), a vulnerable population that cannot afford additional barriers to healthcare coverage. The Society therefore urges the state to withdraw this proposal. People with MS should not be penalized if their health condition is preventing them from working, particularly in a manner that revokes health coverage and access to needed treatments and services. Promoting employment is a worthy goal, but there are better avenues to accomplish this, such as providing better workplace supports and more accessible transportation. Work requirements come with many unforeseen consequences that will impede work and access to needed health care.

The Society also wishes to highlight that on page nine of the proposal, South Dakota states that it cannot predict the impact of the waiver on enrollment or expenditures. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. To meet these transparency requirements, South Dakota must include these projections

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and their impact on budget neutrality provisions. If South Dakota intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.

One major consequence of the waiver will be to increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked and other “monthly milestones” they have met that are not fully defined. Ironically, work requirements could keep someone with MS from getting the coverage and services they need to be healthy enough to work. Or, people with MS could experience significant MS exacerbations that cause them to temporarily stop working and because of stringent work requirements, lose their health coverage. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.ⁱ

Failing to navigate these burdensome administrative requirements could have serious consequences for people with serious, acute and chronic diseases including MS. If the state finds that individuals have failed to comply with the new requirements for three months, they will have 30 days to prove their compliance or will be locked out of coverage for 90 days. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care. A growing body of evidence indicates that early and ongoing treatment with an MS disease-modifying therapy is the best way to modify the course of the disease, prevent accumulation of disability and protect the brain from damage—that as of now, is irreversible—due to MS.

The Society is also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees will likely have to provide documentation of their illness during the application and reassessment process, creating opportunities for administrative error that could jeopardize their coverage. No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent. People with MS may experience significant MS symptoms or exacerbations that temporarily interfere with their ability to work, but they may not meet some stringent definitions of “medically frail” or “disabled.” Even exempt Medicaid enrollees will have to provide documentation of their illness, creating opportunities for administrative error that could jeopardize their coverage.

South Dakota also proposes to provide premium assistance for up to one year to certain beneficiaries after their Transitional Medical Benefits expire. However, this premium assistance is capped and may not cover the full cost of individuals’ premiums. Additionally, individuals would not receive any assistance with cost-sharing such as copayments, coinsurance, and deductibles. Research has shown that cost-sharing for low-income populations limits the use of necessary healthcare services.ⁱⁱ To truly help these individuals access

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and use necessary healthcare services, South Dakota should pursue full Medicaid expansion up to 138 percent of the federal poverty level.

Administering these requirements will be expensive for South Dakota. States such as Michigan, Pennsylvania, Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.ⁱⁱⁱ Additionally, the state does not specify how it will pay for case managers that it proposes to assign for all program participants. These costs would divert resources from Medicaid's core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of South Dakota.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Many of the hypotheses that the waiver proposes to test – particularly 2.1 through 2.5 – are connected to employment outcomes but have no direct link to improving individuals' health. Additionally, most people on Medicaid who can work already do so.^{iv} A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.^v The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

The Society believes healthcare should be affordable, accessible, and adequate. South Dakota's Section 1115 Demonstration Proposal does not meet that standard, and the Society urges the state to withdraw this proposal. Thank you for the opportunity to provide comments.

Sincerely,

Dan Endreson
Senior Manager of Advocacy
National Multiple Sclerosis Society
200 12th Avenue South, Minneapolis, MN 55410
612-335-7930

ⁱ Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

ⁱⁱ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

ⁱⁱⁱ Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf>; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, <http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf>; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

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^{iv} Rachel Garfield, Robin Rudowitz, and Anthony Damico, “Understanding the Intersection of Medicaid and Work,” Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

^v Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med*. Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

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June 18, 2018

William Snyder
Director, Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501

Re: Career Connector Public Comment

Dear Mr. Snyder:

The Leukemia & Lymphoma Society (LLS) appreciates the opportunity to provide additional comments on the pending "Career Connector: A South Dakota 1115 Demonstration Proposal" waiver request. At LLS, our mission is to cure leukemia, lymphoma, Hodgkin's disease and myeloma, and improve the quality of life of patients and their families. LLS exists to find cures and ensure access to treatments for blood cancer patients. In light of that mission, LLS urges the state of South Dakota to withdraw its waiver request to protect patient access to needed services under Medicaid.

We believe that work requirements will have harmful and unintended consequences for access to health care in Medicaid. The entirety of public testimony on the waiver proposal in Sioux Falls and Rapid City spoke to similar concerns: organizations and private citizens unanimously said that work requirements go against the best interests of South Dakota residents and should not be pursued.

LLS believes firmly that all patients and consumers should have access to high quality, stable coverage to ensure that they are able to receive appropriate and timely care. Medicaid serves a vital role in making sure that no one is left without access to such coverage. While LLS is generally supportive of the flexibility offered by the Section 1115 waiver process, LLS believes that changes authorized through that process should not cause fewer people to receive or retain coverage or make it harder to obtain necessary health care.¹ It's on those grounds that LLS opposes the pending "Career Connector" proposal, as detailed in the concerns outlined below.

¹ Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care," Center on Budget and Policy Priorities, August 29, 2017, <https://www.cbpp.org/sites/default/files/atoms/files/8-28-17health.pdf>.

MEDICAID: A VITAL SOURCE OF COVERAGE

Medicaid guarantees access to life-saving care for low-income Americans

As the nation's public health insurance program for low-income children, adults, seniors, and people with disabilities, Medicaid covers 1 in 5 Americans.² Many of them have complex and costly health care needs, making Medicaid a critical access point for disease management and care for many of the poorest and sickest people in our nation.³ Today about 38,000 non-elderly, non-disabled adult South Dakotans rely on Medicaid to deliver the coverage they cannot find through work alone.

Thanks to Medicaid coverage, enrollees have access to screening and preventive care, which translates into well-child care and earlier detection of health and developmental problems in children, earlier diagnosis of cancer, diabetes, and other chronic conditions in adults, and earlier detection of mental illness in people of all ages.⁴ Medicaid also ensures access to physician care, prescription drugs, emergency care, and other services that – like screening and prevention – are critical to the health and well-being of any American.

Medicaid is a crucial source of coverage for specialty care too, including cancer care. In fact, evidence suggests that public health insurance has had a positive impact on cancer detection: researchers have determined that states that expanded Medicaid experienced a 6.4 percent increase in early detection of cancer from pre-Affordable Care Act (ACA) levels.⁵

WORK REQUIREMENTS

Making coverage contingent on work will disrupt access to care

Medicaid's core mission is to provide comprehensive coverage to low-income people so they can obtain the health care services they need.⁶ In service of that mission, the ACA streamlined Medicaid enrollment and renewal processes across all states.⁷ The intent was to reduce the number of uninsured and keep individuals covered over time by reducing the burden of paperwork. But in contrast, South Dakota's proposed work requirement will initiate a return to increased bureaucracy and paperwork and, in turn, coverage losses. It's because of those losses that LLS firmly opposes making Medicaid coverage contingent on work requirements.

Due to work requirements, the State of Alabama, for example, is projected to yield a drop of 8,700 beneficiaries in adult Medicaid enrollment in its first year alone. In a state with income requirements of only 18 percent of federal poverty level, some of these coverage losses will be triggered by a Catch-22 that is also applicable to South Dakota: many enrollees who comply with the new standards will earn too much to remain eligible for

² Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, January 2018, <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

³ Paradise, Julia, "Data Note: Three Findings about Access to Care and Health Outcomes in Medicaid," March 23, 2017, <https://www.kff.org/medicaid/issue-brief/data-note-three-findings-about-access-to-care-and-health-outcomes-in-medicaid/>.

⁴ Ibid.

⁵ Soni, A, Simon, K, Cawley, J, Sabik, L. Effect of Medicaid expansions of 2014 on overall and early-state cancer diagnoses [published online December 21, 2017]. *Am J Public Health*, doi: 10.2105/AJPH.2017.304166.

⁶ 42 U.S.C. 1396.

⁷ Kaiser Family Foundation, "Implication of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Processes," February 2018, <https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/>.

Medicaid coverage, but will still earn far too little to be able to afford private health insurance. The impact will be felt disproportionately among mothers, will hit rural communities harder, and will increase the odds that children in these families will face economic and health-related hardships.⁸

Work requirements will also result in some enrollees losing coverage not because they failed to maintain employment but because of difficulty navigating compliance processes or satisfying the burden of additional paperwork. When Washington State required increased reporting as part of its Medicaid renewal process, approximately 35,000 fewer children were enrolled in the program, despite the fact that many remained eligible. Families reported that they had simply lost track of the paperwork.⁹ It's important to note that many in the Medicaid population face barriers associated with disability, mental illness, insecure work, frequent moves, and homelessness – all factors that pose significant challenges to successfully navigating any system.

This effect has been borne out in other contexts too: data shows that in Temporary Assistance for Needy Families (TANF), for example, many people who were working or should have qualified for exemptions from work requirements lost benefits because they did not complete required paperwork or were unable to document their eligibility for exemptions.¹⁰

The fact is loss of coverage is a grave prospect for anyone, in particular a patient living with a serious disease or condition. People in the midst of cancer treatment, for example, rely on regular visits with healthcare providers, and many of those patients must adhere to frequent, if not daily, medication protocols. Thus LLS is seriously concerned that individuals who are unable to satisfy work requirements may end up going without necessary care, perhaps for an extended period of time. LLS is equally concerned about Medicaid enrollees who do not currently live with a cancer diagnosis; if during a lock-out period an individual develops blood cancer, it's likely the disease won't be diagnosed early enough to ensure the best possible health outcomes.

It's important to note that exempting some beneficiaries from having to comply with work requirements will not sufficiently mitigate the access barriers that will result from making coverage contingent on work. Under commercial health insurance, exemption and exceptions procedures have a long track record of limiting or delaying access to care for patients living with serious medical needs. At times this is due to the slow pace of the determination process. At other times, the challenge is simply understanding the exemption process itself or having the time and resources to pursue appeals. It's highly likely that, where it concerns exemptions from work requirements, Medicaid enrollees will find it similarly complicated, time-consuming, and expensive to secure and maintain an exemption.

⁸ Joan Alker, Phyllis Jordan, Olivia Pham, Karina Wagnerman, "The Impact of Alabama's Proposed Medicaid Work Requirement on Low-Income Families with Children," Georgetown University Health Policy Institute Center for Children and Families, March 20, 2018, <https://ccf.georgetown.edu/wp-content/uploads/2018/03/AL-Work-Requirements-3-19.pdf>.

⁹ Margot Sanger-Katz, "Hate Paperwork? Medicaid Recipients Will Be Drowning In It," *The New York Times*, January 18, 2018.

¹⁰ Solomon, Judith, "Kentucky Waiver Will Harm Medicaid Beneficiaries," Center on Budget and Policy Priorities, January 16, 2018, <https://www.cbpp.org/research/health/kentucky-waiver-will-harm-medicaid-beneficiaries>.

Implementation will strain already-limited government resources

Implementation of work requirements will obligate the state to devote significant resources to tracking work program participation and compliance or, alternatively, incur the cost of contracting out that function.¹¹ A draft operational protocol prepared for the implementation of Kentucky's proposed waiver illustrates the costs involved: nearly \$187 million in the first six months alone.¹² Similarly, Tennessee estimates that the implementation of a Medicaid work requirement would cost the state an estimated \$18.7 million each year.¹³

Yet, critically, states are already working under the strain of limited budgets; according to the Center for Budget and Policy Priorities, 32 states operated with a budget shortfall in fiscal year 2017 or 2018 alone, including South Dakota. If South Dakota is willing to increase its spending on Medicaid, those additional dollars ought to be prioritized for uses that are directly related to access to care, not the creation of a work requirements bureaucracy.

Ultimately, the requirements outlined in South Dakota's waiver proposal do not further the goals of the Medicaid program. Instead, they needlessly compromise access to care for a very vulnerable population. LLS urges you to focus instead on solutions that can promote adequate, affordable, and accessible Medicaid coverage for all South Dakotans.

Thank you for your consideration of LLS's comments on this important matter. If we can address any questions or provide further information, please don't hesitate to contact me at dana.bacon@lls.org or 612.308.0479.

Regards,



Dana Bacon
Regional Director, Government Affairs
The Leukemia & Lymphoma Society

¹¹ 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/>.

¹² *Roll Call*, "Medicaid Changes Require Tens of Millions in Upfront Costs," Feb. 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

¹³ *Ibid.*



May 23, 2018

William Snyder
Director, Medical Services
South Dakota Department of Social Services
700 Governors Drive, Kneip Building
Pierre, SD 57501-2291

Dear Mr. Snyder:

Our organizations write to ask you to withdraw the 1115 Demonstration Proposal released on May 22, 2018, as it fails to meet federal public notice and comment requirements for Section 1115 waivers.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country and in South Dakota. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage serious and chronic health conditions. The diversity of our groups and of those we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves.

The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on page 9 of this demonstration proposal, South Dakota states that it cannot predict the impact of the waiver on enrollment or expenditures. However, in order to meet these transparency

requirements, South Dakota must include these projections and their impact on budget neutrality provisions.

Again, we request you to withdraw this waiver until this information can be provided so that the public has an opportunity to comment on this important issue with adequate information.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Epilepsy Foundation
Hemophilia Federation of America
Hemophilia Foundation of Minnesota/Dakotas
Leukemia and Lymphoma Society
National Alliance on Mental Illness
National Multiple Sclerosis Society



American Cancer Society
Cancer Action Network
4904 S Technopolis Dr.
Sioux Falls, SD 57106
605.323.3559
acscan.org/sd

June 18, 2018

Sarah Aker
Deputy Director
Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Re: Career Connector – A South Dakota 1115 Demonstration Proposal

Dear Deputy Director Aker:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on South Dakota's Medicaid Section 1115 Demonstration Proposal. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that are helping to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

ACS CAN supports South Dakota's goal to improve the health and wellbeing of their adult Medicaid recipients, but we believe the proposed Career Connector program could negatively impact the adult Medicaid population, particularly cancer patients, survivors, and those who will be diagnosed with cancer in their lifetime. Over 5,000 South Dakotans are expected to be diagnosed with cancer this year¹ – many of whom are receiving health care coverage through the South Dakota Medicaid program. ACS CAN wants to ensure that cancer patients and survivors in South Dakota will have adequate access and coverage under the Medicaid program, and that specific requirements do not create barriers to care for low-income cancer patients, survivors, and those who will be diagnosed with cancer. We strongly urge the South Dakota Department of Social Services ("the Department") to address the following concerns or reject this waiver in its current form.

Career Connector Program

The requirement that all able-bodied adults residing in Minnehaha County or Pennington County be employed 80 hours per month or achieve monthly milestones in their "individualized plan" in order to maintain eligibility or enrollment in the Medicaid program could unintentionally disadvantage patients with serious illnesses, such as cancer. We understand the intent of the proposal is to incentivize employment, but many cancer patients in active treatment are often unable to work or require

¹ American Cancer Society. *Cancer Facts & Figures 2018*. Atlanta, GA: American Cancer Society; 2018.

significant work modifications due to their treatment.^{2,3,4} ACS CAN opposes tying access to affordable health care for lower income persons to work or participate in community engagement requirements because cancer patients, survivors, and those who will be diagnosed with the disease - as well as those with other complex chronic conditions - could find themselves without Medicaid coverage. Research suggests that between 40 and 85 percent of cancer patients stop working while receiving cancer treatment, with absences from work ranging from 45 days to six months depending on the treatment.⁵ If work and community engagement activities are required as a condition of eligibility, many cancer patients, recent survivors, and those with other chronic illnesses could find that they are ineligible for the lifesaving care and treatment services provided through the state's Medicaid program.

We appreciate the Department acknowledging that not all people are able to work and your decision to include several exemptions and good cause exceptions from the work or community engagement requirement and the associated lock-out period. However, the waiver does not go far enough to protect vulnerable individuals, including recent cancer survivors, and those with other serious chronic diseases linked to their cancer treatments.⁶ Additionally, the additional administrative requirements for enrollees to attest to their working status would likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not.

Lock-Out Period

We are deeply concerned about the proposed 90-day lock-out period for non-compliance with the Career Connector program. The Department offers individuals who have failed to complete the requirement a 90-day compliance grace period, where the Department of Labor and Regulation (DLR) establishes a corrective action plan for the enrollee that must be completed in 30 days. Additionally, the Department offers "good cause" exemptions for enrollees who have failed to meet the work requirements, but it is unclear how long the appeals process would take for good cause exemptions and whether the beneficiary would lose health coverage during the process.

If individuals are locked out of coverage during the good cause exemptions process or after their 90-day compliance grace period they will likely have no access to health care coverage, making it difficult or impossible for individuals being treated for cancer to continue treatment or pay for their maintenance medication until it is determined that they have "good cause." For those cancer patients who are mid-treatment, a loss of health care coverage could seriously jeopardize their chance of survival. Being denied access to one's cancer care team could be a matter of life or death for a cancer patient or

² Whitney RL, Bell JF, Reed SC, Lash R, Bold RJ, Kim KK, et al. Predictors of financial difficulties and work modifications among cancer survivors in the United States. *J Cancer Surviv.* 2016; 10:241. doi: 10.1007/s11764-015-0470-y.

³ de Boer AG, Taskila T, Tammimga SJ, et al. Interventions to enhance return to work for cancer patients. *Cochrane Database Syst Rev.* 2011; 16(2): CD007569. doi: 10.1002/14651858.CD007569.pub2.

⁴ Stergiou-Kita M, Pritlove C, van Eerd D, Holness LD, Kirsh B, Duncan A, Jones J. The provision of workplace accommodations following cancer: survivor, provider, and employer perspectives. *J Cancer Surviv.* 2016; 10:480. doi:10.1007/s11764-015-0492-5.

⁵ Ramsey SD, Blough DK, Kirchoff AC, et al. Washington State Cancer Patients Found to be at Greater Risk for Bankruptcy than People Without a Cancer Diagnosis," *Health Affairs*, 32, no. 6, (2013): 1143-1152.

⁶ Mehta LS, Watson KE, Barac A, Beckie TM, Bittner V, Cruz-Flores S, et al. Cardiovascular disease and breast cancer: Where these entities intersect: A scientific statement from the American Heart Association. *Circulation.* 2018; 137(7): CIR.0000000000000556.

survivor and the financial toll that the lock-out would have on individuals and their families could be devastating.

Premium Assistance Program

Although ACS CAN appreciates the state offering to help pay for Career Connector participants' private health insurance premiums as a "pathway from Medicaid to private health insurance coverage," we are concerned that even with the premium assistance, low-income Medicaid adults could still be unable to pay their share of private insurance premiums. The premium assistance program covers up to the previous year's Transitional Medical Benefit (TMB) per member per month amount, but the enrollee would be subject to the cost sharing terms and conditions of the plan into which they are enrolled, including any portion of premiums not covered by premium assistance and payment for any services not covered under the employer-sponsored plan or the Qualified Health Plan (QHP).

Individuals who are shifted from the Medicaid program to the premium assistance program could experience higher out-of-pocket costs and may be more likely to forgo needed care. Imposing copayments on low-income populations has been shown to decrease the likelihood that they will seek health care services, including preventive screenings.^{7,8,9} Cancers that are found at an early stage through screening are less expensive to treat and lead to greater survival.¹⁰ Uninsured and underinsured individuals already have lower screening rates resulting in a greater risk of being diagnosed at a later, more advanced stage of disease.¹¹ Proposals that place greater financial burden on the lowest income residents create barriers to care and could negatively impact Career Connector enrollees – particularly those individuals who are high service utilizers with complex medical conditions. We urge the Department to consider our recommendations to ensure that low-income South Dakota residents continue to have access to quality, affordable, and comprehensive health insurance.

Moving cancer patients and survivors out of the more robust Medicaid program and into employer-sponsored insurance or a QHP could result in reduced benefits and a significant increase in out-of-pocket cost sharing – even with premium assistance – making coverage less comprehensive and unaffordable. We are concerned that the proposal would leave individuals exposed to significant cost-sharing, beyond what is permitted under current federal requirements.

Premiums and cost sharing above the five percent of family income maximum for Medicaid enrollees would be particularly burdensome for a high-utilizer of health care services, such as an individual in active cancer treatment or a recent survivor. Cancer patients in active treatment require many services shortly after diagnosis and thus incur a significant portion of cost sharing over a relatively short period of time. It can be challenging for an individual – particularly an individual with limited means – to be able

⁷ Solanki G, Schauffler HH, Miller LS. The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research*. 2000; 34: 1331-50.

⁸ Wharam JF, Graves AJ, Landon BE, Zhang F, Soumerai SB, Ross-Degnan D. Two-year trends in colorectal cancer screening after switch to a high-deductible health plan. *Med Care*. 2011; 49: 865-71.

⁹ Trivedi AN, Rakowski W, Ayanian JA. Effect of cost sharing on screening mammography in Medicare health plans. *N Eng J Med*. 2008; 358: 375-83.

¹⁰ American Cancer Society. *Cancer Prevention & Early Detection Facts & Figures 2016-2017*. Atlanta: American Cancer Society; 2017.

¹¹ Ibid.

to afford their cost-sharing requirements. Likewise, a recent survivor may require frequent follow-up visits to prevent cancer recurrence. Having to pay the full cost up front would likely result in many cancer patients and survivors delaying their treatment and could result in them forgoing their treatment or follow-up visits altogether. We strongly urge the Department to reconsider increasing cost sharing for enrollees switching to the premium assistance program. If the Department were to move forward with this proposal, we request that the Department considering exempting individuals who meet the federal definition of “medically frail,” including cancer patients and recent cancer survivors.

Transitioning Coverage & Continuity of Care

Cancer patients undergoing an active course of treatment for a life-threatening health condition need uninterrupted access to the providers and facilities from whom they receive treatment. Disruptions in primary cancer treatment care, as well as longer-term adjuvant therapy, such as hormone therapy, can result in negative health outcomes.

We note that the South Dakota 1115 waiver amendment fails to provide specific provisions to ensure that individuals transitioning from the Career Connector program to premium assistance can continue to see their health care provider if medically necessary. Failure to consider the care delivery and/or treatment regimen of patients, especially those individuals managing a complex, chronic condition like cancer, could have devastating effects on patients, their families, and providers.

If the Department were to move forward with these provisions, we ask that you provide additional continuity of care provisions that would minimize disruptions in coverage and care for individuals in active treatment for life-threatening illnesses, such as cancer. Additionally, the state should establish a clearly defined process through which Career Connector enrollees being transitioned to premium assistance/TMB or their physician can inform the Department that they are in active treatment; allowing them to maintain their cancer care treatment regimen and continue to see their providers through the same health care systems through the end of their treatment.

Promoting Health

We commend the Department for wanting to improve health outcomes of its Medicaid enrollees by promoting the utilization of preventive services. We urge the Department to ensure that all preventive services recommended by the United States Preventive Services Task Force (USPSTF) are included as part of this effort. Early detection of cancer through preventive services generally results in less expensive treatments and better health outcomes.¹² For example, colorectal and cervical cancer screenings can prevent cancer by detecting and removing pre-cancerous lesions. Detecting these cancers earlier helps to save lives, as well as save state dollars, when cancers are caught at earlier, less expensive stages.

Conclusion

We appreciate the opportunity to provide comments on South Dakota's 1115 waiver demonstration proposal. The preservation of eligibility and coverage through Medicaid remains critically important for many low-income South Dakotans who depend on the program for cancer and chronic disease prevention, early detection, diagnostic, and treatment services. We ask the Department to weigh the

¹² American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2017-2018. Atlanta: American Cancer Society; 2017.

potential impact community engagement requirements, lock-out periods, and cost sharing requirements could have low-income South Dakotans' access to lifesaving health care coverage, particularly those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the South Dakota Department of Social Services to ensure that all South Dakotans' are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at 605.323.3559 or davidw.benson@cancer.org.

Sincerely,



David W. Benson
South Dakota Government Relations Director
American Cancer Society Cancer Action Network



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

*South Dakota
Section*

June 19, 2018

Sarah Aker
Deputy Director
Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

**RE: South Dakota Section of ACOG's Comments on the South Dakota Section 1115
Waiver Proposal: Career Connector**

Dear Deputy Director Aker,

The South Dakota Section of the American College of Obstetricians and Gynecologists (ACOG), representing 85 practicing obstetrician-gynecologists (ob-gyns), welcomes the opportunity to comment on the South Dakota Department of Social Services' Section 1115 Waiver: Career Connector. As physicians dedicated to providing quality care to women, we are concerned that the proposed waiver would place certain Medicaid beneficiaries at risk for financial harm and deter our patients from seeking necessary care. Additionally, we believe this waiver application does not meet federal regulations because it does not provide "a sufficient level of detail to ensure meaningful input from the public, including...an estimate of the expected increase or decrease in annual enrollment."¹ We encourage you not to submit this waiver for consideration by the Centers for Medicare and Medicaid Services (CMS).

Promoting Work

ACOG disagrees with the State's work requirement provision, despite the exemptions proposed for pregnant women and parents of dependent children under one year living in the parent's residence, and the initial smaller-scale implementation. We believe imposing a work requirement will be burdensome on Medicaid patients with limited resources. Indeed, as demonstrated by the experience of the Temporary Assistance for Needy Families (TANF) program, imposing work requirements on Medicaid beneficiaries would lead to the loss of health care coverage for substantial numbers of people who are unable to work or face major barriers to finding and retaining employment.² Most people on Medicaid who can work, do so. In fact, 70 percent of adult and child Medicaid patients in South Dakota are in families with at least one worker.³

Arbitrary requirements like those proposed in the State's 1115 waiver proposal will not help those who face major obstacles to employment overcome them.

Nationally, nearly eight in ten non-disabled adults with Medicaid coverage live in working families, and 60 percent are working themselves.⁴ Of those not working, more than one-third reported that illness or a disability was the primary reason, 30 percent reported that they were taking care of home or family, and 15 percent were in school.⁵ In addition, these types of work requirements would disproportionately and adversely impact the estimated 29,380 women age 19-64 currently enrolled in South Dakota Medicaid.⁶ According to an April 2017 post in *Health Affairs*, if work requirements, like the South Dakota proposal in question, were implemented nationwide, almost two-thirds (63 percent) of those at risk of losing coverage are women.⁷ As women's health care physicians, we must advocate against any policy that would jeopardize our patients' ability to access care.

The complexity of the requirements and how they interplay with the exceptions will likely increase the State's administrative burdens and costs without increasing employment rates. The experiences of TANF and federal housing assistance demonstrate that imposing such requirements on Medicaid beneficiaries would result in few, if any, long-term gains in employment rates.⁸ In addition to being ineffective in increasing employment over time, these types of requirements would add considerable complexity and costs to South Dakota's Medicaid program. State experience in implementing similar TANF requirements suggests that adding such requirements to Medicaid could cost South Dakota thousands of dollars per beneficiary.⁹ TANF caseworkers must spend significant time tracking and verifying clients' work activities and hours, and there is little indication that this 1115 waiver application would result in any less burden for the State's Medicaid staff.¹⁰ These additional costs would detract significantly from any anticipated savings and would divert much-needed funds from beneficiary care to cover unnecessary administrative costs. This proposal, in its pilot and statewide versions, will not bring about any positive gains to either Medicaid beneficiaries or the State budget.

Not only would there be a considerable administrative burden placed on the State's Medicaid staff and our Medicaid patients, but this requirement would also potentially impose administrative burdens on ob-gyns and other health care providers. We are troubled by the likelihood that physicians will have to provide documentation that proves our patients meet the exception that they are medically frail in order to maintain their coverage. Increasing our paperwork burden detracts from our ability to provide patient care and is antithetical to CMS' "Patients Over Paperwork" initiative. At a time when there are increasing reports of physician burnout and an anticipated growing physician shortage, placing more administrative burdens on South Dakota's ob-gyns and other health care providers may make it more difficult to attract and retain health care workforce in the State.¹¹ We believe that policymakers should be working to reduce barriers for ob-gyns to care for South Dakota's Medicaid patients, not placing more in our way.

Non-Compliance

Unlike private insurance, Medicaid is an entitlement program, established to ensure that health care is available to all, not just those with financial means. Medicaid allows Americans to have

access to the health care they need regardless of their socioeconomic status. The Medicaid program is a critical part of a continuum of coverage that assures non-elderly adults access to coverage even if their income fluctuates or their job status changes over time. South Dakota seeks to strictly enforce the proposed work requirement by threatening otherwise-eligible enrollees with a loss of Medicaid benefits for 90 days if they do not comply. This proposal is antithetical to the tenets of the Medicaid program. While the State proposes a few, very limited “good cause” exemptions, the mandated thirty-day time frame that enrollees have to report all changes to the State is far too short, and an enrollee “lockout” is too severe a penalty for an administrative oversight. Among the “good cause” exemptions included is a forward-thinking and necessary exemption for victims of domestic violence, which we thank the State for including. However, we must still oppose the proposed “lockout” of Medicaid enrollees for administrative noncompliance because it is too severe a penalty for failure to complete an administrative requirement on an unrealistic time frame. Disenrollment of our patients from the Medicaid program inhibits our ability to maintain continuity of care and to receive payment for services provided. When participants experience a lapse in coverage because of this provision, we will be forced to provide uncompensated care or refer patients to safety net providers, both of which disrupt our practice of medicine and increase the risk of adverse medical outcomes.

Illness and injury often occur at unexpected times. The State’s waiver application, as currently proposed, is ambiguous regarding how it would treat a woman who has been locked out of the Medicaid program for administrative noncompliance, but then becomes pregnant. At a minimum, this policy should be clarified to ensure that her pregnancy, including prenatal and postpartum care, is completely covered. As it stands, this waiver could deny Medicaid coverage to a woman in her childbearing years, who also does not have employer-sponsored or other job-based coverage. She would not have access to contraception to help her avoid pregnancy, which could endanger both her health and the health of any future children she may have. If this “lockout” provision is approved, we strongly recommend that a childless adult woman who becomes pregnant while locked out of the program be immediately made eligible for Medicaid, if she would otherwise qualify.

General Comments

According to federal regulations, states must give the public notice of any 1115 waiver application, and that notice must contain “a sufficient level of detail to ensure meaningful input from the public, including...an estimate of the expected increase or decrease in annual enrollment.”¹² Similarly, the waiver application is required to include “an estimate of the expected increase or decrease in annual enrollment,” as well as “enrollment projections expected over the term of the demonstration for each category of beneficiary whose health care coverage is impacted by the demonstration.”¹³ South Dakota fails to provide this information in its waiver application, effectively limiting the public’s opportunity to truly assess the impact of these proposed changes. This data must be provided, followed by another state-level, 30-day public comment period, before this waiver is submitted to CMS.

ACOG is a strong supporter of the landmark coverage and access gains made in the Affordable Care Act (ACA), including the expansion of coverage to low-income women through the Medicaid program.¹⁴ The positive impact of Medicaid coverage on maternal and child health

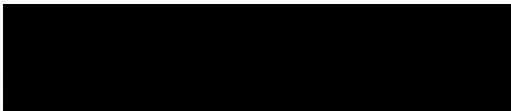
outcomes is well-documented.^{15,16,17,18,19} Medicaid expansion has increased insurance coverage among women of reproductive age with incomes below 100 percent of the Federal Poverty Level (FPL) by 13.2 percent, on average.²⁰ Further, recent research concludes that states expanding Medicaid coverage under the ACA saw greater declines in infant mortality rates between 2010 and 2016 than non-expansion states.²¹ These findings suggest that South Dakota should be looking for ways to increase access to care for Medicaid beneficiaries, not erecting new barriers through arduous work requirements. If the State truly wants to improve the health and wellbeing of its residents, we urge you to exercise your authority to expand Medicaid under the ACA.

South Dakota ACOG Recommendations:

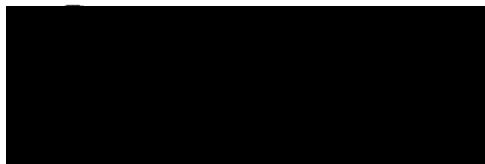
- Do not submit this waiver requesting creation of a work requirement.
- Do not submit this waiver requesting a lockout period for noncompliance.
- If submitted, clarify that women who become pregnant while “locked out” will be deemed eligible for Medicaid so long as they otherwise qualify.
- Revise the waiver to include a plausible Budget Neutrality Worksheet and begin a new state-level, 30-day public comment period.
- Adopt Medicaid Expansion as intended under the ACA.

Thank you for the opportunity to provide comments on the South Dakota 1115 waiver proposal. We hope you have found our comments useful. We would be happy to work with your office to develop solutions that both improve health outcomes and reduce the costs in the Medicaid program. To discuss these recommendations further, please contact Dr. Erica Schipper, South Dakota Section Legislative Chair, at elschipper@gmail.com, or Emily Eckert, ACOG Health Policy Analyst, at eeckert@acog.org or 202-863-2485.

Sincerely,



Rochelle Christenson, MD, FACOG
Chair, South Dakota Section



Erica Schipper, MD, FACOG
Legislative Chair, South Dakota Section

¹ 42 CFR 431.408(a)(1)(i)(C).

² Pavetti, LaDonna, Derr, Michelle, and Sama Martin, Emily. “Assisting TANF recipients living with disabilities to obtain and maintain employment: conducting in-depth assessments.” Mathematica Policy Research, Inc., February 2008.

³ Kaiser Family Foundation. Medicaid in South Dakota. June 2017. Available at: <http://files.kff.org/attachment/fact-sheet-medicaid-state-SD>

⁴ Kaiser Family Foundation. Understanding the intersection of Medicaid and work. Revised January 2018. Available at: <https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>

⁵ Ibid.

⁶ Kaiser Family Foundation. Women’s health insurance coverage. October 2017. Available at: <http://files.kff.org/attachment/fact-sheet-womens-health-insurance-coverage>

⁷ Ku, Leighton and Brantley, Erin. Medicaid work requirements: who’s at risk? Health Affairs Blog, Apr. 12, 2017. Retrieved May 4, 2018. Available at <http://healthaffairs.org/blog/2017/04/12/medicaid-work-requirements-whos-at-risk/>

⁸ Urban Institute. Work requirements in social safety net programs: a status report of work requirements in TANF, SNAP, Housing Assistance, and Medicaid. December 2017. Available at:

<https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf>

⁹ Gayle Hamilton *et al.*, “National evaluation of welfare-to-work strategies: how effective are different welfare-to-work approaches? Five-year adult and child impacts for eleven programs,” Manpower Demonstration Research Corporation, December 2001, Table 13.1.

¹⁰ Urban Institute. Work requirements in social safety net programs: a status report of work requirements in TANF, SNAP, Housing Assistance, and Medicaid. December 2017. Available at:

<https://www.urban.org/sites/default/files/publication/95566/work-requirements-in-social-safety-net-programs.pdf>

¹¹ Shanafelt, T. D., Hasan, O., Dyrbye, L. N., Sinsky, C., Satele, D., Sloan, J., and West, C. P. (2015). Changes in burnout and satisfaction with work-life balance in physicians and the general US working population between 2011 and 2014. *Mayo Clinic Proceedings*, 90:1600-1613.

¹² 42 CFR 431.408(a)(1)(i)(C).

¹³ Ibid.

¹⁴ American College of Obstetricians and Gynecologists. Health reform principles. January 2017. Available at: <https://www.acog.org/-/media/About-ACOG/ACOG-ACA-Principles.pdf?dmc=1&ts=20170310T1525289409>

¹⁵ Kaiser Family Foundation. Medicaid’s role for women. June 2017. Available at: <http://files.kff.org/attachment/Fact-Sheet-Medicoids-Role-for-Women>

¹⁶ Kaiser Family Foundation. Medicaid coverage of pregnancy and perinatal benefits: results from a state survey. April 2017. Available at: <https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-pregnancy-and-perinatal-benefits-results-from-a-state-survey/>

¹⁷ Jeffrey F. Peipert, Tessa Madden, Jenifer E. Allsworth, Gina M. Secura. Preventing unintended pregnancies by providing no-cost contraception. *Obstet Gynecol.* 2012;120(6):1291–1297.

¹⁸ Centers for Disease Control and Prevention, National Center for Health Statistics. Infant mortality rates by state, 2015. Available at: https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

¹⁹ Susan Marquis M, Long SH. The role of public insurance and the public delivery system in improving birth outcomes for low-income pregnant women. *Med Care.* 2002;40(11):1048–1059.

²⁰ Emily M. Johnston, Andrea E. Strahan, Peter Joski, Anne L. Dunlop, and Kathleen Adams. Impacts of the Affordable Care Act’s Medicaid expansion on women of reproductive age: differences by parental status and state policies. *Women’s Health Issues.* 2018;28(2):122-129. [https://www.whijournal.com/article/S1049-3867\(17\)30242-6/pdf](https://www.whijournal.com/article/S1049-3867(17)30242-6/pdf)

²¹ Chintan B. Bhatt, MBBS, MPH, and Consuelo M. Beck Sagué. Medicaid expansion and infant mortality in the United States. *Am J Public Health.* 2018;108(4):565-567. <https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.2017.304218>



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June 19, 2018

Ms. Sarah Aker, Deputy Director, Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

RE: South Dakota Medicaid 1115 Waiver Demonstration-Career Connector Public Comment

Dear Deputy Director Aker:

AARP welcomes the opportunity to submit comments on the proposed South Dakota 1115 Demonstration Waiver Proposal. AARP, with its nearly 109,230 members in South Dakota, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

As a non-Medicaid expansion state, South Dakota's Medicaid proposal will apply to an estimated 1,300 "parents and caretaker relatives eligibility group" who have very low incomes, up to 57 percent of the Federal Poverty Level (FPL). As such, we believe that many of the changes proposed in South Dakota's 1115 waiver proposal would adversely impact a large number of Medicaid recipients. If approved by the Centers for Medicare and Medicaid Services (CMS), and implemented, this would be an unprecedented step by a non-Medicaid expansion state and the waiver would likely worsen health outcomes; create significant financial hardship for many South Dakota Medicaid members in need of coverage; increase administrative costs to the state; and result in increased uncompensated care costs for South Dakota health providers.

Work Requirement

The Demonstration Proposal includes a work participation or job training requirement for adult Medicaid beneficiaries who reside in Minnehaha or Pennington Counties, with certain exemptions. Beneficiaries who are subject to this requirement must participate in the Career Connector Program "employment and training plan" such as employment, soft skills training, searching for a job, volunteer work, or certain education-related activities. Parents and other caretaker relatives must participate in work or job training activities for 80 hours or more per month or achieve "monthly milestones in their individualized plan," to maintain their Medicaid coverage.

Real Possibilities

AARP believes that the proposed waiver provision seeking to impose such a mandatory work requirement is not authorized by Section 1115 of the Social Security Act because it is not “likely to assist in promoting the objectives” of the Medicaid Act. 42 U.S.C. § 1315(a). Specifically, this provision is not likely to assist in promoting the objective of enabling the state “to improve the health and wellbeing of able-bodied adult Medicaid recipients while empowering them to obtain full-time meaningful work.” 42 U.S.C. § 1396-1(1). It would also present an unnecessary barrier to health coverage for a sector of South Dakota’s population that is most in need of coverage. This includes the many individuals who have recurring periods of illness due to chronic and behavioral health conditions who may be determined not to be exempted from employment-related activities. Moreover, we are concerned that it may be burdensome for individuals who should be exempt to continually prove they are meeting the requirements, which may lead to inappropriate denials of coverage.¹

It is also unclear how an individual will document that they have met the work requirements. Any new reporting system and process will impose new administrative costs on the state, including new staffing needs, to develop or expand the reporting system, verify the accuracy of member reporting, and conduct fact finding hearings. We believe that these costs will ultimately divert resources away from other pressing state priorities.

While we appreciate the inclusion of qualifying exemptions for certain beneficiaries, such as for individuals age 60 and older and for individuals with a disability or who are medically frail, we are concerned about imposing a work requirement upon parents and caregivers of children under the age of one. In addition, AARP believes that any work requirement must include clear exemptions for family caregivers beyond those proposed by the state. We strongly urge the state to ensure that beneficiaries who are family caregivers -- providing critical care for their loved ones of any age with chronic, disabling or serious health conditions -- regardless of the caregiver living in the same residence of their loved one -- are exempted from these work requirements. Further, we are concerned about the lack of additional information on what criteria the state will use to determine these exemptions, how a Medicaid beneficiary will be assessed for an exemption, and the lack of details about the process by which beneficiary hours will be verified.

In the event these proposed work and training requirements are permitted to be imposed as a condition of participation for South Dakota Medicaid benefits, it will be critical to maintain an individual’s due process rights and all existing Medicaid protections. Furthermore, we seek assurances that disputes will be fairly and expeditiously resolved; that individuals will continue to receive adequate notice of state agency actions and a meaningful opportunity to have unfavorable administrative decisions reviewed with reasonable promptness; that coverage of care will continue pending resolution of an appeal; and that Medicaid applicants and beneficiaries will retain their right to request a fair hearing on eligibility determinations and coverage issues, offers of proof, and request a new assessment if their situation changes.

The waiver application details that beginning July 1, 2018 the Career Connector program will be voluntary for qualified Medicaid recipients in the Minnehaha and Pennington counties. The program will become mandatory for qualifying Medicaid recipients in these two counties “within 90 days of CMS approving the demonstration.” In addition to our overall concerns outlined above, AARP questions the appropriateness of hastily moving forward with a CMS application for mandatory coverage without taking time to review and analyze results of the voluntary launch and evaluating the participant experience of the Career Connector program for the voluntary group of Medicaid recipients.

Support Services

The application also mentions referrals to “support services” for certain Career Connector enrollees. The waiver proposal states that these support services will include an “integrated resource team to facilitate referrals to community and support services.” While assistance with child care costs is identified as a support service, no similar assistance appears to be offered for family caregivers taking care of a loved one. The additional burden that will be placed on family caregivers as a result of the Career Connector program requirements will force families to make agonizing decisions about the care and safety of their loved one. We believe, in the event work requirements are imposed, that support services should be provided for all family caregivers regardless of their enrollment in the Career Connector Program. Referrals, at a minimum, should include home care assistance and respite services.

Transitional Medicaid Benefits

AARP appreciates the state’s attempt to address some of the coverage gaps that may result from Career Connector participants potentially earning incomes that will preclude them from qualifying for the Medicaid program. The state proposes to extend health care benefits for one year through Transitional Medicaid Benefits and one year of premium assistance for recipients who no longer meet the Medicaid income level. The extended benefits may temporarily help some, however, if it is the state’s goal to ensure that people continue to have health care coverage and want to encourage the development of healthy habits, we strongly encourage the state to expand Medicaid coverage to the approximately 13,000 South Dakotans whose annual incomes are too high to qualify for Medicaid at existing eligibility levels.

Lock-out

AARP has serious concerns with the proposal’s imposition of a 90-day lock-out period for members who do not meet Department of Labor and Regulation compliance requirements within a 30-day grace period. We believe that lock-out periods for low-income members with serious health needs would have particularly harsh consequences. For example, a Medicaid beneficiary with behavioral health needs may lose access to medication. The coverage gaps created by terminating enrollment will lead to added uncompensated care costs for providers, inability of health plans to manage care over time, and poorer health outcomes for members resulting in health conditions that will be more expensive to treat later.

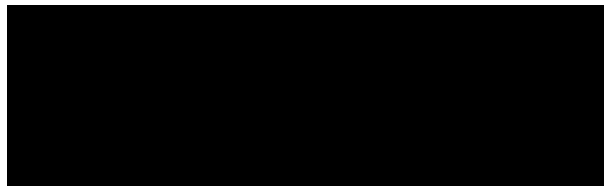
Inconsistent or interrupted healthcare coverage is likely to lead to increased use of more costly alternatives like emergency department visits, in-patient hospitalizations, and, in some cases, institutional placements. This is especially true for those who need substance abuse or mental health treatment.

While the state proposes a 90 day lock-out period for non-compliance, there are no further details on the process by which a termination may be lifted, how the termination may be appealed, or if the termination will be delayed pending an appeal. AARP is also greatly concerned about the undefined “suspend eligibility” language for recipients who continue to be non-compliant of the Career Connector program requirements. Again, no details are provided on if a continued non-compliant Medicaid recipient can eventually re-enroll in the Medicaid program.

Conclusion

We thank you for the opportunity to express our thoughts and concerns with this proposal, and we look forward to working with you to make improvements to this waiver request. If you have any questions, please contact Erik Nelson from AARP South Dakota at enelson@aarp.org, or 605-350-6348.

Sincerely,



Erik Gaikowski, State Director
AARP South Dakota

¹ https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/?utm_campaign=KFF-2017-Dec-Medicaid-work&utm_content=65347856&utm_medium=social&utm_source=twitter&stream=top-stories

Harold P. Wimmer
National President and
CEO

June 18, 2018

Sarah Aker
Deputy Director
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Re: Section 1115 Demonstration Proposal for Career Connector

Dear Ms. Aker:

The American Lung Association in South Dakota appreciates the opportunity to submit comments on South Dakota's Section 1115 Demonstration Proposal for the Career Connector program.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including over 81,000 South Dakota residents. The Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease through research, education and advocacy.

The Lung Association believes everyone should have access to quality and affordable healthcare coverage. Unfortunately, the proposed waiver will jeopardize access to healthcare by requiring certain people enrolled in the state's Medicaid program to either prove they work at least 80 hours per month or meet exemptions. This requirement would apply to parents and caregivers ages 19-59 with incomes below 51 percent of the federal poverty level (\$866 per month for a family of three), a vulnerable population that cannot afford additional barriers to healthcare coverage. The Lung Association therefore urges the state to withdraw this proposal.

The Lung Association also wishes to highlight that on page nine of the proposal, South Dakota states that it cannot predict the impact of the waiver on enrollment or expenditures. The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal

Advocacy Office:

1331 Pennsylvania Avenue NW, Suite 1425 North
Washington, DC 20004-1710
Ph: 202-785-3355 F: 202-452-1805

Corporate Office:

55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

with adequate information to assess its impact. In order to meet these transparency requirements, South Dakota must include these projections and their impact on budget neutrality provisions. On May 23, the Lung Association and eight other organizations sent a letter to Director Snyder requesting that this information be provided (Attachment A). If South Dakota still intends to move ahead with this proposal, the state should at a minimum provide the required information to the public and reopen the comment period for an additional 30 days.

One major consequence of the waiver will be to increase the administrative burden on all patients. Individuals will need to either prove that they meet certain exemptions or provide evidence of the number of hours they have worked and other “monthly milestones” they have met that are not fully defined. Increasing administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt or not. For example, after Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.¹

Failing to navigate these burdensome administrative requirements could have serious – even life or death – consequences for people with serious, acute and chronic diseases, including lung disease. If the state finds that individuals have failed to comply with the new requirements for three months, they will have 30 days to prove their compliance or will be locked out of coverage for 90 days. People who are in the middle of treatment for a life-threatening disease, rely on regular visits with healthcare providers or must take daily medications to manage their chronic conditions cannot afford a sudden gap in their care.

The Lung Association is also concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from working. Regardless, even exempt enrollees will likely have to provide documentation of their illness during the application and reassessment process, creating opportunities for administrative error that could jeopardize their coverage. No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

Administering these requirements will be expensive for South Dakota. States such as Michigan, Pennsylvania, Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.² Additionally, the state does not specify how it will pay for case managers that it proposes to assign for all program participants. These costs would divert resources from Medicaid’s core goal – providing health coverage to those without access to care – as well from other important initiatives in the state of South Dakota.

Ultimately, the requirements outlined in this waiver do not further the goals of the Medicaid program or help low-income individuals improve their circumstances without needlessly compromising their access to care. Many of the hypotheses that the waiver proposes to test – particularly 2.1 through 2.5 – are connected to employment outcomes but have no direct link to



improving individuals' health. Additionally, most people on Medicaid who can work already do so.³ A recent study, published in *JAMA Internal Medicine*, looked at the employment status and characteristics of Michigan's Medicaid enrollees.⁴ The study found only about a quarter were unemployed (27.6 percent). Of this 27.6 percent of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work.

South Dakota also proposes to provide premium assistance for up to one year to certain beneficiaries after their Transitional Medical Benefits expire. However, this premium assistance is capped and may not cover the full cost of individuals' premiums. Additionally, individuals would not receive any assistance with cost-sharing such as copayments, coinsurance, and deductibles. Research has shown that cost-sharing for low-income populations limits the use of necessary healthcare services.⁵ To truly help these individuals access and use necessary healthcare services, South Dakota should pursue full Medicaid expansion up to 138 percent of the federal poverty level.

The American Lung Association believes healthcare should be affordable, accessible, and adequate. South Dakota's Section 1115 Demonstration Proposal does not meet that standard, and the Lung Association urges the state to withdraw this proposal. Thank you for the opportunity to provide comments.

Sincerely,



Vanessa Marvin
Vice President, State Advocacy - Western Division

¹ Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.

² Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf>; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, <http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf>; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

³ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

⁴ Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med*. Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055

⁵ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

Attachment A



May 23, 2018

William Snyder
Director, Medical Services
South Dakota Department of Social Services
700 Governors Drive, Kneip Building
Pierre, SD 57501-2291

Dear Mr. Snyder:

Our organizations write to ask you to withdraw the 1115 Demonstration Proposal released on May 22, 2018, as it fails to meet federal public notice and comment requirements for Section 1115 waivers.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country and in South Dakota. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage serious and chronic health conditions. The diversity of our groups and of those we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves.

The federal rules at 431.408 pertaining to state public comment process require at (a)(1)(i)(C) that a state include an estimate of the expected increase or decrease in annual enrollment and expenditures if applicable. The intent of this section of the regulations is to allow the public to comment on a Section 1115 proposal with adequate information to assess its impact. However, on page 9 of this demonstration proposal, South Dakota states that it cannot predict the impact of the waiver on enrollment or expenditures. However, in order to meet these transparency

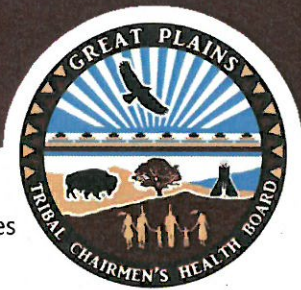
requirements, South Dakota must include these projections and their impact on budget neutrality provisions.

Again, we request you to withdraw this waiver until this information can be provided so that the public has an opportunity to comment on this important issue with adequate information.

Sincerely,

American Cancer Society Cancer Action Network
American Heart Association
American Lung Association
Epilepsy Foundation
Hemophilia Federation of America
Hemophilia Foundation of Minnesota/Dakotas
Leukemia and Lymphoma Society
National Alliance on Mental Illness
National Multiple Sclerosis Society

"So That The People May Live"



"Hecel Oyate Kin Nipi Kte"

South Dakota, Department of Social Services
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Attn: Sarah Aker, Deputy Director
Division of Medical Services, South Dakota Department of Social Services

Dear Ms. Aker,

Thank you for the opportunity to provide comments on Career Connector a South Dakota 1115 Demonstration Proposal. This proposal was developed in response to CMS's January 11, 2018 State Medicaid Director letter titled Opportunities to Promote Work and Community Engagement among Medicaid Beneficiaries.

As a GPTCHB representative to the Medicaid Work Requirement & Employment and Training Stakeholder Workgroup Member and as only one four American Indians to the workgroup, we have consistently opposed work and community engagement requirements as a condition of eligibility for Medicaid and have maintained that such requirements would serve as a barrier to enrollment of American Indian and Alaska Native (AI/AN) beneficiaries in Medicaid unless tribal governments receive an exemption from state requirements. Without an exemption dual IHS/Medicaid eligible, AI/AN beneficiaries would be disproportionately impacted negatively by the South Dakota 1115 Demonstration Proposal.

Approximately 30% of the Medicaid beneficiaries that would have work requirement imposed on them are AI/AN. The requirements imposed by the South Dakota 1115 Demonstration Proposal will have a devastating impact of the existing and potential enrollment of AI/ANs in Medicaid in Pennington County. The IHS budget for the Rapid City Service Unit is already less than half of the level of need, so any additional loss of Medicaid Revenue will have a drastic impact on the program.

A January 11th letter to state Medicaid directors and a January 17th letter to tribal leaders, both from CMS Director Brian Neale; takes the position that CMS cannot grant an exemption for Indians from state Medicaid waiver requests. CMS claims it cannot accommodate tribal governments, reasoning that doing so would be discriminating based on race. However, GPTCHB and tribes across the country believe CMS has ample legal authority to provide accommodations to AI/ANs in the receipt of health care without violating the Constitution's equal protection clause or, by extension, statutes prohibiting discrimination based on race.

This position is shared amongst a bipartisan congressional delegation that recognizes that there's longstanding legal precedent that established Native American tribes as separate governments that recently noted that "[F]ederal classifications fulfilling federal obligations to Indians are not based on race but instead on a political relationship between the tribes and the federal government."

While we disagree with CMS on this issue, CMS leadership recently indicate that it had reconsidered its policy and would be open to other alternative proposals from States that would accommodate tribal concerns. For example, Administrator Verma stated during her remarks to the American Hospital Association Annual Membership Meeting that the implementation of community engagement requirements can impact local tribes and affirmed that CMS allows states flexibility and discretion to work with tribes to try to help them achieve their goals and determine how best to apply community engagement to serve their populations. Following those comments, Calder Lynch, Senior Counselor to Administrator Verma told the Secretary's Tribal Advisory Committee meeting that CMS is actively considering a proposal by the State of Arizona that would exempt individuals who are not required to enroll in managed care. American Indians are one group that is not required to enroll in managed care in Arizona. He also mentioned that CMS would consider an exemption for IHS eligible individuals, although he noted that no state had proposed such an exemption. It is in that spirit that we recommend that the State include one of the following to the list of those exempted from participation:

- Individuals already exempted from cost sharing requirements under CMS rules
- Individuals dually eligible for Indian Health Service

As you may know, American Indians and Alaska Natives are exempt from cost-sharing because of concerns that imposing cost-sharing on them would discourage enrollment in the Medicaid program. The same concerns exist with regard to the proposed work requirements in Pennington County. We are concerned that this proposal will lead to large scale disenrollment by Indians in Pennington County from the Medicaid program, leading to significant reductions in third party billing opportunities for the Rapid City Service Unit. As you know, the Oglala Sioux Tribe, the Rosebud Sioux Tribe, and the Cheyenne River Sioux Tribe recently authorized the Great Plains Tribal Chairman's Health Board to assume the functions of the Rapid City Service Unit. The Tribes believe that collectively, through self-determination, they can provide significantly better health care services than the IHS is currently providing. However, they cannot do so if the State raises a barrier to Medicaid enrollment that has a unique effect on the Indian beneficiaries they serve. While we support any program that will increase employment for tribal citizens in the State, this program will not achieve that goal. Instead, it will discourage Medicaid enrollment for Indians. We urge the State to reconsider its position.

Lastly, the South Dakota Waiver is contradictory to the President Trump's Cut the Red Tape Initiative, which aims to address burdensome regulations across the entire federal government. CMS's initiative is called "Patients over Paperwork".

It is estimated that 1,300 recipients (without exemptions for users of IHS facilities) in these areas will meet the eligibility criteria for the Career Connector program. The bureaucracy and cost of

implementing the Career Connector program will far exceed any perceived benefit of implementing work requirements for a select few.

TH

[REDACTED]
Jerilyn Church, CEO
Great Plains Tribal Chairmen's Health Board

CC:

Kim Malsam-Rysdon, Secretary of the Department of Health

Lynne A. Valenti, Cabinet Secretary

Brenda Tidball-Zeltinger, Deputy Secretary

William Snyder, Director, Division of Medical Services

Carrie Johnson, Director, Division of Economic Assistance

Dr. Brian Shiozawa, Director of Intergovernmental and External Affairs, Regional 8, U.S. Department of Health and Human Services.

Kitty Marx, Director, Division of Tribal Affairs, Intergovernmental External Affairs Group, Center for Medicaid and CHIP Services, CMS

Timothy Hill, Acting Deputy Administrator & Director for the Center for Medicaid & CHIP Services (CMCS), Centers for Medicare & Medicaid Services (CMS), U.S. Department of HHS

South Dakota Tribal Leaders & Tribal Council Representatives



June 18, 2018

Sarah Aker
Deputy Director
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Dear Ms. Aker:

On behalf of the American Heart Association and the American Stroke Association (AHA/ASA), we would like to thank you for the opportunity to provide written comments on the South Dakota Career Connector Section 1115 Demonstration Proposal. As the nation's oldest and largest organization dedicated to fighting heart disease and stroke, we would like to express our significant concerns over the proposed changes put forward by your department.

The AHA represents over 100 million patients with cardiovascular disease (CVD) including many who rely on Medicaid as their primary source of care.¹ In fact, twenty-eight percent of adults with Medicaid coverage have a history of cardiovascular disease² and the Medicaid program provides critical access to prevention, treatment, disease management and care coordination services for these individuals. Because low-income populations are disproportionately affected by CVD – with these adults reporting higher rates of heart disease, hypertension, and stroke – Medicaid provides the coverage backbone for the healthcare services these individuals need.³

The connection between health insurance and health outcomes is clear and well documented. Americans with CVD risk factors who lack health insurance or are underinsured, have higher mortality rates⁴ and poorer blood pressure control⁵ than their insured counterparts. Further, uninsured stroke patients suffer from greater neurological impairments, longer hospital stays,⁶ and a higher risk of death⁷ than similar patients covered by health insurance. To treat and prevent heart

¹ RTI. Projections of Cardiovascular Disease Prevalence and Costs: 2015–2035, Technical Report. http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491513.pdf Accessed June 19, 2017.

² Kaiser Family Foundation. The Role Of Medicaid For People With Cardiovascular Diseases. 2012. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_cd.pdf. Accessed August 15, 2016.

³ Ibid.

⁴ McWilliams JM, Zaslavsky AM, Meara E, Ayanian JZ. Health insurance coverage and mortality among the near-elderly. *Health Affairs* 2004; 23(4): 223-233.

⁵ Duru OK, Vargas RB, Kerman D, Pan D, Norris KC. Health Insurance status and hypertension monitoring and control in the United States. *Am J Hypertens* 2007;20:348-353.

⁶ Rice T, LaVarreda SA, Ponce NA, Brown ER. The impact of private and public health insurance on medication use for adults with chronic diseases. *Med Care Res Rev* 2005; 62(1): 231-249.

⁷ McWilliams JM, Meara E, Zaslavsky AM, Ayanian JZ. Health of previously uninsured adults after acquiring Medicare coverage. *JAMA*. 2007; 298:2886 –2894.

disease and stroke, it is critically important to ensure that everyone in South Dakota – regardless of employment status – has access to affordable, quality healthcare.

Work Requirement

The inclusion of a work requirement to qualify for Medicaid coverage is deeply troubling to the association. Most people on Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage are members of working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason; 28 percent reported that they were taking care of home or family; and 18 percent were in school.⁸ Additionally, individuals with CVD often experience lapses in employment due to their condition or may have been directed by a physician to take time away from work as part of their treatment and recovery. Therefore, participation in work or work searches as a condition of Medicaid eligibility could discriminate against these individuals and create inappropriate and unwarranted barriers to medical care.

This proposal would limit access to health care coverage for parents and caregivers making less than 50 percent of the federal poverty level (approximately \$866 per month for a family of three) if they do not work at least 80 hours a month. The proposal lacks significant detail on how the requirement would be implemented, enforced, and funded – including clear definitions of who might be exempt from the requirement.

The intent of the 1115 Demonstration Wavier program is to increase access and test innovative approaches to delivering care.⁹ The application states that the objective of the program is for an individual to obtain meaningful work. This does not satisfy either requirement and could significantly harm patients, including those with CVD, by reducing their access to healthcare services both in the short and long term. Medicaid statute currently defines the factors states can consider in determining eligibility for Medicaid, such as income, citizenship and immigration status, and state residence. The statute does not include an individual's employment status or ability to work, whether or not they are seeking work, or their ability to engage in work-related activities as a permissible factor in determining Medicaid eligibility.¹⁰

While the AHA/ASA understands the need to address poverty and control costs, we are concerned that the proposed changes will require a substantial state investment in infrastructure that does not align with, and could detract from, the Medicaid program's goal of providing access to care. To that end, the application appears to be incomplete. The budget neutrality estimates included in the proposal do not include cost estimates and enrollment impact for the group of enrollees being impacted.

Additionally, implementing work requirements will necessitate new administrative processes and programs, which will require considerable financial resources that would be far better used to provide care to the populations that will be impacted by this proposal. The proposal indicates that the state plans to assign each effected beneficiary to a case manager. Yet it is not clear if the state already has an adequate number of case managers, if they plan to hire more, or how those positions would be funded.

⁸ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

⁹ <https://www.medicaid.gov/medicaid/section-1115-demo/index.html>

¹⁰ Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program, (March 2017).

Administering this program will be expensive. States such as Michigan, Pennsylvania, Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.¹¹ The 2017 Federal Budget cut Labor Department funding by 21%, shifting the responsibility to states for certain job placement programs. In addition, CMS has made it clear that it will not provide states with the authority to use Medicaid funding to finance employment related services for individuals. We are concerned that the proposal has not indicated how it will provide sufficient job training, child care, transportation, and other supportive programs to enable its affected Medicaid beneficiaries to meet the proposed requirement. Without such supports, we believe that the work requirements will not in fact result in more able-bodied adults working, nor produce positive health effects.

The process of documenting eligibility and compliance is likely to create barriers to accessing or maintaining coverage for patients. Battling administrative red tape in order to keep coverage should not detract from a patients' focus on maintaining their or their family's health. Furthermore, programs similar to this proposal, when implemented, have not been proven to increase employment or access to care.¹² According to the Medicaid and CHIP Payment and Access Commission (MACPAC), any employment gains that followed TANF work requirements tended to be temporary and short-lived, with limited positive effect on income.¹³

The imposition of new requirements will demand tedious reporting, which means more red tape for beneficiaries. Language barriers, disabilities, mental illness, insecure work opportunities, frequent moves, and temporary or chronic homelessness are more prevalent among the Medicaid population and are significant barriers to fulfilling these kinds of requirements. Preventing these people from obtaining and maintaining coverage will exacerbate the many barriers to care they already face and which Medicaid is intended to help beneficiaries overcome. Hinging health care coverage on the ability to find and maintain work penalizes the Medicaid population for their poverty. Preventing people from maintaining coverage will only exacerbate the many barriers to care they already face, and which Medicaid is intended to help beneficiaries overcome.

Non-compliance

Of additional and significant concern is the proposed lockout period for non-compliance with the work requirement. The application currently includes a 90-day process to comply with the new requirement before terminating coverage for 90 days. This is a harmful policy that will penalize South Dakotans, forcing them to be without coverage, putting their health and financial future at risk. CVD patients require regular care and medication to manage their conditions. For example, many patients rely upon medication to keep their blood pressure in check, and to avoid heart disease, stroke, and kidney failure.

¹¹ Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf>; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, <http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf>; Misty Williams, "Medicaid Changes Require Tens of Millions in Upfront Costs," Roll Call, February 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

¹² Garfield, R, Rudowitz, R, Damico, A. Kaiser Family Foundation Issue Brief: Understanding the Intersection of Medicaid and Work. Revised December 2017. Accessed January 5, 2018 at: <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>

¹³ Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF. MACPAC. October 2017. At: <https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf>

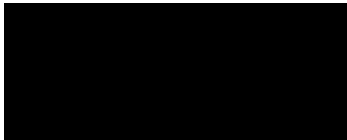
Losing coverage could create a life-threatening barrier to care for patients with cardiovascular disease as these individuals are unlikely to have access to ongoing and necessary treatments and medications.

Premium Assistance

Lastly, we express concern over the premium assistance concept. In this proposal, premium assistance is only available to some beneficiaries who are able to meet certain criteria and have an income below 100% FPL. We are deeply concerned that those who do will face significant financial risk as the assistance has a capped amount and is not guaranteed to cover the full cost of a premium. Additionally, the state is offering no cost-sharing benefits, leaving the parent responsible for the cost of copayments, coinsurance, and deductibles. Research suggests that cost sharing may not result in the intended cost-savings because low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes.¹⁴ This is of particular concern for heart disease and stroke survivors managing chronic conditions over long periods of time who could experience lapses in needed medication and treatments.

For the reasons listed above, the association strongly opposes this measure and strongly recommend that the state refocus its Medicaid resources on improving the health of the patients it serves, rather than imposing additional and unjustified administrative burdens with little or no proven return on investment. Thank you for reviewing our comments and hope that the department will take the experiences and expertise offered by the association under serious consideration. We appreciate the opportunity to provide feedback on this application. If you have any questions, please contact Justin Bell – Regional Vice President of Advocacy for SD, MN, IA.

Sincerely,



Justin Bell – J.D.

Regional Vice President of Advocacy
American Heart Association
2750 Blue Water Road, Suite 250 – Eagan, MN 55121
justin.bell@heart.org | www.heart.org P 952.278.7921

¹⁴ See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. *J Gen Intern Med.* 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." *Center on Budget and Policy Priorities* (July 2005), available at <http://www.cbpp.org/5-31-05health2.htm>.



South Dakota Department of Social Services
Division of Medical Services
Care of: Sarah Aker, Deputy Director
700 Governors Dr.
Pierre, SD 57501

RE: Career Connector Public Comment

Dear Ms. Aker,

Thank you for the opportunity to provide comment on South Dakota's Career Connector ("Career Connector"), a Medicaid 1115 Waiver Proposal. LEAD (Leaders Engaged and Determined) South Dakota, is non-profit, non-partisan organization focused on bringing awareness to issues facing South Dakota, the United States, and abroad that would effect positive change for women and families in South Dakota. Our grassroots network of over 2,500 members, the majority of which are South Dakotans, is built on our core values of inclusion, civility, action, social justice, and empowerment¹.

LEAD, like many South Dakotans, know there is value in work, and agree that it is a worthwhile use of public funds to invest in evidenced-based programs that connect people to jobs, work training programs or community volunteer opportunities. Since the release of this proposal we have learned that of the 1300 individuals that are the target population, 87% are women and as many as half have children between the ages of 1 and 6 years old. LEAD is concerned that this proposal will adversely impact very low-income South Dakota families with young children.

As you know, Medicaid in South Dakota only serves the very neediest families, who have less than a monthly income of \$990 for a family of four². Studies show that when parents have healthcare coverage, their children have better odds of receiving the healthcare that they need to grow and reach their full potential³. LEAD is concerned that this proposal would create a "catch 22" for families with young children that ultimately results in no healthcare coverage for the caretakers in the family.

The "catch 22" that very low-income South Dakotan families will face is highlighted in a recent report released from the Center on Budget Policy and Priorities⁴. The report notes that as family

¹ LEAD South Dakota. Accessed at <https://leadsouthdakota.org/> on June 14, 2018

² South Dakota State Department of Social Services. Medical Programs Available in South Dakota. Accessed at <https://dss.sd.gov/medicaid/generalinfo/medicalprograms.aspx> on June 14, 2018

³ Venkataramani M, Pollack CE, Roberts ET. Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services. *Pediatrics*. 2017;140(6):e20170953

⁴ Center on Budget Policy and Priorities. *Non-Expansion States Can't Fix "Catch-22" in Their Proposals to Take Medicaid Coverage Away From Parents Not Meeting Work Requirements*. June 12, 2018 Accessed at



earnings increase they no longer qualify for Medicaid, but still cannot afford health insurance premiums to actually utilize the healthcare system. While the Career Connector program attempts to ease this transition, unfortunately purchasing healthcare coverage still costs more than what these families can afford and makes healthcare coverage out of reach.

As discussed above, this proposal may create scenarios where healthcare coverage for parents is out of reach, ultimately impacting the health of their children. Other considerations that promote work and self-sufficiency, like varying transportation options to and from worksites, and increased demand for quality, affordable childcare need to be addressed when the target audience is families with young children. These concerns make it difficult to achieve the intended goal of the proposal, to better the health of low-income families in South Dakota.

Thank you for the opportunity to provide comment on this proposal. If you have any questions, please contact LEAD South Dakota at board@leadsouthdakota.org

Sincerely,

LEAD South Dakota Board of Directors

Susan Kroger
Carmen Toft
Stacey Burnette
Nikki Gronli
Roxanne Hammond
Sonia Hernandez
Taneeza Islam
Michaela Seiber
Kelly Sullivan
Jennifer Noll Folliard

<https://www.cbpp.org/research/health/non-expansion-states-cant-fix-catch-22-in-their-proposals-to-take-medicaid-coverage> on June 14, 2018



June 19, 2018

Sarah Aker
Deputy Director
Division of Medical Services
700 Governors Drive
Pierre, SD 57501-2291

Re: Section 1115 Demonstration Proposal for Career Connector

Dear Ms. Aker,

National Patient Advocate Foundation (NPAF) appreciates the opportunity to submit comments to South Dakota's Section 1115 Demonstration Proposal for the Career Connector program. We strongly urge the state to withdraw this proposal that would subject parents and caregivers, aged 19-59 below 51 percent of the federal poverty level, to work requirements as a condition of eligibility.

NPAF represents the voices of millions of adults, children and families coping with serious and chronic illnesses nationwide as the advocacy affiliate of Patient Advocate Foundation (PAF). PAF provides direct case management, financial support, and educational services to tens of thousands of primarily low-income patients and caregivers each year who are experiencing distressing financial, employment, insurance coverage, or material hardships because of their health conditions. Over the past ten years, PAF has served as an important safety net for hundreds of patients and families in South Dakota.

NPAF supports person-centered initiatives that ensure all patients and families have equitable access to affordable, quality care. We echo the concerns of the broader patient community that conditioning coverage on 80 hours of work activity per month may have serious unintended consequences for the affected Medicaid beneficiaries and inadvertently reduce access to care.

Foremost, we question the value of a waiver that would subject such a small subset of Medicaid beneficiaries to a work requirement – an estimated 1,300 would meet criteria for the Career Connector Program out of over 115,000 beneficiaries enrolled.^{1,2} Additional analysis has confirmed that only six percent of adult Medicaid beneficiaries are not already working and would likely not meet an exemption.³ We ask that South Dakota consider whether the benefit of instituting a work requirement applicable to such a small percentage of overall beneficiaries outweighs the risk of terminating coverage for patients and families relying on Medicaid as a lifeline.

In practice, written communication to inform people about new work requirements and eligibility may not suffice without supplemental outreach. As beneficiaries do become aware of the requirements, the paperwork burden coupled with any existing household material hardships they may be experiencing

¹ Medicaid Work Requirements & Employment and Training Stakeholder Workgroup Meeting Minutes. April 4, 2018. Available at: https://dss.sd.gov/docs/medicaidworkgroup/Minutes_4.4.18.pdf

² Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data. Available at: <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/monthly-reports/index.html>

³ Kaiser Family Foundation. Implications of Work Requirements in Medicaid: What Does the Data Say? Jan 12, 2018. Available at: <http://files.kff.org/attachment/Issue-Brief-Implications-of-Work-Requirements-in-Medicaid-What-Does-the-Data-Say>

can preclude them from complying even if they are pursuing work activities. Low-income patients will often sacrifice paying living expenses to afford medical treatment as they cope with serious, chronic illness. In fact, PAF case managers consistently report that household material hardships such as inability to afford transportation, rent or mortgage and utilities were among the top five issues among patients seeking assistance.⁴ People's ability to receive healthcare should not be restricted because of separate challenges balancing financial and household material hardships.

We appreciate South Dakota's intent to connect all non-exempt program participants with a case manager to assist beneficiaries in meeting the work requirements. However, since South Dakota has not indicated that additional federal funding is available for work support services such as child care, job training and transportation, we remain concerned that patients will face mounting challenges in meeting the proposed work requirements. Importantly, we fear that the proposed non-compliance policy that would lock individuals out of Medicaid coverage for 90 days would further penalize vulnerable families and exacerbate gaps in care.

Coverage losses would lead to disruptions in chronic disease management and delays in treatment. As a result, people's health and well-being would suffer and counteract the demonstration waiver goals of improving patients' health, encouraging the development of healthy habits and empowering beneficiaries to be successful in today's workforce. We ask that South Dakota consider the harmful implications of the waiver request to the many beneficiaries that actuaries estimate will not comply with work requirements and therefore lose coverage.⁵

Finally, we are disappointed by the exemptions list that outlines medically frail or disabled individuals and parents of children less than one year old. We urge South Dakota to reconsider the exemptions list to include parents with children up to age six or any parents that reside with minor children to prevent families coping with health conditions from experiencing additional discrimination, stress and hardship.

Complex factors lead patients to enter and rely on Medicaid. We request that South Dakota protect patients from losing their health care by withdrawing this Medicaid demonstration proposal. NPAF stands ready to provide person-centered insights South Dakota takes steps to reform its Medicaid program. Please contact Nicole Braccio, policy director, at 202-308-0247 or Nicole.Braccio@npaf.org if we can provide further details or assistance.

Respectfully submitted,



Rebecca A. Kirch
EVP Health Care Quality and Value

⁴ Patient Advocate Foundation. 2017 Annual Impact Report. Available at: https://dev.patientadvocate.org/wp-content/uploads/sites/8/2017_AnnualImpactReport.pdf

⁵ Society of Actuaries. In the Public Interest. Issue 16. Jan 2018. Available at <https://www.soa.org/News-and-Publications/Publications-Browse/In-The-Public-Interest/2018/ipi-2018-iss-16.aspx>



South Dakota Chapter of the American Academy of Pediatrics
INCORPORATED IN SD

June 18, 2018

SD AAP Chapter
26447 467th Avenue
Sioux Falls, SD 57107
sd_aap_chapter@hotmail.com

**South Dakota Chapter
Executive Committee**

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Sarah Aker, Deputy Director
Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive Pierre, South Dakota 57501-2291

Re: Career Connector Public Comment

Dear Deputy Director Aker,

The South Dakota Chapter of the American Academy of Pediatrics (SD-AAP), a nonprofit organization representing nearly 150 pediatricians from across the state, dedicated to the health, safety and well-being of all South Dakota infants, children, adolescents and young adults, thanks you for the opportunity to provide comments on the Career Connector Section 1115 Demonstration Proposal.

We write today to express our concerns with this proposed waiver application, which would create significant barriers to affordable health care coverage for low-income parents, including those already enrolled in the program. Notably, South Dakota is seeking waiver authority to add work as a condition of Medicaid coverage for the traditionally eligible parent caregiver group, members of whom are at significantly low incomes. While the efforts in creating the Career Connector program and offering to assist low income parents and caregivers in creating individualized employment and training plans could be beneficial, we remain concerned that Medicaid coverage may be punitively denied for those who do not meet the requirements. Moreover, this proposal appears to be punishing low-income parents for achieving the stated goals of the work requirement.

Currently in the South Dakota Medicaid program, a parent in the caregiver eligibility group must have a family income at or below 57% of the federal poverty level (FPL, with a 5% disregard); for a family of 3 that would be \$883 per month. Under this new waiver proposal, a single mother with 2 children over the age of 1 would be required to work at least 80 hours per month or achieve monthly milestones in an individualized plan to maintain Medicaid coverage. However, even when parents meet these conditions, they will still be required to leave the Medicaid program resulting in a loss of important cost sharing protections and more out-of-pocket costs.

Low-income parents losing their Medicaid coverage will have an impact on the health of South Dakota children as well. As pediatricians, we know that parents who are enrolled in coverage are more likely to have children enrolled in coverage, and parents with coverage are also more likely to maintain their children's coverage over time. Research shows the positive effects that Medicaid coverage of adults is having in other states in terms of coverage, access to care, utilization, affordability, health outcomes, and many economic measures.¹ New research also demonstrates that coverage of parents has spillover effects in terms of increased used of preventive services by children.²

Also, while the goal of moving people to employer sponsored coverage is admirable, low-wage jobs rarely provide such a benefit. A 2014 study showed that only 28% of employees of private firms with low average wages obtain health insurance through

their jobs, and 42% are not even eligible for employer sponsored coverage,³ demonstrating that simply being employed does not guarantee these individuals will be able to obtain health insurance.

Our additional concerns are outlined below:

Waiver of EPSDT for 19-20 Year Olds. We are concerned with the intention to move all adult Medicaid recipients in the parent/caregiver eligibility group, including those age 19-20, to either employer sponsored or marketplace coverage. As stated in South Dakota's October 2017 Medicaid Report, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit is required to be provided to all Medicaid eligible recipients.⁴ By including 19-20 year old beneficiaries in this demonstration they will no longer have access to these vital benefits. EPSDT plays a critical role in ensuring that benefit limitations do not impede access to medically necessary treatment – without EPSDT, 19 and 20-year old individuals with very real medical needs may find their treatment no longer covered. EPSDT is uniquely designed to help maximize potential by addressing developmental delays and health conditions that affect school performance and success in life. EPSDT is critically important at a time in a young adult's life when they are transitioning to higher education or work, and we must not put them at unneeded risk by eliminating this needed benefit.

Increased cost sharing. Medicaid beneficiaries in the Career Connector program will be eligible for Transitional Medical Benefits (TMB) for one year, and then could be eligible for premium assistance to help them purchase employer sponsored insurance after that. However, even with premium assistance, these low-income beneficiaries would now not have the cost sharing protections that Medicaid provides. Under the current Medicaid program, a visit to the doctor will cost a parent \$3 per visit, while outpatient hospital or ambulatory surgical center services are capped at \$50. Once on employer sponsored or marketplace coverage these costs are likely to increase. Even nominal increases in cost sharing can have a significant impact on families with low incomes.⁵

90 Day Lockout Period. While the non-compliance policy does give beneficiaries many opportunities for corrective action, we remain concerned about the 90-day lockout period. While the waiver would allow individuals to take corrective action and resume coverage within 30 days of the loss of eligibility, those who do not, or cannot, may face an unnecessarily perilous time when coverage would be unavailable. This could not only interrupt an existing course of medically necessary treatment, but also block coverage when a significant diagnosis is reached or injury occurs, resulting in uncovered visits to emergency rooms.

Increased cost to South Dakota. South Dakota is also likely to see an increase in costs if this waiver is approved and implemented. The application does not indicate how the premium assistance for Career Connector participants will be funded other than to indicate that the non-federal share of expenditures will be paid for using the state's general funds. Is the state planning on making cuts from other programs to fund premium assistance or finding other ways to increase revenue? Will funding be taken from the Medicaid program to the detriment of providing services to other eligibility groups such as children and individuals with disabilities?

¹<https://www.kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-september-2017/>

² <http://pediatrics.aappublications.org/content/early/2017/11/09/peds.2017-0953>

³ https://meps.ahrq.gov/mepsweb/survey_comp/Insurance.jsp

⁴ https://dss.sd.gov/docs/news/reports/2017_medicaid_report.pdf

⁵ <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>

The state is also likely to see additional financial burdens because of the administrative costs of implementing these work requirements and the Career Connector program. While we appreciate the intent of developing individualized career plans for beneficiaries, how will these plans be developed? The proposal indicates that Department of Labor and Regulation (DLR) employment specialist will

develop these plans and work under a contractual agreement with the Department of Social Services (DSS). However, how will this extra work be funded? Will this program be paid for by DLR or DSS? How will staff at DLR handle the additional responsibilities or will new staff need to be added to ensure the program works as intended? When Tennessee implemented work requirements in its Temporary Assistance for Needy Families (TANF) program, the state spent more than \$70 million to do so.⁶

The intent of the Medicaid program is to provide needed coverage to low-income residents—most of whom already work—who cannot afford private insurance. While providing premium subsidies to low-income parents for a limited period of time may help delay a loss of coverage, the additional cost-sharing burdens and eventual termination of those subsidies will result in additional individuals losing coverage. Adding an onerous work requirement as proposed contradicts the very nature of Medicaid as a health care lifeline for those most in need.

This waiver proposal creates additional complexity to the Medicaid program for traditionally eligible beneficiaries while adding administrative costs. The waiver is also likely to increase health care system costs, including that of uncompensated care for the parents who inevitably lose coverage.

Thank you for the opportunity to provide comments on this renewal application. We hope the state takes the thoughts of South Dakota's pediatricians into consideration as it contemplates changes to this renewal request. If you have questions regarding our concerns, please contact myself, Nicole Poppinga, MD via cell at 701-799-0866 or email at poppingan@gmail.com.

Sincerely,

Nicole Poppinga, MD, FAAP, FACP
President
South Dakota Chapter American Academy of Pediatrics
[701-799-0866](tel:701-799-0866) (cell)
poppingan@gmail.com

⁶ <http://www.governing.com/topics/health-human-services/gov-medicaid-work-requirements-states-cost-impleme nt.html>



CITY OF RAPID CITY

RAPID CITY, SOUTH DAKOTA 57701-2724

CDBG PROGRAM DIVISION

300 Sixth Street
Rapid City, SD 57701-5035
(605) 394-4181
barbara.garcia@rcgov.org

June 5, 2018

Bill Snyder, Director
Division of Medical Services
Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Dear Mr. Snyder:

I strongly support your application to the Center for Medicare & Medicaid Services (CMS) for the Career Connector Program demonstration pilot project and encourage their consideration for approval of the project.

Helping to raise people out of poverty is one of Rapid City's highest priority goals. The Career Connector Program will not only provide a plan for success, but also the job and skills development, case manager support, and supportive services needed to succeed. The addition of supportive services, such as transportation, rent, health insurance premium, and child care assistance will remove four of the most significant barriers that hold people back from being able to pursue job and skill training, and work.

This is a positive program promoting work, while recognizing that some individuals' current situations, age or health make it impossible for them to work, or would impose too great a burden if arbitrarily required. It provides a good balance.

I believe this program is well thought out and will be a positive step forward for our state and a great opportunity for residents to improve their financial situations for a better future.

Sincerely,


Barbara Garcia
CDBG Program Manager



Equal Opportunity Employer and Lender

The City of Rapid City does not discriminate based on disability and provides reasonable accommodations to ensure people with disabilities have equal access to City programs, services, and employment opportunities. To request a reasonable accommodation, please contact Nick Stroot, Section 504 and ADA Coordinator, at (605) 394-4146. To request language assistance to participate in City programs and services, including free oral interpretation or translation of written materials, please call (605) 394-4181. For TDD/TTY, please dial 711.



SENATOR REYNOLD F. NESIBA | DISTRICT 15

June 19, 2018

William Snyder
Director, Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501

Dear Mr. Snyder:

Thank you for the opportunity to share my thoughts on our state's pending "Career Connector: A South Dakota 1115 Demonstration Proposal" waiver request. As we briefly discussed at the hearing in Sioux Falls, I am strongly opposed to this imposition of work requirements on Medicaid recipients with young children and ask that our waiver request be withdrawn. My reasons for this are summarized in four sections below.

1. This proposal lacks appropriate funding and staffing.

I serve as State Senator from District 15 representing the people in downtown and the north-end of Sioux Falls. In that capacity, I have also served on the Joint Committee on Appropriations for the last two legislative sessions. Governor Dennis Daugaard announced at the beginning of this past legislative session that he intended to request a 1115 waiver and impose work requirements on some qualified Medicaid recipients. Despite this advanced notice, there has been a systematic lack of planning for this waiver request.

There is nothing in the Governor's Budget to support the increased staffing that will be necessary in the Department of Labor and Regulation (DLR) or the Department of Social Services (DSS). Further, no request was made to the Joint Committee on Appropriations by either the DLR or DSS for fiscal year 2019 in our legislative budgeting process to alter staffing or expenditures related to this waiver request. The end result is that the legislature has made no provision in the state FY19 budget for FTEs or funding for this program. The 2018 legislative session ended March 26 with the budget established for FY19. The next budget, for FY20, will not be made until March 2019.

I repeat, for emphasis: No staff hours or other funds are budgeted for FY19 for this program's expanded record keeping and intense management of the Medicaid caseload. This is important because on page 9 of the proposal it states, "The state proposes to finance the non-federal share of expenditures under the demonstration using state general funds." **Adding or repurposing staffing or budget within DLR or DSS to meet the needs of this program would require legislative approval. This approval was never requested and it therefore has not been granted. Thus, this waiver request should be denied on this basis alone.**

2. The proposal is incomplete and does not demonstrate revenue neutrality.

The proposal contains no estimate of the state funds needed for various aspects of the program, nor any estimate of the number of parents who would lose Medicaid, nor any estimate of the resulting decrease in state share of their Medicaid. Rather, it backs out of making these estimates and instead substitutes the use of purposely vague generalities like the following:

"some individuals may choose not to participate in Career Connector and lose coverage" (p. 9)

“At this time it is not clear how many individuals will increase their income... or chose to not participate[sic]...” (p. 9)

“Any decreases in annual enrollment would likely also result in decreases in annual expenditures.”(page 9)

“The numbers above do not reflect the projected Career Connector eligible member months or total expenditures.” (p. 17, 18 and 19)

Policy decisions should be evidence-based, not founded on vague supposition. **The proposal seems to suggest that program is revenue neutral because some people will choose not to participate. However, no actual evidence or even an estimated range is provided.** If the tables at the end of the proposal are intended to make that case, they are unpersuasive. Are we expected to deduce revenue neutrality from the difference in monthly cost for premium assistance between Tables 2 and 3? If that is what the proposal is attempting to explain, it needs to be spelled out in detail and plain English, because it is not clear to me despite experience reading tables and budgets on the Joint Committee on Appropriations, my PhD in economics, and my 23 years of experience as an economics professor at Augustana University. I am competent, but Tables 2 and 3 do not make sense. My appeal to an explanation from our Legislative Research Council staff further confirmed that I am not the only one struggling to make sense of these poorly designed and explained supportive documents.

Much else in this proposal is also left unexplained. For example none of the following is included:

- a. There are no estimates of staff hours or FTE’s for staff training, notifications, assessments, finding classes and training opportunities, assigning, coordination, tracking, evaluations, or making reports. Staff at several departments and divisions may be involved in any one case and we do not have as much as a wild guess of how much staff time will be taken up with these new responsibilities. (And remember, FTEs and funds cannot be transferred to meet these needs without legislative approval.)
- b. There are no estimates of additional state funds needed for support services, including consultations, trainers, childcare, transportation, or other work supports. There is no clear assessment as to whether funds are actually available for some of these services as the proposal suggests. It is understood that no Medicaid funds may be used for these purposes.
- c. There is no explicit comparison of the state’s expected expenses for the program to the state’s decreases in expenditures freed-up by parents’ loss of Medicaid. (Clearly, there will be no freed-up funds for at least 3 months, although program expenses will start from day 1. How those first three months could ever be revenue neutral is a mystery to me.)
- d. For an evidence-based proposal, the plan should include performance data from the current work programs for SNAP and TANF. These were not included in the proposal, but queries to the Departments of Social Services and Labor have netted the following information that suggests many are likely to lose access to health care.

In FY2017, a monthly average of 1,689 individuals participated in SNAP’s Employment and Training program (E&T). The monthly average of individuals gaining employment was 105 with 93% retaining employment after 30 days, 10 enrolling in an educational/training programs, and 5 enrolled in community work sites. **The disturbing figure is an average of 406 individuals per month were removed from the SNAP benefit for failure to participate.** This is not exactly a comparison of apples to apples. Admittedly, SNAP’s E&T requires more work hours than Career Connector, but it also exempts the more difficult group—parents with children under age 6. **How many people—parents of children between the age of 1 and 6—are likely to lose access to health care because of these proposed changes? No one knows! The proposal fails to even make an estimate.** However, the performance of our current SNAP work program does not

inspire confidence in South Dakota's ability to help people retain their Medicaid and land good jobs that will more than cover the requisite costs of additional childcare and transportation.

3. Case management for these proposed programs will be labor intensive and there is no evidence that this has been fully recognized.

The management of this program is likely to be even more intensive than the state's current work programs for SNAP and TANF. This is important in any estimate of staff hours needed. There are special considerations for each of the two groups of parent participants. The parents designated for this new program are a subset of the parents in South Dakota's Low Income Families (LIF) program. South Dakota's LIF program is in response to the requirement of the 1996 welfare reform law, section 114, in which Congress wanted parents to retain their Medicaid eligibility. Because they are in LIF, the participants are all parents. According to the SD Department of Social Services, approximately half of the parents are in each of these two groups:

A. Parents with children younger than age 6.

With incomes this low, it can be assumed that most are single parents with no one to help juggle schedules and caregiving responsibilities. Due to the young ages of children, these parents are working as caregivers in an intense way already, especially as they have so few resources. Their lives have more than normal complications and stress. Having a job outside the home is often a parent's goal, but it is more difficult to achieve due to the ages of the children and the sleep deprivation that often continues well past a child's infancy.

It is widely accepted that these parents have a lot on their plate already and it would likely not be cost-effective to attempt to provide the supports necessary to move them out of the home while the children are so young. **The other states with Medicaid work programs approved at this time, Kentucky, Indiana, Arkansas and New Hampshire, do not have work requirements for parents with children younger than age 6.** The only small exception is in New Hampshire, and only if more than one parent is in the home.

In addition, this year the US House of Representatives sent a clear signal that parents of very young children should not be subject to the work requirements. They defeated an amendment that would have applied SNAP work requirements to parents with children as young as age 3. The vote was 83 in favor to 330 against.

B. Parents whose children are all older than age 6.

With incomes low enough to qualify for LIF Medicaid, all of these parents should also qualify for SNAP. South Dakota already has work requirements for SNAP, when there are no children under age 6 in the home. (It requires even more hours than the Career Connector.) Thus, it seems these parents would already be subject to the SNAP work requirements.

Note that the proposal says that parents participating in other work programs would be exempt from Career Connector program (pages 3-4).

So, why do these parents comprise approximately half of the projected caseload in the Career Connector program? If they are not able to manage the SNAP work program, that should be a clue that extra staff time will be needed to assess, encourage, guide, and monitor these parents through the Career Connector process from no job to a family-sustaining job.

4. Parents will be discouraged by South Dakota's "child care assistance cliffs."

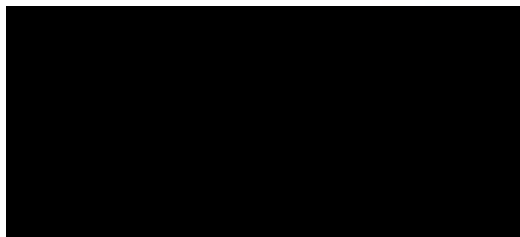
As a member of Appropriations Committee, it has come to my attention that South Dakota parents on the way to family sustaining jobs encounter a set of "child care assistance cliffs." What is this "cliff" for childcare assistance? When a parent's income increases from 110% of federal poverty line (FPL) to 115%, the increase in the parent's co-pay for childcare takes up all but \$10 of the increase in pay. **When the income goes from 115% to 120%, the increase in the parent's cost for childcare eats up the entire pay increase. This happens again when income rises from 120 to 125%.** These can be seen on the chart titled "South Dakota 2018 Child Care Subsidy Co-Payments" https://dss.sd.gov/docs/childcare/sliding_fee_scale.pdf

For example, for a mother of two who earns \$1,992 a month, a pay increase of \$86 will make her cost for childcare increase by that same \$86. Facing such a situation, the incentive for work is eliminated. This is important because the Career Connector program says (page 4) that the program will continue to work with people until they reach 120 hours/month or 150% FPL income or drop out. With South Dakota's median hourly pay the 4th lowest median hourly pay in the nation it could take parents many years, if ever, for them to rise up through the pay scale toward achieving 150% of FPL.

As a member of Appropriations Committee, I am committed to work to increase funding to childcare so that the co-pay chart will not have such "cliffs" and also so that assistance can be restored up to 200% of FPL, as it was before South Dakota's 2012 budget cuts. I would prefer to continue to seek childcare funds to solve these two problems rather than to have to divert childcare funds for a new program.

Given the profound problems noted above regarding 1) a lack of adequate staffing and funding, 2) an absence of demonstrated revenue neutrality, 3) a failure to anticipate the increased intensity of caseload, and 4) our failure to address benefit cliffs in childcare assistance, I respectfully request that our Career Connector 1115 waiver be immediately withdrawn. If submitted, the request should be expeditiously denied.

Sincerely,



Reynold F. Nesiba
SD State Senator, District 15

SOUTH DAKOTA
COUNCIL OF MENTAL HEALTH CENTERS, Inc.
P.O. Box 532
Pierre, South Dakota 57501-0532

June 18, 2018

William Snyder
Director, Medical Services
SD Department of Social Services
700 Governors Drive
Pierre, South Dakota 57501

RE: Career Connector 1115 Demonstration Proposal Letter of Support

Dear Mr. Snyder:



This letter is provided to express the South Dakota Council of Mental Health Centers' (SDCMHC) support for the 1115 Demonstration application that the South Dakota Department of Social Services plans to submit to the Center for Medicare & Medicaid Services to implement the proposed Career Connector Program.

The SDCMHC is a private, non-profit association comprised of the eleven Community Mental Health Centers (CMHCs) serving South Dakota. CMHCs focus on the provision of high quality, community-based, outpatient behavioral health services. Council members contract with a variety of state agencies to assure the delivery of services to the state's most seriously mentally ill populations and to families in need of other priority therapeutic interventions. Every county in the state is included within the designated catchment area of one of the eleven CMHCs. Collectively, our Council represents the only statewide system of comprehensive outpatient behavioral health care serving South Dakota.

The SDCMHC concurs with the principles and methodologies set forth in the application to achieve successful workforce participation by promoting individualized employment and training plans and by mitigating barriers that interfere with effective career engagement. We are especially supportive of the use of local Integrated Resource Teams to facilitate preventative care and help increase identification and treatment of behavioral health and chronic conditions. The SDCMHC strongly believes that these concepts are worthy of demonstration and, if the application is approved, will work proactively with the Department to assure positive project outcomes.

I may be reached by calling 605-224-0123; my e-mail is tladosch@dakota2k.net.

Very truly yours,



Terrance L. Dosch
Executive Director

Phone & FAX: (605) 224-0123

June 19, 2018

Sarah Aker, Deputy Director
Division of Medical Services
Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Re: "Career Connector – A South Dakota 1115 Demonstration Proposal"

Dear Secretary:

NAMI appreciates the opportunity to submit comments on South Dakota's Section 1115 Medicaid Demonstration Request: "Career Connector – A South Dakota 1115 Demonstration Proposal." NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI South Dakota is the state organization of NAMI. Together, our mission is to improve the quality of life of individuals and families affected by mental illness through education, support and advocacy.

Access to coverage and care is essential for people with mental illness to successfully manage their condition and get on a path of recovery. Unfortunately, the proposed waiver will jeopardize access to healthcare by requiring certain beneficiaries to either prove they work at least 80 hours per month or meet exemptions. This requirement would apply to parents and caregivers ages 19-59 with incomes below 51 percent of the federal poverty level (\$866 per month for a family of three), a vulnerable population that cannot afford additional barriers to healthcare coverage. NAMI South Dakota is concerned that the demonstration proposal will jeopardize access to care and will have harmful implications for individuals living with mental health conditions in South Dakota. NAMI South Dakota urges the Department of Medical Services to withdraw this demonstration proposal.

Unnecessary Risks for People with Mental Illness

NAMI appreciates South Dakota's goal to empower beneficiaries to be successful in today's workforce. NAMI recognizes that people with mental illness are disproportionately unemployed. Only 1 in 5 adults with mental health conditions who receive community mental health services are competitively employed—and the numbers drop to only 6.7% for adults with a diagnosis of schizophrenia.ⁱ Employment offers many benefits to people with mental illness, and most people who live with mental health conditions want to work. However, work requirements present unnecessary risks for people with mental illness.

NAMI recognizes that South Dakota's proposal includes an exemption for "medically frail individuals." While that exemption may sound reasonable, there are several reasons why NAMI is concerned that work requirements would still have an adverse impact on people with mental illness. Serious mental illnesses are, by their very nature, chronic and recurring conditions that fluctuate in severity over time. This means that an individual could be in a state of recovery at the time they are assessed and face few obstacles to working at that time. However, the person's condition could change rapidly – without the knowledge of the Medicaid system. Battling administrative red tape in order to keep coverage should

not take away from patients' or caregivers' focus on maintaining their or their family's health. Work requirements would mean that an individual who is experiencing a crisis or decline in their condition could lose both their employment and health care coverage at the very time they need access to mental health care the most. Additionally, people who are dropped from Medicaid coverage for failing to fulfill work requirements will likely not seek care until their conditions are acute and costly to treat, driving up state costs.

Unnecessary Administrative Costs

NAMI is also concerned about the cost of implementing this demonstration proposal. Studies show that work requirements do not lead to long-term, stable employment. Instead, they increase state administrative costs and complexity.ⁱⁱ States such as Michigan, Pennsylvania, Kentucky, Tennessee and Virginia have estimated that setting up the administrative systems to track and verify exemptions and work activities will cost tens of millions of dollars.ⁱⁱⁱ Rather than spending scarce public resources on the administration of new requirements, NAMI South Dakota urges the state to instead implement evidence-based supported employment programs, which have proven effective in helping vulnerable populations, such as people with mental illness recover and return to work.^{iv} This meets the intent of the demonstration proposal without the adverse consequences presented by a mandatory work requirement.

Incomplete Proposal

We are concerned that the current proposal does not include an estimate of the expected increase or decrease in annual enrollment and expenditures, contrary to the requirement in federal regulations.^v On page 9 of this demonstration proposal, South Dakota states that it cannot predict the impact of the waiver on enrollment or expenditures. However, in order to meet federal transparency requirements, South Dakota must include these projections and their impact on budget neutrality provisions. Therefore, we request you to withdraw this waiver until this information can be provided so that the public has an opportunity to comment on this important issue with adequate information.

Ultimately, the requirements outlined by South Dakota do not further the goals of the Medicaid program or help low-income families improve their circumstances without needlessly compromising their access to care. NAMI South Dakota urges the state to withdraw this proposed Medicaid demonstration as it will not promote patient care and will harm patients with mental health conditions. We encourage the South Dakota Department of Medical Services to focus on solutions to implement evidence-based supported employment for Medicaid recipients. Thank you for the opportunity to provide comments.

Sincerely,

Wendy Giebink, Executive Director
NAMI South Dakota
PO Box 88808
Sioux Falls, SD 57109

ⁱ Tim Knettlar, Ted Lutterman et al, NRI, *Latest Trends in State Mental Health Agencies*.

<https://www.nasmhpd.org/sites/default/files/latest-trends-in-state-mental-health-agencies.pdf> (August 8, 2016).

ⁱⁱ Jane Perkins, Mara Youdelman & Ian McDonald, National Health Law Program, *Work Requirements: Not a Healthy Choice*, <http://www.healthlaw.org/publications/browse-all-publications/medicaid-work-requirementsnot->

ⁱⁱⁱ Senate Fiscal Agency, Bill Analysis for SB 897, March 21, 2018, <http://www.legislature.mi.gov/documents/2017-2018/billanalysis/Senate/pdf/2017-SFA-0897-S.pdf>; House Committee on Appropriations, Fiscal Note for HB 2138, April 16, 2018, <http://www.legis.state.pa.us/WU01/LI/BI/FN/2017/0/HB2138P3328.pdf>; Misty Williams, “Medicaid Changes Require Tens of Millions in Upfront Costs,” Roll Call, February 26, 2018, <https://www.rollcall.com/news/politics/medicaid-kentucky>.

^{iv} Examples of successful evidence-based programs include IPS Supported Employment (which places people with mental illness in competitive jobs in the community) and the comprehensive service array in First Episode Psychosis programs (FEP) that includes supported employment. Both these interventions have been shown to improve the employment outcomes of people with mental illness at rates far higher than the national average.

^v 431.408

June 19, 2018

Sarah Aker
Deputy Director
Division of Medical Services
South Dakota Department of Social Services
700 Governors Drive
Pierre, SD 57501

Dear Ms. Aker:

On behalf of the more than 30 million Americans living with diabetes and the 84 million more with prediabetes, the American Diabetes Association provides the following comments on the State of South Dakota Department of Social Services' (Department) Section 1115 Demonstration Proposal for the Career Connector program.

According to the Centers for Disease Control and Prevention, over 9% of adults in South Dakota have diabetes and another 35.5% have prediabetes.¹ Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. Adults with diabetes are disproportionately covered by Medicaid.² For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low-income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions.

Work Requirements

The ADA is deeply concerned by the Department's proposal to limit or revoke certain Medicaid beneficiaries' enrollment if they do not meet proposed work or community engagement standards. This type of coverage limit is in direct conflict with the Medicaid program's objective to offer health coverage to those without access to care. Most people with Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.³ For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.⁴ Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured Americans who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.^{5,6}

Cost-Sharing

Research has shown that cost-sharing for low income populations limits the use of necessary health care services.⁷ The Department proposes in this waiver to provide premium assistance for up to one year to



1 in 11

**Americans has
diabetes today.**



**Every 21 seconds,
someone in the
United States
is diagnosed
with diabetes.**

**Nearly
18,000
youth are
diagnosed with
type 1 diabetes
every year.**

certain beneficiaries after their Transitional Medical Benefits expire. However, the premium assistance is capped and may not cover the full cost of the individuals' premiums. Additionally, individuals would not receive any assistance with cost-sharing such as copayments, coinsurance, and deductibles. Patients with uncontrolled diabetes or with diabetes complications have medical costs as high as eight times that of people with well-controlled or non-advanced diabetes.⁸ Fortunately, studies show that diabetes complications can be avoided or delayed with adequate management of blood glucose.⁹ The premium assistance program is inadequate coverage for individuals in the Medicaid gap trying to manage a chronic illness like diabetes. To truly help these individuals access and use necessary healthcare services, South Dakota should pursue full Medicaid expansion up to 138 percent of the federal poverty level. This will ensure that diabetes patients are screened earlier and have continuous care, reducing the chance of costly, life threatening complications.

Administrative Burden

Under this proposed waiver, individuals will need to either prove they meet certain exemptions or provide evidence of the number of hours they have worked as well as other monthly milestones they have met, all of which significantly increases the administrative burden of health care. Increasing the administrative requirements will likely decrease the number of individuals with Medicaid coverage, regardless of whether they are exempt. Diabetes is a complex, chronic illness that requires continuous medical care and people with diabetes cannot afford a sudden gap in health insurance coverage. This waiver proposal creates administrative barriers impeding access to health services that diabetes patients need.

Summary

We strongly urge the state to withdraw the 1115 Demonstration Proposal for the Career Connector Program as it creates barriers to accessible, affordable, and adequate healthcare. The ADA appreciates the opportunity to comment on the Department's Proposal. If you have any questions, please contact Christine Fallabel, Director of State Government Affairs and Advocacy at CFallabel@diabetes.org or directly at 800-676-4065x7016

Sincerely,


Christine Fallabel, MPH
South Dakota Director, State Government Affairs & Advocacy

¹ Center for Disease Control and Prevention, Diagnosed Diabetes. Available at: <https://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html>

² Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.

³ Garfield R, Rudowitz R and Damico A, Understanding the Intersection of Medicaid and Work, Kaiser Family Foundation, February 2017. Available at: <http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work>

⁴ Kaiser Family Foundation, Are Uninsured Adults Who Could Gain Medicaid Coverage Working?, February 2015. Available at: <https://www.kff.org/medicaid/fact-sheet/are-uninsured-adults-who-could-gain-medicaid-coverage-working/>

⁵ Rector R, Work Requirements in Medicaid Won't Work. Here's a Serious Alternative, Heritage Foundation, March 2017. Available at: <https://www.heritage.org/health-care-reform/commentary/work-requirements-medicaid-wont-work-heres-serious-alternative>

⁶ Katch H, Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment, Center on Budget and Policy Priorities, July 2016. Available at: <https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly>

⁷ Samantha Artiga, Petry Ubri, and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017. Available at: <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/>.

⁸ Economic Cost of Diabetes in the U.S. in 2017. March 2018. Available at: <http://care.diabetesjournals.org/content/early/2018/03/20/dci18-0007.full-text.pdf>

⁹ Klein BEK, Lee KE, et al., The 25-Year Cumulative Incidence of Lower Extremity Amputations in People with Type 1 Diabetes, 34 Diabetes Care 3, March 2011. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3041199/pdf/649.pdf>



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June 13, 2018

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**BILL SNYDER DIRECTOR
DIVISION OF MEDICAL SERVICES
DEPARTMENT OF SOCIAL SERVICES
700 GOVERNORS DRIVE
PIERRE SD 57501-2291**

Dear Bill:

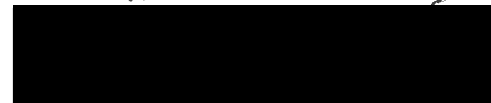
I am writing in support of the South Dakota Career Connector program.

This program will offer individuals the opportunity to gain greater independence through work and decreased reliance on Medicaid. It is individualized to meet educational needs, if desired, and a case manager will be assigned to ensure success. The participant will be assessed to determine barriers that prevent them from gaining and maintaining employment. Identified barriers, ie. transportation, child care, clothing, will be addressed through existing resources in the community. Those individuals with significant barriers to work will be exempted.

The program is meant to promote long term success for both meaningful work and health considerations including preventative annual check-ups and preventative dental care. However, flexibility is built into the program to account for unexpected life events.

These are some of the reasons why I am in support of the South Dakota Career Connector Program.

Sincerely,



Cindy Dannenbring
Executive Director

CD:mg



ICAP is an equal opportunity provider and employer.



June 19, 2018

Division of Medical Services
Department of Social Services
700 Governors Drive
Pierre, SD 57501-2291

Re: Career Connector: A South Dakota 1115 Demonstration Proposal

Dear Deputy Director Sarah Aker,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit organization advancing policy solutions for low-income people. We work at both federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's deep expertise with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the 1115 Waiver Demonstration Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in South Dakota. Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act.¹ A waiver that does not promote the provisions of health care would not be permissible.

This waiver proposal's attempt to transform Medicaid and reverse its core function will result in parents losing needed coverage, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent *New England Journal of Medicine* review concludes, "Insurance coverage increases access to care and improves a wide range of health outcomes."² This waiver is therefore

inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be rejected. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements

CLASP does not support South Dakota's proposal to take away health coverage from parents who do not meet new work requirements. Our comments focus on the harmful impact the proposed work requirements will have on South Dakotans and the state. South Dakota is proposing to implement a work requirement for adult recipients age 19 to 59, unless they qualify for an exemption. Medicaid enrollees will be deemed exempt or compliant with the work requirement if they are:

- engaged in at least 80 hours of work per month or achieve monthly milestones in their individualized plan;
- 18 years of age or younger;
- 60 years of age or older;
- full-time students;
- pregnant women;
- persons with disability;
- medically frail;
- participating in a workforce participation program;
- parents residing with their children of less than one year of age; or
- primary caregivers of elderly or disabled individuals.

After three months of non-compliance, Medicaid enrollees will be disenrolled and locked out of coverage for 90 days if their eligibility is not reinstated within 30 days of non-compliance.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges South Dakota to reconsider their approach to workforce development. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment or who work the variable and unpredictable hours characteristic of many low-wage jobs. The reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventive and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements Do Not Promote Employment

Lessons learned from TANF, SNAP, and other programs demonstrate that proposals to take away health coverage from parents who do not meet new work requirements are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.³ A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder, and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.⁴ Making Medicaid more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

South Dakota's proposal to take away health coverage from parents who do not meet new work requirements would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement is a significant undertaking that will require new administrative costs and possibly new technology expenses to update IT systems. Lessons from other programs show that the result of this new administrative complexity and red tape is that **eligible** people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome. Evidence from Medicaid waivers in Indiana, Iowa, and Michigan show that states have done a poor job of informing enrollees in an understandable manner of what they need to do to maintain their coverage.⁵

The administrative overhead costs associated with South Dakota's waiver will be substantial and arguably a poor allocation of resources. According to South Dakota's waiver language, the state plans to connect all program participants with a case manager, who will connect individuals to support services, promote preventative health services available through Medicaid coverage, and remind individuals of Career Connector program elements. In total, the state estimates approximately 1,300 individuals to enroll in the Career Connector program annually. Establishing an entirely new bureaucratic system of paperwork, verifications, case management, and IT systems for such a small segment of the Medicaid population is wasteful and an irresponsible use of administrative dollars.⁶

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take away health coverage from parents who do not meet new work requirements do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off the program during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum numbers of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.⁷ This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements are Likely to Increase Churn

South Dakota's proposal to take away health coverage from parents who do not meet new work requirements is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid (after their 90 day lock-out period) as their hours increase or the seasons change. People may be most likely to seek to re-enroll once they need healthcare, and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

Disenrollment and lock out would lead to worse health outcomes, higher costs

After three months of non-compliance, enrollees subject to new work requirements will be disenrolled from Medicaid. If they are not able to comply within 30 days following disenrollment, they will be locked out of coverage for 90 days. Even if someone comes into compliance with the work requirement during their 90 day lock-out period, they will still be ineligible for coverage for the duration of the 90-day period.

The lock-out period serves no purpose other than to be punitive and does not encourage work. Once terminated from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.⁸ Further, during the lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

Persons are likely to remain uninsured following the end of the 90 day period because they are not aware they may be eligible for Medicaid if they are working and meet the work requirement. This will only lead to poorer health outcomes and higher uncompensated costs for providers.

Children are likely to lose coverage

Research shows that when parents have health insurance their children are more likely to have health insurance.⁹ South Dakota's proposal to disenroll parents from Medicaid for not meeting a work requirement will reduce the number of parents with health insurance, which the evidence suggests will lead to children becoming uninsured.

South Dakota states in their proposal, "Closure of the participant's Medicaid eligibility will not affect the eligibility of a child, spouse, or other household member that is not required to participate." This is not likely to hold true. When a parent loses coverage they may not understand that their children remain eligible for Medicaid. Should South Dakota move forward with their work requirement proposal, they should track enrollment of children whose parents are disenrolled from Medicaid.

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose coverage because of the work requirement. Even though South Dakota proposes to exempt people with disabilities or those determined disabled by the Social Security Administration, many people who are not able to work due to disability or unfitness are not likely to receive an exemption because of the complexity of paperwork. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working.¹⁰ In South Dakota, this rate is nearly one-third (29%).

An Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,¹¹ and nearly 20 percent had filed for Disability/SSI within the previous 2 years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement, including proving they are exempt. The end result is that many people with disabilities will in fact be subject to the work requirement and be at risk of losing health coverage.

Proposals to Take Health Coverage Away from Parents Who Do Not Meet New Work Requirements Would Create an Affordability Cliff in South Dakota

Proposals to take health coverage away from parents who do not meet new work requirements are harmful, regardless of whether the state has expanded Medicaid. However, in non-expansion states, such as South Dakota, work requirements create a catch-22.¹² If a family receives enough hours of work to satisfy the eligibility rules they will earn too much to qualify for Medicaid; if they don't work enough hours they will also lose their health care. South Dakota proposes a premium assistance program to mitigate this cliff effect, but

the state's proposal does not solve the problem.

Following 12 months of transitional Medicaid, the state proposes to provide people a monthly subsidy to purchase health insurance on the Marketplace or through an employer. The subsidy amount will be equal to the monthly cost of the previous year of transitional Medicaid.

This proposal has several problems and does not solve the subsidy cliff Administrator Verma referenced.¹³ People who are eligible for this subsidy will be earning between 50 and 100 percent of poverty, which means they are *ineligible* for Advance Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs) through the marketplace. Furthermore, the amount of the state subsidy (equal to the previous year's PMPM cost for Transitional Medicaid) will likely not cover the cost of a monthly premium for a plan purchased through the Marketplace. These factors combined mean that someone who is eligible for the premium assistance subsidy from the state will be responsible for the following costs: The difference between the subsidy and the actual premium cost each month, the full deductible for a plan, co-payments, and co-insurance until their out-of-pocket maximum is reached. These costs will add up to thousands of dollars, effectively making the premium assistance option from the state completely ineffective.

The state's assumption that the proposed premium assistance program will be used to purchase employer-sponsored coverage is erroneous. In 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under their employer-offered insurance.¹⁴

South Dakota's proposal does not eliminate the subsidy cliff created by imposing work requirements on Section 1931 parents. The only solution to truly eliminate the subsidy cliff is for South Dakota to expand Medicaid as intended by the Affordable Care Act (ACA).

Budget neutrality information is insufficient

The state's proposal does not include budget neutrality information that is necessary to evaluate the anticipated impact of the waiver. The state does not provide any estimate of the number of people who are expected to become disenrolled from Medicaid. Rather, the state's budget neutrality documents state that expenditures for the LIF population with and without the waiver would be identical. This is implausible on the face of it, as all other states with similar waiver proposals have suggested that there would be savings due to decreases in enrollment. Without further explanation this claim is impossible to evaluate. The state should provide detail about the anticipated change in enrollment in the pilot counties and corresponding budget implications. Without this detail, it is impossible to fully understand the impact of the waiver.

Conclusion

Our comments include citations to supporting research and documents for the benefit of South Dakota's Department of Social Services in reviewing our comments. We direct the Department of Social Services to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposal for purposes of the Administrative Procedures Act.

Thank you for considering CLASP's comments. Contact Suzanne Wikle (swikle@clasp.org) with any questions.

All sources accessed June 2018.

- ¹ Jane Perkins, “Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver,” National Health Law Program, 2017, <http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRIBFWnHIU>.
- ² Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., Health Insurance Coverage and Health — What the Recent Evidence Tells Us, *New England Journal of Medicine*, July 21, 2017. <http://www.nejm.org/doi/full/10.1056/NEJMSb1706645>.
- ³ Jessica Gehr, “Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers,” CLASP, June 2017, <https://www.clasp.org/sites/default/files/publications/2017/08/Doubling-Down-How-Work-Requirements-in-Public-Benefit-Programs-Hurt-Low-Wage-Workers.pdf>.
- ⁴ Jessica Gehr and Suzanne Wikle, “The Evidence Builds: Access to Medicaid Helps People Work,” February 2017, CLASP, <https://www.clasp.org/publications/fact-sheet/evidence-builds-access-medicaid-helps-people-work>.
- ⁵ Judith Solomon, “Complex Medicaid Changes Likely to Cost Many People Coverage,” Center on Budget and Policy Priorities, May 30, 2018, <https://www.cbpp.org/blog/complex-medicaid-changes-likely-to-cost-many-people-coverage>.
- ⁶ Kaiser Family Foundation “Total Monthly Medicaid and CHIP Enrollment” (Washington, DC: KFF, 2018) <https://www.kff.org/health-reform/state-indicator/total-monthly-medicaid-and-chip-enrollment/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22south-dakota%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.
- ⁷ Liz Ben-Ishai, “Volatile Job Schedules and Access to Public Benefits” CLASP, September 2015, <https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf>.
- ⁸ Kaiser Family Foundation, “Key Facts About the Uninsured Population” September 2017, <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.
- ⁹ Stephanie Schmit, Rebecca Ullrich, Patricia Cole, and Barbara Gebhard “Health Insurance: A Critical Support for Infants, Toddlers, and Families” (Washington, DC: CLASP and Zero to Three, 2017) <https://www.clasp.org/sites/default/files/publications/2017/10/Health%20Insurance%20FINAL%2010-3-17%20%282%29.pdf>.
- ¹⁰ Rachel Garfield, Robin Rudowitz, and Anthony Damico, “Understanding the Intersection of Medicaid and Work, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.
- ¹¹ Ohio Association of Foodbanks, Comprehensive Report: Able-Bodied Adults Without Dependents, 2015, http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_2014-2015-v3.pdf.
- ¹² Judith Solomon and Aviva Aron-Dine “Non-Expansion State Can’t Fix “Catch-22” in their Proposals to Take Medicaid Coverage Away from Parents Not Meeting Work Requirements” (Washington, DC: Center on Budget and Policy Priorities, 2018) <https://www.cbpp.org/research/health/non-expansion-states-cant-fix-catch-22-in-their-proposals-to-take-medicaid-coverage>; and Community Catalyst “Work Requirements: A One-Way Ticket to the Coverage Gap” (Boston, MA: Community Catalyst, 2018) https://www.communitycatalyst.org/resources/publications/document/2018/Community-Catalyst_Work-Requirements-and-Medicaid-Eligibility-in-Non-Expansion-States-Analysis.pdf.
- ¹³ Virgil Dickson “CMS warns non-expansion states to rethink Medicaid work rules” (Modern Healthcare, 2018) <http://www.modernhealthcare.com/article/20180501/NEWS/180509987>.
- ¹⁴ U.S. Department of Labor, “Table 2. Medical care benefits: Access, participation, and take-up rates,” Bureau of Labor Statistics, December 2017, <https://www.bls.gov/news.release/ebs2.t02.htm>.

Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver

Prepared by NHeLP-NC (contact: [Jane Perkins](#))
July 5, 2017

Section 1115 of the Social Security Act (SSA) provides the Secretary of Health and Human Services (HHS) with limited authority to waive requirements of the Medicaid Act. Section 1115 states, in relevant part:

- (a) In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter . . . XIX of this chapter [*i.e.*, Medicaid], . . . in a State or States -

(1) the Secretary **may waive compliance with any of the requirements of section . . . 1396a** of this title, . . . to the extent and for the period he finds necessary to enable such State or States to carry out such project, and

(2)(A) costs of such project which would not otherwise be included as expenditures under section . . . 1396b of this title, . . . shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan

SSA, § 1115, 42 U.S.C. § 1315a (emphasis added). This issue brief addresses requirements that appear in 1396a, but nevertheless cannot be waived by the Secretary.¹

By its terms, § 1115(a)(1) authorizes the Secretary to waive only those Medicaid requirements contained in 42 U.S.C. § 1396a. Section 1396a describes the mandatory and optional components of the state Medicaid plan and, as such, is a pivotal Medicaid provision. That said, the Medicaid Act is a complex and lengthy statute that begins with § 1396 (Medicaid and CHIP payment and access commission) and § 1396-1 (appropriations and purpose) and goes through § 1396w-5 (addressing health disparities). Many of these provisions impose important requirements on states. For an example of a provision found outside of § 1396a, see 42 U.S.C. § 1396d(a)(29), which prohibits Medicaid payments for any individual under 65 years old who is

¹ With the exception of § 1115, this memo refers to provisions as they appear in the United States Code (U.S.C.), as opposed to the Social Security Act.

a patient in an institution for mental diseases (facilities with more than 16 beds primarily serving persons with mental diseases).

All told, there are 52 provisions outside of § 1396a. The requirements appearing in these provisions cannot be waived unless they are clearly incorporated by reference into § 1396a. Notably, even when referred to in § 1396a, some requirements cannot be waived according to their own terms or the terms of a separate Medicaid Act provision. The chart below lists such requirements. The chart will be updated as additional provisions are identified.

Medicaid Act Requirements That Cannot Be Waived Under 42 U.S.C. § 1315	
Subsection of § 1396a	Provision that Prohibits its Waiver
(a)(10)(E) – Medicare cost sharing for qualified Medicare beneficiaries as defined in § 1396d(p)	§ 1396d(p)(4) – requires state operating under § 1115 waiver to meet requirement of a(a)(10)(E) as if it were operating under a state plan rather than a waiver
(a)(14) – enrollment fee, premium, copayment, and cost sharing limits only as provided in § 1396o.	<p>Regarding enrollment fees, premiums: § 1396o-1 – independently requires the state plan to contain its mandatory provisions and is not mentioned in § 1396a</p> <p>Regarding copayments, similar charges: § 1396o(f) – “Under any waiver authority,” no deduction, copayment or similar charge may be imposed unless the demonstration project meets five tightly circumscribed criteria (maintained under § 1396o-1(a)).</p>
(a)(28) – requires Medicaid nursing homes to comply with §§ 1396r(b)-(d), 1396r(f)(7), and the state to comply with requirements of § 1396r(e), 1396r(g), 1396r(h)(2)(B), 1396r(h)(2)(D)	§ 1396r – Nursing Home Reform Act: Establishes comprehensive requirements for nursing homes, states, and Secretary of HHS to improve and maintain quality of nursing home care and resident rights, including instances where provisions can be waived and the circumstances for granting those waivers
(a)(34) – retroactive coverage	§ 1396d(a) – independently requires medical assistance to include care and services if provided in or after the third month before the month of application
(a)(42) – requirements for state auditing for improper payments & recoupments	§ 1396a(42)(B) – applies under any waiver of the state plan

(a)(46)(B) – verification of citizenship & nationality for eligibility purposes (including reasonable opportunity)	§ 1396a note (Pub. L. No. 111-3, 123 Stat. 8, CHIPRA Reauth. Act): Notwithstanding § 1115, the Secretary may not waive requirements of § (a)(46)(B).
(a)(51) – community spouse protection requirements of § 1396r-5	§ 1396r-5(a)(4)(A) requires states operating under § 1115 waiver to comply with the requirements of the section in the same manner as would be required if the state were operating under a state plan.
(a)(52) – Transitional Medical Assistance requirements of § 1396r-6	§ 1396r-6(a)(1) – provides that the state must provide for TMA “notwithstanding any other provision of this subchapter” & specifies the circumstances for a waiver
(a)(63) - eligibility for those deemed eligible because they meet 1996-AFDC eligibility standards based on § 1396u-1	§ 1396u-1(g) - provides that “[t]he provisions of this section shall apply notwithstanding any other provision of this chapter.”
(a)(69) – Medicaid program integrity requirements established under § 1396u-6	§ 1396u-6(b)(1) –requires state operating § 1115 waiver to review actions of providers for fraud, waste, and abuse
(a)(74) – maintenance of effort under ACA in accordance with § 1396a(gg)	§ 1396a(gg)(2) – requires continuation of eligibility standards, methodologies, and procedures for children under age 19 through Sept. 30, 2019, MOE under any waiver of the plan
(a)(e)(14) [2d] – required use of modified adjusted gross income (MAGI), no disregards, and no asset test for determining eligibility of most population groups	§ 1396a(e)(14)(A), (B), (C) – requires MAGI, no disregards, and no asset test “under any waiver”
(a)(l) – coverage for children, infants, & pregnant women based on income according to federal poverty level	§ 1396a(l)(4)(A) – in the case of any state with § 1115 waiver, the Secretary must require the state to provide medical assistance to these groups of children, infants, and pregnant women “in the same manner” as under a state plan

NOTE: In addition to the § 1396a limit, § 1115 places other restrictions on the Secretary’s authority. For example, the project must be an experiment that is likely to promote the objectives of the Medicaid Act. Also, the Secretary cannot waive the U.S. Constitution or other statutes, such as the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

SOUNDING BOARD

Health Insurance Coverage and Health — What the Recent Evidence Tells Us

Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H.,
and Katherine Baicker, Ph.D.

The national debate over the Affordable Care Act (ACA) has involved substantial discussion about what effects — if any — insurance coverage has on health and mortality. The prospect that the law's replacement might lead to millions of Americans losing coverage has brought this empirical question into sharp focus. For instance, politicians have recently argued that the number of people with health insurance is not a useful policy metric¹ and that no one dies from a lack of access to health care.² However, assessing the impact of insurance coverage on health is complex: health effects may take a long time to appear, can vary according to insurance benefit design, and are often clouded by confounding factors, since insurance changes usually correlate with other circumstances that also affect health care use and outcomes.

Nonetheless, over the past decade, high-quality studies have shed light on the effects of coverage on care and health. Here, we review and synthesize this evidence, focusing on the most rigorous studies from the past decade on the effects of coverage for nonelderly adults. Previous reviews have provided a thorough discussion of older studies.³ We concentrate on more recent experimental and quasi-experimental studies of the ACA and other expansions of public or private insurance. The effects of coverage probably vary among people, types of plans, and settings, and these studies may not all directly apply to the current policy debate. But as a whole, this body of research (Table 1) offers important insights into how coverage affects health care utilization, disease treatment and outcomes, self-reported health, and mortality.

FINANCIAL PROTECTION AND THE ROLE OF INSURANCE

Before we assess these effects, it is worth recognizing the role of insurance as a tool for managing financial risk. There is abundant evidence that having health insurance improves financial security. The strongest evidence comes from the Oregon Health Insurance Experiment, a rare randomized, controlled trial of health insurance coverage.³¹ In that study, people selected by lottery from a Medicaid waiting list experienced major gains in financial well-being as compared with those who were not selected: a \$390 average decrease in the amount of medical bills sent to collection and a virtual elimination of catastrophic out-of-pocket expenses.^{4,8} Studies of other insurance expansions, such as Massachusetts' 2006 health care reform,⁷ the ACA's 2010 "dependent-coverage provision" enabling young adults to stay on a parent's plan until age 26,⁶ and the ACA's 2014 Medicaid expansion,⁵ have all revealed similar changes, including reduced bill collections and bankruptcies, confirming that insurance coverage reduces the risk of large unpredictable medical costs.

But from a policy perspective, health insurance is viewed differently from most other types of insurance: there is no push, for example, for universal homeowners' or renters' insurance subsidized by the federal government. We contend that there are two reasons for this difference. First, policymakers may value publicly subsidized health insurance as an important part of the social safety net that broadly redistributes resources to lower-income populations. Second, policymakers may view health insur-

Table 1. Evidence on the Effects of Health Insurance on Health Care and Health Outcomes, 2007–2017.

Domain and Findings	Insurance or Policy Examined*	Studies
Financial security		
Reduction in medical bills sent to collection and in catastrophic medical spending	Medicaid	Baicker et al. 2013 ⁴ ; Hu et al. 2016 ⁵
Reduced out-of-pocket medical spending	DCP, Medicaid	Chua and Sommers 2014 ⁶ ; Baicker et al. 2013 ⁴
Reduced personal bankruptcies and improved credit scores	MA	Mazumder and Miller 2016 ⁷
Access to care and utilization		
Increased outpatient utilization and rates of having a usual source of care/personal physician	Medicaid, MA	Finkelstein et al. 2012 ⁸ ; Sommers et al. 2014 ⁹ ; Simon et al. 2017 ¹⁰
Increased preventive visits and some preventive services including cancer screening and lab tests	Medicaid, MA	Baicker et al. 2013 ⁴ ; Sommers et al. 2014 and 2016 ^{9,11} ; Simon et al. 2017 ¹⁰
Increased prescription drug utilization and adherence	Medicaid	Ghosh et al. 2017 ¹² ; Sommers et al. 2016 ¹¹
Mixed evidence on emergency department use, with some studies showing an increase and others a decrease	Medicaid, DCP, MA	Taubman et al. 2014 ¹³ ; Akosa Antwi et al. 2015 ¹⁴ ; Miller 2012 ¹⁵ ; Sommers et al. 2016 ¹¹
Improved access to surgical care	DCP, MA	Scott et al. 2016 ¹⁶ ; Loehrer et al. 2016 ¹⁷
Chronic disease care and outcomes		
Increased rates of diagnosing chronic conditions	Medicaid	Baicker et al. 2013 ⁴ ; Wherry and Miller 2016 ¹⁸
Increased treatment for chronic conditions	Medicaid	Baicker et al. 2013 ⁴ ; Sommers et al. 2017 ¹⁹
Improved depression outcomes	Medicaid	Baicker et al. 2013 ⁴
No significant change in blood pressure, cholesterol, or glycated hemoglobin	Medicaid	Baicker et al. 2013 ⁴
Mixed evidence on cancer stage at time of diagnosis	MA, DCP	Keating et al. 2013 ²⁰ ; Robbins et al. 2015 ²¹ ; Loehrer et al. 2016 ¹⁷
Well-being and self-reported health		
Improved self-reported health in most studies	Medicaid, MA, DCP, ACA	Baicker et al. 2013 ⁴ ; Sommers et al. 2012 ²² ; Van Der Wees et al. 2013 ²³ ; Chua and Sommers 2014 ⁶ ; Sommers et al. 2015 ²⁴ ; Simon et al. 2017 ¹⁰ ; Sommers et al. 2017 ¹⁹
Some ACA-specific studies have shown limited or nonsignificant changes	Medicaid, ACA	Courtemanche et al. 2017 ²⁵ ; Miller and Wherry 2017 ²⁶
Mortality		
Conflicting observational studies on whether lack of insurance is an independent predictor of mortality	Private insurance	Kronick 2009 ²⁷ ; Wilper et al. 2009 ²⁸
Highly imprecise estimates in randomized trial, unable to rule out large mortality increases or decreases	Medicaid	Finkelstein et al. 2012 ⁸
Significant reductions in mortality in quasi-experimental analyses, particularly for health care–amenable causes of death	Medicaid, MA	Sommers et al. 2012 ²² ; Sommers et al. 2014 ⁹ ; Sommers 2017 ²⁹

* “Medicaid” includes pre-ACA expansions of Medicaid in selected states and the ACA’s 2014 Medicaid expansion. ACA denotes Affordable Care Act (specifically applies here to the 2014 coverage expansions including Medicaid and subsidized marketplace coverage), DCP dependent-coverage provision (the ACA policy enacted in 2010 that allows young adults to remain on their parents’ plan until the age of 26 years), and MA Massachusetts statewide health care reform (enacted 2006).

ance as a tool for achieving the specific policy priority of improved medical care and public health. Evaluating the impact of insurance coverage on health outcomes — and whether these benefits justify the costs of expanding coverage — is our focus.

ACCESS TO CARE AND UTILIZATION

For coverage to improve health, insurance must improve people's care, not just change how it's paid for. Several observational studies have found that the ACA's coverage expansion was associated with higher rates of having a usual source of care and being able to afford needed care,^{32,33} factors typically associated with better health outcomes.³⁴ Stronger experimental and quasi-experimental evidence shows that coverage expansions similarly lead to greater access to primary care,^{11,24} more ambulatory care visits,⁸ increased use of prescription medications,^{4,12} and better medication adherence.¹¹

There is also strong evidence that coverage expansion increases access to preventive services, which can directly maintain or improve health. Studies of Massachusetts' health care reform⁹ and the ACA's Medicaid expansion found higher rates of preventive health care visits,¹¹ and although the utility of the "annual exam" is uncertain, such visits may facilitate more specific evidence-based screening. For instance, the ACA Medicaid expansion has led to significant increases in testing for diabetes,¹¹ hypercholesterolemia,¹⁸ and HIV,¹⁰ and the Oregon study revealed a 15-percentage-point increase in the rate of cholesterol screening and 15- to 30-percentage-point increases in rates of screening for cervical, prostate, and breast cancer.⁴

The connection between health outcomes and use of other services, such as surgery, emergency-department (ED) care, and hospitalizations, tends to be more complicated. Much of this utilization serves critical health needs, though some may represent low-value care or reflect poor outpatient care. Thus, it is perhaps not surprising that the evidence on the effects of coverage on ED use and hospitalizations is mixed.³⁵ Both types of utilization went up in the Oregon study,^{8,13} whereas studies of other coverage expansions found reductions in ED use,^{11,14,15} and changes in hospital use have not been significant in several ACA studies^{11,26} — though these studies may not

have had an adequate sample size to examine this less common outcome. Meanwhile, studies of Massachusetts' reform and the ACA's dependent-coverage provision indicate that insurance improves access to some high-value types of surgical care.^{16,17}

CHRONIC DISEASE CARE AND OUTCOMES

The effects of coverage are particularly important for people with chronic conditions, a vulnerable high-cost population. Here, the Oregon experiment found nuanced effects. After 2 years of coverage, there were no statistically significant changes in glycosylated hemoglobin, blood pressure, or cholesterol levels.⁴ On the basis of these results, some observers have argued that expanding Medicaid does not improve health and is thus inadvisable.³⁶ However, the study revealed significant increases in the rate of diagnosis of diabetes that were consistent with findings in two recent post-ACA studies,^{18,37} along with a near-doubling of use of diabetes medications,⁴ again consistent with more recent data on the ACA's Medicaid expansion.¹² Glycosylated hemoglobin levels did not improve, but, as the authors note, the confidence intervals are potentially consistent with these medications' working as expected.⁴ The investigators did not detect significant changes in diagnosis of or treatment for high cholesterol or hypertension. One recent quasi-experimental study, however, showed that the ACA's Medicaid expansion was associated with better blood-pressure control among community health center patients.³⁸

Meanwhile, the Oregon study found substantial improvements in depression, one of the leading causes of disability in the United States.³⁹ It also found an increased rate of diagnosis, a borderline-significant increase in the rate of treatment with antidepressant medication, and a 30% relative reduction in rates of depressive symptoms.⁴

Other studies have assessed the effects of insurance coverage on cancer, the leading cause of death among nonelderly adults in the United States.⁴⁰ Though not all cancer results in chronic illness, most cancer diagnoses necessitate a period of ongoing care, and approximately 8 million U.S. adults under age 70 are currently living with cancer.⁴¹ Beyond increases in cancer screening, health insurance may also facilitate more

timely or effective cancer care. However, evidence on this front is mixed. A study of Massachusetts' reform did not find any changes in breast-cancer stage at diagnosis,²⁰ whereas the ACA's dependent-coverage provision was associated with earlier-stage diagnosis and treatment of cervical cancer among young women.²¹ Another Massachusetts study revealed an increase in rates of potentially curative surgery for colon cancer among low-income patients after coverage expansion, with fewer patients waiting until the emergency stage for treatment.¹⁷

Coverage implications for many other illnesses such as asthma, kidney disease, and heart failure require additional research. Studies do show that for persons reporting any chronic condition, gaining coverage increases access to regular care for those conditions.^{19,30} Overall, the picture for managing chronic physical conditions is thus not straightforward, with coverage effects potentially varying among diseases, populations, and delivery systems.

WELL-BEING AND SELF-REPORTED HEALTH

Although the evidence on outcomes for some conditions varies, evidence from multiple studies indicates that coverage substantially improves patients' perceptions of their health. At 1 year, the Oregon study found a 25% increase in the likelihood of patients reporting "good, very good, or excellent" health, and more days in good physical and mental health.⁸ Evidence from quasi-experimental studies indicates that self-reported health and functional status improved after Massachusetts' reform²³ and after several pre-ACA state Medicaid expansions,²² and that self-reported physical and mental health improved after the ACA's dependent-coverage provision went into effect.⁶

Recent studies of the ACA's 2014 coverage expansion provide more mixed evidence. Multiple analyses have found improved self-reported health after the ACA's coverage expansion, either in broad national trends²⁴ or Medicaid expansion studies,^{10,11} whereas one found significant changes only for select subpopulations²⁵ and another not at all.²⁶ Larger coverage gains have generally been associated with more consistent findings of improved self-reported health.¹⁹

Does self-reported health even matter? It

squarely fits within the World Health Organization's definition of health as "a state of complete physical, mental, and social well-being," and improved subjective well-being (i.e., feeling better) is also a primary goal for much of the medical care delivered by health care professionals. In addition, self-reported health is a validated measure of the risk of death. People who describe their health as poor have mortality rates 2 to 10 times as high as those who report being in the healthiest category.^{42,43}

MORTALITY

Perhaps no research question better encapsulates this policy debate than, "Does coverage save lives?" Beginning with the Institute of Medicine's 2002 report *Care without Coverage*, some analyses have suggested that lack of insurance causes tens of thousands of deaths each year in the United States.⁴⁴ Subsequent observational studies had conflicting findings. One concluded that lacking coverage was a strong independent risk factor for death,²⁸ whereas another found that coverage was only a proxy for risk factors such as socioeconomic status and health-related behaviors.²⁷ More recently, several studies have been conducted with stronger research designs better suited to answering this question.

The Oregon study assessed mortality but was limited by the infrequency of deaths in the sample. The estimated 1-year mortality change was a nonsignificant 16% reduction, but with a confidence interval of -82% to +50%, meaning that the study could not rule out large reductions — or increases — in mortality. As the authors note, the study sample and duration were not well suited to evaluating mortality.

Several quasi-experimental studies using population-level data and longer follow-up offer more precise estimates of coverage's effect on mortality. One study compared three states implementing large Medicaid expansions in the early 2000s to neighboring states that didn't expand Medicaid, finding a significant 6% decrease in mortality over 5 years of follow-up.²² A subsequent analysis showed the largest decreases were for deaths from "health-care-amenable" conditions such as heart disease, infections, and cancer, which are more plausibly affected by access to medical care.²⁹ Meanwhile, a study of Massachusetts' 2006 reform found significant reductions

in all-cause mortality and health-care–amenable mortality as compared with mortality in demographically similar counties nationally, particularly those with lower pre-expansion rates of insurance coverage.⁹ Overall, the study identified a “number needed to treat” of 830 adults gaining coverage to prevent one death a year. The comparable estimate in a more recent analysis of Medicaid’s mortality effects was one life saved for every 239 to 316 adults gaining coverage.²⁹

How can one reconcile these mortality findings with the nonsignificant cardiovascular and diabetes findings in the Oregon study? Research design could account for the difference: the Oregon experiment was a randomized trial and the quasi-experimental studies were not, so the latter are susceptible to unmeasured confounding despite attempts to rule out alternative explanations, such as economic factors, demographic shifts, and secular trends in medical technology. But — as coauthors of several of these articles — we believe that other explanations better account for this pattern of results.

First, mortality is a composite outcome of many conditions and factors. Hypertension, dyslipidemia, and elevated glycated hemoglobin levels are important clinical measures but do not capture numerous other causes of increased risk of death. Second, the studies vary substantially in their timing and sample sizes. The Massachusetts and Medicaid mortality studies examined hundreds of thousands of people gaining coverage over 4 to 5 years of follow-up, as compared with roughly 10,000 Oregonians gaining coverage and being assessed after less than 2 years. It may take years for important effects of insurance coverage — such as increased use of primary and preventive care, or treatment for life-threatening conditions such as cancer, HIV–AIDS, or liver or kidney disease — to manifest in reduced mortality, given that mortality changes in the other studies increased over time.^{9,22}

Third, the effects on self-reported health — so clearly seen in the Oregon study and other research — are themselves predictive of reduced mortality over a 5- to 10-year period.^{42,43} Studies suggest that a 25% reduction in self-reported poor health could plausibly cut mortality rates in half (or further) for the sickest members of society, who have disproportionately high rates of death. Finally, the links among mental health, financial stress, and physical health are numer-

ous,⁴⁵ suggesting additional pathways for coverage to produce long-term health effects.

DIFFERENT TYPES OF COVERAGE

In light of recent evidence on the benefits of health insurance coverage, some ACA critics have argued that private insurance is beneficial but Medicaid is ineffective or even harmful.⁴⁶ Is there evidence for this view? There is a greater body of rigorous evidence on Medicaid’s effects — from studies of pre-ACA expansions, from the Oregon study, and from analyses of the ACA itself — than there is on the effects of private coverage. The latter includes studies of the ACA’s dependent-coverage provision, which expanded only private insurance, and of Massachusetts’ reform, which featured a combination of Medicaid expansion, subsidies for private insurance through Medicaid managed care insurers, and some increase in employer coverage. But there is no large quasi-experimental or randomized trial demonstrating unique health benefits of private insurance. One head-to-head quasi-experimental study of Medicaid versus private insurance, based on Arkansas’s decision to use ACA dollars to buy private coverage for low-income adults, found minimal differences.^{11,19} Overall, the evidence indicates that having health insurance is quite beneficial, but from patients’ perspectives it does not seem to matter much whether it is public or private.⁴⁷ Further research is needed to assess the relative effects of various insurance providers and plan designs.

Finally, though it is outside the focus of our discussion, there is also quasi-experimental evidence that Medicare improves self-reported health⁴⁸ and reduces in-hospital mortality among the elderly,⁴⁹ though a study of older data from Medicare’s 1965 implementation did not find a survival benefit.⁵⁰ However, since universal coverage by Medicare for elderly Americans is well entrenched, both the policy debate and opportunities for future research on this front are much more limited.

IMPLICATIONS AND CONCLUSIONS

One question experts are commonly asked is how the ACA — or its repeal — will affect health and mortality. The body of evidence summarized here indicates that coverage expansions

significantly increase patients' access to care and use of preventive care, primary care, chronic illness treatment, medications, and surgery. These increases appear to produce significant, multifaceted, and nuanced benefits to health. Some benefits may manifest in earlier detection of disease, some in better medication adherence and management of chronic conditions, and some in the psychological well-being born of knowing one can afford care when one gets sick. Such modest but cumulative changes — which one of us has called “the heroism of incremental care”⁵¹ — may not occur for everyone and may not happen quickly. But the evidence suggests that they do occur, and that some of these changes will ultimately help tens of thousands of people live longer lives. Conversely, the data suggest that policies that reduce coverage will produce significant harms to health, particularly among people with lower incomes and chronic conditions.

Do these findings apply to the ACA? Drawing on evidence from recent coverage expansions is, in our view, the most reasonable way to estimate future effects of policy, but this sort of extrapolation is not an exact science. The ACA shares many features with prior expansions, in particular the Massachusetts reform on which it was modeled. But it is a complex law implemented in a highly contentious and uncertain policy environment, and its effects may have been limited by policies in some states that reduced take-up,⁵² Congress's partial defunding of the provisions for stabilizing the ACA's insurance marketplaces,⁵³ and plan offerings with high patient cost sharing. Furthermore, every state's Medicaid program has unique features, which makes direct comparisons difficult. Finally, coverage expansions and contractions will not necessarily produce mirror-image effects. For these reasons, no study can offer a precise prediction for the current policy debate. But our assessment, in short, is that these studies provide the best evidence we have for projecting the impact of the ACA or its repeal.

The many benefits of coverage, though, come at a real cost. Given the increases in most types of utilization, expanding coverage leads to an increase in societal resources devoted to health care.⁸ There are key policy questions about how to control costs, how much redistribution across socioeconomic groups is optimal, and how tradeoffs among federal, state, local, and private

spending should be managed. In none of these scenarios, however, is there evidence that covering more people in the United States will ultimately save society money.

Are the benefits of publicly subsidized coverage worth the cost? An analysis of mortality changes after Medicaid expansion suggests that expanding Medicaid saves lives at a societal cost of \$327,000 to \$867,000 per life saved.²⁹ By comparison, other public policies that reduce mortality have been found to average \$7.6 million per life saved, suggesting that expanding health insurance is a more cost-effective investment than many others we currently make in areas such as workplace safety and environmental protections.^{29,54} Factoring in enhanced well-being, mental health, and other outcomes would only further improve the cost-benefit ratio. But ultimately, policymakers and other stakeholders must decide how much they value these improvements in health, relative to other uses of public resources — from spending them on education and other social services to reducing taxes.

There remain many unanswered questions about U.S. health insurance policy, including how to best structure coverage to maximize health and value and how much public spending we want to devote to subsidizing coverage for people who cannot afford it. But whether enrollees benefit from that coverage is not one of the unanswered questions. Insurance coverage increases access to care and improves a wide range of health outcomes. Arguing that health insurance coverage doesn't improve health is simply inconsistent with the evidence.

Disclosure forms provided by the authors are available at [NEJM.org](http://www.nejm.org).

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Doubling Down: How Work Requirements in Public Benefit Programs Hurt Low-Wage Workers

Today, many jobs that once provided workers with economic security have been replaced by temporary, part-time, and other contingent employment arrangements that offer few benefits or basic labor protections. These typically low-paying and low-quality jobs are often the only ones available to low-income individuals, meaning many workers are not able to earn enough to cover basic needs. Therefore, they frequently need support from public benefit programs, such as Temporary Assistance for Needy Families (TANF), the Supplemental Nutrition Assistance Program (SNAP) and Medicaid, to make ends meet.

In the face of a labor market that offers many low-income people only unstable, low-quality jobs, these crucial programs help people find and keep work and also lift millions of families out of poverty every year. Recently renewed efforts to impose work requirements to receive public benefits reflect a profound misunderstanding of the realities of low-wage jobs. When the nature of the low-wage labor market is taken into account, it is clear that work requirements are misguided, hinder people's ability to get ahead, and are an administrative burden for state governments.

The reality of low-wage work

Low-wage jobs occupy a growing share of the labor market with nearly one in three workers earning under \$12 an hour.¹ Six of the 20 largest occupations in the country — retail salespersons, cashiers, food preparation and serving workers, waiters and waitresses, stock clerks, and personal care aides—have median wages close to or below the poverty threshold for a family of three (\$20,420).² Policymakers considering work requirement policies must understand the reality that many low-wage workers face. Because such workers are provided limited benefits—including little to no paid sick days or leave—and are subject to volatile work schedules, they often need public benefits to supplement their hard work.

Limited health benefits

With few employers offering health insurance to their low-wage or part-time employees, workers often have to rely on Medicaid to get health coverage for themselves and their families, or they will go uninsured. Only 12 percent of workers earning the lowest wages³ had employer-provided health insurance in 2016.⁴ Even at higher wages, part-time workers have less access to health coverage—just 22 percent of part-timers have access to health insurance coverage compared to 73 percent of full-timers.⁵

Volatile schedules

Scheduling challenges take a variety of forms, with some low-wage workers experiencing several at once. Such challenges are widespread among low-wage workers—about half of low-wage hourly workers have schedules that don't conform to the traditional Monday-Friday, 9-5 work schedule.⁶ Three common types of scheduling challenges are fluctuating hours, unstable schedules, and involuntary part-time work.

Fluctuating hours

Many workers have hours that vary from week-to-week or season-to-season. Nearly one-third of Americans experience considerable fluctuations in their incomes, with over 40 percent attributing these fluctuations to irregular work schedules.⁷ Three-quarters of early-career (ages 26 to 32) hourly workers experience fluctuations in their weekly hours (meaning total hours worked vary by more than eight hours per week on average).⁸ For example, a retail worker may be scheduled to work 35 hours a week during December for the holidays but only 10 hours a week during February when business is slower. Fluctuating hours mean families are unable to maintain a consistent budget to plan for their expenses because of paycheck variations from month-to-month.

Unstable schedules

Many workers can't predict when they will be working, receive little notice of their shifts, or are assigned split shifts (shifts with non-consecutive hours, interrupted by unpaid time longer than a meal break) or on-call shifts (shifts during which they must wait for notification of whether or not they will work). In a study of early-career workers, 41 percent received less than one week notice of their schedules.⁹ According to another national poll, 24 percent of workers experience unstable work schedules, including irregular and split shifts.¹⁰ Additionally, many workers are subject to employer retaliation, including reduced hours or even job loss, when they are not available for on-call shifts. Such unpredictability at work prevents planning and coordination for child care, transportation, education, or a second job.

Involuntary part-time

A significant number of workers want to work full-time but are only receiving part-time hours from their employer. In the most recent data, just over 5 million workers reported working part-time involuntarily.¹¹ While this is well below the rate at the peak of the Great Recession, it remains significantly higher than in previous periods of low unemployment. The persistence of involuntary part-time work is the result of employer preferences and structural changes in how businesses function. For instance, advances in technology have allowed businesses to use the "just-in-time" scheduling approach, which lets employers modify schedules in real-time to respond to changes in sales and demand, ignoring the effect on workers' lives and wellbeing.

Inability to take time off for illness or family care

Approximately 42 percent of all workers in the lowest 25 percent of wage earners have no paid leave of any kind.¹² With no federal law guaranteeing workers the ability to earn paid sick days or paid family and medical leave, low-wage workers—especially working parents—must make challenging choices between health and employment.

BOX 1. COMMON SCHEDULING CHALLENGES

- Inadequate hours
- Highly variable hours per week
- Little advanced notice of shifts, including being sent home from work early or called in right before a shift
- Little worker input or control over schedules
- Split shifts and on-call shifts

Low-wage workers are both the least likely to get paid sick days and the least able to get by when forced to miss a day's pay.¹³ Nearly 60 percent of workers in the bottom quartile of wage earners (those earning under roughly \$28,000 per year) are not paid when they miss work due to illness.¹⁴ Consequently, they are not able to take care of their own health or the health of family members, lose wages from having to miss work, and may even lose their jobs. In one survey, almost one in five low-wage working mothers reported having lost a job due to sickness or caring for a family member.¹⁵

Further, low-wage workers rarely have access to paid family or medical leave or even unpaid job-protected leave. Low-income workers are both less likely to be eligible for leave through the federal Family and Medical Leave Act (FMLA),¹⁶ and less likely to receive pay when taking leave.¹⁷ About 49 percent of workers earning less than \$40,000 per year are eligible for FMLA, compared to about 60 percent of those earning \$40,000 or more per year.¹⁸ Moreover, serious racial and ethnic inequities persist for low-income families in accessing unpaid FMLA or paid leave through employers. Lacking paid family and medical leave reduces the chance that caregivers stay employed at their current job.

Setting the record straight on work requirements

Work requirements are based on the false assumption that many people receiving benefits could be working but aren't. However, most working-age adults receiving benefits are working, or in working families, but need support to help them make ends meet because of a low-wage labor market rife with low-paying, unstable jobs.

The realities of the low-wage labor market help to set the record straight on the effectiveness of work requirements and their implications. First, strong evidence shows that work requirements frequently lead to a loss of benefits, which only makes it harder to work. Second, there is little evidence that work requirements increase employment outcomes or reduce poverty. Finally, work requirements create an unnecessary burden for workers and state governments.

Working-age adults receiving benefits are working, or in working families, but need support to help them make ends meet.

Work requirements lead to loss of benefits

Since the 1990s, both cash assistance under TANF and nutrition assistance under SNAP have required some or all recipients to work or participate in education and training activities. Work hour requirements in SNAP and TANF were set arbitrarily, with no relationship to the labor market. In SNAP and TANF, failure to meet the arbitrary requirements eventually leads to recipients being cut off from critical benefits—without taking into account the demands of the low-wage labor market. For example, TANF recipients are typically required to participate in a limited set of countable activities for at least 30 hours per week (20 hours for single parents of children under 6). Under SNAP, states can require adult recipients to engage in employment and training activities for up to 120 hours a month.

The most common effect of work requirements is that recipients lose benefits. Largely due to implementation of the SNAP time limit for unemployed childless adults, an estimated 500,000 childless adults lost food assistance at some point in 2016.¹⁹ TANF work requirements have sharply reduced the share

of families in poverty who receive cash assistance. In 2015, just 23 families received TANF benefits for every 100 families with children in poverty, down from 68 families when TANF was first enacted.²⁰ This is not because fewer families need assistance: the Government Accountability Office has calculated that 87 percent of the TANF caseload decline from 1995 to 2005 was due to fewer eligible families participating not because they no longer financially qualified.²¹

Those most likely to be affected have personal or family challenges, such as physical or mental health issues, homelessness, or lack of child care or transportation, that limit their ability to work or participate in education and training activities. Work requirement policies often fail to recognize an individual's limitations that may make it harder to work. For example, an Ohio study found that one-third of those referred to a SNAP employment program reported a physical or mental limitation and nearly 20 percent had applied for disability benefits within the previous two years.²² This occurred even though formal policies exempted recipients with physical or mental limitations. Similarly, repeated studies of TANF programs have found that clients with physical and mental health issues are disproportionately likely to be sanctioned.²³ Such clients may not understand what is required of them or may find it difficult to complete paperwork or travel to appointments to be assessed for exemptions.

Other recipients will lose their benefits should their hours dip below the arbitrary threshold for reasons they can't control. For example, poor sales may result in retail workers being called in for fewer hours than scheduled. Although workers were scheduled and wanted to work more, they may lose benefits because their employer cut their hours last minute and now their hours don't meet the arbitrary work hour requirement. Additionally, workers may struggle to retain employment because of a lack of paid time off or other workplace protections. A worker who does not have paid sick days may lose wages when taking time off to care for a sick child and also risks losing critical benefits if their hours dip below the requirement. It is not feasible for workers to simply find another job that is more stable and predictable; workers often have limited skills and training, and the characteristics of low-wage work are similar across many industries.

Little evidence work requirements promote work or reduce poverty

Cutting people off from benefits because of arbitrary work requirements only makes it harder to work because people will be hungrier, less healthy, and more stressed. Programs, such as TANF, SNAP, and Medicaid help bring stability to people's lives—providing the necessary support for focusing energy on finding and keeping work.²⁴ For example, a study of Ohio Medicaid expansion beneficiaries found that three-quarters (74.8 percent) of unemployed Medicaid expansion enrollees looking for work reported that their health coverage made it easier to seek employment.²⁵ Denying people benefits makes it harder for them to find and keep work.

Since many recipients of public benefit programs are working and connected to the labor force, yet require assistance because of the realities of low-wage work, mandatory employment and training programs do little to improve employment outcomes or reduce poverty.²⁶ For recipients not attached to the labor force, many face one or multiple barriers to work. Mandatory work requirement programs would do little to help recipients overcome these barriers.

Programs provide the necessary support for people to focus their energy on finding and keeping work.

Instead, states should focus on voluntary employment and training programs that have been shown to increase earnings and employment without the harmful consequences of mandatory programs.²⁷

Work requirements are burdensome for workers and state governments

Evidence shows that verifying work requirements is costly and leads to more administrative time and resources being spent on tracking work hours than providing services.²⁸ Workers and state administrators will have to devote considerable time documenting endless changes to changing schedules and hours—leaving less time and resources for creating or strengthening effective education and training programs. There is little reason to believe that these costs will be offset by savings. Even when workers find jobs, they typically do not earn enough to transition off benefit programs.

Conclusion

Benefit programs are intended to help families get on their feet and into the labor market. With the changing labor market and the nature of low-wage work, imposing work requirements on public benefit programs is simply bad policy that is not rooted in today's workers' experiences. States and the federal government should not expand or add work requirements to public benefit programs, whether through legislation or administrative action, that put workers at risk of losing public assistance when they need it the most. Rather, states should focus on providing robust programs and services and enact job quality policies that meet the needs of those employed in today's labor market.

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The Evidence Builds: Access to Medicaid Helps People Work

Untreated illness can make it hard to work. Health insurance is a key work support and tool that provides working-age adults with access to care that helps them get and keep a job. Reports from Ohio¹ and Michigan² provide compelling new information about the ability of Medicaid expansion enrollees to seek and maintain employment. These reports add to the growing body of research confirming the benefits of Medicaid expansion.³

Under the Affordable Care Act (ACA), states are incentivized to expand Medicaid to provide affordable health insurance to people with incomes below 138 percent of poverty (\$16,400 for a single person). A geographically diverse mix of 32 red and blue states⁴ took advantage of the ACA's provision to expand Medicaid. As a result, millions of low-income adults in those states now have access to affordable care, resulting in better health, greater financial, physical, and mental stability, and fewer deaths.

Most Adult Medicaid Enrollees are Working

Nationwide, the majority of non-disabled working-age adults who are insured through Medicaid are working or living in a family with a worker. In fact, 60 percent of adult recipients are employed and 79 percent live with someone who is working. Furthermore, among Medicaid recipients who are employed, more than half (51 percent) work full-time for the entire year.⁵ However, their positions often offer low wages and/or are in small businesses that do not provide health benefits. Only 12 percent of workers earning the lowest wages had employer-provided health insurance in 2016.⁶ Medicaid expansion enrollees typically hold physically demanding jobs⁷ clustered in employment settings such as restaurants, construction sites, retail stores, and gas stations.⁸

Without the support of Medicaid, health concerns would threaten employment stability.

Key findings from Ohio and Michigan confirm that providing access to affordable health care helps people maintain employment. **More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working.**⁹ **In Michigan, 69 percent of enrollees said that Medicaid helped them do their job better.**¹⁰ Without the support of Medicaid, health concerns would threaten employment stability.

Medicaid Expansion Reduces Barriers to Employment

Disability and illness are among the main reasons why working-age adults may not be employed. An analysis by the Kaiser Family Foundation found that 36 percent of adults enrolled in Medicaid cited illness or

disability as the primary reason for not working.¹¹ Similarly, a July 2016 report from the American Enterprise Institute found that for working-age adults without children, illness and disability were the primary barriers to employment.¹² The Ohio report confirms that access to Medicaid reduces these barriers to employment. **The majority of unemployed Medicaid enrollees in Ohio (74.8 percent)¹³ and Michigan (55 percent)¹⁴ reported that having Medicaid made it easier to look for employment.**

Ohio study participants noted that Medicaid allowed them to get treated for chronic conditions that previously had prohibited them from working. Additionally, about one-third of enrollees screened positive for depression or anxiety disorders, which can limit employment and other routine activities. Enrollees with depression and anxiety reported greater improvement in access to care and prescriptions—key resources needed to stay in the workforce.

Another way Medicaid expansion supports employment is by eliminating the so-called “cliff effect”—the sudden loss of health insurance if earnings exceed Medicaid eligibility limits. For example, prior to Medicaid expansion, a parent with one child who worked 30 hours per week at the minimum wage with annual earnings of \$12,000 was eligible for Medicaid in Ohio. But if that parent worked 35 hours per week and earned \$14,000, he or she was not eligible.¹⁵ With Medicaid expansion, parents are now incentivized to continue increasing their earnings, because they no longer risk losing their health care due to additional income. Should their income rise above the Medicaid limit, they become eligible for subsidized private health insurance through the ACA's exchange. By contrast, in non-expansion states, parents can still fall into a coverage gap, where they earn too much to qualify for Medicaid but too little for exchange subsidies. Eliminating the cliff effect by expanding Medicaid allows parents to best provide for their families by continuing to improve their employment prospects.

Supporting Work Leads to Better Financial Stability

Prior studies have shown that financial stress is reduced under Medicaid expansion because it provides clear physical and mental health benefits. The Ohio report found that enrollees were more than twice as likely to note improvements in their financial situation. Medicaid enrollment allowed participants to meet other basic needs. More than half of enrollees reported that health coverage made it easier to buy food; about half stated that it was easier to pay their rent or mortgage, and 44 percent said it was easier to pay off other debts.¹⁶ When families are able to meet their basic needs, they can turn their energy to engaging in the workplace.

When families are able to meet their basic needs, they can turn their energy to engaging in the workplace.

Conclusion

The reports from Ohio and Michigan add to the growing body of research showing that Medicaid expansion improves lives by increasing access to health care, reducing financial burden on low-income families, and supporting employment. A recent survey found that 84 percent of Americans support continuing the funding for Medicaid expansion.¹⁷ Congress should avoid any changes that would roll back these gains or undermine the fundamental structure of Medicaid.

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Complex Medicaid Changes Likely to Cost Many People Coverage

BLOG POST | MAY 30, 2018 AT 9:45 AM | BY JUDITH SOLOMON

Arkansas, which received Trump Administration approval for a demonstration project (or “section 1115 waiver”) to take Medicaid coverage away from people who don’t work or engage in work activities for a set number of hours each month, will begin implementing the new rules on June 1. The Administration has also approved work requirement proposals from Indiana, Kentucky, and New Hampshire and proposals from Kentucky and Indiana to end coverage for those who don’t pay premiums or renew their eligibility on time. Enrollees, including many who are working or should be exempt from the new requirements, will likely end up losing coverage due to red tape and complexity, as our new paper explains.

The experience of several states that the Obama Administration allowed to test premiums and complex incentives to adopt healthy behaviors highlights the challenge of informing enrollees of what they need to do to protect their coverage. (Those waivers, however, don’t take coverage away from people who don’t adopt the healthy behaviors.) In Iowa, Michigan, and Indiana, many enrollees didn’t fully understand the new rules, state evaluations found.

- **Iowa:** Iowa charges premiums to enrollees with incomes above 50 percent of the poverty line. Enrollees don’t have to pay premiums in the first year they’re enrolled, and premiums are waived in later years if enrollees complete a health risk assessment and get a wellness exam. But in 2015, just 17 percent of beneficiaries with incomes below the poverty line and 8 percent with incomes above it qualified for a premium waiver, an interim evaluation found. Some 90 percent of beneficiaries surveyed *didn’t know* they could get their premiums waived if they got a wellness exam. Even in September 2017, three years after the policy took effect, only about 25 percent of enrollees subject to premiums completed the health risk assessment and wellness exam.
- **Michigan:** Michigan’s Medicaid expansion program under the Affordable Care Act requires adults to pay co-payments for most services but reduces their cost-sharing obligation if they complete a health risk assessment and adopt certain healthy behaviors. Yet only 15 percent of individuals enrolled in a health plan for at least six months completed the assessment and most enrollees interviewed said “they had no idea” about the healthy behavior rewards, a 2016 state analysis found. In June 2017, the state reported that only 18 percent of enrollees completed the activities necessary to reduce their cost-sharing obligation despite state efforts to increase participation.
- **Indiana:** Indiana’s waiver program (called the Healthy Indiana Plan) gives every enrollee an account modeled on a health savings account; at the end of the year, enrollees who paid all their premiums for the year can roll over a portion of unspent funds in the account to reduce their premiums in the following year. But only 60 percent of survey respondents in the state’s evaluation said they’d heard of the accounts, and only three-fourths of those who had said they had one.

Despite the findings, Indiana plans to implement a work requirement starting next year, and Michigan lawmakers are close to adopting a requirement. The risks that enrollees will not understand the rules are much greater in states

with work requirements and lock-outs – with people losing coverage, not just the opportunity to reduce their out-of-pocket costs.

In states pursuing work requirements, many enrollees are at risk of losing coverage because the new policies are complex and hard for states to explain. Kentucky, for example, will have to provide notices that include a long list of details about the new work requirement – including when it takes effect, how to claim an exemption, how to satisfy the requirement, how to document hours, what triggers a coverage suspension and the impact of suspension on annual renewal, how to apply for an exception for good cause, how to regain coverage after a suspension, and how to appeal. The state will have to provide similar information about premiums and new lock-outs of coverage for not renewing coverage or reporting changes on time.

So far in Arkansas and Kentucky, the state is apparently relying mainly on written notices to explain the new rules. Given the state experiences cited above, plus the new rules' complexity – especially in Kentucky, which is *simultaneously* implementing a work requirement, premiums, and lock-outs for not renewing coverage or reporting changes on time – the new rules will likely keep some eligible people from staying covered simply because they don't understand them.

TOPICS: Health, Medicaid and CHIP

Total Monthly Medicaid and CHIP Enrollment



Timeframe: Mar 2018

TABLE

Location	Pre-ACA Average Monthly Enrollment	Total Monthly Medicaid/CHIP Enrollment	Percent Change
South Dakota	115,501	118,650	3%

NOTES

0.

Notes

Data are reported for each calendar month. Monthly enrollment data may be updated in Eligibility and Enrollment Reports.

The total increase in Medicaid and CHIP enrollment between the Pre-ACA Average Monthly Enrollment and each month reported post-ACA implementation include data only from 3 periods.

For more information, please see [CMS, Medicaid and CHIP Applications, Eligibility Determination Data](http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html) (<http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html>).

For more information on the current status of Medicaid expansion decisions, please visit [Status of State Action on the Medicaid Expansion Decision](http://kff.org/health-reform/state-indicator/expanding-medicaid-under-the-affordable-care-act/) (<http://kff.org/health-reform/state-indicator/expanding-medicaid-under-the-affordable-care-act/>).

In addition, see the following brief for analysis of trends in this data: [Recent Trends in Medicaid and CHIP Enrollment as of January 2015: Early Findings from the CMS Performance Indicator Project](http://kff.org/medicaid/issue-brief/recent-trends-in-medicaid-and-chip-enrollment-as-of-january-2015-early-findings-from-the-cms-performance-indicator-project/) (<http://kff.org/medicaid/issue-brief/recent-trends-in-medicaid-and-chip-enrollment-as-of-january-2015-early-findings-from-the-cms-performance-indicator-project/>).

Sources

CMS, Medicaid & CHIP Monthly Applications, Eligibility Determinations, and Enrollment Reports, March 2018 (preliminary), as of May 31, 2018. Monthly CMS Medicaid & CHIP Enrollment data are available from CMS [here](http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html) (<http://www.medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html>).

Definitions

Pre-ACA Average Monthly Medicaid/CHIP Enrollment: The average number of individuals enrolled in Medicaid and CHIP for each month during the July-September, 2013 period using an average of 3 months of data submitted by the states for each month in this period. Not all states submitted three months of data. The unit of measure is the number of individuals enrolled as of the last day of the reporting period (month).

Post-ACA Medicaid/CHIP Monthly Enrollment: The total unduplicated number of individuals enrolled in Medicaid and CHIP as of the last day of each reporting period, including those with retro presumptive eligibility. This indicator is a point-in-time count of total program enrollment of those newly enrolled during the reporting period. This number includes only those individuals enrolled for comprehensive benefits (e.g., emergency Medicaid, family planning-only coverage and demonstration populations are excluded). Medicaid Section 1115 demonstration populations are excluded. CHIP children subject to a waiting period or those who are considered eligible but not enrolled and are not included. Data are subject to change.

CMS enrollment reports. Other reporting on Medicaid and CHIP enrollment by states and some beneficiaries excluded in these data (because comprehensive coverage is not provided by different methodology).

Percent Change: The percentage change in total post-ACA Medicaid and CHIP enrollment (average monthly Medicaid and CHIP Enrollment (July-Sept 2013) to each monthly enrollment described above). Percent change is calculated for each month as compared to the base enrollment levels are driven by the number of newly enrolled individuals as well as by those whose coverage has terminated.

N/A: Data not available.

Please see full [CMS reports \(http://www.medicaid.gov/medicaid-chip-program-information/program-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html\)](http://www.medicaid.gov/medicaid-chip-program-information/program-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html) and caveats.

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Volatile Job Schedules and Access to Public Benefits

September 16, 2015

Liz Ben-Ishai

Introduction

For many low-wage workers, Monday-through-Friday, nine-to-five jobs are a thing of the past. Instead, volatile schedules are the norm, especially in retail, restaurant, and other service jobs. Among early career workers (ages 26 to 32) in hourly jobs, more than 40 percent receive one week or less advance notice of their job schedules.¹ Half of these workers have no input into their schedules and three-quarters experience fluctuations in the number of hours they work, with hours varying by more than eight hours per week on average. Many workers receive less than three days' notice.²

These schedules make it difficult for workers to secure child care, hold a second job, or attend job training. *Scheduling* instability also leads to *income* instability. When workers do not know whether they will work 10 hours or 40 hours in a given week, it is nearly impossible for them to budget and to make ends meet. A recent study found that nearly one-third of Americans experience considerable fluctuations in their income; of these individuals, more than 40 percent attribute the ups and downs to irregular work schedules.³

When combined with low wages and low income, workers with volatile schedules often find themselves in need of income support from public benefits programs, such as cash assistance under Temporary Assistance for Needy Families (TANF) and nutritional assistance under the Supplemental Nutrition Assistance Program (SNAP). These safety net programs are crucial to reducing poverty. One recent estimate found that government tax and transfer policies reduced the share of people who were poor by almost half (from 29 percent to 16 percent) in 2012.⁴ Safety net programs also support work, especially for low-income parents, providing crucial stability that helps them advance in their jobs and ensures their children's healthy development. For millions, the safety net has made work pay and lifted families out of poverty.⁵

Ironically, the very job scheduling issues that contribute to many workers' financial insecurity and consequent need for public benefits often create obstacles to *accessing* these benefits.⁶ Some of these programs require recipients to work a certain number of hours. As a result, when workers are scheduled for fewer hours, their wages *and* their public benefits go down.⁷ Temporary increases in work hours can also be cause for concern. Workers who fail to report increased earnings—even if temporary—can be denied benefits or even charged with fraud. Workers who report increased earnings may have their benefits cut or become ineligible. This is often referred to as the “benefits cliff.” Yet many workers whose income increases as a result of additional hours may quickly lose those hours, making them eligible for benefits once again. The reapplication process can

be cumbersome and time consuming, contributing to a process known as “churn” that is as costly for administrative agencies as it is a hardship for families.

Volatile job schedules also exacerbate logistical problems that hinder benefits access. From trying to schedule an appointment with a caseworker to attempting to project one’s income to calculate benefits, workers with volatile job schedules find that the path to benefit eligibility is anything but straightforward. Rules related to quitting one’s job and technological flaws in the system used to verify income may also present challenges for these workers.

Despite playing an essential role in lifting American workers out of poverty when their employers fail to pay them adequately and treat them fairly, the social safety net needs to be updated to keep up with the changing nature of work. In particular, states’ rules and practices are in need of revisions. Workers and advocates can help drive this change; already, their advocacy for stronger workplace protections and collective bargaining rights has effectively increased public support for state and local policy solutions to volatile scheduling. Further advocacy can also drive change at the level of public benefits rules.

This brief examines the ways that volatile schedules complicate and constrain access to public benefits, including those provided under TANF, SNAP, the Child Care Development Fund (CCDF), and Medicaid.⁸ (See Appendix A for brief descriptions of each program.) Many of these programs vary considerably across states—both in law and in practice. Because no source tracks state choices in all of these areas, the brief does not offer a comprehensive, state-by-state analysis. Instead, after providing overviews of how scheduling issues may affect benefit access within the context of several categories of rules, requirements, and circumstances, we pose a series of questions to help advocates, policymakers, and researchers assess the effects of their state’s practices on recipients and applicants employed in jobs with volatile schedules. We also offer some broad best practices to consider across program areas.

Volatile Schedules: Background

Common scheduling challenges include: little advance notice of shifts; fluctuations in shifts from day to day or week to week; highly variable hours per week; being sent home from work early or called in at the last moment; split shifts (nonconsecutive hours); working late-night closing shifts followed by early morning opening shifts (“clopening”); and inadequate hours. These practices are symptomatic of the “just-in-time” approach to scheduling. Under this model, employers modify employee schedules in response to even small changes in sales and demand without regard for the impact on workers, often using scheduling systems that automatically limit hours. However, scheduling software itself is not inherently unfair to workers; when combined with human intervention, it can improve business success *and* worker wellbeing.⁹ There is evidence that this collaborative approach is more profitable for businesses than scheduling practices that don’t take workers’ needs into account.¹⁰

New and emerging research demonstrates that volatile schedules are remarkably common. According to an analysis of the National Longitudinal Study of Youth, more than 40 percent of early career hourly-workers (ages 26 to 32) receive one week or less advance notice of their job schedules. Half of these workers have no input into their schedules and three-quarters experience fluctuations in the number of hours they work, with hours varying by more than eight hours per week on average.¹¹ According to a study of workers of all ages, about 17 percent of the workforce experiences unstable work shift schedules, which includes irregular, on-call, split, and rotating shifts.¹² Parents of young children—the primary recipients of a number of benefits programs—are among those most likely to experience volatile job schedules. Nearly 70 percent of mothers and 80 percent of fathers of children 12 or younger who work in hourly jobs receive hours that fluctuate by up to 40 percent.¹³

Erratic schedules have severe effects on workers’ lives. Workers struggle to arrange child care, transportation, medical appointments, and higher education; they experience fatigue and stress that affects family life and health outcomes; and they struggle to stay afloat financially.¹⁴ To curb these devastating effects, a growing movement of workers and advocates across the country is fighting to pass new labor standards that would require employers to improve scheduling practices. At the federal level, the Schedules that Work Act (S. 1772/H.R. 3071) would give all employees at firms with more than 15 people the right to request scheduling accommodations; it would also provide employees in certain categories a right to *receive* those accommodations unless employers have bona fide business reasons to refuse. For workers at firms with more than 15 people in the retail, restaurant, and building cleaning industries, the bill includes additional provisions that require advance notice of schedules and compensation for last-minute changes, on-call work, and split shifts, as well as minimum pay for showing up to work (even if they are sent home early).¹⁵ Legislation to address schedule volatility has also been introduced in 12 states, as well as several local jurisdictions, over the past year. In 2015,

San Francisco passed the Retail Workers Bill of Rights, which will improve scheduling for workers employed by large chain retailers in the City and County of San Francisco.¹⁶

Low-wage Workers and Public Benefits

About 4 in 10 children (more than 31 million) are poor or near poor, with racial and ethnic minorities disproportionately affected.¹⁷ These children live in families that have difficulty paying the rent or mortgage and keeping food on the table.¹⁸ Yet more than half of poor and near-poor children live with a full-time, year-round worker.¹⁹ Despite the many challenges they face, three-quarters of poor and near-poor single mothers with very young children are participants in the labor force.²⁰ Among those who work less than full time, more than 6.5 million people would like more hours but aren't able to get them.²¹ An additional 1.9 million people are working two part-time jobs.²² Despite a lot of hard work, many low-wage workers simply can't make ends meet.

Safety net programs, particularly SNAP, Medicaid, and refundable tax credits, have come to play a critical role in filling the gap between what low-wage jobs provide and what families need to get by. In 2013, Medicaid served 57.4 million individuals²³ and SNAP supported 47.6 million individuals.²⁴ The Earned Income Tax Credit (EITC) benefitted 28 million individuals.²⁵ Programs with capped funding reached smaller shares of needy families. TANF served 1.75 million families, while child care subsidies through the Child Care and Development Fund reached 1.46 million children.²⁶ Overall, government tax and transfer policies reduced the share of people who were poor by almost half in 2012.²⁷

Many of those who benefit from these programs are in working families. In some cases, such as the EITC or child care, eligibility is directly linked to employment. Most parents receiving child care subsidies are working; 94 percent are either employed or in education or training programs.²⁸ But even in other programs, participants have significant work attachment. For example, among all SNAP households with at least one working-age adult not receiving disability benefits, more than half have a member who works while receiving SNAP. Additionally, more than 80 percent work either in the year prior to or in the year following SNAP receipt. The rates are even higher for SNAP households with children.²⁹ These figures reflect deliberate actions by federal and states governments over the past two decades to increase support for low-income working families who are unable to make ends meet based on wages and benefits earned.

Public Benefits Challenges for Workers with Volatile Job Schedules

Although the programs covered in this brief vary widely along legal, policy, and practice lines, a common set of challenges related to volatile job schedules emerges for affected applicants and recipients. Below, we consider how certain broad requirements or rules affect each program's capacity to serve workers with volatile schedules. Since these programs are administered by states, with the exception of certain federally mandated requirements, policies and practices may vary widely depending on geographic location. The specifics of how states apply these requirements will shape workers' experiences.

Work requirements

Since workers with volatile schedules experience instability and unpredictability in their hours, programs that impose work hour requirements pose a particular challenge. Work requirements vary significantly between programs.

- States must engage a specified share of TANF recipients in a limited set of countable activities for a minimum number of hours per week. To be counted toward the federal work participation rate (WPR), recipients must participate a minimum of 20 to 35 hours per week depending on family composition.³⁰ States have the option of setting their work requirements higher; some have elected to do so, partly because they anticipate variation in weekly hours among recipients. There is no partial credit for recipients who fall just short of the federal standard; consequently, states want a cushion to increase the likelihood of receiving credit.
- SNAP recipients who are not working 30 hours per week (or are otherwise exempt due to age, caregiving responsibilities, disability, or student status) may be required to participate in employment and training activities.³¹ (Earning a weekly average of 30 hours per week times the minimum wage is deemed equivalent to working 30 hours.) So-called “able-bodied adults without dependents” (“ABAWDS”) can only access SNAP for three months out of a three year-period *unless* they are working or participating in a qualified work activity for a minimum of 20 hours per week.³² SNAP regulations specify that recipients who are subject to this time limit must report any instances in which their work hours fall below 20 hours per week, averaged across a month, even if they would otherwise not need to report fluctuations in income.³³
- To qualify for child care assistance under CCDF, parents must participate in a work or education activity or have a child in need of protective services. States each establish their own policies defining acceptable work activities for the purposes of eligibility. Those activities may include employment, job search, job training, or educational programs. The federal child care assistance law prescribes no

minimum work requirement. Nearly half of states have policies requiring parents to work a minimum number of hours.³⁴ Of those that have set such a minimum, more than half require 20 hours of work or more per week for assistance with full-time care; some require 30 hours of work. States with these higher minimums for full-time care sometimes also establish a lower minimum threshold for part-time care.³⁵ However, within the context of federal parameters, states have the freedom to modify their rules to ensure that programs meant to support work are in sync with the challenges of today's low-wage labor market.

As Susan Lambert and Julia Henly note in their study of early career workers, work-hour requirements are based on an assumption that workers have control over how many hours they work (meaning those that work less are doing so because of a preference or personal barriers).³⁶ Yet existing data and workers' stories show this is far from true. While eligibility rules for TANF do not require recipients to find jobs that pay a certain wage or offer specific benefits, they do require a minimum number of hours. This requirement does not reflect the realities of low-wage work.³⁷

During the Great Recession, high unemployment meant that most states became eligible for—and took up—state-wide waivers for the ABAWD time limit. Unemployed individuals in these states were not automatically cut off from SNAP if they reached their 3-month time limit and were unable to obtain 20 hours a week of employment or training. However, with the economic recovery, many states are no longer eligible for—or are no longer taking up—the state-wide waivers, despite the ongoing struggles many recipients face in finding sufficient hours of work. In 2015, 31 of the 37 states eligible for state-wide waivers took them up.³⁸ According to an analysis by the Center on Budget and Policy Priorities, roughly one million people are likely to lose SNAP benefits in 2016 as state-wide waivers expire.³⁹ While the population expected to lose benefits is often completely unemployed, it will also include those who are underemployed (either on an ongoing basis or as a result of volatile scheduling practices that cause hours to fluctuate).

Work requirements may also present unique challenges for recipients who have part-time jobs or jobs with fluctuating schedules. For example, TANF recipients with part-time jobs may not be offered enough hours of work to meet their state's participation requirements. To meet the requirement, they may be assigned to “job club” (a formal job search group). However, these assignments may not account for workers' job schedules, especially those that fluctuate. In some cases, recipients may need to choose between missing work and attending their mandated “work activities.”⁴⁰

The reasons for and ways in which workers *leave* jobs may also affect their eligibility for benefits. Workers who “voluntarily quit” their jobs are typically disqualified from receiving certain benefits, including SNAP and TANF.⁴¹ Yet “quitting” may be the only option for workers with erratic schedules that cause untenable conflicts between their work obligations and their family, school, and health obligations. Some states may have

exceptions for quits deemed to be motivated by “good cause,” but TANF rules vary from state to state. For SNAP, by statute, good cause for leaving employment may include discrimination by an employer, unreasonable work conditions (such as working without pay), or acceptance or enrollment in a recognized education or training program on at least half-time basis.⁴²

Fluctuating benefit amounts

Means-tested programs are designed to provide more support to those with the greatest need; therefore, they adjust benefit levels in response to changes in recipients’ earnings or other income. However, when benefits are adjusted in response to even small or temporary changes in income, the resulting fluctuations in benefit levels—on top of fluctuating earnings—can make it difficult for workers and their families to maintain stability in all aspects of their lives. It may be particularly challenging for families that experience a lag between when earnings change and when they are reflected in benefit amounts. High earnings one month may result in lower benefits the following month. Meanwhile, workers’ earnings may well drop and return to previous levels, leaving them struggling to make ends meet on the lower benefits. This can have severe, potentially long-lasting consequences. One report found that in families who experienced decreases in SNAP benefits, children were 70 percent more likely to experience developmental delays; 55 percent more likely to be food insecure; 36 percent more likely to be in poor health; and 12 percent more likely to be hospitalized.⁴³

As with work requirements, state policies and practices are critical in determining how volatile schedules will affect benefit levels. States and programs use different methods to calculate benefit amounts; some project earnings in advance of work (prospective budgeting), while some use actual earnings information to budget (retrospective budgeting). States also vary in their requirements regarding how frequently recipients must report income changes or what level of change warrants reporting (see the eligibility verification section below).

Many states now require SNAP recipients to report on their income and household circumstances only at defined intervals—typically every three to six months—unless household income rises above a threshold level. (Recipients who lose income may choose to report it sooner in order to have their benefits adjusted up.) However, other states require monthly reporting.⁴⁴ In addition, individuals subject to the SNAP time limits must report reductions in work hours below the 20-hour-per-week threshold.

In recent years, nearly all states have adopted “simplified reporting” processes for SNAP; these require recipients to submit information every six months. Under this system, households must only immediately report changes that push their income over 130 percent of the federal poverty level (FPL).

State policies regarding child care assistance sometimes require care hours to closely match parents’ work hours; as a result, children experience instability in their care arrangements as parents’ hours fluctuate.⁴⁵ Researchers have found that such instability is harmful to children’s development. In addition, parents in these

circumstances may find it difficult to identify quality child care providers that will accept their children. This is because in the unsubsidized child care market, families typically pay for care regardless of whether their children are present on a given day. (This is necessary for providers to maintain financial stability.) Even working parents who receive child care subsidies may have difficulty finding quality care. Their struggles with unstable, unpredictable schedules may discourage providers from accepting their children.

There are no federal rules mandating that states impose such requirements on work and care hours. The federal Office of Child Care has clarified that states need not authorize care based on the work, training, or educational schedule of parents. Furthermore, the recently reauthorized child care law specifically encourages states to support fixed costs of care and to use generally accepted payment practices in compensating care providers. Colorado provides one example of a state that does not impose restrictions on child care hours by tying them to parents' work hours. In 2014, it passed legislation prohibiting such rules.⁴⁶

Historically, the need to report changes in employment or other family statuses and to regularly recertify has led to fluctuations in benefit amounts and barriers to maintaining subsidies. In the past, many states required parents to report any changes to income and work schedules to state agencies as they occurred, both for the purposes of maintaining eligibility and to adjust required parent co-payments. For workers with variable schedules, frequent reporting requirements can be burdensome. These restrictive policies, imposed by states, are not federal requirements. States can minimize the changes that must be reported, simplify reporting, and minimize how often they act upon reported changes. State implementation of the new Child Care and Development Block Grant (CCDBG) law, which requires 12-month eligibility unless family income goes over the federal eligibility level (85 percent of state median income), is likely to reduce the burden of reporting requirements for families during their eligibility period.

The new CCDBG law also includes several other provisions that should limit benefit fluctuations and increase child care stability. These include a requirement that states not terminate child care assistance based on parental job loss or cessation of education and training unless they continue assistance for a period of at least three months, in order to provide time for job search. States are also required to demonstrate how they will take irregular fluctuations in parents' earnings into account when determining and redetermining eligibility.⁴⁷

Utah's Approach to Benefits for Workers with Volatile Schedules and Incomes

Utah takes a common-sense approach to calculating income and eligibility for workers with volatile schedules who receive public benefits. Many of the state's policies are designed to reduce barriers for these workers. Nevertheless, continued training and policy refinements are needed to ensure adequate access.

Utah's eligibility workers are trained to estimate recipients' prospective income for cash assistance, SNAP, and child care programs by averaging, anticipating, and/or annualizing income. While check stubs continue to be the gold standard for documenting income, they are not always indicative of expected earnings for the prospective eligibility period (typically 6 or 12 months). Agencies can use other methods to obtain income information, such as documents, collateral contacts, electronic data interface, and the professional judgment approach.⁴⁸

Agency staff may call an employer to inquire about a recipient's expected hours and potential for overtime. The professional-judgment approach allows an eligibility worker to estimate income in cases without check stubs and when collateral contact information may be minimal or unattainable. This subjective area, meant to allow for flexibility, highlights the importance of comprehensive agency training. Income estimates must be carefully narrated in the case file for case reviewers and auditing purposes.⁴⁹

Utah has increasingly relied on electronic data sources to obtain information pertinent to a recipient household's case. This serves several purposes, including: reducing the verification burden for families, who are focused on finding and maintaining jobs; streamlining eligibility processes for agency staff; and improving case accuracy. A customized system called eFind pulls data from dozens of state and federal databases, including motor vehicles, new hire registry, social security, and wage match information.⁵⁰ As part of the eligibility determination process, agencies use this data to verify customer-provided information or to access newly reported information. When information from the data is straightforward and clear, eligibility workers can take action on a case, with appropriate notice requirements (typically 1 day or 10 days) for negative actions, such as benefit decreases and case closures. Workers are, however, encouraged to follow up on information that is inconsistent or does not provide a clear picture their particular situation (e.g., wage data from several quarters ago).

Another component of Utah's technologically advanced eligibility process is myCase, which is a customer-friendly website where basic case information can be accessed, including EBT balances, application or review status, and outstanding information needed. Recipients can report changes and complete applications and reviews online, as well as opt in to receive all notices electronically. This allows recipients to access information 24/7 and provides a modern channel through which to communicate with eligibility workers.⁵¹

Utah has developed technological systems to streamline eligibility processes, enabling recipients to reduce their verification burden when information can be obtained through data interfaces. While these systems are generally a good thing, there are still potential pitfalls to this approach. Eligibility workers should continue to be trained and encouraged to apply common sense and good judgment to estimate prospective income. This includes considering job scheduling fluctuations in the context of the current labor market, characterized by volatile jobs; engaging with employers to approximate expected work hours; and ensuring transparency with recipients regarding how income was calculated so that discrepancies or inconsistencies can be properly communicated and addressed.

Benefit Cliffs

Most means-tested programs are designed to gradually phase out benefits as income increases. TANF programs typically allow recipients to keep all of their initial earnings and phase out benefits over time. With SNAP, an additional dollar of earnings typically results in a loss of 24 to 36 cents worth of benefits.⁵² However, some

programs have “benefit cliffs,” meaning a small change in income can lead to a large decline in benefits or even lost eligibility. In these instances, recipients may end up *worse off* when they work more hours or earn additional income. That’s fundamentally unfair to people working hard to get ahead.

One benefit cliff that low-wage workers with volatile schedules may encounter is the “gross income limit” under SNAP. Under SNAP eligibility rules, households without an elderly or disabled member typically must have gross or total income below 130 percent of FPL. However, benefits are based on net income after taking into account deductions such as child care and other work-related expenses or excessive housing costs. This means that small increases in earnings that push a household over the gross income limit may result in a significant loss of benefits. (States can keep SNAP cases open for a month with zero benefits in order to avoid churn, but if income remains above the gross income limit for a longer period, the case must be closed.)

However, states have the flexibility to raise the gross income limit through a policy called “broad-based categorical eligibility.” As of April 2015, 27 states and the District of Columbia had used this option to raise the gross income limit up to as much as 200 percent of FPL for at least some SNAP recipients.⁵³ In these states, SNAP benefits will phase out gradually with increased income, without a sharp “benefits cliff.”

In its recent reauthorization of the federal child care assistance program, Congress required all states to adopt policies that transition families off child care assistance when they are no longer eligible and provide children with stable care as families’ earnings fluctuate (a common occurrence among low-wage workers). First, states are now required to offer 12 months of continuous coverage to children receiving child care assistance, as long as their income stays below the federal cap of 85 percent of state median income—a relatively high threshold. Second, at the end of the 12-month eligibility period, states must have provisions in place to ease families who are no longer income eligible under state eligibility rules off subsidies over some period of time. Combined, these two policy changes could help workers with volatile schedules. However, they may come with additional costs—and most states do not have new money available to cover them. Without significant federal investment, states may choose to reduce the number of families served.

In the 30 states that have adopted the Medicaid expansion under the Affordable Care Act (ACA), one of the most damaging cliffs is gone. Parents no longer have to take the enormous risk of going without health insurance if they add hours to a low-wage job and exceed a pre-ACA Medicaid eligibility ceiling that, in many states, was far below the poverty level. Under ACA, working parents have access to Medicaid coverage at the lowest income levels and, as their income rises, subsidized coverage on a sliding scale through the health insurance exchange. However, in states that have not expanded their Medicaid eligibility to 138 percent of FPL, there is still a steep benefit cliff. Adults in these states will experience a benefit cliff when their income exceeds the state’s income eligibility level and they do not earn enough to receive APTCs (Advance Premium Tax Credits) through the Marketplace (see Appendix B for a description of APTCs). For example, in Kansas, the Medicaid eligibility limit for parents with dependent children is 38 percent of FPL (adults without dependent

children are not eligible at all). Therefore, if a parent in Kansas receives her health care through Medicaid and her income rises above 38 percent, she will not have access to affordable health insurance until her income reaches at least 100 percent of FPL, making her eligible for APTCs through the Marketplace. Children have higher eligibility and do not experience a benefit cliff between Medicaid and APTC eligibility.

Eligibility Verification and Program Churn

Recipients of public assistance must verify their eligibility at designated time intervals; if they no longer meet eligibility requirements, they will lose their benefits. In addition, whether or not they are *actually ineligible*, if they fail to provide adequate documentation of their eligibility, they may also lose their benefits. Many recipients who are denied benefits at redetermination due to lack of documentation later reapply and resume receiving benefits. This cycle of losing and then regaining eligibility is called “churn.” In addition to creating turmoil and instability in the lives of recipients and their families, churn leads to increased costs and administrative burdens for states. Logistical challenges related to unstable work schedules make it difficult for workers to meet (often burdensome) administrative requirements. Requalifying for benefits after a loss of eligibility is also difficult and involves lengthy waiting periods that delay access to critical services.⁵⁴

A study by the U.S. Department of Agriculture (USDA) found that the rate of churn for SNAP is between 17 and 28 percent. The vast majority of those who leave and then return to the program are gone for less than one month.⁵⁵ Churn can result from procedural complications or increased income, both likely scenarios for workers with volatile schedules.⁵⁶

Provisions in the newly reauthorized CCDBG law will reduce the frequency of eligibility redetermination for child care assistance, which has contributed to churn in the past. When families were unable to meet the requirements for eligibility redetermination—because it interfered with employment or because they were unable to gather the required information—they often lost their child care assistance, even if they were still technically eligible.

Prior to reauthorization, churn was common in child care subsidy programs, and it may continue to be an issue until states have fully implemented the eligibility provisions of the new law. One study from 2002 found that 35-58 percent of families returned to the program within one year.⁵⁷ Loss of child care assistance is particularly devastating because child care subsidies are not guaranteed to all eligible families. Each state serves only a small fraction of eligible families because of limited funding. At present, 18 states have waiting lists or have frozen intake for child care assistance.⁵⁸ This means that losing eligibility temporarily due to administrative challenges may ultimately lead to a lengthy wait before regaining access. Families may spend anywhere from a week to over a year on states’ child care assistance waiting lists. Even when families who lose and regain benefits are not placed at the bottom of the waiting list, their child care providers may not be able to hold their

spot without compensation. This forces parents to seek out a new provider, creating instability for children. Further, parents may have difficulty identifying a new provider that can accommodate their volatile job schedules.

While churning at the point of redetermination has been a consistent struggle for Medicaid programs, new options provided by the Affordable Care Act are beginning to contribute to improvements. States are now required to use existing data sources to automate renewals (known as “ex parte renewals”) when possible and provide enrollees with prepopulated renewal forms when ex parte renewals are not possible. States also have the option to implement 12-month continuous eligibility, an ideal approach that ensures recipients will not have to report income fluctuations and other work changes for an entire year once approved for Medicaid. States have had this option for children since 1997; those that have exercised it have experienced reduced churn. In states that have not opted for 12-month continuous eligibility, recipients must report income changes throughout the year, potentially causing them to churn on and off Medicaid if their income fluctuates above and below the eligibility threshold.

Missed appointments can also lead to churn. Workers with volatile job schedules may have as little as one day’s notice of their work hours, making it difficult to arrange and keep appointments. Even phone interviews can be difficult to schedule. While they reduce the need for travel, workers with inflexible jobs may not have enough break time to take calls related to benefits. Some states issue sanctions to workers who miss appointments, potentially leading to case closure. Other states are more accommodating of workers’ job schedules. Some allow phone appointments (which are only helpful to some), weekend or evening in-person meetings, or other concessions that acknowledge the severe challenges recipients face when trying to arrange meetings. One strategy that can be particularly useful for workers with volatile schedules is “on-demand interviews,” where instead of assigning a client a specific time for an interview, the state provides clients with a several-day window during which they may call in at times of their own choosing and be connected with a caseworker who will conduct the interview. Implementing on-demand interviews for SNAP requires a waiver from the USDA’s Food and Nutrition Service, which will monitor states to ensure clients’ calls are being answered and processed in a timely manner.⁵⁹

The new CCDBG law attempts to explicitly address barriers that workers may encounter as they juggle work and benefit access. It requires states to describe how their redetermination procedures and policies will ensure working parents, particularly those enrolled in TANF, are able to comply without disrupting their employment.⁶⁰

Addressing Logistical Barriers to Benefit Access: A Legislative Approach

A bill recently proposed in the California State Assembly (AB 357) takes an innovative approach to addressing the logistical hurdles many workers with volatile job schedules face when they seek out benefits.⁶¹ In addition to requiring employers to provide more notice to workers and accommodate scheduling needs, the proposed legislation sought to make broad changes to labor standards. It included the following provisions:

- Employers cannot take adverse actions against an employee who takes an unscheduled absence to attend an appointment with a county human services agency, provided the employee provides documentation.
- Welfare agencies cannot sanction employees who refuse employment or requirements related to employment if the employer is not complying with fair scheduling rules proposed under the same law.

Many states use electronic verification systems to track workers' income and verify reports from employees and employers. Electronic verifications can reduce the burden on recipients when they are used to automatically redetermine eligibility and to substitute for paperwork. However, such verifications can be burdensome and counterproductive when recipients are forced to explain and document even minor discrepancies between clients' self-reported income and income reported electronically.

Best Practices ⁶²

For many of the programs discussed above, states have considerable leeway in adopting practices that could make their safety net more accommodating to workers with volatile schedules. The following recommendations apply to most programs and are in effect in some states already:

Work requirements

- Use the maximum flexibility allowed under federal law to project work hours or average hours over time.
- TANF allows documented hours of work to be projected forward for 6 months.
- States may request a waiver to average hours of work across a month for students (who are subject to restrictions on SNAP eligibility unless they work at least 20 hours per week).⁶³
- Provide recipients with flexible “add-on activities,” such as online education programs, self-directed job search, or self-organized community service that can be fit around fluctuating work hours, rather than requiring them to attend programs at fixed hours.⁶⁴

- Consider allowing TANF recipients to participate for less than the minimum hours needed to count toward the federal work participation requirement if staying in the same job is a wise decision for their long-term economic prospects. For example, workers may wish to stay in a job that offers fewer hours now but will later give them the seniority to get better shifts/hours.
- Do not tie child care subsidies tightly to actual hours of work.
- Implement new CCDBG rules that allow children to retain subsidies while parents are searching for work after unemployment.
- Treat highly volatile scheduling practices as “good cause” for voluntarily quitting a job, particularly when child care is not available.

Variable benefit amounts

- Allow for variation of income and work hours within a reasonable range without requiring reporting, and/or
- Allow for income calculations that take into account income fluctuations by averaging income over a period of time or incorporating anticipated changes into calculations.
- Disregard temporary increases in earnings that are not expected to last.
- Raise asset limits that restrict the amount of assets, including emergency savings, that benefit recipients can save.⁶⁵

Eligibility cliffs

- Implement new CCDBG rules that provide 12 months of continuous eligibility.
- Offer transitional benefits for recipients that exceed income thresholds for benefit access.
- Adopt eligibility rules that minimize cliff effects, including Medicaid expansion and raising the gross income limit under SNAP.

Verification/churn

- Lengthen recertification periods and assess income eligibility less frequently.
- Minimize the need for face-to-face appointments with caseworkers.
- Allow on-demand interviews, which enable recipients to determine the best time for phone interviews.
- Use electronic verifications to substitute for paperwork and streamline redetermination processes. Develop systems that disregard minor discrepancies and that do not generate constant verification notices for workers with variable schedules.

Conclusion

As workers struggle with employer scheduling practices that leave them with little stability, predictability, and flexibility, many must turn to the safety net for support. While some aspects of public benefits programs are adapting to the realities of the labor market, others are premised on an assumption that recipients can find full-time, standard-hour, predictable employment when desired. This is clearly not the reality for most recipients of income support. Further, some states administering public benefit programs ignore the many logistical challenges created by volatile job scheduling. Keeping an appointment or taking a phone call may be out of reach for a worker who receives little notice of her schedule or faces the constant threat of losing much-needed hours at work.

Across the country, workers' rights advocates are making a strong case for labor standards that create a floor for fair scheduling. But as the scheduling fight proceeds on the labor front, it is also critical that public benefits advocates work to ensure program rules and state policies and practices accommodate workers with volatile schedules. Advocates from each field should collaborate to encourage states to adopt the changes workers need and that are often allowed under federal law. CLASP looks forward to working with partners engaged on both issues to improve the lives of low-income families.

Appendix A: Key Public Benefits Programs

In this brief, we focus on four means-tested public benefit programs where workers who experience volatile schedules may have challenges accessing and sustaining eligibility. While schedule volatility may affect access to other programs as well, these programs illustrate the range of challenges that workers may face. Brief descriptions of each program covered in this paper follow.

Temporary Assistance for Needy Families (TANF)

TANF is a federally funded block grant that states use to provide cash assistance and other benefits and services to poor families with children. States have full flexibility to determine benefit levels and eligibility rules. A key feature of TANF is its emphasis on work for families receiving benefits; states require most adult TANF recipients of cash assistance to be employed or participate in specified “work activities.” If adults fail to comply with work requirements, families receive penalties ranging from removing the adult from the case (resulting in a lower benefit) to termination of the entire family’s benefit. Federal work participation rates require states to engage half of families receiving TANF in a countable work activity for a minimum of 35 hours per week (for 2-parent families), 30 hours a week (for single parents of children over 6), or 20 hours per week (for single parents with children 6 and under).⁶⁶ There is no partial credit for hours worked below these thresholds; consequently, a single parent who works 19 hours per week counts towards the federal rates the same as one who does not have any work at all.

Supplemental Nutrition Assistance Program (SNAP)

The Supplemental Nutrition Assistance Program (SNAP), formerly known as food stamps, is the nation’s largest and one of the most important anti-hunger programs, providing nutrition assistance to over 46.5 million people in low-income households in 2014.⁶⁷ SNAP benefits are fully federally funded, and the federal government sets the benefit levels and eligibility rules, although applications and eligibility determinations are conducted by the states. SNAP is responsive to the needs of individuals and households, expanding to serve more people during economic decline and retracting once the economy recovers. It is a critical part of the nation’s safety net. And unlike most other means-tested programs, which are often restricted to particular categories of low-income individuals, SNAP is available to all who are eligible.

Child Care and Development Fund (CCDF)⁶⁸

The Child Care and Development Fund (CCDF) provides child care assistance to low-income families who are employed or enrolled in education or training programs. In 2014, CCDF served over 1.4 million children.⁶⁹ The federal law allows states to establish their programs within broad parameters that allow for considerable discretion. States determine what activities count as work or education; whether recipients must work a minimum number of hours to be eligible; procedures for verifying working hours; and procedures related to reporting changes to schedules and work hours. In 2014, CCDF was reauthorized by Congress. The updated law

includes provisions that are meant to make access to the program less burdensome for families and improve children's continuity of care; several of these provisions are particularly important for parents with volatile work schedules. If implemented as intended, they could considerably improve access to and retention of child care assistance among families struggling with scheduling challenges.

Medicaid

Medicaid is a joint program between the federal government and states that provides health care to low-income individuals and families. Eligibility and exact medical benefits vary across states, with some states offering more robust health care access than others. There are multiple eligibility categories for Medicaid, including low-income seniors, persons with disabilities, pregnant women, and general income eligibility. Information included in this paper refers only to the general income eligibility population. One intent of the Affordable Care Act (ACA) was to create a uniform minimum income eligibility standard of 138 percent of the Federal Poverty Level (FPL) for Medicaid across all states. However, the 2012 Supreme Court ruling on the ACA gave states the option of whether or not to expand their Medicaid eligibility to 138 percent. Thirty-one states (including the District of Columbia) have chosen to expand Medicaid eligibility to 138 percent eligibility, while 19 states have not expanded eligibility. One state is still considering whether to expand.⁷⁰ In the states without Medicaid expansion, income eligibility ranges from zero eligibility for adults with no dependent children to 148 percent of FPL for parents with dependent children. In the majority of non-expansion states, there is no Medicaid eligibility for adults without dependent children and an eligibility limit below 67 percent of FPL for adults with dependent children.⁷¹ Eligibility for children is consistently higher than that for adults and is less affected by fluctuating income.

Appendix B: Programs not covered in this report

Earned Income Tax Credits (EITCs)

The EITC program is a refundable tax credit granted to families who, despite working, earn a low or moderate income. Eligibility and benefit amount depend on the size of families and earnings of working family members.⁷² Families receive the EITC in a lump sum when they file their taxes annually; it is based on annual income for the previous calendar year. We do not discuss the EITC in this report because while many families receiving this benefit are affected by volatile work schedules and income, annual income-based calculations mean EITC access is not affected by this volatility. Rather, the EITC acts as a cushion for many families, providing support to help alleviate the effects of income volatility.⁷³

Advance Premium Tax Credits (APTCs)

APTCs are subsidies provided through the tax system to individuals and families who enroll in health insurance through the Marketplace (federal or state-based). While exact eligibility requirements can be complicated,

people generally qualify for APTCs if their household income is between 100 percent and 400 percent of FPL and they do not have another source of affordable health insurance, such as through an employer or Medicaid. In 2015, approximately 84 percent of all persons receiving insurance through the Marketplace are receiving APTCs, totaling 8.3 million enrollees.⁷⁴ Like EITC, APTCs are calculated on the basis of annual income. However, because credits are paid to insurance companies during the year, recipients must estimate or project their income for the remainder of the year in order to determine their subsidy. Therefore, if they have schedule changes that significantly affect their annual incomes, they should report their income changes to the Marketplace in order for APTCs to be adjusted accordingly.

Workers with volatile incomes, including those with erratic schedules, may find it difficult to project income. They may either overestimate or underestimate their income. If income is overestimated, they may not receive the full amount of APTCs for which they qualify, increasing their monthly out-of-pocket expense for health insurance. Though they will receive a tax refund for the additional APTC amount they should have received, many workers may be unable to wait until tax time to receive such support and may drop their coverage. If a worker underestimates her income, she may receive more APTCs than she is eligible for and be required to pay back some or all of the difference when filing taxes, potentially imposing a significant and unexpected burden at tax time.⁷⁵

Unemployment Insurance (UI)

UI provides an important safety net for jobless workers, including workers with volatile schedules who must quit their jobs or are fired due to conflicts created by such scheduling practices. The program also offers support (“partial UI”) to workers whose hours are significantly cut. We explore the implications of volatile scheduling for access to UI in another publication, *Out of Sync: How Unemployment Insurance Rules Fail Workers with Volatile Job Schedule*.⁷⁶

Appendix C: Questions for Advocates to Ask

With so much state variation in practices regarding public benefits access, advocates concerned with the intersection of volatile scheduling practices and benefits access must look closely at their local requirements. Following are a series of questions that advocates may want to consider as they evaluate the types of changes and improvements that are needed in their states to ensure workers with volatile schedules can access the income supports they need.

Work requirements

- *What is the minimum number of hours of work required to receive benefits?*
- *Does the state allow for variation in work hours within a certain range?*

- *How frequently must the recipient report on work hours?*
- *What amount of change in work hours is considered large enough to warrant reporting the change to the agency?*
- *Are benefits available to workers employed in part-time jobs? What is considered part time? Full time?*
- *What are the consequences for workers who fail to report changes in hours or who inaccurately estimate their work hours?*
- *Is the change reporting process user-friendly?*

Benefit fluctuations

- *Does the state use a prospective or retrospective budgeting system for each benefit program?*
- *In prospective systems, what are the consequences for recipients who inaccurately estimate their work hours?*
- *How often do recipients have to recertify their eligibility/report changes in their schedules or work hours?*
- *Does the state impose restrictions or requirements that cause benefits to fluctuate and are not required by federal law?*

Eligibility verification and churn

- *How often is eligibility assessed?*
- *Has the state adopted 12-month continuous eligibility for any/all of its programs?*
- *How user-friendly is the eligibility assessment process?*
- *How burdensome is the process of reapplying for benefits when hours are reduced?*
- *Are there waiting lists for programs? What is the waiting list policy for recently ineligible recipients who are reapplying for benefits?*
- *Does the state collect data on churn?*
- *Do programs share information when conducting redeterminations? Are redetermination processes for various states coordinated with one another to reduce burden on recipients?*

Benefit cliffs

- *Does the state have “transitional benefits” for workers that have earned enough to become ineligible, so that they do not face a steep “cliff?”*
- *Has the state expanded Medicaid for adults to 138 percent of FPL?*
- *Is funding available to enact policy changes that would ease cliffs?*

Other issues

- *Does the state have a policy regarding sanctions for missed or rescheduled appointments? Does the policy take into account recipients' job schedules?*
- *Does the state take into account workers' job schedules when assigning them to "job club" or other activities?*
- *Are evening, weekend, or phone appointments available to help accommodate workers' schedules?*
- *How does the state treat voluntary quits? Are scheduling challenges considered "good cause" to quit?*
- *What electronic verification systems are in use? Have there been reports of mistakes, particularly for workers with volatile schedules?*

Endnotes:

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⁷ Lambert and Henly, "Double Jeopardy."

⁸ See Liz Ben-Ishai, Rick McHugh and Claire McKenna, *Out of Sync: How Unemployment Insurance Rules Fail Workers with Volatile Job Schedules*, Center for Law and Social Policy and National Employment Law Project, August 2015, <http://www.clasp.org/resources-and-publications/publication-1/Out-of-Sync-Report.pdf>.

⁹ Ethan Bernstein, "Work Schedules: The False Tradeoff Between Fair and Productive," *Roll Call*, July 22, 2015, <http://blogs.rollcall.com/beltway-insiders/work-schedules-the-false-tradeoff-between-fair-and-productive-commentary/?dcz=>.

¹⁰ Liz Ben-Ishai, *Job Schedules that Work for Businesses*, Center for Law and Social Policy, November 26, 2014, <http://www.clasp.org/resources-and-publications/publication-1/Job-Schedules-that-Work-for-Businesses.pdf>.

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¹⁴ Liz Ben-Ishai, Sasha Hammad, and Christina Warden, *Tackling Unstable and Unpredictable Work Schedules: A Policy Brief on Guaranteed Minimum Hours and Reporting Pay Policies*, Center for Law and Social Policy, Retail Action Project, and Women Employed, March 7, 2014, <http://www.clasp.org/resources-and-publications/publication-1/Tackling-Unstable-and-Unpredictable-Work-Schedules-3-7-2014-FINAL-1.pdf>.

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¹⁶ "Retail Workers Bill of Rights", Jobs for Justice San Francisco, <http://retailworkerrights.com/get-the-facts/>.

For information on the movement and latest legislative developments, visit CLASP's National Repository of Resources on Job Scheduling Policy:

CLASP, "A National Repository of Resources on Job Scheduling Policy," <http://www.clasp.org/issues/work-life-and-job-quality/scheduling-resources>.

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Key Facts about the Uninsured Population

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The Affordable Care Act (ACA) led to historic gains in health insurance coverage by extending Medicaid coverage to many low-income individuals and providing Marketplace subsidies for individuals below 400% of poverty. Under the law, the number of uninsured nonelderly Americans decreased from 44 million in 2013 (the year before the major coverage provisions went into effect) to less than 28 million as of the end of 2016. Recent efforts to alter the ACA fundamentally change the structure of Medicaid may pose a challenge to further reducing the number of uninsured and may threaten coverage gains seen in recent years.

[ber of #uninsured people changed under the #ACA?](https://twitter.com/share?number+of+%23uninsured+people+changed+under+the+%23ACA%3F&url=http%3A%2F%2Fkaiserf.am%2F2xjuZyV) [_](https://twitter.com/share?number+of+%23uninsured+people+changed+under+the+%23ACA%3F&url=http%3A%2F%2Fkaiserf.am%2F2xjuZyV) (<http://twitter.com/share?number+of+%23uninsured+people+changed+under+the+%23ACA%3F&url=http%3A%2F%2Fkaiserf.am%2F2xjuZyV>).

This fact sheet describes how coverage has changed under the ACA, examines the characteristics of the uninsured population, and summarizes the access and financial implications of not having coverage.

Summary: Key Facts about the Uninsured Population

How has the number of uninsured changed under the ACA?

In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance. Beginning in 2014, the ACA expanded coverage to millions of previously uninsured people through the expansion of Medicaid and the establishment of Health Insurance Marketplaces. Data show substantial gains in public and private insurance coverage and historic decreases in uninsured rates under the ACA. Coverage gains were particularly large among low-income people living in states that expanded Medicaid. Still, millions of people—27.6 million in 2016— remain uninsured.

Why do people remain uninsured?

Even under the ACA, many uninsured people cite the high cost of insurance as the main reason they lack coverage. In 2016, 45% of uninsured adults said that they remained uninsured because the cost of coverage was too high. Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid, remain ineligible for financial assistance for coverage. Some people who are eligible for financial assistance under the ACA may not know they can get help, and undocumented immigrants are ineligible for Medicaid or Marketplace coverage.

Who remains uninsured?

Most uninsured people are in low-income families and have at least one worker in the family. Reflecting the more limited availability of public coverage in some states, adults are more likely to be uninsured than children. People of color are at higher risk of being uninsured than non-Hispanic Whites.

How does the lack of insurance affect access to health care?

People without insurance coverage have worse access to care than people who are insured. One in five uninsured adults in 2016 went without needed medical care due to cost. Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.

What are the financial implications of lacking coverage?

The uninsured often face unaffordable medical bills when they do seek care. In 2016, uninsured nonelderly adults were over twice as likely than their insured counterparts to have had problems paying medical bills in the past 12 months. These bills can quickly translate into medical debt since most of the uninsured have low or moderate incomes and have little, if any, savings.

How has the number of uninsured changed under the ACA?

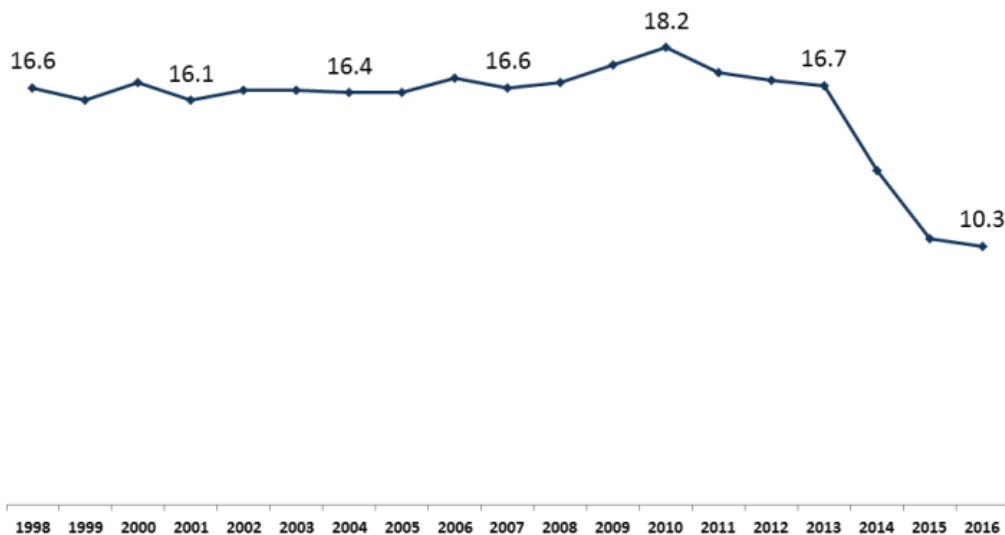
In the past, gaps in the public insurance system and lack of access to affordable private coverage left millions without health insurance, and the number of uninsured Americans grew over time, particularly during periods of economic downturns. By 2013, more than 44 million people lacked coverage. Under the ACA, as of 2014, Medicaid coverage has been expanded to nearly all adults with incomes at or below 138% of poverty in states that have expanded their programs, and tax credits are available for people who purchase coverage through a health insurance marketplace. Millions of people have enrolled in these new coverage options, and the uninsured rate has dropped to a historic low. Coverage gains were particularly large among low-income adults living in states that expanded Medicaid. Still, millions of people—27.6 million nonelderly individuals in 2016—remain without coverage.¹

Key Details:

- The share of the nonelderly population that was uninsured hovered around 16% between 1998 and 2007, then peaked during the ensuing economic recession (Figure 1). As early provisions of the ACA went into effect in 2010, and as the economy improved, the uninsured rate began to drop. When the major ACA coverage provisions went into effect in 2014, the uninsured rate dropped dramatically and continued to fall in subsequent years. In 2016, the nonelderly uninsured rate was 10.3%, the lowest in decades.

Figure 1

Uninsured Rate Among the Nonelderly Population, 1998-2016



NOTES: Includes nonelderly individuals ages 0-64.

SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.



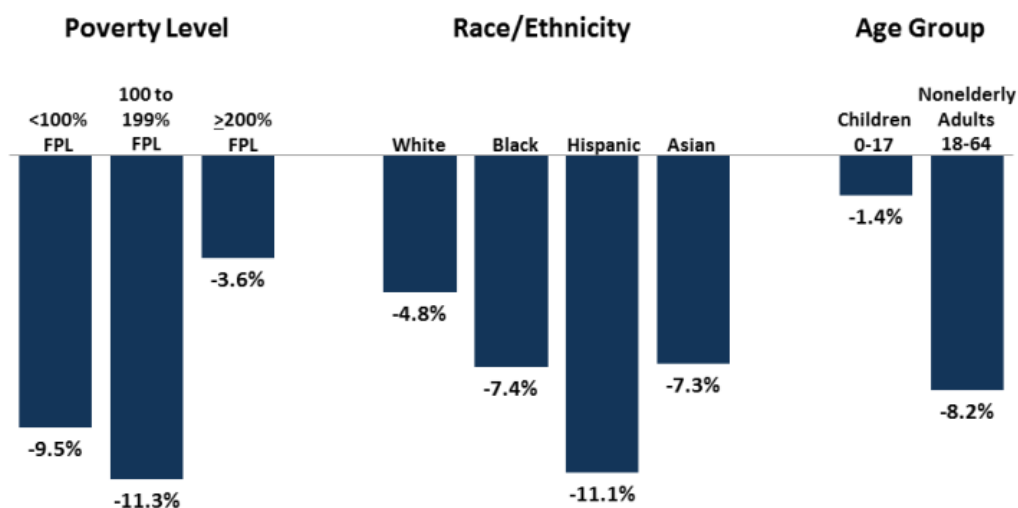
Figure 1: Uninsured Rate Among the Nonelderly Population, 1998-2016

- Coverage gains from 2013 to 2016 were particularly large among groups targeted by the ACA, including adults and poor and low-income individuals. The uninsured rate among

nonelderly adults, who are more likely than children to be uninsured, dropped from 20.5% in 2013 to 12.2% in 2016, a 40% decline. In addition, between 2013 and 2016, the uninsured rate declined substantially for poor and near-poor nonelderly individuals (Figure 2). People of color, who had higher uninsured rates than non-Hispanic Whites prior to 2014, had larger coverage gains than non-Hispanic Whites. Though uninsured rates dropped across all states, they dropped more in states that chose to expand Medicaid, decreasing by 7.1 percentage points compared to 3.7 points in non-expansion states.² (See Appendix A for state-by-state data on changes in the uninsured rate).

Figure 2

Percentage Point Change in Uninsured Rate among the Nonelderly Population by Selected Characteristics, 2013-2016



NOTES: Includes nonelderly individuals ages 0-64.

SOURCE: Kaiser Family Foundation analysis of the 2013 and 2016 National Health Interview Survey.



Figure 2: Percentage Point Change in Uninsured Rate among the Nonelderly Population by Selected Characteristics, 2013-2016

- Coverage gains were seen in new ACA coverage options. As of February 2017, over 10 million people were enrolled in state or federal Marketplace plans,³ and as of June 2017, Medicaid enrollment had grown by over 17 million (29%) since the period before open enrollment (which started in October 2013).⁴

Why do people remain uninsured?

Most of the nonelderly in the United States obtain health insurance through an employer, but not all workers are offered employer-sponsored coverage or, if offered, can afford their share of the premiums. Medicaid covers many low-income individuals, and financial assistance for Marketplace coverage is available for many moderate-income people. However, Medicaid eligibility for adults remains limited in some states, and few people can afford to purchase coverage without financial assistance. Some people who are eligible for coverage under the ACA may not know they can get help, and others may still find the cost of coverage prohibitive.

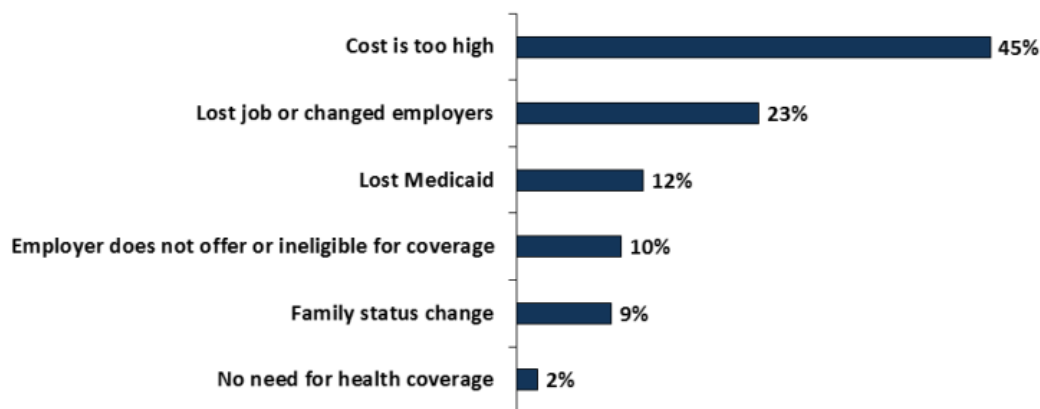
Key Details:

- Cost still poses a major barrier to coverage for the uninsured. In 2016, 45% of uninsured nonelderly adults said they were uninsured because the cost is too high, making it the most common reason cited for being uninsured (Figure 3). Though financial assistance is available to many of the remaining uninsured under the ACA,⁵ not everyone who is uninsured is eligible for free or subsidized coverage. In addition, some uninsured who are eligible for help may not be aware of coverage options or may face barriers to enrollment.⁶ Outreach and enrollment assistance was key to facilitating both initial and ongoing enrollment in ACA coverage, but these programs face challenges due to funding cuts and high demand.⁷

Figure 3

Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2016

Share who say they are uninsured because:



NOTES: Includes nonelderly adults ages 18-64. Respondents can select multiple reasons. Status change includes marital status change, death of spouse or parent, or ineligible due to age or leaving school.

SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.



Figure 3: Reasons for Being Uninsured Among Uninsured Nonelderly Adults, 2016

- Access to health coverage changes as a person's situation changes. In 2016, 23% of uninsured nonelderly adults said they were uninsured because the person who carried the health coverage in their family lost their job or changed employers (Figure 3). Nearly one in ten was uninsured because of a marital status change, the death of a spouse or parent, or loss of eligibility due to age or leaving school (9%), and some lost Medicaid because of a new job/increase in income or the plan stopping after pregnancy (12%).
- As indicated above, not all workers have access to coverage through their job. In 2016, 74% of nonelderly uninsured workers worked for an employer that did not offer health benefits to the worker.⁸ Moreover, nine out of ten uninsured workers who do not take up an offer of employer-sponsored coverage report cost as the main reason for declining (90%).⁹ From 2006 to 2016, total premiums for family coverage increased by 58%, and the worker's share increased by 78%, outpacing wage growth.¹⁰

- Medicaid and CHIP are available for low-income children, but eligibility for adults is more limited. As of January 2017, 31 states plus DC had expanded Medicaid eligibility for adults under the ACA.¹¹ However, in states that have not expanded Medicaid, eligibility for adults remains limited, with median eligibility level for parents at just 44% of poverty and adults without dependent children ineligible in most cases.¹² Millions of poor uninsured adults fall in a “coverage gap” because they earn too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits.¹³
- Undocumented immigrants are ineligible for Medicaid or Marketplace coverage.¹⁴ While lawfully-present immigrants under 400% of poverty are eligible for Marketplace tax credits, only those who have passed a five-year waiting period after receiving qualified immigration status can qualify for Medicaid.

Who remains uninsured?

Most remaining uninsured people are in working families, are in families with low incomes, and are nonelderly adults.¹⁵ Reflecting income and the availability of public coverage, people who live in the South or West are more likely to be uninsured. Most who remain uninsured have been without coverage for long periods of time.

Key Details:

- In 2016, three quarters of the uninsured (75%) had at least one full-time worker in their family, and an additional 11% had a part-time worker in their family (Figure 4).

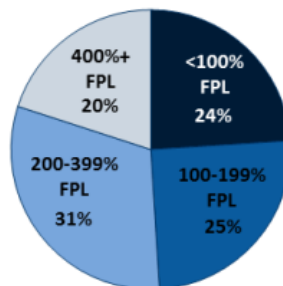
Figure 4

Characteristics of the Nonelderly Uninsured, 2016

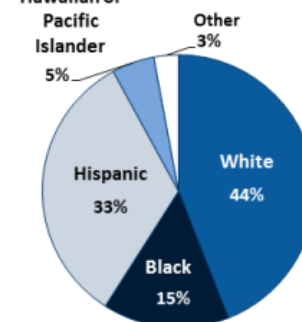
Family Work Status



Family Income (%FPL)



Race



Total = 27.5 Million Nonelderly Uninsured

NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was \$19,318 in 2016. Data may not total 100% due to rounding. Persons of Hispanic origin may be of any race; all other race/ethnicity groups are non-Hispanic.

SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

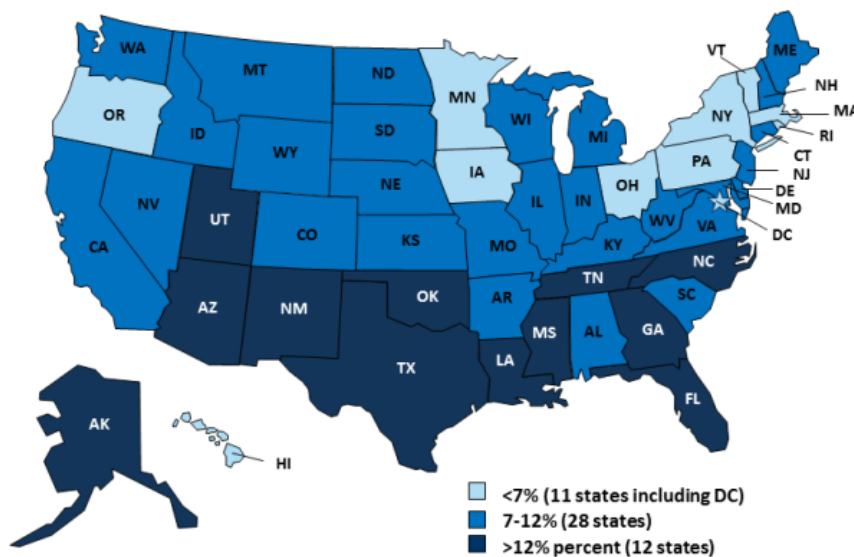


Figure 4: Characteristics of the Nonelderly Uninsured, 2016

- Individuals below poverty¹⁶ are at the highest risk of being uninsured. In total, eight in ten of the uninsured were in families with incomes below 400% of poverty in 2016 (Figure 4).
- While a plurality (44%) of the uninsured are non-Hispanic Whites, people of color are at higher risk of being uninsured than Whites. People of color make up 42% of the nonelderly U.S. population but account for over half of the total nonelderly uninsured population (Figure 4). Hispanics and Blacks have significantly higher uninsured rates (16.9% and 11.7% respectively) than Whites (7.6%).¹⁷
- Most (85%) of the uninsured are nonelderly adults. The uninsured rate among children was just 5% in 2016, less than half the rate among nonelderly adults (12%),¹⁸ largely due to broader availability of Medicaid/CHIP for children than for adults.
- Most of the uninsured (78%) are U.S. citizens, and 22% are non-citizens.¹⁹ Uninsured non-citizens include both lawfully present and undocumented immigrants. Undocumented immigrants are ineligible for federally funded health coverage, but legal immigrants can qualify for subsidies in the Marketplaces and those who have been in the country for more than five years are eligible for Medicaid.²⁰
- Uninsured rates vary by state and by region, with individuals living in the South and West the most likely to be uninsured. The eight out of the twelve states with the highest uninsured rates in 2016 were in the South (Figure 5 and Appendix A). This variation reflects different economic conditions, state expansion status, availability of employer-based coverage, and demographics.

Figure 5

Uninsured Rates Among the Nonelderly by State, 2016



NOTES: Includes nonelderly individuals ages 0-64.

SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.



Figure 5: Uninsured Rates Among the Nonelderly by State, 2016

- Over two-thirds (67%) of the remaining uninsured in 2016 have been without coverage for more than a year.²¹ People who have been without coverage for long periods may be particularly hard to reach in outreach and enrollment efforts.

How does the lack of insurance affect access to health care?

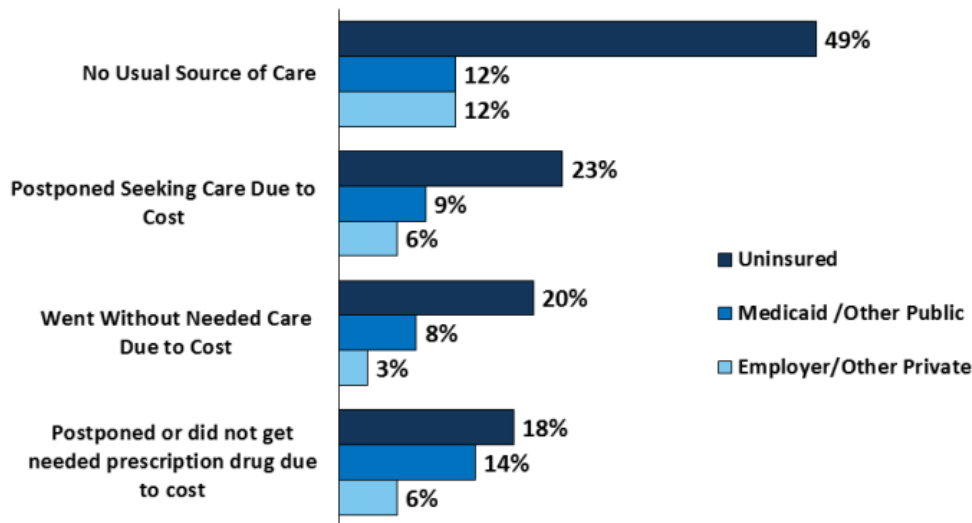
Health insurance makes a difference in whether and when people get necessary medical care where they get their care, and ultimately, how healthy they are. Uninsured adults are far more likely than those with insurance to postpone health care or forgo it altogether. The consequences can be severe, particularly when preventable conditions or chronic diseases go undetected.

Key Details:

- Studies repeatedly demonstrate that the uninsured are less likely than those with insurance to receive preventive care and services for major health conditions and chronic diseases.^{22, 23} One in five (20%) nonelderly adults without coverage say that they went without care in the past year because of cost compared to 3% of adults with private coverage and 8% of adults with public coverage. Part of the reason for poor access among the uninsured is that many (49%) do not have a regular place to go when they are sick or need medical advice (Figure 6).

Figure 6

Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2016



NOTE: Includes nonelderly adults ages 18-64. Includes barriers experienced in past 12 months. Respondents who said usual source of care was the emergency room were included among those not having a usual source of care. All differences between uninsured and insurance groups are statistically significant ($p < 0.05$).

SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.



Figure 6: Barriers to Health Care Among Nonelderly Adults by Insurance Status, 2016

- Because of the cost of care, many uninsured people do not obtain the treatments their health care providers recommend for them. In 2016, uninsured nonelderly adults were three times as likely as adults with private coverage to say that they postponed or did not get a needed prescription drug due to cost (18% vs. 6%).²⁴ And while insured and uninsured people who are injured or newly diagnosed with a chronic condition receive similar plans for follow-up care, people without health coverage are less likely than those with coverage to obtain all the recommended services.²⁵

- Because people without health coverage are less likely than those with insurance to have regular outpatient care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health. When they are hospitalized, uninsured people receive fewer diagnostic and therapeutic services and also have higher mortality rates than those with insurance.^{26,27,28,29}
- Research demonstrates that gaining health insurance improves access to health care considerably and diminishes the adverse effects of having been uninsured. A seminal study of a Medicaid expansion in Oregon found that uninsured adults who gained Medicaid coverage were more likely to receive care than their counterparts who did not gain coverage.³⁰ A comprehensive review of research on the effects of the ACA Medicaid expansion finds that expansion led to positive effects on access to care, utilization of services, the affordability of care, and financial security among the low-income population.³¹
- Public hospitals, community clinics and health centers, and local providers that serve disadvantaged communities provide a crucial health care safety net for uninsured people. However, safety net providers have limited resources and service capacity, and not all uninsured people have geographic access to a safety net provider.^{32,33}

What are the financial implications of lack of coverage?

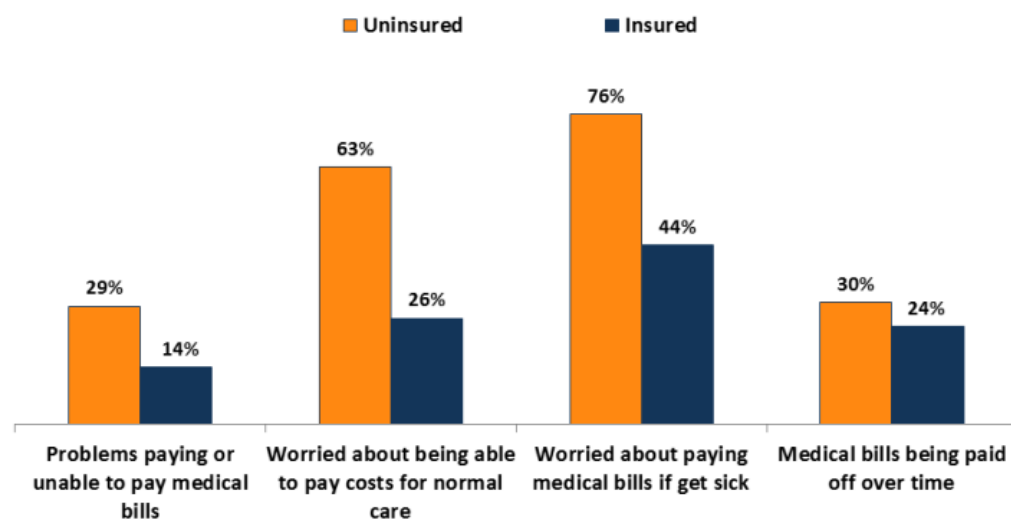
The uninsured often face unaffordable medical bills when they do seek care. These bills can quickly translate into medical debt since most of the uninsured have low or moderate income and have little, if any, savings.³⁴

Key Details:

- Those without insurance for an entire year pay for one-fifth of their care out-of-pocket.³⁵ In addition, hospitals frequently charge uninsured patients much higher rates than those paid by private health insurers and public programs.^{36,37}
- Medical bills can put great strain on the uninsured and threaten their financial well-being. In 2016, nonelderly uninsured adults were over twice as likely as those with insurance to have problems paying medical bills (29% vs. 14%; Figure 7) with two thirds of uninsured who had medical bill problems unable to pay their medical bills at all (67%).³⁸ Uninsured adults are also more likely to face negative consequences due to medical bills, such as using up savings, having difficulty paying for necessities, borrowing money, or having medical bills sent to collection.³⁹

Figure 7

Problems Paying Medical Bills by Insurance Status, 2016



NOTE: Includes nonelderly adults ages 18-64. All differences between uninsured and insured groups are statistically significant ($p < 0.05$).

SOURCE: Kaiser Family Foundation analysis of the 2016 National Health Interview Survey.



Figure 7: Problems Paying Medical Bills by Insurance Status, 2016

- Uninsured nonelderly adults are also much more likely than their insured counterparts to lack confidence in their ability to afford usual medical costs and major medical expenses or emergencies. Uninsured nonelderly adults are over twice as likely as insured adults to worry about being able to pay costs for normal health care (63% vs. 26%; Figure 7). Furthermore, over three quarters of uninsured nonelderly adults (76%) say they are very or somewhat worried about paying medical bills if they get sick or have an accident, compared to 44% of insured adults.
- Lacking insurance coverage puts people at risk of medical debt. In 2016, three in ten (30%) of uninsured nonelderly adults said they were paying off at least one medical bill over time (Figure 7). Medical debts contribute to over half (52%) of debt collections actions that appear on consumer credit reports in the United States⁴⁰ and contribute to almost half of all bankruptcies in the United States.⁴¹ Uninsured people are more at risk of falling into medical bankruptcy than people with insurance.⁴²
- Though the uninsured are typically billed for medical services they use, when they cannot pay these bills, the costs may become bad debt or uncompensated care for providers. State, federal, and private funds defray some but not all of these costs. With the expansion of coverage under the ACA, providers are seeing reductions in uncompensated care costs, particularly in states that expanded Medicaid.⁴³
- Research suggests that gaining health coverage improves the affordability of care and financial security among the low-income population. Multiple studies of the ACA have found larger declines in trouble paying medical bills in expansion states relative to non-expansion states. A separate study found that, among those residing in areas with high shares of low-income, uninsured individuals, Medicaid expansion significantly reduced the number of unpaid bills and the amount of debt sent to third-party collection agencies.⁴⁴

Conclusion

Millions of people have gained coverage under the ACA provisions that went into effect in 2014, and current debate over rolling back ACA coverage threaten these gains in coverage and make it difficult to reach the 27.6 million who remain without coverage. Proposed policies to change the structure of the Medicaid program or cut back subsidies for Marketplace coverage may lead to even more uninsured individuals. On the other hand, if additional states opt to expand Medicaid as allowed under the ACA, there may be additional coverage gains as low-income individuals gain access to affordable coverage. Going without coverage can have serious health consequences for the uninsured because they receive less preventive care, and delayed care often results in serious illness or other health problems. Being uninsured also can have serious financial consequences. The outcome of current debate over health coverage policy in the United States has substantial implications for people's coverage, access, and overall health and well-being.

Appendix A: Uninsured Rate Among the Nonelderly by State, 2013-2016

	2013 Uninsured Rate	2016 Uninsured Rate	Change in Uninsured Rate	Change in Number of Uninsured
Expansion States	13.6%	8.1%	-5.5%	-9,110,784
Alaska	15.8%	15.2%	-0.5%	-4,601
Arizona	21.2%	14.0%	-7.1%	-383,714
Arkansas	17.8%	9.1%	-8.7%	-206,014
California	16.4%	8.7%	-7.6%	-2,526,524
Colorado	13.8%	10.8%	-3.1%	-139,374
Connecticut	11.8%	7.2%	-4.6%	-145,214
Delaware	8.3%	10.6%	2.3%	20,754
District of Columbia	8.9%	5.9%	-2.9%	-15,884
Hawaii	5.7%	6.3%	0.6%	7,414
Illinois	11.9%	8.6%	-3.3%	-403,104
Indiana	14.6%	7.6%	-7.0%	-382,504
Iowa	9.5%	6.2%	-3.3%	-87,374
Kentucky	16.3%	7.2%	-9.1%	-351,744
Louisiana	16.4%	12.1%	-4.3%	-158,234
Maryland	13.3%	7.2%	-6.0%	-309,204
Massachusetts	3.6%	6.4%	2.7%	161,494
Michigan	12.1%	7.4%	-4.8%	-412,914
Minnesota	7.9%	6.9%	-1.0%	-52,384
Montana	19.0%	8.5%	-10.4%	-85,494
Nevada	22.0%	10.2%	-11.8%	-270,524
New Hampshire	13.2%	7.6%	-5.6%	-65,364
New Jersey	13.4%	9.0%	-4.4%	-339,454
New Mexico	19.5%	13.0%	-6.5%	-112,784
New York	11.1%	6.6%	-4.5%	-775,314
North Dakota	12.1%	8.9%	-3.2%	-19,614
Ohio	13.9%	6.5%	-7.4%	-708,784
Oregon	14.2%	6.2%	-8.0%	-257,144
Pennsylvania	11.6%	5.7%	-5.9%	-647,344
Rhode Island	10.7%	5.8%	-5.0%	-43,874
Vermont	9.1%	6.5%	-2.6%	-13,544

Washington	13.4%	8.1%	-5.4%	-299,746
West Virginia	14.2%	8.8%	-5.4%	-82,646
Non-Expansion States	18.1%	13.3%	-4.8%	-4,575,853
Alabama	17.8%	10.1%	-7.7%	-305,486
Florida	22.0%	14.6%	-7.5%	-1,128,466
Georgia	18.5%	13.7%	-4.7%	-334,626
Idaho	16.8%	10.2%	-6.6%	-87,056
Kansas	11.5%	9.8%	-1.7%	-41,996
Maine	11.3%	8.7%	-2.6%	-30,796
Mississippi	16.4%	13.9%	-2.6%	-63,176
Missouri	13.1%	9.8%	-3.2%	-168,356
Nebraska	10.6%	8.2%	-2.4%	-38,716
North Carolina	17.3%	12.4%	-5.0%	-377,656
Oklahoma	18.1%	12.4%	-5.7%	-163,856
South Carolina	18.9%	10.8%	-8.1%	-297,346
South Dakota	11.6%	9.4%	-2.2%	-15,266
Tennessee	15.2%	13.2%	-2.0%	-90,106
Texas	22.8%	17.1%	-5.7%	-1,191,136
Utah	13.7%	13.5%	-0.2%	16,346
Virginia	13.1%	11.5%	-1.7%	-125,846
Wisconsin	10.4%	8.3%	-2.2%	-98,296
Wyoming	17.5%	11.2%	-6.3%	-34,046

SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Appendix Table B: Characteristics of the Nonelderly Uninsured, 2016

	Nonelderly (millions)	Percent of Nonelderly	Uninsured (millions)	Percent of Uninsured	Uninsured Rate
Total Nonelderly	271.1	100.0%	27.5	100.0%	10.1%
Age					
Children - Total	78.2	28.8%	4.2	15.3%	5.4%
Nonelderly Adults - Total	192.9	71.2%	23.3	84.7%	12.1%
Adults 19 - 25	29.8	11.0%	3.9	14.2%	13.1%
Adults 26 - 34	39.7	14.7%	6.2	22.7%	15.7%
Adults 35 - 44	40.0	14.8%	5.3	19.1%	13.1%
Adults 45 - 54	42.0	15.5%	4.3	15.8%	10.3%
Adults 55 - 64	41.3	15.2%	3.5	12.8%	8.5%
Annual Family Income					
<\$20,000	35.9	13.3%	6.7	24.3%	18.6%
\$20,000 - <\$40,000	43.1	15.9%	6.8	24.9%	15.9%
\$40,000 +	192.1	70.8%	13.9	50.8%	7.3%
Family Poverty Level					
<100%	36.5	13.5%	6.5	23.6%	17.7%
100% - <200%	44.2	16.3%	6.8	24.7%	15.3%
200% - <400%	78.8	29.1%	8.6	31.4%	10.9%
400%+	111.6	41.2%	5.6	20.4%	5.0%
Household Type					
Single Adults Living Alone	45.0	16.6%	6.7	24.5%	15.0%
Single Adults Living Together	35.7	13.2%	4.9	17.7%	13.6%
Married Adults	37.1	13.7%	3.2	11.5%	8.5%
1 Parent with Children	23.4	8.6%	2.2	8.1%	9.5%
2 Parents with Children	83.4	30.7%	5.5	19.9%	6.6%
Multigenerational	14.2	5.2%	1.6	5.9%	11.4%
Other with Children	32.3	11.9%	3.4	12.4%	10.5%
Family Work Status					
2+ Full-time	93.4	34.4%	6.8	24.8%	7.3%
1 Full-time	131.1	48.4%	13.7	49.9%	10.4%
Only Part-time	19.4	7.2%	2.9	10.7%	15.1%
Non-Workers	27.2	10.0%	4.0	14.6%	14.7%

Race/Ethnicity						
White	157.5	58.1%	12.0	43.9%	7.6%	
Black	34.9	12.9%	4.1	14.9%	11.7%	
Hispanic	53.6	19.8%	9.1	33.0%	16.9%	
Asian/N. Hawaiian and Pacific Islander	17.1	6.3%	1.4	5.2%	8.3%	
American Indian/Alaska Native	2.1	0.8%	0.4	1.5%	18.9%	
Two or More Races	5.8	2.1%	0.4	1.6%	7.4%	
Citizenship						
U.S. Citizen – Native	233.7	86.2%	19.8	72.3%	8.5%	
U.S. Citizen – Naturalized	15.7	5.8%	1.6	6.0%	10.4%	
Non-U.S. Citizen, Resident for <5 Years	5.9	2.2%	1.4	5.0%	23.2%	
Non-U.S. Citizen, Resident for 5+ Years	15.8	5.8%	4.6	16.7%	29.0%	
Health Status						
Excellent/Very Good	186.8	68.9%	16.9	61.5%	9.0%	
Good	61.9	22.8%	8.0	29.0%	12.9%	
Fair/Poor	22.4	8.3%	2.6	9.5%	11.7%	

NOTES: Includes nonelderly individuals ages 0-64. The U.S. Census Bureau's poverty threshold for a family with two adults and one child was \$19,318 in 2016. Parent includes any person with a dependent child. Multigenerational/other families with children include families with at least three generations in a household, plus families in which adults are caring for children other than their own. Part-time workers were defined as working <35 hours per week. Respondents who identify as mixed race who do not also identify as Hispanic fall into the "Two or More Races" category. All individuals who identify as Hispanic ethnicity fall into the Hispanic category regardless of race.

SOURCE: Kaiser Family Foundation analysis of the March 2017 Current Population Survey, Annual Social and Economic Supplement.

Endnotes

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BUILDING STRONG FOUNDATIONS: Advancing Comprehensive Policies for Infants, Toddlers, and Families



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Health Insurance: A Critical Support for Infants, Toddlers, and Families

Low-income infants, toddlers, parents, and pregnant woman should have quality, affordable, publicly financed health insurance. Access to health care is arguably the most basic ingredient for children's healthy development and wellbeing. Infants and toddlers need medical care to support their physical, cognitive, and emotional development. Parents' health is also critical to children's wellbeing, as parents need to be healthy in order to support their children as they learn and grow. More effective parenting is possible when parents get treatment for physical and mental health needs. Health insurance offsets the cost of medical expenses, such as routine check-ups, sick visits, prescriptions, diagnostic and surgical procedures, as well as specialized care for chronic illnesses, disabilities, and pregnancy.

Children with insurance are generally healthier and more likely to receive necessary treatment when sick or injured, in addition to the preventive care so important to their health and wellbeing.¹ Children's and mothers' access to health insurance during pregnancy and in the first months of life can be the difference between life and death, since coverage is linked to significant reductions in infant mortality, childhood deaths, and the incidence of low birthweight.² Well-baby checks and routine screenings catch problems before they worsen and become more difficult and costly to treat. Over the long term, health coverage for low-income children can also improve high school and postsecondary success, with enduring effects on employment over their lifetime.³

Parents' access to health care matters greatly for children. Children do better when their parents and other caregivers are healthy, both emotionally and physically.⁴ Adults' access to health care supports

effective parenting, while untreated physical and mental health needs can interfere with parents' ability to care for their children. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.⁵ Untreated chronic illnesses or pain can contribute to high levels of parental stress, which are particularly harmful to children during their earliest years.⁶ The first few years of a child's life set the foundation for healthy development,⁷ and children need stability—coupled with responsive, nurturing relationships with caregivers—to learn and grow.⁸ Additionally, health insurance coverage is key to the entire family's financial stability, particularly because coverage lifts the burdens of unexpected health problems and related costs.

Medicaid and the Children's Health Insurance Program (CHIP) are the largest public health insurance programs in the United States, collectively covering 45 percent of children ages 5 and younger.⁹ In Medicaid, the federal government requires states to cover certain groups of people, including children in families with income up to 138 percent of the Federal Poverty Line (FPL).¹⁰ States are also required to provide certain mandatory health care services, such as access to physicians and family planning. Most important for children is the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which is a set of preventive health care services that ensure children's health and development is monitored regularly and that problems are identified and addressed early.¹² Beyond federal requirements, states can choose to extend coverage to other groups and have the flexibility to determine the types, amount, duration, and scope of medical services they will cover. Medicaid is a federal-state partnership, meaning that the federal government covers a fixed percentage of states' health care costs—ranging from 50 to 74 percent—and states are required to cover the rest.¹³ CHIP complements Medicaid by providing funds to states for health insurance coverage of children whose family income is too high to qualify for Medicaid.¹⁴

The Affordable Care Act (ACA) was enacted in 2010 with the goals of expanding health care coverage, reducing costs for patients, and improving the health care delivery system.¹⁵ Thanks to Medicaid and CHIP, the uninsured rate for children was already fairly low. However, the ACA improved children's health care coverage and further increased enrollment by streamlining Medicaid income eligibility definitions; extending the CHIP program; and mandating that all qualified health insurance plans offer a minimum set of benefits known as Essential Health Benefits (EHB), which include preventive care, prenatal and newborn care, mental health services, pediatric services, and rehabilitative therapies.¹⁶ Moreover, prior to passage of the ACA, many low-income parents did not have coverage for themselves because they were not offered it at work or could not afford private insurance and also were not eligible for Medicaid. The ACA also allowed states to expand Medicaid eligibility to non-elderly adults at or below 138 percent FPL.¹⁷ Collectively, ACA provisions provided coverage to many parents for the first time, which had the secondary effect of increasing children's enrollment in health care coverage.¹⁸

Historic gains in health coverage over the last three years have resulted in the lowest uninsured rates on record for children and their parents, and these rates must be preserved. Today, nearly all children in America—95 percent—have the health insurance coverage they need to survive and thrive.¹⁹ In 2014, Medicaid covered 36.1 million children, and CHIP covered more than 8.1 million children.²⁰ Medicaid and CHIP also play a particularly important role for children of color, covering more than half of all Black, Hispanic, and American Indian and Alaska Native children.²¹ Over half of Medicaid enrollees are children.²² Together with Medicaid, which covers almost half of all births in the United States,²³ and CHIP, the ACA has helped reduce the proportion of uninsured children in the United States from 13 percent for young children under 5 years old in 1997 to a record low of 3.2 percent for that same group in 2015.²⁴

Growing evidence shows that children enrolled in Medicaid in their early years not only do better in childhood than children without health insurance, but also have better health, educational, and employment outcomes in adulthood.²⁵ Research also demonstrates that Medicaid coverage improves access to care and overall health and reduces mortality rates.²⁶

By opting to expand Medicaid under the ACA, 31 states and D.C. have taken a crucial step to support child wellbeing by enabling low-income parents to get health and mental health services.²⁷ Research

suggests that Medicaid expansion has not only improved access to medical benefits and affordability of care, but also improved access to behavioral health treatment for newly eligible enrollees in expansion states.²⁸ Expansion states have also experienced greater increases in coverage compared to non-expansion states, which have higher proportions of uninsured people who are eligible for Medicaid. In states that did not expand Medicaid, children comprise three quarters of the uninsured population that is eligible for Medicaid or CHIP.²⁹

Additionally, access to care for pregnant women and the services that they receive improved since the ACA's enactment. With the EHB requirement in the ACA, all private health insurance plans have to cover maternity and newborn care. Prior to the ACA, 62 percent of plans in the individual market did not include such coverage.³⁰ The ACA requires insurance to cover breast pumps for nursing mothers and amended federal labor laws to require employers to protect mothers' ability to pump at work, enabling babies to benefit from breastfeeding longer.³¹

Children and parents need access to health insurance for their short-term and long-term health and wellbeing. The federal government should maintain the structure and financing of Medicaid and the ACA to allow states to continue improving infants', toddlers', and parents' health. States that have not yet expanded Medicaid should seize the opportunity to do so and provide health insurance to a group of people who may otherwise struggle with cost or ineligibility for publicly funded insurance. All states can identify and implement high-priority improvements in Medicaid and related policies to support access to needed services for children and families. Jeopardizing coverage for children and their parents will negatively impact the wellbeing of children's health, school readiness, and future success. Because parents' and children's wellbeing are so inextricably linked, the loss of necessary health and mental health services can have long-term, dire consequences for them both.

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Child Care in the FY 2018 Omnibus Spending Bill

The fiscal year 2018 (FY 2018) omnibus spending bill, passed by the U.S. House of Representatives today, includes the largest-ever single-year increase in federal funding for the Child Care and Development Block Grant (CCDBG). The bill increases CCDBG discretionary funding by \$2.4 billion.¹

This investment will fully fund the 2014 child care reauthorization, according to estimates from the U.S. Department of Health and Human Services (HHS).² The reauthorization included provisions to improve the health, safety, and quality of child care and make child care assistance a more stable support for families.³ The funds will also allow states to expand access to child care assistance—reversing course from years of decline. Over nine years, CCDBG served 21 percent fewer children in an average month—resulting in the smallest number of children served in the program’s history in 2015.⁴

CLASP estimates that after funding the reauthorization costs, the increase will provide resources for more than 151,000 additional children to gain child care assistance.⁵ The actual number of children served will depend on states’ current compliance with the reauthorization as well as state policy choices, including quality initiatives and provider payment rates.

State Impact of \$2.37 Billion Increase in CCDBG Funding		
State	Additional Funding in FY 18 ⁶	Additional Children to Receive CCDBG-funded Child Care
Alabama	\$44,088,000	2,690
Alaska	\$4,417,000	388
Arizona	\$59,281,000	2,643
Arkansas	\$27,862,000	803
California	\$252,727,000	11,770
Colorado	\$29,321,000	1,833
Connecticut	\$15,248,000	923
Delaware	\$6,358,000	783
District of Columbia	\$3,823,000	161

State	Additional Funding in FY 18⁷	Additional Children to Receive CCDBG-funded Child Care
Florida	\$139,521,000	8,906
Georgia	\$98,679,000	6,384
Hawaii	\$8,496,000	736
Idaho	\$13,888,000	723
Illinois	\$82,813,000	5,005
Indiana	\$53,575,000	3,767
Iowa	\$20,369,000	1,787
Kansas	\$21,465,000	1,519
Kentucky	\$42,802,000	1,097
Louisiana	\$41,585,000	1,994
Maine	\$7,505,000	301
Maryland	\$29,960,000	1,887
Massachusetts	\$29,497,000	3,199
Michigan	\$69,675,000	3,480
Minnesota	\$31,734,000	2,536
Mississippi	\$32,679,000	2,222
Missouri	\$44,556,000	3,901
Montana	\$6,680,000	348
Nebraska	\$12,932,000	1,258
Nevada	\$21,247,000	609
New Hampshire	\$4,930,000	596
New Jersey	\$42,478,000	5,199
New Mexico	\$20,106,000	1,780
New York	\$106,694,000	11,811
North Carolina	\$79,943,000	6,946
North Dakota	\$3,689,000	241
Ohio	\$79,631,000	5,112

State	Additional Funding in FY 18 ⁸	Additional Children to Receive CCDBG-funded Child Care
Oklahoma	\$32,660,000	2,630
Oregon	\$26,860,000	1,660
Pennsylvania	\$69,759,000	10,131
Rhode Island	\$5,467,000	649
South Carolina	\$42,045,000	1,171
South Dakota	\$5,969,000	442
Tennessee	\$55,449,000	2,764
Texas	\$242,556,000	12,105
Utah	\$27,580,000	1,171
Vermont	\$3,064,000	468
Virginia	\$45,878,000	2,690
Washington	\$40,547,000	4,865
West Virginia	\$14,937,000	890
Wisconsin	\$35,482,000	3,005
Wyoming	\$2,937,000	348
Total	\$2,370,000,000⁹	151,370

Endnotes

¹ The federal government provides states with mandatory funding, or the Child Care Entitlement, authorized in Section 418 of the Social Security Act, and discretionary funding, authorized in the CCDBG Act and appropriated annually by Congress. The increase in discretionary funding would bring total annual federal funding, including mandatory and discretionary funds, for child care assistance to \$8.1 billion in FY 2018—an increase of \$2.4 billion over FY 2017 funding.

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⁵ CLASP estimated the number of children served based on a per-child cost derived from CCDF expenditures and

participation. We also accounted for the costs of implementing the 2014 child reauthorization as outlined in the CCDF Final Rule and the costs of maintaining current caseloads.

⁶ Estimated allocations based on FY 2017 CCDF Allocations, U.S. Department of Health and Human Services, Administration for Children and Families, 2017, <https://www.acf.hhs.gov/occ/resource/fy-2017-ccdf-allocations-including-redistributedfunds>. Actual amounts may differ due to Secretary discretion in set-aside funding.

⁷ Estimated allocations based on FY 2017 CCDF Allocations, U.S. Department of Health and Human Services, Administration for Children and Families, 2017, <https://www.acf.hhs.gov/occ/resource/fy-2017-ccdf-allocations-including-redistributedfunds>. Actual amounts may differ due to Secretary discretion in set-aside funding.

⁸ Estimated allocations based on FY 2017 CCDF Allocations, U.S. Department of Health and Human Services, Administration for Children and Families, 2017, <https://www.acf.hhs.gov/occ/resource/fy-2017-ccdf-allocations-including-redistributedfunds>. Actual amounts may differ due to Secretary discretion in set-aside funding.

⁹ Included in the \$2.4 billion is funding for U.S. territories; tribes; technical assistance; research and evaluation; and a national hotline and website.

Understanding the Intersection of Medicaid and Work

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ISSUE BRIEF

Medicaid is the nation's public health insurance program for people with low incomes. Overall the Medicaid program covers one in five Americans, including many with complex and costly needs for care. Historically, nonelderly adults without disabilities accounted for a small share of Medicaid enrollees; however, the Affordable Care Act (ACA) expanded coverage to nonelderly adults with income up to 138% FPL, or \$16,642 per year for an individual in 2017. As of December 2017, 32 states have implemented the ACA Medicaid expansion.¹

(<https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/view/footnotes/#footnote-245492-1>) By design, the expansion extended coverage to the working poor (both parents and childless adults), most of whom do not otherwise have access to affordable coverage. While many have gained coverage under the expansion, the majority of Medicaid enrollees are still the "traditional" populations of children, people with disabilities and the elderly.

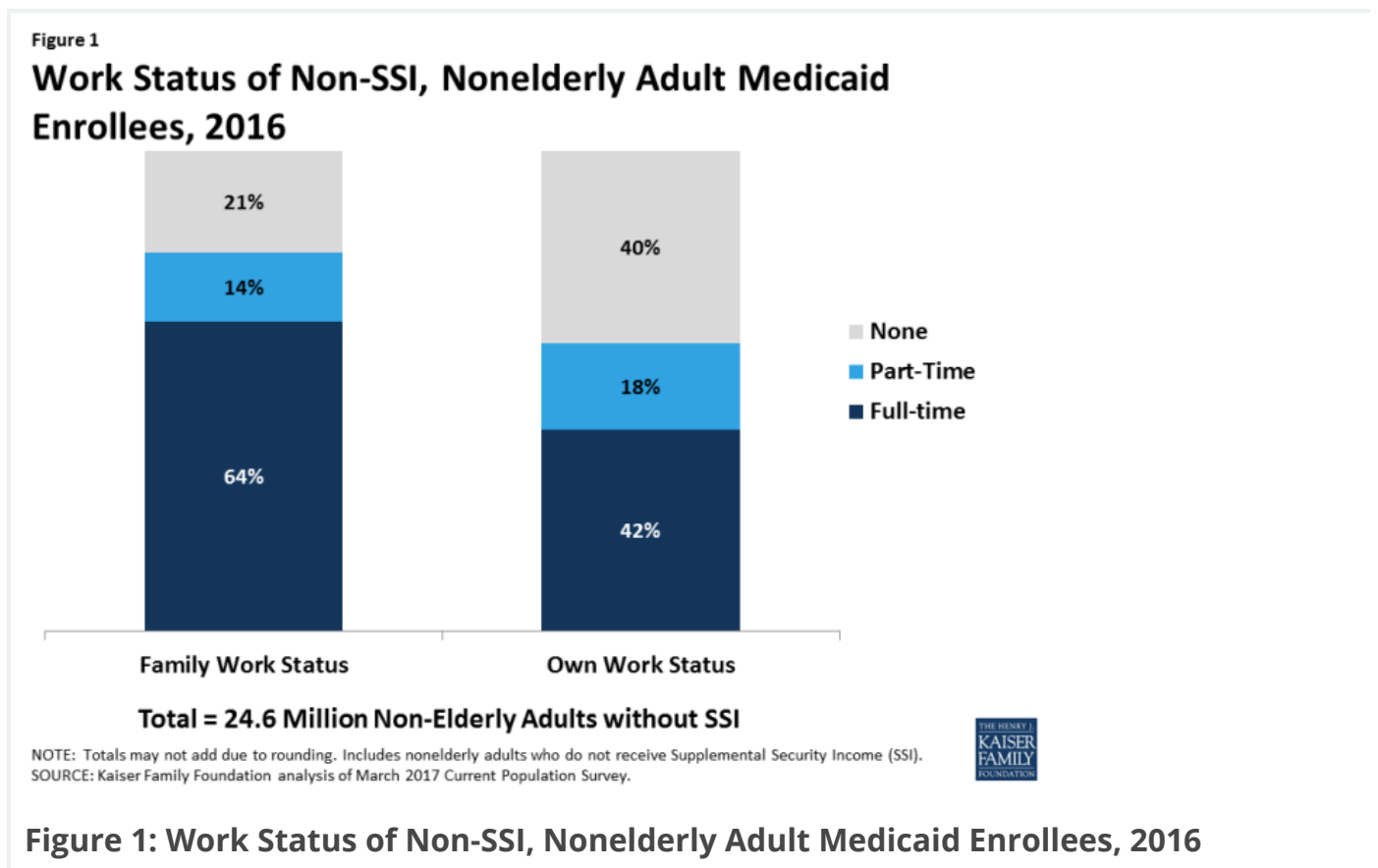
Some states and the Trump administration have stated (<https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-11-07.html>) that the ACA Medicaid expansion targets "able-bodied" adults and seek to make Medicaid eligibility contingent on work. Under current law, states cannot impose a work requirement as a condition of Medicaid eligibility, but some states are seeking waiver authority to do so. These types of waiver requests were denied by the Obama administration, but the Trump administration has indicated a willingness to approve such waivers (<https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf>). This issue brief provides data on the work status of the nearly 25 million non-elderly adults without SSI enrolled in Medicaid (referred to as "Medicaid adults" throughout this brief) to understand the potential implications of work requirement proposals in Medicaid. Key takeaways include the following

- Among Medicaid adults (including parents and childless adults — the group targeted by the Medicaid expansion), nearly 8 in 10 live in working families, and a majority are working themselves. Nearly half of working Medicaid enrollees are employed by small firms, and many work in industries with low employer-sponsored insurance offer rates.

- Among the adult Medicaid enrollees who were not working, most report major impediments to their ability to work including illness or disability or care-giving responsibilities.
- While proponents of work requirements say such provisions aim to promote work for those who are not working, these policies could have negative implications on many who are working or exempt from the requirements. For example, coverage for working or exempt enrollees may be at risk if enrollees face administrative obstacles in verifying their work status or documenting an exemption.

Data Findings

Among nonelderly adults with Medicaid coverage—the group of enrollees most likely to be in the workforce—nearly 8 in 10 live in working families, and a majority are working themselves. Because policies around work requirements would be intended to apply to primarily to nonelderly adults without disabilities, we focus this analysis on adults whose eligibility is not based on receipt of Supplemental Security Income (SSI, see methods box for more detail). Data show that among the nearly 25 million non-SSI adults (ages 19-64) enrolled in Medicaid in 2016, 6 in 10 (60%) are working themselves (Figure 1). A larger share, nearly 8 in 10 (79%), are in families with at least one worker, with nearly two-thirds (64%) with a full-time worker and another 14% with a part-time worker; one of the adults in such families may not work, often due to caregiving or other responsibilities.

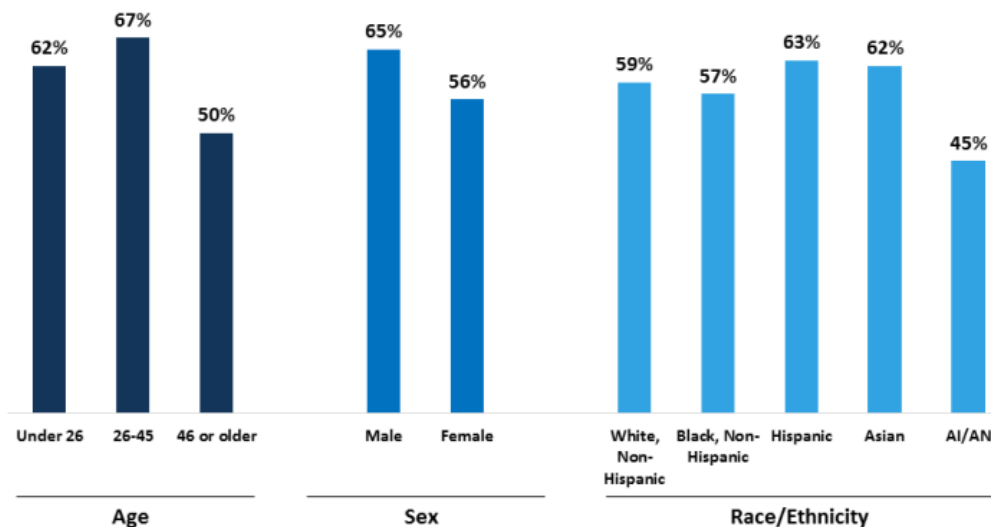


Because states that expanded Medicaid under the ACA cover adults with family incomes at higher levels than those that did not, adults in Medicaid expansion states are more likely to be in working families or working themselves than those in non-expansion states (Table 1). Adults who are younger, male, Hispanic or Asian were more likely to be working than those who are older, female, or White, Black, or American Indian, respectively (Figure 2 and Table 2). Not surprisingly, adults with more education or better health were more likely to work than others (Figure 3 and Table 2). Perhaps reflecting job market conditions, those living in the South were less likely to work than those in other areas, though similar rates of enrollees in urban and rural areas were working (Table 2). For state-level data, see [Appendix tables \(https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix\)](https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-appendix).

Figure 2

Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees by Key Demographics, 2016

Share who are working themselves:



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI). "Asian" includes Asian, Native Hawaiian, or Pacific Islander. "AI/AN" includes American Indian or Alaska Native.

SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.

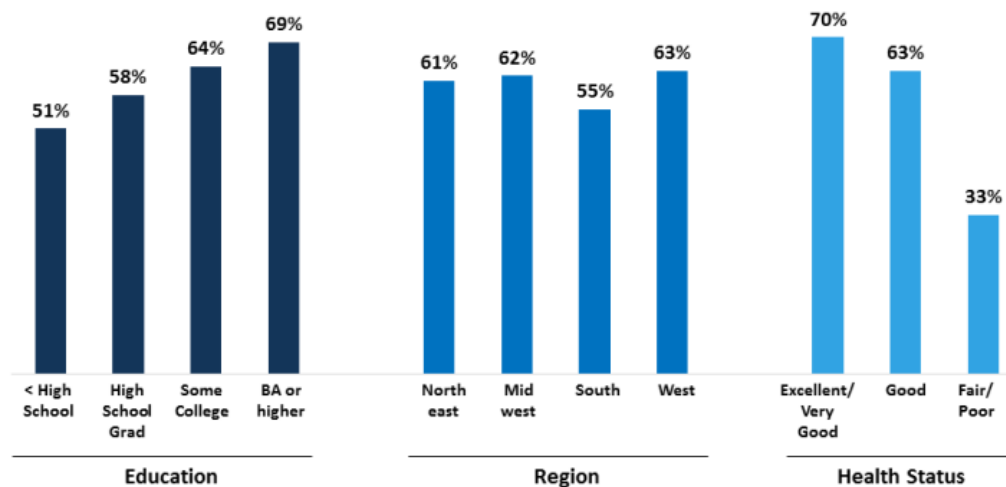


Figure 2: Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees by Key Demographics, 2016

Figure 3

Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees by Key Demographics, 2016

Share who are working themselves:



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI). "Asian" includes Asian, Native Hawaiian, or Pacific Islander. "AI/AN" includes American Indian or Alaska Native.

SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



Figure 3: Work Status of Non-SSI, Nonelderly Adult Medicaid Enrollees by Key Demographics, 2016

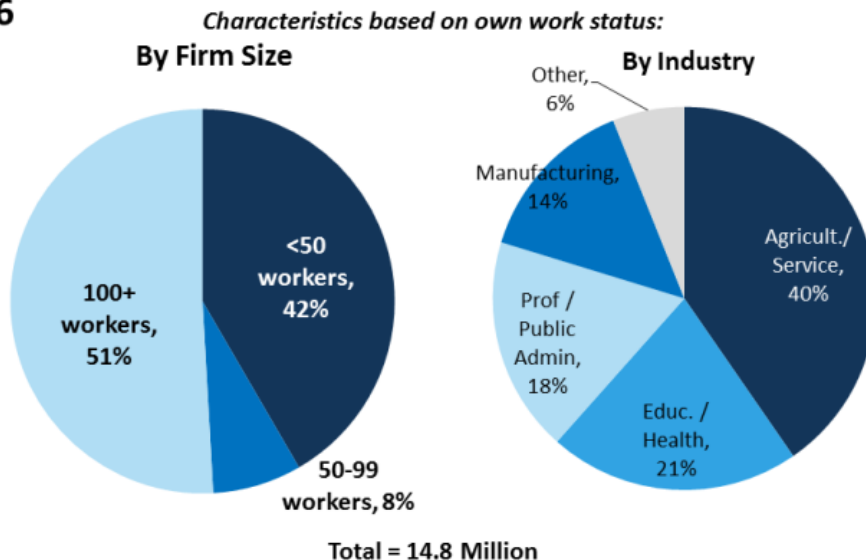
Most Medicaid enrollees who work are working full-time for the full year, but their annual incomes are still low enough to qualify for Medicaid. Among adult Medicaid enrollees who work, the majority (51%) worked full-time (at least 35 hours per week) for the entire year (at least 50 weeks during the year) (Table 3).² (<https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/view/footnotes/#footnote-245492-2>). Most of those who work for only part of the year still work for the majority of the year (26 weeks or more). By definition (that is, in order to meet Medicaid eligibility criteria), these individuals are working low-wage jobs. For example, an individual working full-time (40 hours/week) for the full year (52 weeks) at the federal minimum wage (<https://www.dol.gov/general/topic/wages/minimumwage>) would earn an annual salary of just over \$15,000 a year, or about 125% of poverty, below the 138% FPL maximum targeted by the ACA Medicaid expansion.

Many Medicaid enrollees working part-time face impediments to finding full-time work Among adult Medicaid enrollees who work part-time, many cite economic reasons such as inability to find full-time work (10%) or slack business conditions (11%) as the reason they work part-time versus full-time. Other major reasons are attendance at school (14%) or other family obligations (14%).

Nearly half of working adult Medicaid enrollees are employed by small firms, and many work in industries with low employer-sponsored coverage offer rates. Working Medicaid enrollees work in firms and industries that often have limited employer-based coverage options. More than four in ten adult Medicaid enrollees who work are employed by small firms with fewer than 50 employees that will not be subject to ACA penalties for not offering coverage (Figure 4). Further, many firms do not offer coverage to part-time workers. Four in ten Medicaid adults who work are employed in industries with historically low insurance rates such as the agriculture and service industries. A closer look by specific industry shows that one-third of working Medicaid enrollees are employed in ten industries, with one in 10 enrollees working in restaurants or food services (Figure 5). The Medicaid expansion was designed to reach low-income adults left out of the employer-based system, so, it is not surprising that among those who work, most are unlikely to have access to health coverage through a job.

Figure 4

Work Characteristics of Working Adult Medicaid Enrollees, 2016



Notes: Data may not sum to 100% due to rounding. Includes nonelderly adults who do not receive Supplemental Security Income (SSI). Industry classifications: Agricult./Service includes agriculture, construction, leisure and hospitality services, wholesale and retail trade. Educ./Health includes education and health services. Prof./Public Admin includes finance, professional and business services, information, and public administration. Manufacturing includes mining, manufacturing, utilities, and transportation.

SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



Figure 4: Work Characteristics of Working Adult Medicaid Enrollees, 2016

Figure 5

Industries with Largest Number of Workers Covered by Medicaid, 2016

Industry	Number of Adult Workers with Medicaid
Restaurant and food services	1,486,000
Construction	974,000
Elementary and secondary schools	461,000
Grocery stores	396,000
Hospitals	354,000
Department stores and discount stores	328,000
Home health care services	311,000
Services to buildings and dwellings	294,000
Nursing care facilities	275,000
Child day care services	274,000
Total for Listed Industries (38% of adult Medicaid enrollees who are workers)	5,153,000

NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



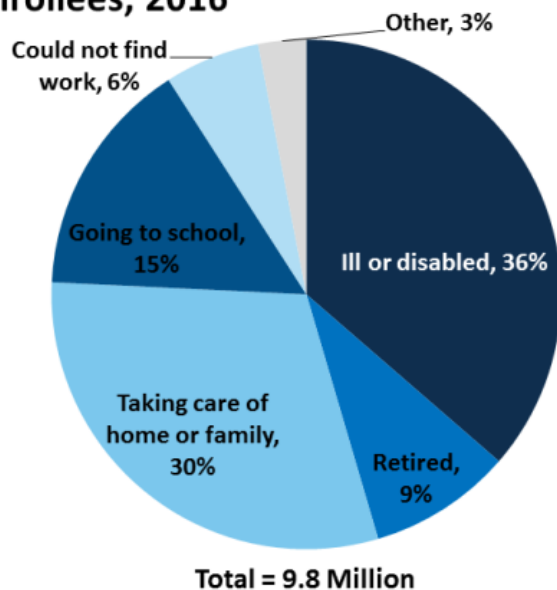
Figure 5: Industries with Largest Number of Workers Covered by Medicaid, 2016

Among the adult Medicaid enrollees who were not working, most report major impediments to their ability to work. Even though individuals qualifying for Medicaid on the basis of a disability through SSI were excluded from this group, more than one-third of those not working reported that illness or disability was the primary reason for not working. SSI disability criteria are stringent and can take a long time to establish. People can have physical and/or mental health disabilities that interfere with their ability to work, or to work full-time, without those impairments rising to the SSI level of severity. Other analysis indicates that nearly nine in ten (88%) non-SSI Medicaid adults who reports not working due to illness or disability has a functional limitation, and more than two-thirds (67%) have two or more chronic conditions such as arthritis or asthma.³ (<https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/view/footnotes/#footnote-245492-3>)

30% of non-working Medicaid adults reported that they did not work because they were taking care of home or family; 15% were in school; 6% were looking for work and another 9% were retired (Figure 6). Women accounted for 62% of Medicaid enrollees who were not working in 2016, and parents with children under the age of 6 accounted for 17%.

Figure 6

Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016



NOTE: Includes nonelderly adults who do not receive Supplemental Security Income (SSI).
SOURCE: Kaiser Family Foundation analysis of March 2017 Current Population Survey.



Figure 6: Main reasons for not working among non-SSI, adult Medicaid enrollees, 2016

Policy Implications

Under current law, states cannot impose a work requirement as a condition of Medicaid eligibility. As with other core requirements, the Medicaid statute sets minimum eligibility standards, and states are able to expand coverage beyond these minimum levels (<http://kff.org/medicaid/issue-brief/current-flexibility-in-medicaid-an-overview-of-federal-standards-and-state-options/>). Prior to the ACA, individuals had to meet not only income and resource requirements but also categorical requirements to be eligible for the program. These categorical requirements provided coverage pathways for adults who were pregnant women or parents as well as individuals with disabilities, but other adults without dependent children were largely excluded from coverage. The ACA was designed to fill in gaps in coverage and effectively eliminate these categorical eligibility requirements by establishing a uniform income threshold for most adults. States are not allowed to impose other eligibility requirements that are not in the law.

Some states have proposed tying Medicaid eligibility to work requirements using waiver authority that may be approved by the Trump Administration. Under Section 1115 of the Social Security Act, the Secretary of HHS can waive certain provisions of Medicaid as long as the Secretary determines that the initiative is a “research and demonstration project” that “is likely to assist in promoting the objectives” of the program. The Obama administration did not approve waivers that would condition Medicaid eligibility on work on the grounds that they

did not meet the waiver test to further the purpose of the program which is to provide health coverage. The Trump Administration has indicated a willingness to approve waivers to require work.

Research shows that Medicaid expansion has not negatively affected labor market participation, and some research indicates that Medicaid coverage supports work. A [comprehensive review of research on the ACA Medicaid expansion](http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/) (<http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/>) found that there is no significant negative effect of the ACA Medicaid expansion on employment rates and other measures of employment and employee behavior (such as transitions from employment to non-employment, the rate of job switches, transitions from full- to part-time employment, labor force participation, and usual hours worked per week). In addition, [focus groups](http://kff.org/health-reform/issue-brief/aca-coverage-and-the-changing-labor-market-voices-from-the-field/) (<http://kff.org/health-reform/issue-brief/aca-coverage-and-the-changing-labor-market-voices-from-the-field/>), [state studies](http://medicaid.ohio.gov/RESOURCES/ReportsandResearch.aspx) (<http://medicaid.ohio.gov/RESOURCES/ReportsandResearch.aspx>) [studies](http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches) (<http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches>), and anecdotal reports highlight examples of Medicaid coverage supporting work and helping enrollees transition into new careers. For example, individuals have reported that receiving medication for conditions like asthma or rheumatoid arthritis through Medicaid is critical in supporting their ability to work. Addressing barriers to work requires adequate funding and supports. While [TANF spending on work activities and supports is critiqued by some as too low, it exceeds estimates of state Medicaid program spending to implement a work requirement](https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/) (<https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>).

Implementing work requirements can create administrative complexity (<https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience/>) **and put coverage at risk for eligible enrollees who are working or who may be exempt.** States can incur additional costs and demands on staff, and some eligible people could lose coverage. While work requirements are intended to promote work among those not working, coverage for those who are working could be at risk if beneficiaries face administrative obstacles in verifying their work status or documenting an exemption. In addition, some individuals who may be exempt may face challenges in navigating an exemption which could also put coverage at risk.

Methods

This analysis is based on Kaiser Family Foundation analysis of the March 2017 Current Population Survey (CPS), which reflects health insurance coverage in 2016. We included nonelderly adults (age 19-64) who indicated that they had Medicaid at some point during the year. We excluded people who indicated that they received Supplemental Security Income (SSI) during the year, since these individuals likely qualify for Medicaid on the basis of having a disability (and would likely be excluded from work requirements). To match timing of work variables to health insurance coverage, we used measures of work status throughout 2016. Individuals who worked at any point in 2016 were classified as “working.”

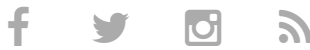
Rachel Garfield and Robin Rudowitz are with the Kaiser Family Foundation. Anthony Damico is an independent consultant to the Kaiser Family Foundation.

[TABLES \(HTTPS://WWW.KFF.ORG/REPORT-SECTION/UNDERSTANDING-THE-INTERSECTION-OF-MEDICAID-AND-WORK-TABLES/\)](https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-tables/) >

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Franklin County

Work Experience Program

Comprehensive Report

*Able-Bodied Adults
Without Dependents*



2014 OHIO ASSOCIATION OF FOODBANKS 2015

Work Experience Program
Ohio Association of Foodbanks
101 E. Town St. Ste, 540
Columbus, OH 43215
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Table of Contents

1
2
3
4
6
7
8
9
11
13
16
17
20
23

Executive Summary

Assessment of ABAWDS in Franklin County

*Age & Gender
Veteran Status*

Communication

Criminal History

Forms of Identification

Transportation

Disabilities & Limitations

*Children & Families
Education*

Employment

Work Experience Program

WEP Volunteer Host Sites

Recommendations

Host Site Partner Organizations

Executive Summary

For almost two years, the Ohio Association of Foodbanks has been assisting able-bodied adults without dependents (ABAWDs) receiving Supplemental Nutrition Assistance Program (SNAP) benefits in Franklin County with meeting the federal work requirement to maintain their food assistance as part of an ongoing partnership with the Franklin County Department of Job and Family Services (FCDJFS). The association has been able to grow this Work Experience Program (WEP), offering more services and resources to ABAWDs in need. WEP provides work experience and job training for participants who are currently unemployed or underemployed, as a means to enhance their ability to secure sustainable employment.

Prior to assigning a client in a job placement within our network of partner nonprofit and faith-based organizations, the association meets with each ABAWD to perform an in-depth assessment. To date, we have assessed close to 5,000 individuals. The data we have collected through these assessments continue to reinforce what we have been able to identify as key barriers for many of our clients as they seek gainful employment. Our findings indicate that many of our clients struggle with accessing reliable transportation, unstable living situations, criminal records, education, and both physical and mental health problems. Our deeper understanding of these issues has led us to partner with organizations that can help ABAWDs navigate through many of their challenges, giving our clients a better chance at improving their lives and supporting themselves.

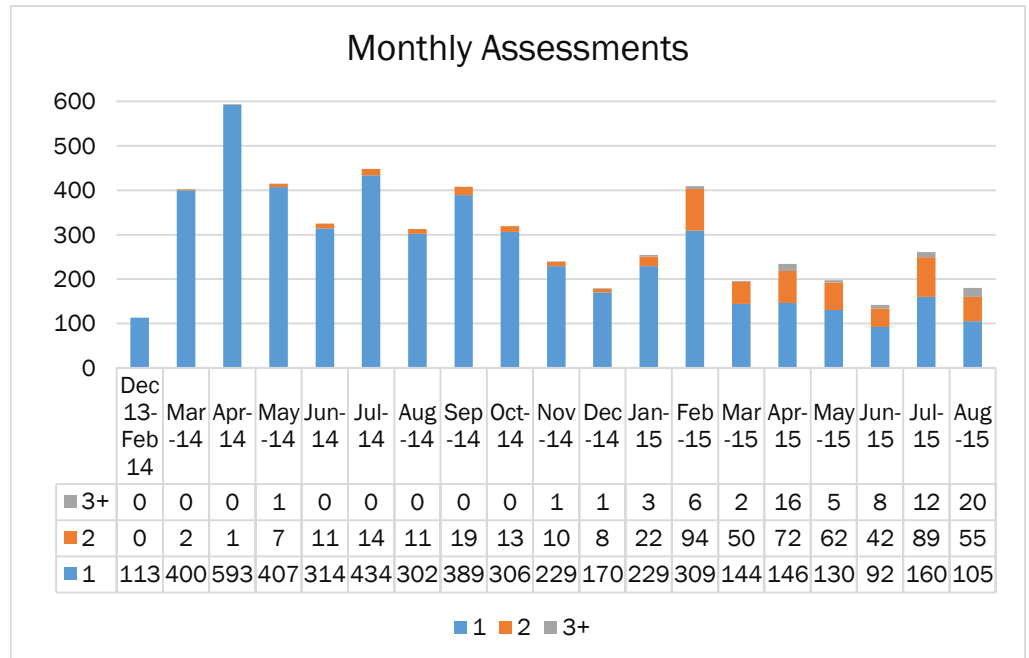
The data has prompted many recommendations to FCDJFS including but not limited to: providing additional funding for programs that support WEP participants and low-income households; expanding enrollment of nationally certified educational programs as well as programs for youth aging out of foster care; and creating an employment pipeline into strategic aspects of the job market.

Assessment of ABAWDs in Franklin County, OH

When Franklin County Department of Job and Family Services (FCDJFS) caseworkers make the determination that a client receiving SNAP benefits meets the criteria to be considered an able-bodied adult without dependents (ABAWD) and is required to work under federal regulations, the client is referred to their local opportunity center to meet with an Ohio Association of Foodbanks Work Experience Program (WEP) assessment specialist. Each specialist completes a comprehensive interview with each client using a series of questions on the Work Experience Assessment Portal. The assessment is designed to determine employability and identify barriers to employment.

The assessment process is part of an ongoing contract targeting clients who are subject to a strict, three-month time limit in every 36-month period for SNAP eligibility. As we approach the second anniversary of this program, we have closely examined the data collected from 4,827 ABAWDs and gathered from 5,434 self-reported employability and skills assessments that took place between December 10, 2013 and September 1, 2015. Over the past two years the information obtained for this ongoing project represents the most comprehensive and up-to-date information collected about this misunderstood population. These findings offer instructive, meaningful insight into who these individuals are and what will be needed to address the barriers and challenges faced by these individuals as they attempt to secure stable employment.

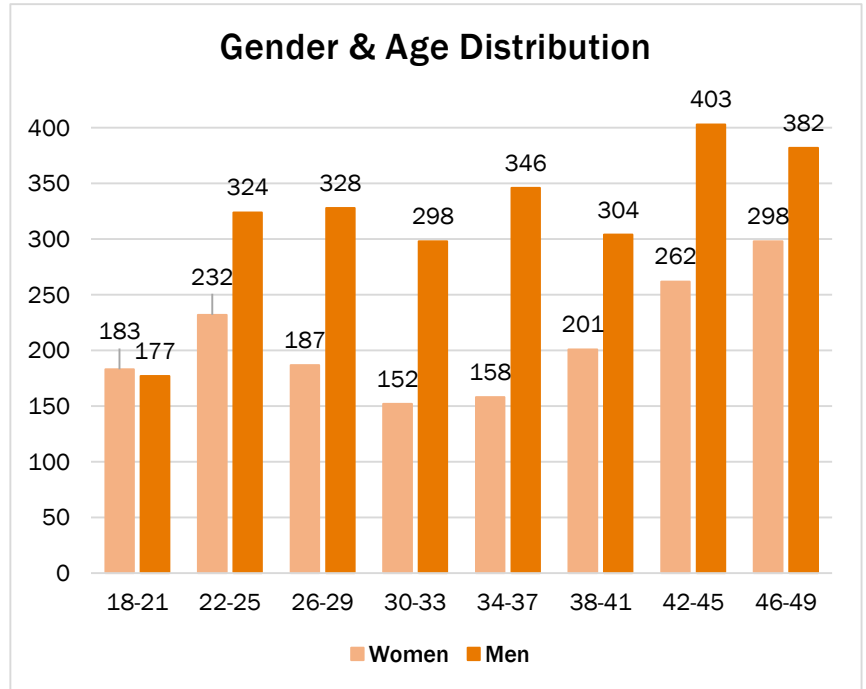
The chart depicts the number of ABAWD assessments performed by association staff for each month. Clients coming in for an initial assessment each month appear in blue, second time visits in any given month appear in orange, and clients who are completing the assessment for the third or more times appear in gray.



Age & Gender

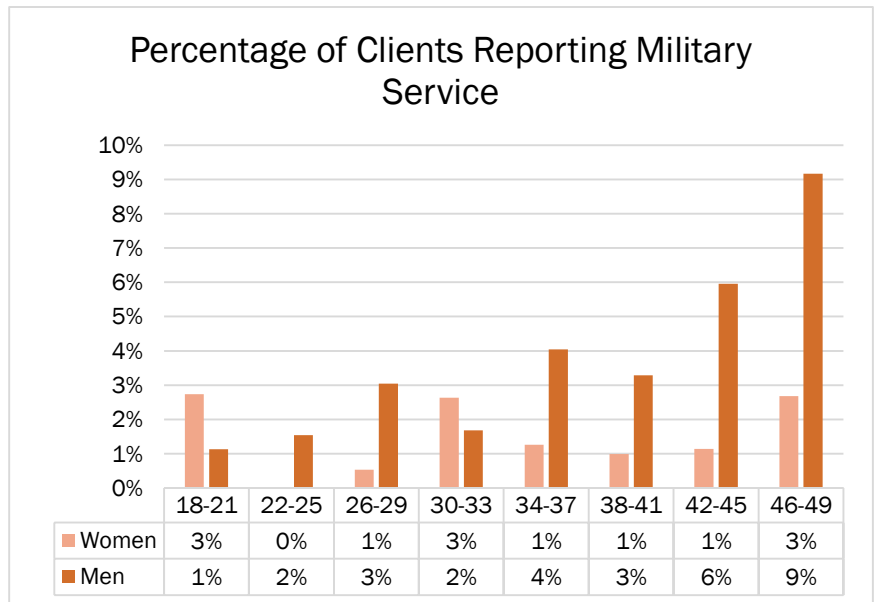
From the total population of 4,827 ABAWDs surveyed, **1,880** clients (**38.9%**) were **female**, and **2,945** clients (**61.0%**) were **male**. Two clients preferred to be identified as **transgender**.

The chart represents a distribution of the ABAWDs based on age and gender. This distribution does not include the 507 clients (176 female and 331 male) for which there was no age listed, nor does it include the 83 clients (31 female and 52 male) who were over 50 at the time of the assessment and therefore exempted from the program.



Veteran Status

Only 156 clients (**3.2%**) reported that they were **veterans**. While veterans make up a relatively small percentage of all ABAWD clients, they represent a significant portion of the male population over the age of 35 as represented in the chart. As we encounter veterans, we are able to help them find resources designated to assist them with housing, employment, and shelter.



Communication

Communication is critical to clients participating in WEP, and maintaining a reliable form of communication with clients has continued to be a challenge as FCDJFS and the association communicate with clients primarily by mail. Since we started collecting mailing information in April 2014, 65 clients have indicated that they do not have a mailing address, while 31 clients provided a mailing address and identified themselves as homeless. Additionally, 152 clients have provided a mailing address that is known to be a homeless shelter, check-in center, or mental health facility.

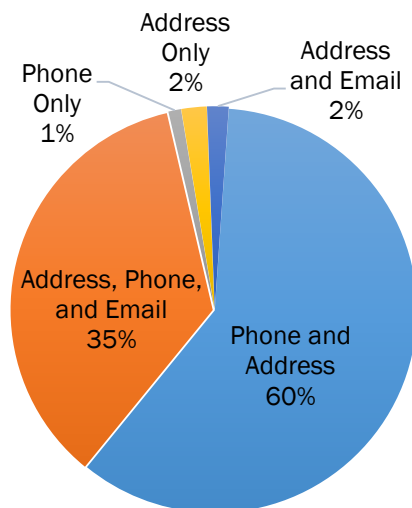
- Faith Mission (245 N Grant Ave) **16** Clients
- Friends of the Homeless (924 E. Main St.) **21** Clients
- Open Shelter (61 E. Mound St.) **24** Clients
- Holy Family Soup Kitchen and Shelter (57 S. Grubb St.) **17** Clients
- Star House (1621 N. 4th) **4** Clients
- YWCA (595 Van Buren) **17** Clients
- YMCA (40 W. Long) **39** Clients
- Southeast Community Mental Health Center (16 W. Long St.) **10** Clients
- North Central Mental Health (1301 N. High St.) **4** Clients

This indicates that at least 248 clients (5.1%) of our ABAWD clients are dealing with housing insecurity. These numbers do not capture the homeless clients who provide the mailing address of a relative or friend, and do not specifically identify that they are homeless.

Types of Communication Reported

- 4,625 clients (95.8%) listed phone numbers
- 1,800 clients (37.3%) listed e-mail addresses
- 4,381 clients (90.8%) listed mailing addresses
- 65 clients (1.3%) reported not having an address
- 380 clients (7.9%) were assessed before address information was asked

Communication Avenues



While 95.8% of clients reported having phone numbers, this does not mean that they have continuous access to a phone. Clients using subsidized government provided cell phones often run out of wireless minutes before the end of the month, or in many other cases their personal phones have been disconnected, or phone numbers are frequently changed due to using prepaid cellular devices. We can only assume that if we are unable to contact clients via phone, potential employers are also unable to reach them.

The association always offers clients the opportunity to register for an e-mail address as a viable, dependable alternative to a phone. Because most major employers require clients to fill out job applications online, having an e-mail address is critical to the application process. We encourage clients to visit their local libraries to check their messages, but find that some clients may not have reliable or readily available community-based access to the Internet. In this process, we also find that many clients struggle with using technology and computers.

Additional information gleaned from the 531 repeat ABAWD clients reinforces our findings, and provides insight into other forms of stable communication for this population. This 11% of ABAWD clients who have taken the assessment more than once shows:

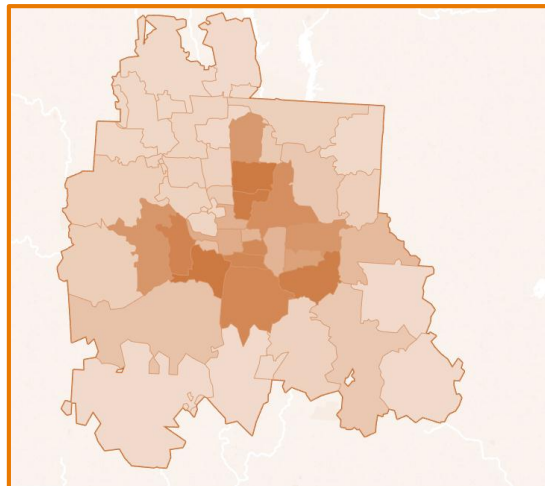
- 47% (253) have changed their phone number between assessments
- 34% (181) have changed their addresses between assessments

This transiency can have real consequences for ABAWD clients who are sanctioned (cut off from their benefits) because they did not receive an appointment or assignment notice from FCDJFS which required action to avoid a disruption in their benefits.

Client Locations

While the clients who have reported addresses represent 58 different zip codes in Franklin County, **over 55% of clients come from 9 zip codes:**

- 43223: 141 clients (7.0%)
- 43224: 140 clients (6.9%)
- 43211: 137 clients (6.8%)
- 43232: 133 clients (6.6%)
- 43204: 123 clients (6.1%)
- 43206: 117 clients (5.8%)
- 43207: 116 clients (5.7%)
- 43205: 112 clients (5.5%)
- 43219: 104 clients (5.1%)

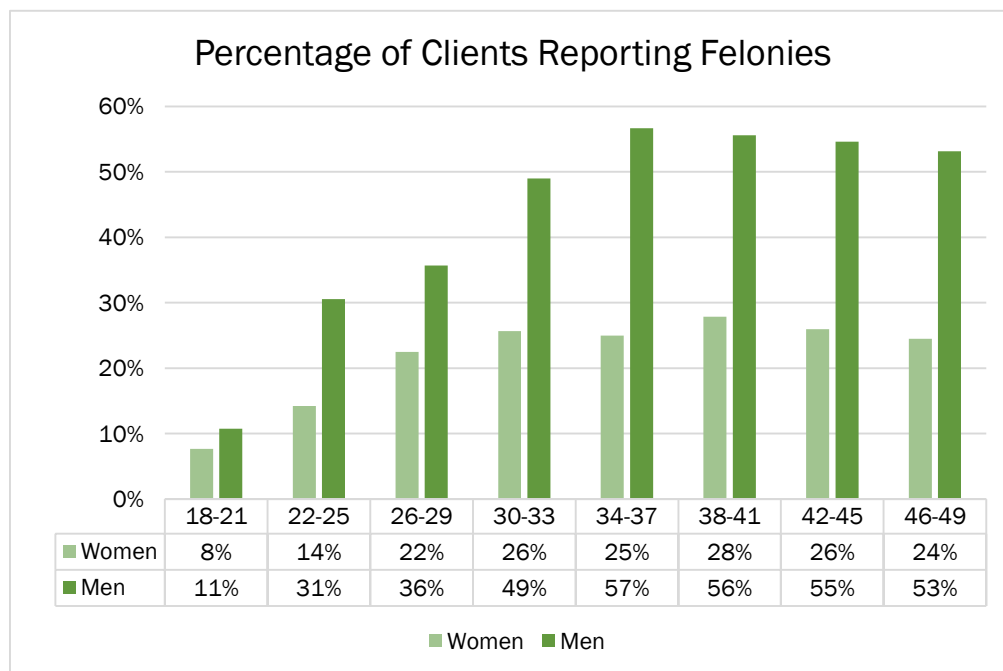


Criminal History

As part of the ABAWD assessment, clients are asked if they are willing to complete an FBI/BCI background check. Over 96% of clients agree to comply with this request.

A history of criminal activity or previous incarceration can have an incredibly damaging impact. The stigma of a felony conviction can follow someone for a lifetime, even if their release is meant to suggest that they have been rehabilitated. These restored citizens miss out on many opportunities, job related or otherwise.

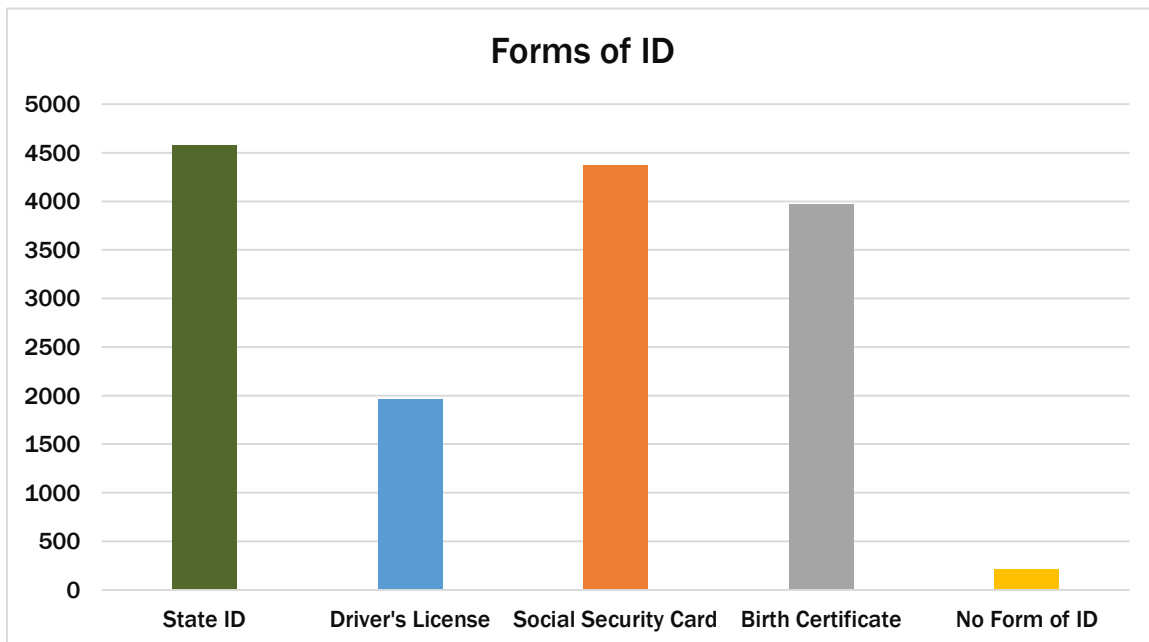
- Over 35.8% of the clients in our program reported having a felony conviction. Some clients have multiple felonies, or a combination of felonies and misdemeanors.
- Close to 12.8% of clients are on probation or parole which means they may not qualify for services offered through legal aid, such as record sealing.
- 541 clients (11.2%) have indicated that they have domestic violence charges.
- 709 clients (14.7%) reported having DUI or OVI violation. These types of violations can severely limit a client's ability to secure employment.



Forms of ID

To apply for jobs, housing, and government benefits, to vote, or to obtain a driver's license, most agencies usually require two forms of Identification (ID). Because the association requires all participants to have an FBI and BCI background check to be placed at one of our host organizations we offer vouchers for clients to receive government issued state IDs when they indicate that they do not already have an ID.

- **4,578** clients (94.8%) have some form of State Identification.
 - 1,963 (40.7%) of clients have indicated that they have a driver's license.
 - 2,615 have indicated that their primary form of identification is a State ID.
 - 206 clients 4.3% indicated that they did not have any form of state identification.
- **4,369** clients (90.5%) reported having access to their Social Security card.
 - 370 clients (7.7%) do not have access to their Social Security card.
- **3,969** clients (82.2%) reported having access to their birth certificate.
 - An additional 752 (15.6%) do not have a birth certificate.



Transportation

To assist with transportation, clients receive a monthly travel stipend from FCDJFS in the form of a \$62 check. Many clients report that they have not received the travel stipend. This could be due to an inaccurate mailing address, the inability to contact their caseworker, or a delay in dispersing of funds. Some clients report that the travel stipend is not enough to cover travel to and from work sites. Some clients do not have bank accounts and have to pay a service fee to cash the check they receive from FCDJFS, leaving an insufficient amount to purchase a monthly bus pass which the stipend should cover.

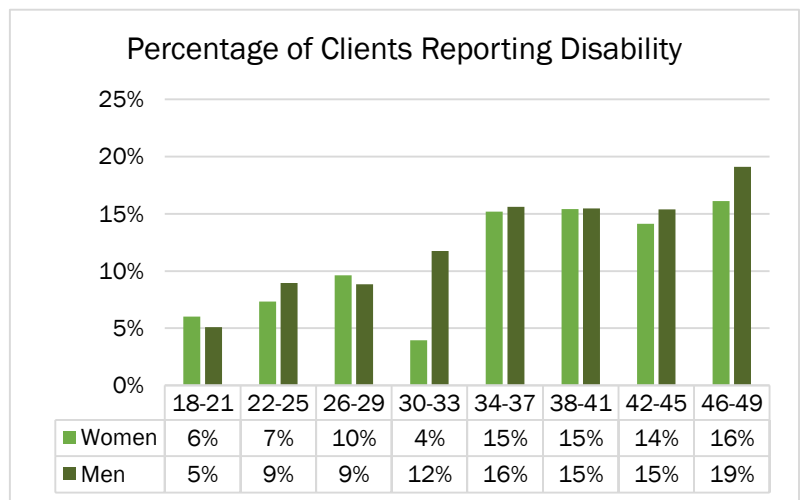
2,749 clients (57.0%) said they have access to reliable transportation, whether it is their own vehicle, the COTA bus system, or a ride from friends and family members. It is important to note that the use of a friend or family member's vehicle may not always be reliable. Owning a vehicle may pose its own challenges for low-income populations, as the car could break down and the client may not have the means to fix it.

- 40% of clients said they do not have reliable transportation.
- **3,565** clients (73.9%) indicated that they live near a bus stop.
- 610 clients (12.6%) indicated that they did not live near a bus stop.
- Only **40%** of clients indicated that they have a valid driver's license, which indicates that clients are either using public transportation or are driving without a license.
 - Some clients may not be able to obtain a driver's license if they owe child support and have had their driving privileges suspended, or if they have outstanding tickets or unpaid fines which they may be unable to resolve with their limited income.
- **904** clients (18.7%) indicated that they did have car insurance.
 - An additional 3,232 clients (67.0%) indicated that they did not have car insurance, inferring that some are driving without insurance which can be attributed to a variety of factors, including affordability. As it is the law to maintain car insurance for any vehicles owned, some clients could be making the tough choice to pay for utilities, food, or medicine instead of car insurance.

Disabilities and Limitations

“Able-bodied” indicates that clients should not be medically certified and documented as physically or mentally unfit for employment. As part of the assessment, clients are asked to self-report disabilities or limitations, both physical and mental.

- **598** ABAWD clients (12.4%) have self-reported a disability. Of these clients, 261 clients (44%) have indicated that they are not able to work and earn \$1010 a month, which could make them eligible for disability benefits.
 - 74 clients (12%) indicated that they are able to work and earn \$1,010 per month.
- **1 in 3** ABAWD clients (32.5%) have self-reported some type of physical or mental limitation. Of these clients, 25% (392) have indicated that their condition limits their ability to perform daily activities.
- 70.3% (1,102) indicated some type of physical limitation.
- 30.1% (471) indicated some type of mental limitation.

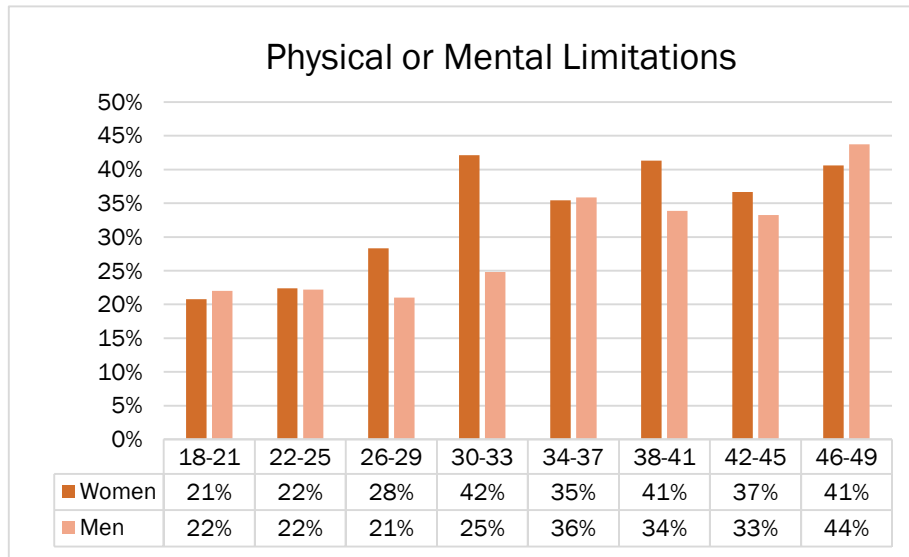


Most Common Types of Physical and Mental Limitations Reported:

- Back Injuries 18.3%
- Respiratory Difficulties 6.0%
- Knee Injuries 5.9%
- Diabetes 3%
- Shoulder Injuries 2.8%
- Arthritis 2.5%
- Heart Conditions 2.3%
- Depression 10.1%
- Bipolar Disorder 9.3%
- Anxiety 8.1%
- Post-Traumatic Stress Disorder 3.1% (PTSD)
- Schizophrenia 1.5%

Additionally, a small percentage of clients reported physical difficulties due to crimes of violence.

- 27 reported physical difficulties as the result of gunshot wounds.
- 4 clients reported physical difficulties as the result of stab wounds.



Social Security and Health Care

1 in 5 ABAWD clients (18.6%) have reported filing for Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI). Of these clients, most have reported filing in the last two years:

- 82 (9%) reported filing in 2015
- 333 (37%) reported filing in 2014
- 155 (17%) reported filing in 2013
- 114 (13%) applied in 2012
- 223 (25%) applied in 2011 or earlier

1 in 4 clients (25.0%) indicated said they were under a doctor's care, and 1,347 clients (27.9%) indicated that they were currently on medications.

Nearly 6 in 10 clients (58.2%) have reported already applying for Medicaid, although all clients may be eligible to receive this expanded necessary health coverage due to their low-income status. 1,950 clients (40.4%) said they had not applied for Medicaid. As part of our outreach process, we invite health care navigators to our monthly WEP events to help clients sign up for health coverage.

Children and Families

According to the USDA definition of an ABAWD, it is assumed that all clients do not have dependents. We found that clients with children, although not in their custody, still spend time parenting their children on a regular basis while the custodial parent works.

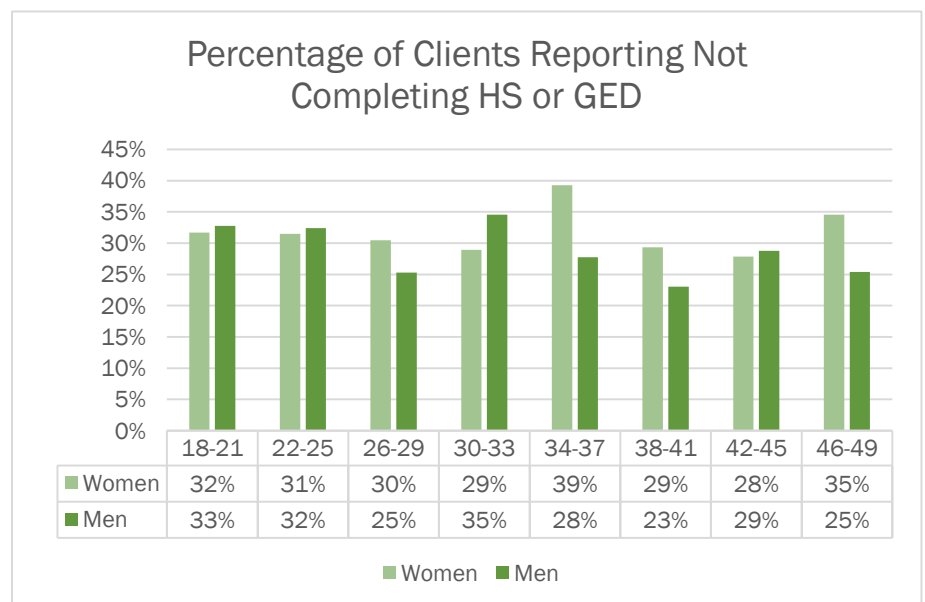
- **1 in 4 clients (23.5%)** indicated that they had **children not in their custody**.
- **868 clients (18.0%)** indicated that they **owe child support**.
- **86 clients (1.8%)** indicated that they **need childcare**.

Having the status of caregiver to a relative should potentially exempt an individual from participating in WEP. Caregivers can often replace the services of a Medicaid or Medicare home-healthcare provider. **618 clients (12.8%)** indicated that they are caregivers for a parent, friend, or relative.

Education

Many of the clients in this population have not earned a degree or certification to work in industries that pay more than entry level wages.

- **3,342 clients (69.2%)** report having earned a high school diploma or GED.
- **1,424 (29.5%)** of clients report never having graduated high school.



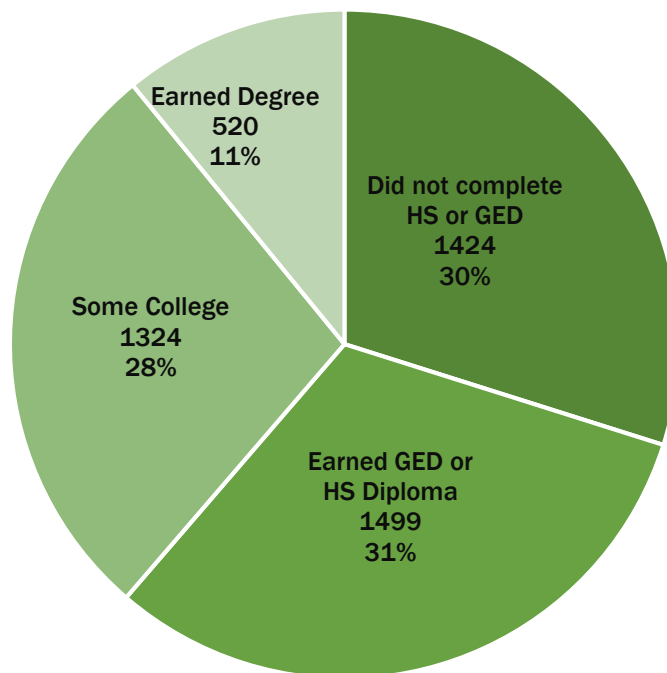
Of those students that did not earn a GED or high school diploma:

- 121 (2.5%) report having attended last in the 12th grade
- 404 (8.4%) report having attended last in the 11th grade
- 316 (6.5%) report having attended last in the 10th grade
- 190 (3.9%) report having attended last in the 9th grade
- 86 (1.8%) report having left school before high school
- 5 clients (0.1%) report never having attended school before

College Education

Of the students who earned either a high school diploma or GED, an additional 1,324 (28%) attended college, and an additional 520 (11%) earned some type of degree or certification.

Highest Level of Education of ABAWD Clients



Employment

Working 20 or more hours of paid employment per week, every week can exempt an ABAWD from participating in WEP.

- **547** clients (11.3%) indicated that they are **currently working**.
 - 16 clients (2.9%) indicate that they are working less than 10 hours per week
 - 62 clients (11.3%) indicate that they are working 10-20 hours per week
 - 75 clients (13.7%) indicate that they are working 20-30 hours per week
 - 34 clients (6.2%) indicate that they are working 30-40 hours per week
 - 23 clients (4.2%) indicate that they are working over 40 hours a week
 - 337 clients (61.1%) did not indicate how many hours they were working

At least 91 clients (**1.9%**) reported that they generally work for **temporary employment agencies** (including day labor and labor pool agencies). These clients may be unable to identify how many hours they work per week due to inconsistent scheduling and availability of consistent job assignments. Because of this, clients may not be able to regularly fulfill the 20 hour work requirement to qualify for an exemption.

Most Common Employment Industry

- Warehouse Work (including pick/pack, forklift)
- Customer Service
- Food Service (including fast food, restaurants, cooking, and food preparation)
- Janitorial and Cleaning
- Construction (including carpentry, masonry, drywall, and electric)

Employment History

Having gaps in a resume can influence an employer's decision in the hiring process, which can negatively impact a client's chances of obtaining employment. Of the 4,284 clients who reported the time since they were last employed, 1,579 (36.8%) reported working last sometime within the current year. An additional 1,216 clients (28.4%) reported working last in the previous year, 665 clients (15.5%) reported working last within the last 2-3 years, 429 (10.1%) reported working last within 4-6 years, 204 (4.8%) reported working last within the last 7-10 years, 109 clients (2.5%) reported working last between 11-15 years, 34 clients (0.7%) reported working last within the last 16-20 years, 12 clients (0.3%) reported working last over 20 years ago, and 36 clients (0.8%) reported having never worked before.



In-Kind Work

Just as traditional employment can exempt a client from participating in WEP, in-kind work may qualify clients from an exemption as well. **402** clients (8.3%) reported **working in-kind** for food or housing.

- 67 clients (16.7%) reported working less than 10 hours per week
- 84 clients (20.9%) reported working 10 to 19 hours per week
- 82 clients (20.4%) reporting working 20 to 29 hours per week
- 21 clients (5.2%) reported working 30 to 39 hours per week
- 28 clients (7.0%) reported working 40 or more hours per week
- 120 clients (29.8%) did not report the number of hours they were working per week

Employment Assistance

The ABAWD assessment screens for additional assistance or equipment clients may need to perform tasks at their worksite.

- **435** clients (9.0%) indicated that they needed **special accommodations** at their worksite in order to do a job. The most commonly requested accommodations were **no heavy lifting** and **no standing or walking** for long periods of time.
- **757** clients (15.7%) indicated that they need **supportive services** to obtain employment. The most commonly requested services were **language interpretation** (especially for Somalian refugees) and help with **transportation**.

Workforce Development

In an effort to offer more job seeking resources to clients, they are referred to Ohio Means Jobs (www.ohiomeansjobs.com). **7 in 10** clients indicated that they were not registered to work through Ohio Means Jobs website. This shows that the outreach for the Ohio Means Jobs website has been ineffective in reaching this population.

We assist clients with creating resumes so they are able to take them to career fairs and apply for jobs that require resumes.

- 2,594 clients (53.8%) indicated that they did not have a current resume.
- **2,183** clients (**45.2%**) indicated that they would like **help to write or update their resume**.
- 2,410 clients (49.9%) indicated that they were not interested in help to write or update their resume.

Unemployment Compensation Benefits

Many job applications ask if applicants have ever been fired or dismissed from a previous position. **1 in 4** clients (24.0%) reported having been previously **fired or dismissed from a job**. When this question appears on a job application it can be a deterrent for employers to hire an applicant.

We inquire if clients have ever received unemployment compensation benefits, as this can qualify them for an exemption in participating in WEP if they are still receiving it. Nearly **8 in 10** clients (**78.3%**) reported that they have **never received unemployment compensation benefits**.

- 886 clients (18.4%) reported that they are receiving or have received unemployment compensation, ranging in time from 1984 to February 2015.

Work Experience Program

Immediate program goals for WEP participants are to actively ensure viable work opportunities for ABAWDs in Franklin County to fulfill the work requirement to maintain their SNAP benefits and prepare ABAWDs for reentry into the workforce. The long-term goals and objectives for WEP participants are focused on decreasing unemployment among Franklin County ABAWDs to break systemic cycles of poverty and hunger and ensure clients can become economically self-sufficient.

Consistent Outreach

During the initial ABAWD assessment at the FCDJFS opportunity centers, clients are given information about job openings and job fairs in Franklin County. When we find that one of the many barriers the assessment is meant to capture is stifling a client in their attempt to secure employment, we refer them to clothing banks, resources for homelessness, mental health facilities, educational opportunities, and food pantries.

All new clients are required to attend a WEP employment and resource fair their first month in the program. We bring together employers (with assistance from FCDJFS Workforce Development and Franklin County Economic Development), health care navigators and certified application counselors, Legal Aid Society of Columbus lawyers, workforce development agencies, GED and adult education or vocational training organizations, and many more stakeholders to ensure we are able to offer clients a variety of valuable services.

At this event, clients also receive a required background check for their job placements. They participate in hands-on activities and receive assistance with filling out job applications and creating or updating resumes, assistance with using computers, and referrals to obtain suiting for job interviews.

Many clients who attend our monthly job and resource fair leave with jobs!



WEP Volunteer Host Sites

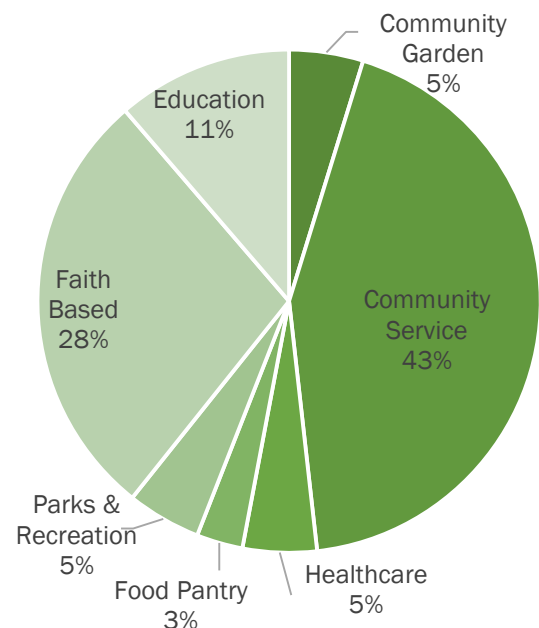
The recruitment process for developing new sites involves calling, mailing, e-mailing, and visiting numerous nonprofit and faith-based organizations in Franklin County. Each organization is required to sign a Memorandum of Agreement, establishing a strong partnership that also holds these organizations accountable for reporting hours for clients.

Each volunteer experience through WEP is intended to give participants training, education, or experience that would be beneficial in an ABAWD's search for future employment. Some sites even report hiring WEP workers when they have open positions available.

A list of possible volunteer roles could include but is not limited to:

- Janitorial Work
- Painting
- Grounds Maintenance & Landscaping
- Warehouse Positions
- Office and Clerical Work
- Manual Labor
- Customer Service
- Food Preparation and Service

Type of Host Sites



“One of our WEP clients began working at the Broad Street Food Pantry in October 2014 as part of the Ohio Association of Foodbanks Work Experience Program. From the time she started, she demonstrated excellent work ethics – never missing a day, always working hard and making sure that customers were served efficiently, the shelves kept full, and the pantry kept clean and neat. Last winter when our assistant moved on to another job, our WEP client was one of the first candidates we identified. After a thorough search, we hired her for the permanent position.”

-Kathy Kelly-Long, Broad Street Food Pantry Director



WEP participants paint a mural at Fusion Bakery and Cafe

Placements

Our network of nonprofits, workforce development partners, and faith-based organizations make it possible for Franklin County ABAWDs to obtain their required work hours through volunteer service or job readiness activities, while also offering work experience. Placements are made at these organizations after clients have completed a background check at the WEP monthly employment and resource fair.

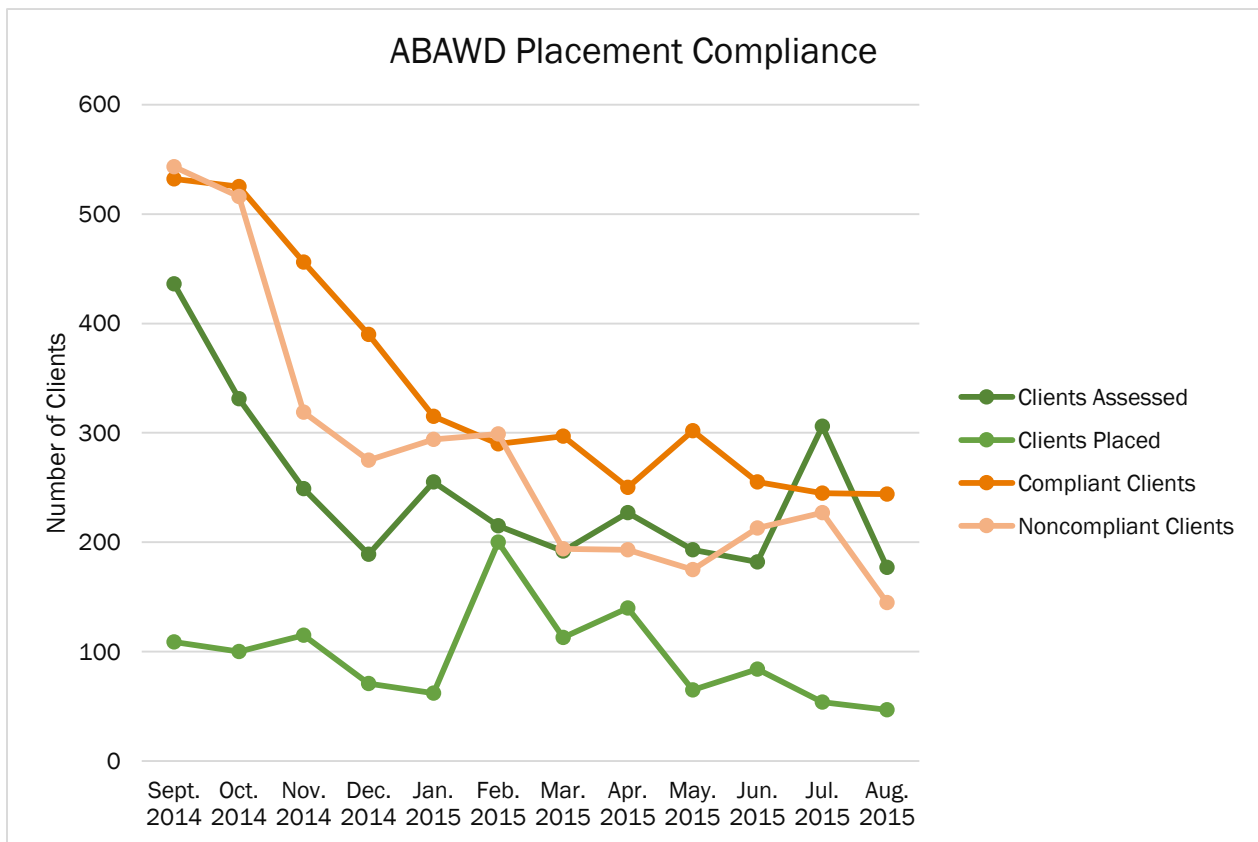
The Ohio Association of Foodbanks requires clients to have a background check to ensure that we are not placing clients in situations that may compromise the integrity of our partners, and to protect their clients and staff in the event of a known conflict of interest. Clients are not eligible to be placed at a volunteer host site until their FBI/BCI background check is received.

Through the assessment process we gather an inventory of job skills from each clients. We are able to determine what jobs would best suit that client, and strategically place them at sites where we believe they will thrive. We do make accommodations for any client that is already volunteering in the community, and make an attempt to bring their volunteer site on as a host organization so that the client can maintain their relationship with that organization.

ABWAD Placement Compliance

At times, it can be very difficult to place clients at a volunteer site. If the host location is not on the bus line or if it is not easily accessible by public transportation, clients can have a hard time getting to their placement. Some host sites even require a college education or degree, which many of our clients do not have. Some sites have a list of restricted felonies which would limit a large portion of our clients from volunteering with those sites. The same is true for workforce development programs. Many clients do not meet the minimum education requirements to enroll in such programs, or struggle with passing an entrance exam.

The Ohio Association of Foodbanks placement specialist makes every effort to place all clients, no matter how limiting their personal situations may be. Even with the best effort to make sure that a client's skills match the site's needs, and that the location is less than an hour bus ride from their address, not all clients report to their assigned placements each month. In order for a client to remain compliant with WEP they must report to their worksite for 23 hours per month. When a client fails their work requirement hours they are sanctioned and at risk of losing their monthly SNAP benefits.





Recommendations

As we bring light to the situations this population faces, we are able to make the following insightful recommendations which are supported by the findings of the WEP assessment data. These recommendations have been presented to FCDJFS after the first analysis of this information. They are meant to encourage other government organizations to consider a further examination of the implication of programs like WEP.

Program Next Steps

The specific program needs of the Ohio Association of Foodbanks will enhance the overall client experience while strengthening relationships with our partners.

- Coordinate with other Departments of Job and Family Services statewide in an effort to replicate the positive results we have seen in Franklin County, to expand this program to other metro and rural areas.
- Increase the efficiency of our program in order to enhance client satisfaction and success while working with very limited resources.
- Coordinate with Franklin County to offer more opportunities for clients to connect with available employment and training.
- Improve quality assurance measures and outcomes as well as communication channels between the Ohio Association of Foodbanks, clients, host sites, and Franklin County Department of Job and Family Services.

Increase Oversight to Improve Effectiveness

- Analyze the expenditures of Workforce Development Programs funded by FCDJFS compared to outcomes. WEP at the Ohio Association of Foodbanks has proven a 24% success rate, compared to a 16% success rate of similar government funded workforce programs in Franklin County.

Provide Additional Funding to Organizations Supporting WEP

- When clients fail a WEP assignment and do not have access to their food stamp benefits, they may begin utilizing the services of their local emergency food programs. This warrants more emergency funding to be provided to Mid-Ohio Foodbank to support the purchase, acquisition, and distribution of additional food for Franklin County food pantries, soup kitchens, shelters, and churches who are feeding the individuals affected.
- Utilize banked months of exemptions (estimated at 405,000) to reenroll participants in the food assistance program while Departments of Job and Family Services work to establish additional work experience program infrastructure.
- Provide additional funding to the Ohio Association of Foodbanks to support the cost of emergency vouchers for transportation, travel vouchers, and basic needs.
- To increase interest in becoming a part of the host site network, there needs to be more incentive for organizations to serve ABAWDs through WEP. By offering operating support to the nonprofit and faith-based organizations that are providing WEP services and slots, we can motivate more sites to partner with the Ohio Association of Foodbanks, while current sites may be able to effectively increase their capacity to serve more ABAWDs.
- Provide supplemental support for the continuation, expansion, and analysis of workforce development programs operated by the Ohio Association of Foodbanks for young adults aging out of the foster care system. All youth who successfully complete these programs either enroll in school or start working, which in many cases exempts them from participating in WEP as ABAWDs.
- Improve the funding and training of a specialized unit dedicated to the implementation of this work requirement and the ABAWD population's specific needs.

Study the Social and Economic Impact of WEP

- Monitor and report on the impacts to well-being, health, and safety of clients, WEP host site staff/volunteers, and the community at large.
- Conduct an Economic Impact Analysis on the loss of food assistance/SNAP benefit issuance on the Franklin County economy.
- Provide funding for comprehensive case-management, longitudinal tracking of employment, wages, public assistance participation, and well-being of the ABAWD population.

Provide More Work Support Opportunities for ABAWDs

- Expand enrollment, participation, and successful completion of nationally certified programs such as the FastPath program at Columbus State Community College, including ServSafe, customer service, advanced logistics, and STNA.
- Create an employment enterprise or pipeline into strategic aspects of the job market. This will help harder-to-employ individuals find opportunities to gain sustainable employment.
- Prioritize Workforce Investment Act funding to provide education, training, and supportive services to ensure a seamless delivery of services.
- Establish a relationship with the Ohio Department of Rehabilitation and Correction in order to address the specific concerns of the employer community in regard to the future employment of felons.
- Examine opportunities to secure additional USDA/SNAP Employment and Training funds to enhance service delivery.

Examine and Evaluate the Needs of Special Populations

- Provide support and funding for a study on the mental and physical health status and outcomes of the ABAWD population and their utilization of Medicaid.
- Fund person-centered, community-based case management of ABAWDs applying for SSI/SSDI, and supportive services including Legal Aid assistance to non-custodial parents and individuals with criminal charges and felony convictions.
- Convene a study group to examine the impact of temporary and day labor employment services and its effects on this population.
- The Ohio Association of Foodbanks will continue to analyze assessments and data including current and previous encounters with the criminal justice system, community impact, and these associated costs.

Host Site Partner Organizations

Without the support of our wonderful network of nonprofit and faith-based organizations we could not offer so many meaningful volunteer opportunities to ABAWDs in Franklin County. We extend our sincere gratitude to each organization for their continued partnership and dedication to serving the community.

- Agora Ministries
- Authority of the Believers
- Beatty Recreation Center
- Brice UMC
- Bridge Community Center
- Broad Street Food Pantry
- Broad Street UMC
- Calhoun Memorial Temple
- Cat Welfare Association
- Catique
- Center for Family Safety
- Chalmers P Wylie VA Ambulatory Care Center
- Charitable Pharmacy of Central Ohio, Inc.
- Child Development Council of Franklin County
- Christ Harvest Church
- City of Whitehall
- Clintonville Beechwold
- Colony Cats (& dogs)
- Columbus Arts Technology Academy
- Columbus Chosen Generation Ministries
- Columbus Growing Collective
- Columbus Humanities Arts & Technology Academy
- Columbus Urban League
- Community Kitchen, Inc.
- Core Resource Center, Inc.
- East Columbus Development Company
- EL Hardy Center
- Family Missionary Baptist Church
- Franklinton Gardens
- Genesis of Good Samaritans Ministries
- Glory Praise & Help Center
- Greater Ebenezer Cathedral of Praise and Kingdom Kids Daycare
- Habitat for Humanity's ReStore
- Hands On Central Ohio
- Heart Food Pantry
- Heart of Christ Community Church
- Helping Hands Health And Wellness Center, Inc.
- Holy Family Soup Kitchen
- House of Refuge for All People
- HUB Community Development Corporation
- J Ashburn Jr Youth Center
- King Arts Complex MLK
- Kingdom Alive Word Church

- Libraries for Liberia Foundation
- Long Lasting Community Development
- Loving Hands Learning Center
- Lutheran Social Services Ohio Benefit Bank – SOUTH
- Lutheran Social Services Ohio Benefit Bank – WEST
- Magic Johnson Bridgescape Academy - New Beginnings
- Mock Rd University for Children
- National Parkinson Foundation Central & Southeast OH
- New Salem Baptist Church and Community Development
- NNEMAP, Inc.
- Ohio Association of Foodbanks
- Ohio Business Development Center
- Ohio Empowerment Coalition
- Pri-Value Foundation
- Project Redeem
- R F Hairston Early Learning Center
- Reeb-Hossack Community Baptist Church
- Seven Baskets Community Development Corp
- Shiloh Christian Center
- Short North Stage at The Garden Theater
- Society Of St Vincent De Paul
- Soldiers of Life Food Pantry
- Somali Bantu Youth Community of Ohio
- Southeast Friends of the Homeless
- Southeast, Inc.
- St Dominic Roman Catholic Church
- St Marks United Methodist Church
- St Philip Episcopal Church Food Pantry
- St Stephens Community House
- Stoddart Avenue Community Garden
- Temple Israel
- Trinity Assembly
- United House of Prayer
- Unity of Columbus
- Welcome Home Ohio
- Wesley Church of Hope UMC

June 12, 2018

Non-Expansion States Can't Fix "Catch-22" in Their Proposals to Take Medicaid Coverage Away From Parents Not Meeting Work Requirements

By Judith Solomon and Aviva Aron-Dine

Some states that haven't adopted the Affordable Care Act's (ACA) expansion of Medicaid to cover more low-income adults are now seeking or considering Medicaid waivers that would take coverage away from poor parents if they do not meet work requirements. In all of these states, substantial numbers of parents likely couldn't meet the requirements, whether because of caregiving responsibilities coupled with a lack of affordable child care, because they work at unstable jobs that don't provide enough hours of work every month, because of an illness or disability, or for other reasons. In many of these states, the proposals would also create a severe catch-22: even parents who did manage to comply with the work requirement would often lose coverage, since working the required number of hours at a minimum-wage job would raise their incomes above their state's very low Medicaid eligibility limits.

Because of their impacts on coverage, access to care, and health, work requirement proposals — in expansion and non-expansion states alike — fail to promote the Medicaid program's objectives, the legal standard that proposals are supposed to meet for the Secretary of Health and Human Services to grant waivers of Medicaid rules. But the Centers for Medicare & Medicaid Services (CMS) has nonetheless approved work requirement proposals in Arkansas, Indiana, Kentucky, and New Hampshire. Those all are states that have adopted the ACA's expansion of Medicaid to cover low-income adults with incomes up to 138 percent of the poverty line.

Now, several states that have *not* expanded Medicaid are considering work requirements, with some of those proposals already pending at CMS (see Appendix). Non-expansion states generally do not offer Medicaid coverage to low-income adults without dependent children, and most of them cover only very low-income parents. Work requirements will almost certainly result in large coverage losses among these parents, with harmful consequences for their children's health and well-being as well.

Supporters of Medicaid work requirements argue that the requirements will benefit enrollees and state economies by strengthening work incentives. The evidence for this claim, however, is weak; as discussed below, work requirements in other programs have not led to sustained gains in employment and incomes, and work requirements in Medicaid would likely make it harder for some

enrollees to find or keep a job, since losing access to needed health care can make it harder for people to work or look for work.¹ But in many non-expansion states, there's a further flaw in the logic underlying these proposals: even many enrollees who *meet* work requirements will still risk losing coverage. That's because, in these states, Medicaid income limits are so low that they result in a "coverage gap," where low-income parents may have incomes too high to qualify for Medicaid but too low to qualify for subsidized coverage in the ACA marketplaces. As a result, instead of being rewarded for working, parents who manage to comply with the work requirement could nonetheless lose their coverage, since working the required number of hours each month would cause their incomes to rise above their state's strict Medicaid eligibility limits.

For example, to qualify for Medicaid in Mississippi, parents must have income below 27 percent of the poverty line, which is \$370 a month for a single parent with one child. Under the state's proposed Medicaid waiver, parents would have to work or engage in work-related activities for 20 hours a week to keep their coverage. Yet if parents were able to work 20 hours a week at the minimum wage, they would earn about \$580 a month, too much to qualify for Medicaid in Mississippi. So, these parents could end up uninsured, because few low-wage jobs (especially part-time jobs) offer coverage, and their income would still be below the poverty line, which is the minimum income needed to qualify for subsidized coverage in the ACA's individual insurance marketplace.²

Nor is Mississippi an isolated case. (See Figure 1 and Appendix Table 1.) In the median non-expansion state, a single parent with one child loses eligibility for Medicaid when the family's income reaches just 43 percent of the poverty line (\$590 per month.)³

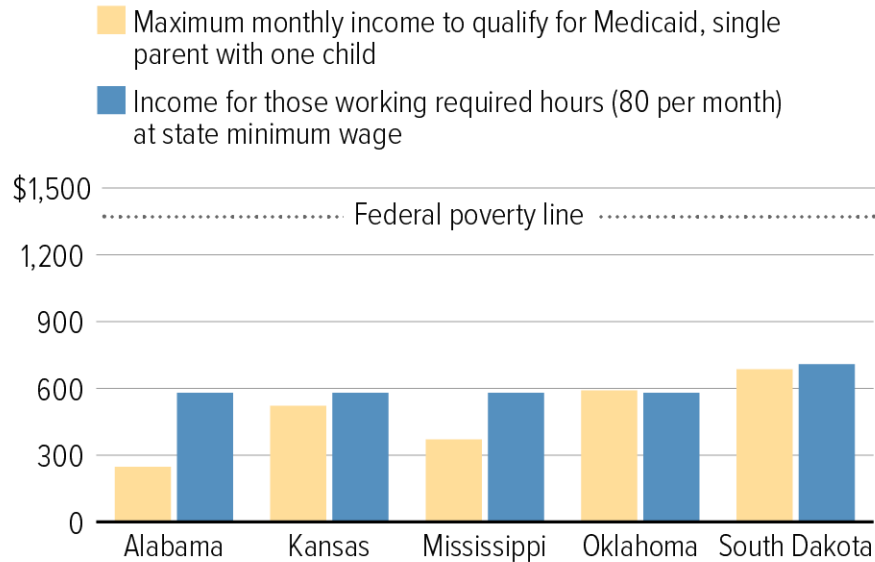
¹ Hannah Katch, Jennifer Wagner, and Aviva Aron-Dine, "Medicaid Work Requirements Will Reduce Low-Income Families' Access to Care and Worsen Health Outcomes," Center on Budget and Policy Priorities, February 8, 2018, <https://www.cbpp.org/research/health/medicaid-work-requirements-will-reduce-low-income-families-access-to-care-and-worsen>.

² See, for example, "How Mississippi's Proposed Medicaid Work Requirement Would Affect Low-Income Families with Children," Georgetown Center for Children and Families, April 2018, <https://ccf.georgetown.edu/2018/04/05/impact-of-mississippis-proposed-new-medicaid-restrictions-on-low-income-families-with-children/>; Community Catalyst, "Work Requirements: A One-Way Ticket to the Coverage Gap," February 2018, <https://www.communitycatalyst.org/resources/publications/document/2018/Community-Catalyst-Work-Requirements-and-Medicaid-Eligibility-in-Non-Expansion-States-Analysis.pdf>.

³ State Health Facts, Medicaid Income Eligibility Limits for Parents, 2002-2018, Kaiser Family Foundation, <https://www.kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-parents/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

FIGURE 1

In Many Non-Expansion States, Both *Meeting* and *Not Meeting* Medicaid Work Requirements Would Likely Mean Losing Coverage



Note: Federal poverty line shown is for a single parent with one child. The states shown are among those proposing work requirements that did not adopt the Affordable Care Act's option to expand Medicaid to adults with income up to 138 percent of the poverty line. Medicaid enrollees who do not meet the work requirements would lose their coverage. But those who meet them through paid employment *also* would likely lose coverage because, by working the required hours, they'd likely earn too much to qualify for Medicaid in these states.

Source: CBPP calculations using information from the Kaiser Family Foundation, minimum wage data, and states' Medicaid waiver applications

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CMS has indicated that it is troubled by the catch-22 aspect of these states' proposals (though not by the harm that would result from Medicaid work requirements generally). In a recent media briefing, CMS Administrator Seema Verma said that she was having conversations with Mississippi policymakers aimed at having the state "try to make the proposal in a way that addresses that issue that there is not that cliff there."⁴ Days later, CMS notified Kansas — which limits Medicaid coverage to parents with incomes below 38 percent of the poverty line — that it couldn't approve Kansas' proposal to end coverage for people who aren't employed or engaged in work-related activities. However, that letter also expressed a willingness to help the state identify a "workable approach to meeting the state's goals."⁵

⁴ Tina Reed, "What CMS' Seema Verma says states should think about before applying for Medicaid waivers," FierceHealthcare, May 2, 2018, <https://www.fiercehealthcare.com/hospitals-health-systems/what-cms-seema-verma-says-states-should-know-before-applying-for-medicaid>.

⁵ Kansas' proposal also had a time limit, which CMS rejected. Under that proposal, people subject to the work requirement would have been eligible for Medicaid for only three months in a 36-month period if they weren't employed. And those who were employed would still have been subject to a *lifetime* limit of 36 months of Medicaid

There is, however, no such workable approach. In any state with a coverage gap for low-income parents, some parents who comply with a work requirement by working the required number of hours per month will still face the loss of their coverage, undercutting the already weak argument that these policies promote work. Meanwhile, with or without this catch-22 feature, implementing work requirements in non-expansion states will result in tens of thousands of low-income parents losing coverage, undermining the objectives of the Medicaid program by worsening their and their children's access to care and health.

Medicaid Expansion Supports Low-Wage Workers

The ACA's Medicaid expansion provides a pathway to coverage for low-income adults who weren't eligible for Medicaid before health care reform. That includes adults who aren't caring for a dependent child as well as parents whose income exceeds the pre-ACA eligibility level for low-income families, which was 64 percent of the poverty line in the median state in 2013. Most current non-expansion states had and still have income eligibility levels below that.⁶

Many adults benefiting from the expansion are low-wage workers without an offer of employer coverage. In 2014, only 37 percent of full-time workers with incomes below the poverty line and 59 percent with incomes between 100 and 250 percent of the poverty line had an offer of employer-sponsored coverage. For part-time workers, only 13 percent of those with incomes below poverty and 20 percent of those with incomes between 100 and 250 percent of poverty had an offer.⁷

The combination of Medicaid expansion and subsidized individual market coverage allows low-income workers to move across Medicaid, subsidized coverage in the individual insurance marketplaces, and available employer coverage as their incomes and circumstances change. But the Supreme Court's decision making the Medicaid expansion a state option has led to 18 states having a coverage gap for workers with incomes below the poverty line, resulting in higher rates of uninsurance.⁸ Overall, in states that expanded Medicaid by January 2016, some 6.5 percent of people were uninsured in 2016, compared to 11.7 percent of people in non-expansion states.⁹ For people with incomes below the poverty line, the uninsured rate in non-expansion states (35.2

coverage. "State Extension Application," December 20, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf>.

⁶ State Health Facts, Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, Kaiser Family Foundation, <https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

⁷ Michelle Long *et al.*, "Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014," Kaiser Family Foundation, March 21, 2016, <https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/>.

⁸ Virginia's recently passed expansion will take effect no later than January 2019. Wisconsin has not taken up the ACA's expansion of Medicaid but does not have a coverage gap, because it covers adults up to the federal poverty line.

⁹ Matt Broaddus, "Census Data: States Not Expanding Medicaid Lag Further on Health Coverage," Center on Budget and Policy Priorities, September 12, 2017, <https://www.cbpp.org/blog/census-data-states-not-expanding-medicaid-lag-further-on-health-coverage>.

percent) was more than double the rate in expansion states (16.7 percent). More than 4 million people would gain coverage if all states expanded Medicaid, according to a recent analysis.¹⁰

The Medicaid coverage gap not only leaves large numbers of low-wage workers uninsured. It also creates work disincentives for very low-income parents enrolled in Medicaid. These parents may lose their health coverage if they start working or increase their hours or wages.

Absent Medicaid Expansion, Work Requirements Can Create a Catch-22

Non-expansion states seeking to promote work could adopt the Medicaid expansion, close the coverage gap, and eliminate the work disincentives the gap can create. Instead, states with coverage gaps for low-income parents — including Alabama, Kansas, Mississippi, Oklahoma, and South Dakota — are proposing to cut off coverage for very low-income parents who don't satisfy work requirements.

In no state are work requirements likely to significantly increase employment. Studies of work requirements in other federal programs have found that they generally have only modest and temporary employment effects, largely failing to increase long-term employment or reduce poverty.¹¹ Meanwhile, by taking away coverage and impeding access to needed health care, work requirements in Medicaid may make it harder for some people to find or keep a job. Majorities of working people who gained coverage through the Medicaid expansion in Ohio and Michigan reported that it made them better at their jobs or made it easier for them to keep working, and majorities of non-working people reported that it made it easier for them to look for work.¹² Conversely, Medicaid work requirements may set off a vicious cycle for some working enrollees, where health problems that lead to job loss also lead to loss of coverage, making it harder to regain health and employment.¹³

But in non-expansion states with very low income eligibility levels for parents, such as Alabama, Kansas, and Mississippi, the basic logic of work requirement proposals breaks down, because even parents who manage to meet the requirement will still be at risk of losing coverage. Some of these proposals create literal catch-22s, where the income of parents who meet the work-requirement standard by working a sufficient number of hours will exceed the state's Medicaid income limit, even if they earn only the minimum wage. (See Figure 1 and Appendix Table 1.) In other states, parents

¹⁰ Matthew Buettgens, "The Implications of Medicaid Expansion in the Remaining States: 2018 Update," Urban Institute, May 17, 2018, <https://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2018-update>.

¹¹ LaDonna Pavetti, "Work Requirements Don't Work," Center on Budget and Policy Priorities, January 10, 2018, <https://www.cbpp.org/blog/work-requirements-dont-work>.

¹² Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," January 2017, <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>. See also Kara Gavin, "Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches," University of Michigan Health Lab, June 27, 2017, <http://labblog.uofmhealth.org/industry-dx/medicaid-expansion-helped-enrollees-do-better-at-work-or-job-searches>.

¹³ 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>.

could theoretically satisfy the work requirement and keep their earnings below the Medicaid income cut-off, but they would risk losing coverage and becoming uninsured if they took a job with wages above the minimum wage or further increased their hours. (The Appendix provides a full list of the non-expansion states that are proposing work requirements.¹⁴)

Most state proposals allow enrollees to comply with work requirements by volunteering or participating in job training, which would avoid the increase in income. But a work requirement policy under which parents can keep their coverage only by *avoiding* paid employment does not create work incentives. Moreover, as explained later in this analysis, many parents trying to comply by engaging in unpaid activities would likely still lose coverage.

Some parents would be eligible to receive transitional medical assistance (TMA) if they would otherwise lose eligibility for Medicaid due to new or increased earnings. But TMA doesn't solve the catch-22, both because it's time limited and because not all parents with earnings would qualify. In general, to qualify, low-income parents must have met Medicaid eligibility requirements in three out of the last six months before their income increased above the state's eligibility limit.¹⁵ Some parents, particularly new Medicaid enrollees, may not meet the requirement for prior coverage and thus may not qualify for TMA even if they fully comply with the work requirement after they enroll. Even for those who do qualify, many parents lose TMA coverage even before the 12-month eligibility period ends due to onerous TMA reporting requirements that apply during TMA's last six months. Moreover, Alabama — a non-expansion state seeking a work requirement and which has the lowest income eligibility in the country (at 18 percent of the poverty line or \$2,963 a year for a family of two) — is also seeking a waiver to limit TMA to six months.¹⁶

Catch-22 Can't Be Fixed

At a recent press briefing, Administrator Verma reiterated concerns with non-expansion state work requirement proposals, but also commented, "I think that when we work with those states, it's our intent to be able to approve waivers for expansion states and non-expansion states."¹⁷ She has not explained how she thinks states like Kansas and Mississippi could address the catch-22 created by work requirement policies, but there are a few approaches that states might attempt. None of them change the basic fact that, in states that have not expanded Medicaid and have coverage gaps for low-income parents, many parents who meet work requirements, as well as those who do not, would be at risk of losing coverage.

¹⁴ As noted in the Appendix, a few non-expansion states with proposals to terminate Medicaid for those not meeting work requirements don't have a coverage gap for parents because they provide coverage to parents with incomes up to the poverty line.

¹⁵ States have had the option since 2009 of waiving the prior coverage requirement and the reporting requirements. But of the non-expansion states with work requirement proposals, only Alabama and Tennessee waive the reporting requirements, and none of these states waive the prior coverage requirement, according to a search of state plan amendments on the CMS website.

¹⁶ Medicaid Workforce Initiative, State of Alabama, February 27, 2018, http://www.medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_Requirements/2.7.5_Final_Work_Requirements_Waiver_Bookmarked_2-27-18.pdf.

¹⁷ James Romoser, "CMS Weighs How to Allow Medicaid Work Requirements in Non-Expansion States Without Risking 'Subsidy Cliff,'" Inside Health Policy, June 5, 2018.

Specifically, some states might try to build on TMA to provide additional transitional help to people whose incomes rise above Medicaid eligibility limits. But this approach has the same limitations as TMA — it offers only temporary help and may not cover all of those affected. Moreover, such proposals to try to address the catch-22 will make even temporary coverage unaffordable for many people if states design them to limit the proposals' costs.

For example, South Dakota, which limits coverage to parents with incomes below 50 percent of the poverty line, recently released a work requirement proposal for comment that some have argued addresses the catch-22.¹⁸ The state would provide parents whose incomes increase above Medicaid limits with premium assistance (i.e. subsidies to help them pay premiums for private coverage) for up to 12 months, following the 12 months of TMA. But after 24 months, parents would still be on their own, with no assistance to pay for health insurance.

Furthermore, South Dakota's premium assistance program would not provide enough help to allow low-income parents to actually afford coverage and care. According to the state's proposal, low-income working parents could use premium assistance, which would be set at the average per enrollee amount that the state spent on TMA in the prior year, to pay their premiums for employer coverage or for a qualified health plan in the individual insurance market. As discussed above, however, few parents employed in low-wage jobs would likely have an offer of employer coverage; and in the individual market, South Dakota's premium assistance program would only cover the cost of a "bronze" plan for most parents.¹⁹ Bronze plan deductibles average about \$6,000, likely an insurmountable barrier for many people with incomes below the poverty line to afford care, and South Dakota would provide no assistance with cost sharing.²⁰

A second possibility is that CMS might decide to allow non-expansion states to impose work requirements provided that individuals can satisfy the requirements through unpaid activities such as volunteering or job training as well as through paid employment. Most pending state proposals would permit this.

Such a work requirement, however, would create a *disincentive* for paid employment relative to other activities, since paid employment, unlike these other activities, would cause enrollees to lose Medicaid. Moreover, conditioning Medicaid on unpaid work could run afoul of the Fair Labor Standards Act (FLSA), which requires that all individuals be compensated in an amount equal to at least the minimum wage in exchange for hours they work. States can operate "workfare" programs as part of their Supplemental Nutrition Assistance Programs (SNAP), for example, but participants

¹⁸ Virgil Dickson, "South Dakota adds a safety net to its Medicaid work requirement waiver," Modern Healthcare, May 23, 2018, <http://www.modernhealthcare.com/article/20180523/NEWS/180529975/south-dakota-adds-a-safety-net-to-its-medicaid-work-requirement>.

¹⁹ "Career Connector, A South Dakota 1115 Demonstration Proposal," https://dss.sd.gov/docs/medicaidstateplan/career_connector_application.pdf. According to the proposal, the monthly cost of premium assistance would be \$408.41 in 2019. In 2018, a silver plan for a 30-year-old parent would cost \$454 a month, while a bronze plan would cost \$342, according to the Kaiser Family Foundation Health Insurance Marketplace Calculator, <https://www.kff.org/interactive/subsidy-calculator/>.

²⁰ Kaiser Family Foundation, "Cost-Sharing for Plans Offered in the Federal Marketplace for 2018," November 3, 2017, <https://www.kff.org/health-reform/fact-sheet/cost-sharing-for-plans-offered-in-the-federal-marketplace-for-2018/>.

can be required to work only for a set number of hours based on their SNAP benefit divided by the higher of the state or federal minimum wage.²¹ In these programs, participants are essentially working for their benefits at the minimum wage. But this isn't possible in Medicaid, as the FLSA doesn't allow states to count health insurance as wages.²²

Even if labor laws are interpreted as allowing states to require people to volunteer to receive Medicaid, volunteer work is unlikely to offer most parents a viable way to keep their coverage, since suitable volunteer opportunities would not be readily available for most of those affected by work requirements. Agencies that utilize volunteers usually require them to have specific skills and go through training and vetting. There is no guarantee that low-income parents could find a suitable volunteer position allowing them to meet the work requirement.

Requiring enrollees to engage in job training raises similar problems. Current proposals don't provide any assurance that suitable job training would be available to enrollees at no cost to them, or that the transportation and child care they would need to participate would be available, either. In fact, CMS guidance on work requirements specifically *prohibits* Medicaid reimbursement for job training, child care, or transportation.²³ Kentucky's approved waiver, for example, merely calls on the state to "make good faith efforts" to connect enrollees to such supports.²⁴

Loss of Coverage Will Harm Parents and Children

The catch-22 feature of non-expansion state work requirements undercuts the argument that these proposals will benefit enrollees or state economies by strengthening work incentives. But the larger problem with these proposals, as with expansion state proposals, is that large numbers of people will lose coverage because they do not meet the work requirement or satisfy the associated documentation and paperwork requirements. Those who will lose coverage include working parents who have difficulty documenting their work activities or meeting the required number of hours each and every month, as well as parents who might qualify for exemptions — because they have a disability, mental illness, or substance use disorder, for example — but are unable to provide the documentation required to prove it.²⁵ And — particularly in non-expansion states, where everyone subject to the requirements would be a parent or caregiver — they will include many parents who cannot balance child care responsibilities with working 80 hours or more every month.

²¹ 7 U.S.C. §2929(a)(1).

²² Department of Labor, "How Workplace Laws Apply to Welfare Recipients," May 22, 1997, <http://nclj.org/wp-content/uploads/2015/11/LaborProtectionsAndWelfareReform.pdf>.

²³ Centers for Medicare & Medicaid Services, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," SMD: 18-001, January 11, 2018, <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf>.

²⁴ Centers for Medicare & Medicaid Services, Special Terms and Conditions: KY HEALTH 1115 Demonstration, January 12, 2018, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf>.

²⁵ Jennifer Wagner and Judith Solomon, "States' Complex Medicaid Waivers Will Create Costly Bureaucracy and Harm Eligible Beneficiaries," Center on Budget and Policy Priorities, May 23, 2018, <https://www.cbpp.org/research/health/states-complex-medicaid-waivers-will-create-costly-bureaucracy-and-harm-eligible>.

None of the approved or pending Medicaid work requirements proposals guarantee child care assistance for enrollees who need it. Even with the additional federal funds for child care provided in the 2018 appropriations bill, it is estimated that only 1 in 5 eligible children nationwide will receive help.²⁶ Moreover, while most of the *expansion* states seeking work requirements are proposing to exempt at least parents of young children (and some would exempt all parents), the *non-expansion* state proposals generally fail to exempt more than a very small share of this group. For example, Alabama and South Dakota propose to apply work requirements to parents except those with a child under 1 year old. Without child care assistance, many parents will likely be unable to comply with the requirements through work or other activities.

Medicaid coverage improves access to care and health, and losing coverage will worsen access and health for these parents.²⁷ In addition, when parents lose coverage, their children's health and development can be put at risk.²⁸ The data show that expansions of Medicaid eligibility for parents have led to increased enrollment of children who were already eligible for coverage. Increased enrollment has occurred not only when states expanded Medicaid under health reform but also in prior expansions of Medicaid eligibility for parents.²⁹ Research also confirms that gains in coverage for parents, and the associated gains for children, improve children's access to care, such as well-child visits.³⁰

Children also suffer directly when their parents lose coverage. Without health insurance, families' financial security is at risk from increased medical debt. Financial insecurity doesn't just affect adults; adverse effects that can result from poverty, such as toxic stress, can also negatively affect children's development.³¹ Children also suffer when parents can't access treatment for such conditions as maternal depression.³²

In short, children benefit when their parents can access the physical and mental health care that they need and can suffer when their parents are shut out of care.

²⁶ David Reich and Chloe Cho, "Unmet Needs and the Squeeze on Appropriations," Center on Budget and Policy Priorities, May 19, 2017, <https://www.cbpp.org/research/federal-budget/unmet-needs-and-the-squeeze-on-appropriations>.

²⁷ Katch, Wagner, and Aron-Dine, *op cit*.

²⁸ Center on Budget and Policy Priorities, "Harm to Children From Taking Away Medicaid From People for Not Meeting Work Requirements," April 11, 2018, <https://www.cbpp.org/research/health/harm-to-children-from-taking-away-medicaid-from-people-for-not-meeting-work>.

²⁹ *Ibid*.

³⁰ Maya Venkataramani, Craig Evan Pollack, and Eric T. Roberts, "Spillover Effects of Adult Medicaid Expansions on Children's Use of Preventive Services," *Pediatrics*, December 2017, <http://pediatrics.aappublications.org/content/140/6/e20170953>.

³¹ American Academy of Pediatrics, "Poverty and Child Health in the United States," *Pediatrics*, December 2016, <http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf>.

³² Joan Alker and Olivia Golden, "Medicaid Expansion Helps Kids by Helping Moms Get Care for Maternal Depression," Georgetown Center for Children and Families, <https://ccf.georgetown.edu/2016/07/21/medicaid-expansion-helps-kids-helping-moms-get-care-maternal-depression/>.

Appendix: Non-Expansion States with Proposals to Take Coverage Away from People Who Don't Meet Work Requirements

Alabama's income eligibility limit for parents is just *18 percent* of the poverty line. The state comment period for its proposal to take coverage away from parents who don't work closed on April 2, 2018, but the proposal hasn't yet been submitted to CMS. Under the proposal, parents of children under 6 would have to work or engage in work-related activities for 20 hours a week while parents of older children would have to work at least 35 hours a week.³³

Kansas' income eligibility limit for parents is 38 percent of the poverty line. Its waiver proposal is pending at CMS. The state also sought to limit Medicaid coverage to three months in a 36-month period for people not meeting the work requirement and put a time limit of 36 months on those meeting the requirement. Parents in single-parent households would have to work 20 hours a week if they have a child under 6 and 30 hours if they have an older child. Parents in two-parent households would have to work a total of 35 or 55 hours a week depending on the age of the child. CMS rejected the time limit proposal on May 7, telling the state it would help it identify a "workable approach" to developing a work requirement.³⁴

Maine's income eligibility limit for parents is 105 percent of the poverty line, meaning that, while Maine has not expanded Medicaid, it does not have a coverage gap for parents. (Adults *without* children who have incomes below the poverty line are ineligible for both Medicaid and subsidized marketplace coverage.) In November 2017, voters approved a ballot initiative committing the state to expand Medicaid, but Maine's governor hasn't taken the steps necessary to expand. The state's proposal to impose a work requirement on parents and other groups, including former foster care children and people whose coverage is limited to family planning services, is pending at CMS.³⁵

Mississippi's income eligibility limit for parents is 27 percent of the poverty line. Its proposal is pending at CMS. Parents would have to work or engage in work-related activities for at least 20 hours a week.³⁶

Oklahoma's income eligibility limit for parents is 43 percent of the poverty line. Recently enacted legislation requires submission of a waiver for a work requirement aligning with the requirement in SNAP that applies to adults without dependent children, which would require non-exempt parents to work 20 hours a week or lose their coverage.³⁷

³³ Medicaid Workforce Initiative, http://www.medicaid.alabama.gov/content/2.0_Newsroom/2.7_Special_Initiatives/2.7.5_Work_Requirements.aspx.

³⁴ KanCare 2.0 Section 1115 Demonstration Renewal Application, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ks/ks-kancare-pa3.pdf>.

³⁵ State of Maine, 1115 Waiver Application, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-mainecare-pa.pdf>.

³⁶ Medicaid Workforce Training Initiative 1115 Demonstration Waiver Application, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ms/ms-workforce-training-initiative-pa.pdf>.

³⁷ Enrolled House Bill 2932, http://webserver1.lsb.state.ok.us/cf_pdf/2017-18%20ENR/hB/HB2932%20ENR.PDF.

South Dakota's income eligibility limit for parents is 50 percent of the poverty line. Its proposal is up for comment at the state level until June 19. Parents would have to meet certain milestones identified by the state and eventually work 80 hours or more a month.³⁸

Tennessee's income eligibility limit for parents is 98 percent of the poverty line, meaning that while Tennessee has not expanded Medicaid, it has only a small coverage gap for parents. State legislation requires the state to submit a waiver proposal with a work requirement for parents of children aged 6 and older. Tennessee wants to use unspent funds from its Temporary Assistance for Needy Families program to implement the waiver.³⁹

Utah's proposal, which is pending at CMS, would apply to enrollees in the state's Primary Care Network (PCN). The PCN provides primary care services (not comprehensive Medicaid coverage) to a limited number of adults with incomes up to the poverty line. PCN enrollees would have to participate in job search or job training as a condition of eligibility.⁴⁰

Wisconsin's income eligibility limit for parents is 100 percent of the poverty line, and the state also covers adults without children with incomes up to that level, so while Wisconsin hasn't expanded Medicaid, it doesn't have a coverage gap for parents or childless adults. Its work requirement proposal, pending at CMS, would apply to adults without children. Months that these adults don't work or engage in job training would count towards a 48-month time limit on benefits. Adults who reach the time limit would be ineligible for six months.⁴¹

APPENDIX TABLE 1

Monthly Medicaid Income Limits vs. Earnings from 80 Hours of Minimum-Wage Work in Selected States Seeking to Impose Work Requirements

	Medicaid Eligibility Level as a Percentage of Poverty	Monthly Eligibility Level for a Single Parent with One Child	Minimum Wage for 80 Hours
Alabama	18%	\$247	\$580
Kansas	38%	\$521	\$580
Mississippi	27%	\$370	\$580
Oklahoma	43%	\$590	\$580
South Dakota	50%	\$686	\$708

Note: Includes states that have not expanded Medicaid, are seeking to impose work requirements on adults eligible for comprehensive Medicaid coverage, and have a significant coverage gap for low-income parents.

Source: CBPP calculations using information from the Kaiser Family Foundation, minimum wage data, and state Medicaid waiver applications.

³⁸ Career Connector, A South Dakota 1115 Demonstration Proposal, https://dss.sd.gov/docs/medicaidstateplan/career_connector_application.pdf.

³⁹ Tennessee Public Chapter No. 869, <http://publications.tnsosfiles.com/acts/110/pub/pc0869.pdf>.

⁴⁰ Utah 1115 PCN Demonstration Waiver Amendment #20, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/ut-primary-care-network-pa3.pdf>.

⁴¹ State of Wisconsin, Section 1115 Demonstration Waiver Amendment Application, June 7, 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-pa.pdf>



Work Requirements: A One-Way Ticket to the Coverage Gap **An analysis of the incompatibility of work requirements with income eligibility levels in Medicaid non-expansion states**

Introduction

The Department of Health and Human Services (HHS) and Centers for Medicare & Medicaid Services (CMS) recently published a letter to state Medicaid directors announcing they will allow work requirements in Medicaid. The announcement marks an unprecedented departure from the goals of the program, as HHS had historically always rejected Section 1115 Medicaid waiver applications (“1115 waivers”) with work requirements out of the belief that they do not promote Medicaid’s objectives.¹

In anticipation of this policy change, 11 states have submitted 1115 waivers to CMS containing work requirements: Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, Mississippi, New Hampshire, North Carolina, Utah, and Wisconsin, with four (Kansas, Mississippi, Utah and Wisconsin) proposing them on the “traditional” Medicaid populations, as these states have not yet fully expanded Medicaid.² Additionally, other non-expansion states are considering work requirement legislation in their upcoming legislative sessions.³

Analysis and Conclusion

Since most Medicaid non-expansion states have very low FPL levels for income eligibility limits, we conducted an analysis to examine whether it’s even possible for parents in these states to meet both the income eligibility and work requirements and still be eligible for Medicaid. Our analysis found that if a parent is the only income-earner in a household of two, he or she would remain eligible for Medicaid **in only 6 states** - Nebraska, South Carolina, Tennessee, Utah, Wisconsin and Wyoming - if he or she also complied with a 20-hour per week work requirement

¹ Kaiser Family Foundation: *Section 1115 Medicaid Expansion Waivers: A Look at Key Themes and State Specific Provisions*; August 16, 2017, <https://www.kff.org/report-section/section-1115-medicaid-expansion-waivers-a-look-at-key-themes-appendix/#table4>

² Kaiser Family Foundation: *Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers*; September 13, 2017, <https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers/>. Kaiser Family Foundation: *Proposed Medicaid 1115 Waivers in Maine and Wisconsin*; August 16, 2017, <https://www.kff.org/medicaid/issue-brief/proposed-medicaid-section-1115-waivers-in-maine-and-wisconsin/>

³ Virginia Legislature, House Bill No. 338, *A Bill to require the Secretary of Health and Human Resources to apply for a waiver to implement a work requirement for able-bodied adult recipients of medical assistance services*, <http://lis.virginia.gov/cgi-bin/legp604.exe?181+ful+HB338>. See also, Dana Ferguson, *Gov. Daugaard to seek work requirement for Medicaid recipients*, Sioux Falls Argus Leader, January 9, 2018, <http://www.argusleader.com/story/news/politics/2018/01/09/gov-daugaard-seek-work-requirement-medicaid-recipients/1015099001/>

in a minimum wage position.⁴ If a household of four has two minimum wage earners, households **in only 3 states** - South Carolina, Tennessee and Wisconsin - would be able to meet both requirements.

Not only will work requirements in these states make those required to comply with them ineligible for Medicaid, they will also likely leave these individuals without *any* coverage options. First, minimum wage jobs are more likely to be with employers who don't offer health coverage.⁵ Secondly, individuals working 20 hours per week and earning minimum wage do not make enough to reach 100% FPL, and therefore are not eligible for financial assistance on the Affordable Care Act's marketplaces. Therefore, for Medicaid-eligible individuals in non-expansion states, imposing work requirements represents a one-way ticket to being in the coverage gap and uninsured.

The catch-22 that work requirements in Medicaid non-expansion states place applicants in can be added to the growing list of reasons why work requirements are unworkable in Medicaid overall. Work requirements in other programs such as TANF have historically not been shown to help individuals gain or maintain employment, while they have proven to be administratively burdensome for states to administer and for beneficiaries to comply with. Rather than help low-income individuals find work, work requirements will merely place barriers between individuals and their health care. Additionally, as this analysis shows, by causing those who comply with the requirement to be ineligible for both Medicaid and the marketplaces, work requirements will leave these individuals with virtually no coverage options, which will make it harder for them to stay healthy, and therefore make it harder for them to work.

Methodology

There are two charts below. The first analyzes whether: 1) a parent in a family of two in a Medicaid non-expansion state earning minimum wage could continue to remain eligible based on income while also meeting a hypothetical 20-hour per week work requirement,⁶ as well as how many hours per week a parent could work in a minimum wage position before losing Medicaid eligibility. The second chart performs the same analysis for a household of four, with two parents/adults earning minimum wage. Both charts calculate the annual income of households

⁴ All work requirement proposals in 1115 waivers submitted thus far are a 20-hour per week minimum with the exception of Indiana and New Hampshire, which seek to impose minimum work hours on enrollees based on length of enrollment.

⁵ According to Kaiser Family Foundation, only 30% of households with incomes below 100% FPL received an offer of employer-sponsored insurance compared to almost 80% of households with incomes above 400% FPL. See Kaiser Family Foundation: *Trends in Employer-Sponsored Insurance Offer and Coverage Rates: 1999-2014*; March 2016, <https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/>

earning minimum wage while meeting a 20-hour per week work requirement and compare it to the respective maximum annual income for Medicaid eligibility in a state. It's also worth noting that while some states seek work requirements for the Medicaid expansion population, this analysis only focuses on the impact of work requirements in non-expansion states.

Could a family of 2 earning min. wage remain eligible for Medicaid if meeting a work requirement?						
State⁷	<u>Medicaid Eligibility Level for Parents</u>	<u>Annual Income for Family of 2</u> (100% FPL = \$16,460 in 2018)	<u>Minimum Wage</u> (Federal minimum wage = \$7.25)	Annual income if 1 household member meets work requirement of 20 hours per week (min.) on min. wage	Eligible for Medicaid if meeting if working 20 hours per week?	How many hours per week could a parent work before losing eligibility?
Alabama	18% FPL	\$2963	No state law - federal min wage law applies (\$7.25)	\$7540	No	7.5
Florida	33% FPL	\$5432	\$8.10	\$8424	No	12.5
Georgia	37% FPL	\$6090	\$5.15 - (\$7.25 - federal min wage law applies when state min wage law is lower)	\$7540	No	16
Idaho	26% FPL	\$4280	\$7.25	\$7540	No	11

⁷ Bolded rows indicate parents in the state who could maintain eligibility for Medicaid while also complying with a 20-hour per week work requirement.

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Kansas	38% FPL	\$6255	\$7.25	\$7540	No	16.5
Mississippi	27% FPL	\$4444	No state law (\$7.25)	\$7540	No	11.5
Missouri	22% FPL	\$3621	\$7.70	\$8008	No	9
Nebraska	63% FPL	\$10,370	\$9.00	\$9360	Yes	22
North Carolina	44% FPL	\$7242	\$7.25	\$7540	No	19
Oklahoma	44% FPL	\$7242	\$7.25	\$7540	No	19
South Carolina	67% FPL	\$11,028	No state law (\$7.25)	\$7540	Yes	29
South Dakota	51%	\$8395	\$8.65	\$8996	No	18.5
Tennessee	99% FPL	\$16,295	No state law (\$7.25)	\$7540	Yes	43
Texas	18% FPL	\$2963	\$7.25	\$7540	No	7.5
Utah	60% FPL	\$9876	\$7.25	\$7540	Yes	26
Virginia	38% FPL	\$6255	\$7.25	\$7540	No	16.5
Wisconsin	100% FPL	\$16,460	\$7.25	\$7540	Yes	43.5
Wyoming	56% FPL	\$9218	\$5.15 - (\$7.25)	\$7540	Yes	24

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Could a family of 4 with 2 min. wage earners remain eligible if meeting a work requirement?						
State	<u>Medicaid Eligibility Level for Parents</u>	Annual Income Eligibility for Family of 4 - (100% FPL = \$25,100 in 2018)	<u>Minimum Wage</u> (Federal minimum wage = \$7.25)	Annual income if 2 household members meet work requirement of 20 hours per week (min.) on min. wage	Eligible for Medicaid if working 20 hours per week?	How many hours per week could 2 earners work before losing eligibility?
Alabama	18% FPL	\$4,518	No state law - federal min wage law applies (\$7.25)	\$15,080	No	11.5
Florida	33% FPL	\$8,283	\$8.10	\$16,848	No	19.5
Georgia	37% FPL	\$9,287	\$5.15 - (\$7.25 - federal min wage law applies when state min wage law is lower)	\$15,080	No	24.5
Idaho	26% FPL	\$6,526	\$7.25	\$15,080	No	17
Kansas	38% FPL	\$9,538	\$7.25	\$15,080	No	25
Mississippi	27% FPL	\$6,777	No state law (\$7.25)	\$15,080	No	17.5
Missouri	22% FPL	\$5,522	\$7.70	\$16,016	No	13.5
Nebraska	63% FPL	\$15,813	\$9.00	\$18,720	No	33

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North Carolina	44% FPL	\$11,044	\$7.25	\$15,080	No	29
Oklahoma	44% FPL	\$11,044	\$7.25	\$15,080	No	29
South Carolina	67% FPL	\$16,817	No state law (\$7.25)	\$15,080	Yes	44.5
South Dakota	51%	\$12,801	\$8.65	\$17,992	No	28
Tennessee	99% FPL	\$24,849	No state law (\$7.25)	\$15,080	Yes	65.5
Texas	18% FPL	\$4,518	\$7.25	\$15,080	No	11.5
Utah	60% FPL	\$15,060	\$7.25	\$15,080	No	39.5
Virginia	38% FPL	\$9,538	\$7.25	\$15,080	No	25
Wisconsin	100% FPL	\$25,100	\$7.25	\$15,080	Yes	66.5
Wyoming	56% FPL	\$14,056	\$5.15 (\$7.25)	\$15,080	No	37

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CMS warns non-expansion states to rethink Medicaid work rules



CMS Administrator Seema Verma

By [Virgil Dickson](#)

The CMS worries that some will lose coverage if it approves work requirements in states that haven't yet expanded Medicaid.

The agency has already approved work requirement waivers in Arkansas, Indiana and Kentucky—all of which expanded Medicaid under the Affordable Care Act. The non-expansion states of Kansas, Maine, Mississippi, Utah and Wisconsin are also asking to require Medicaid enrollees to be either working or looking for a job. Tennessee and Virginia are also reportedly planning to submit such requests.

During a news briefing Tuesday, CMS Administrator Seema Verma said she is worried about a "subsidy cliff."

That would happen if a person earns enough to render him ineligible for Medicaid, but it's not enough to qualify him for financial assistance on the individual insurance exchanges, leaving him without coverage.

"Because there is no tax credit for them to move on to the exchanges, what happens to those individuals?" Verma asked. "We need to figure out a pathway, a bridge to self-sufficiency."

Verma did not rule out approving such waivers, but rather emphasized CMS and the states are seeking solutions.

Her remarks come just days after HHS filed a legal brief in the [litigation of Kentucky's plan](#) to impose work requirements.

In that briefing, the Trump administration said it viewed work requirements primarily as an option for adults in expansion states. The White House seemed wary on their use for other populations.

"Community-engagement initiative would make little sense for vulnerable low-income individuals likely to need medical assistance," HHS said in the April 26 legal filing. "There is nothing irrational in requiring able-bodied adults who are capable of performing community service, working, or going to school to do so as a condition of Medicaid eligibility."

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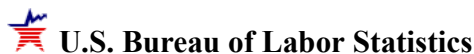


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Table 2. Medical care benefits: Access, participation, and take-up rates

Table 2. Medical care benefits: Access, participation, and take-up rates,(1) March 2017

(All workers = 100 percent)

Characteristics	Civilian(2)			Private industry			State and local government		
	Access	Particip- ation	Take-up rate	Access	Particip- ation	Take-up rate	Access	Particip- ation	Take-up rate
All workers.....	70	52	74	67	49	72	89	71	80
Worker characteristics									
Management, professional, and related.....	88	67	76	86	65	75	92	72	79
Management, business, and financial.....	95	73	77	95	73	76	-	-	-
Professional and related.....	85	64	76	82	61	74	91	71	78
Teachers.....	84	63	75	-	-	-	92	71	77
Primary, secondary, and special education school teachers.....	95	70	74	-	-	-	99	75	76
Registered nurses....	86	63	73	-	-	-	-	-	-
Service.....	44	29	66	39	23	61	80	65	81
Protective service.....	68	51	75	41	21	52	89	73	82
Sales and office.....	68	49	72	66	47	71	89	73	83
Sales and related.....	54	37	69	54	37	69	-	-	-
Office and administrative support	76	55	73	74	53	71	90	74	83
Natural resources, construction, and maintenance.....	74	59	79	72	57	79	95	78	82
Construction, extraction, farming, fishing, and forestry..	67	56	83	65	54	83	-	-	-
Installation, maintenance, and repair	81	62	77	79	60	76	-	-	-
Production, transportation, and material moving.....	75	56	74	75	55	74	85	69	82
Production.....	81	62	76	81	62	76	-	-	-
Transportation and material moving.....	69	50	72	69	49	71	-	-	-
Full time.....	88	65	75	85	63	73	99	80	80
Part time.....	19	12	61	19	11	60	27	19	70
Union.....	94	76	81	93	79	84	95	73	77
Nonunion.....	67	48	72	65	46	71	83	69	83
Average wage within the following categories:(3)									
Lowest 25 percent.....	37	23	63	33	20	60	72	58	80
Lowest 10 percent....	24	14	57	22	12	55	59	46	78
Second 25 percent.....	75	53	72	71	49	69	93	76	81
Third 25 percent.....	87	67	77	85	64	76	97	78	81
Highest 25 percent.....	93	73	78	92	72	78	95	74	78
Highest 10 percent...	94	73	78	94	73	78	93	74	80

Establishment characteristics									
Goods-producing industries.....	85	67	80	85	67	80	-	-	-
Service-providing industries.....	68	49	72	64	45	70	89	71	80
Education and health services.....	79	58	73	73	51	69	90	70	78
Educational services	86	66	77	75	56	74	90	69	77
Elementary and secondary schools..	88	66	75	-	-	-	90	68	76
Junior colleges, colleges, and universities.....	90	72	80	90	70	78	90	74	82
Health care and social assistance....	75	52	70	73	50	68	91	77	84
Hospitals.....	91	68	75	-	-	-	91	77	84
Public administration..	90	75	83	-	-	-	90	75	83
1 to 99 workers.....	57	41	71	55	39	70	85	68	80
1 to 49 workers.....	53	37	71	51	36	70	82	67	82
50 to 99 workers.....	70	50	72	67	47	71	89	69	78
100 workers or more.....	84	63	75	82	61	74	90	72	80
100 to 499 workers.....	79	58	74	78	57	73	86	69	80
500 workers or more....	90	69	77	89	67	76	92	73	80
Geographic areas									
Northeast.....	71	52	74	68	50	73	87	68	78
New England.....	70	49	70	67	46	70	88	64	73
Middle Atlantic.....	71	53	75	69	51	74	87	69	80
South.....	71	52	74	68	48	71	93	77	83
South Atlantic.....	70	51	73	67	47	71	91	75	83
East South Central.....	74	56	75	70	51	72	92	83	90
West South Central.....	71	53	74	67	48	72	96	78	81
Midwest.....	71	50	70	68	47	69	85	64	75
East North Central.....	70	49	70	69	47	69	83	64	77
West North Central.....	71	50	71	68	48	71	88	63	72
West.....	69	54	78	66	51	77	88	70	80
Mountain.....	68	52	76	66	50	76	86	67	78
Pacific.....	69	54	79	66	51	78	89	72	81

1 The take-up rate is an estimate of the percentage of workers with access to a plan who participate in the plan, rounded for presentation.

2 Includes workers in private industry and state and local government. See Technical Note for further explanation.

3 Surveyed occupations are classified into wage categories based on the average wage for the occupation, which may include workers with earnings both above and below the threshold. The categories were formed using percentile estimates generated using wage data for March 2017.

Note: Dash indicates no workers in this category or data did not meet publication criteria. For definitions of major plans, key provisions, and related terms, see the "Glossary of Employee Benefit Terms" at www.bls.gov/ncs/ebs/glossary20162017.htm.

Source: Bureau of Labor Statistics, National Compensation Survey.

[Table of Contents](#)

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