January 11, 2018

VIA U.S. MAIL AND ELECTRONIC SUBMISSION

Brian Neale, Director
Centers for Medicare & Medicaid Services
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: State Medicaid Director Letter, "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries"

Dear Director Neale:

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people.

Earlier today, the Centers for Medicare & Medicaid Services (CMS) sent a letter to State Medicaid Directors titled "Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries," which purports to justify imposing punitive work requirements on Medicaid beneficiaries to achieve better health outcomes. The letter suggests that the Secretary would deem such a requirement likely to promote the objectives of the Medicaid Act.

We have grave concerns, both procedural and substantive, regarding this letter. It not only reverses current agency policy that consistently and adamantly rejects work requirements, but it does so without soliciting public comment or feedback. While members of the public have commented on the work requirements proposed by several states in pending section 1115 waiver applications, as advocates, we had no opportunity to respond to the various, specific issues raised in CMS's letter. As a result, these state-specific comments fall far short of the type of public notice and comment that typically attaches to such a significant about face.

Moreover, CMS's novel proposition that work requirements are consistent with the objectives of the Medicaid Act comes only after the state and federal comment periods have closed on at least seven state

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proposals that contain work requirements. The timing of CMS's letter has precluded any opportunity to comment on how or whether various states' waiver applications address specific requirements and policy issues the letter identifies, such as exception processes, budget neutrality, and evaluation design. By waiting to issue this substantive letter for so long, CMS has effectively undermined stakeholders' ability to comment meaningfully during these prior comment periods.

Equally troubling, CMS's rationale in the letter entirely ignores the wealth of literature regarding the negative health consequences of work requirements, which was repeatedly cited by NHeLP and others in those state-specific comments. It appears that CMS has decided on a policy position first and then cherry-picked a small number of studies in an effort to justify this drastic shift in agency policy. However, as the attached and incorporated by reference Statement of Review from LaDonna Pavetti, an expert on work requirements, explains, the studies that CMS cites do not support its conclusion that punitive work requirements are likely to improve health outcomes.

Accordingly, NHeLP urges CMS to re-open or extend the public comment periods for all pending section 1115 waiver applications that seek to impose work requirements as a condition of eligibility, including Arizona, Arkansas, Indiana, Kansas, Kentucky, Maine, New Hampshire, North Carolina, Utah, and Wisconsin. A re-opened comment period will allow all stakeholders a meaningful opportunity to provide input to CMS's newly announced policy.

Thank you for your consideration.

Sincerely,

Jane Perkins
Legal Director
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Statement of Review

My name is LaDonna Pavetti. I am Vice President for Family Income Support at the Center on Budget and Policy Priorities where I lead our work on the Temporary Assistance for Needy Families (TANF) program and our analysis of poverty trends. I have been doing work on the implementation and effectiveness of TANF since it was created in 1996. Prior to coming to the Center, I worked as a Senior Fellow at Mathematica Policy Research, Inc., one of the nation's top program evaluation firms that has conducted numerous rigorous evaluations of social programs, including TANF. I hold a Ph.D. in public policy from the Kennedy School of Government at Harvard University where I conducted research on movement on and off the Aid to Families with Dependent Children (AFDC) program, which was the precursor to TANF.

One of my areas of expertise is the effect of mandatory work requirements as they have been applied in TANF. I have examined the literature assessing the effectiveness of work requirements extensively and have been asked to present testimony to Congress on this topic multiple times. I also served on the advisory group for a comprehensive synthesis of the impacts of welfare reform on families' employment and earnings.

I have read the Dear State Medicaid Director letter re: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, issued by the Department of Health and Human Services Centers for Medicare & Medicaid Services on January 11, 2018. CMS cites seven resources to support of its assertion that punitive work requirements are likely to improve health outcomes. I have reviewed the cited materials. As discussed below, those studies do not support CMS's conclusion.

First, as a general matter, none of the articles that CMS has relied upon suggest that *requiring* work as a condition of eligibility is likely to promote health outcomes. In fact, the 2006 literature review from Waddell and Burton actually reports evidence to the contrary. It cites strong research finding that forcing people off public benefit programs has negative consequences. In its summary of research on people who leave public benefits programs, the review finds that "[t]he net result is that interventions which encourage and support claimants to come off benefits and successfully get them (back) into work are likely to improve their health and well-being; interventions which simply force claimants off benefits are more likely to harm their health and well-being."[1]

Despite these findings from its own cited study, CMS has decided that it will permit punitive work requirements that will force beneficiaries to lose benefits, while at the same time refusing to offer states federal funding for the work supports that this and other studies have found actually improve health outcomes. Absent a major infusion of state dollars to bolster such supports – which no state has proposed to do – any mandatory work requirement cannot realistically expect to increase employment rates. To the contrary, such an approach directly contradicts the evidence before the agency and will inevitably force some people off Medicaid and force others to seek low-wage, temporary employment with erratic work schedules to the detriment of their health and well-being.

Second, CMS has entirely ignored the evidence that the quality of work matters, choosing instead to erroneously assert that any and all work will improve health outcomes. But the evidence cited by CMS once again undercuts its position. Both Waddell and Burton and van der Noordt et al. suggest that work can

[1] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 30 (2006). *See also, e.g.* R. Dorsett et al., *Leaving Incapacity Benefit. Department of Social Security Research Report No. 86*. The Stationery Office, London (1998) [summarized in Waddell and Burton]

benefit health, but the quality and sustainability of the job matters.[2] In fact, according to the Waddell and Burton review, individuals who lost social security benefits suffered worse health outcomes partly because they often work in poor-quality, low-wage jobs and have ongoing issues with job security.[3] Decent job options can be scarce for this population and enforcing a work requirement that funnels beneficiaries toward predominantly temporary, dead-end jobs could actually worsen their health outcomes.

Third, CMS failed to even consider or discuss the applicability of basing its policy decisions on studies from the United Kingdom and other European countries that offer universal health coverage. The cited longitudinal analysis involves male workers in England and Wales, and both literature reviews draw heavily on studies from Europe and the UK. Individuals in these countries who lose social security benefits nonetheless maintain their health insurance. The review on which CMS relies to assert that "unemployment is generally harmful to health," therefore, in fact has little bearing on how policies that terminate health coverage will influence health outcomes in the United States. Moreover, it bears repeating that, even in the UK, where individuals do have stable access to health care, "interventions which simply force claimants off benefits are more likely to harm their health and well-being."[4]

Fourth, CMS has failed to acknowledge the important distinction between correlation and causation. For instance, van der Noordt et al. acknowledge that their results could be overstated because they were unable to adequately account for a "healthy worker effect," whereby relatively healthier individuals are also more likely to find a job.[5] Similarly, the letter cites a 2014 Gallup poll, which suggests a correlation between long-term unemployment and depression. But many social determinants correlate with health outcomes and improved mental health. For instance, access to steady housing is associated with improved health outcomes, while homelessness is associated with significantly worse outcomes.[6] Of course, requiring people to have a home to maintain their Medicaid benefits – particularly if a state provided no appreciable extra help – would hardly be expected to improve their health outcomes. It would just kick homeless people off the program and exacerbate their problems.

Likewise, while the Gallup poll shows a correlation between unemployment and depression, it does not automatically follow that increased employment will reduce or treat depression. In fact, the study expressly notes that "[t]he causal direction of the relationship, though, is not clear from Gallup's data," and one explanation is that depression makes it harder to find and maintain a job.[7] Even setting aside this criticism, terminating Medicaid benefits for failing to meet a mandatory work requirement is likely to leave many individuals suffering from depression without access to non-emergency care or treatment—a concern which CMS did not address in its letter to the states.

Fifth, the letter claims that community engagement is associated with improved health outcomes and can lead to paid employment. CMS first cites a health plan survey that appears to have made no adjustments

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[2] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 24 (2006).
[3] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 29 (2006).
[4] Gordon Waddell and A Kim Burton, *Is Work Good For Your Health and Well-Being?*, at 30 (2006).
[5] Van der Noordt et al., Health effects of employment: a systematic review of prospective studies, at 735 (2014).
[6] "Homelessness & Health: What's the Connection?" National Health Care for the Homeless Council (June 2011) https://www.nhchc.org/wp-content/uploads/2011/09/Hln_health_factsheet_Jan10.pdf (collecting studies).
[7] Steve Crabtree, "In U.S., Depression Rates Higher for Long-Term Unemployed," Gallup (2014) http://news.gallup.com/poll/171044/depression-rates-higher-among-long-term-unemployed.aspx. *See also*, *e.g.*, C. McLean, *Worklessness and Health: What Do We Know about the Causal Relationship, 1st Edition,* Health Development Agency, London, (2005) [summarized in Waddell and Burton].

at all for relative socioeconomic status, health status, or ability to volunteer among its respondents and thus provides little added value. A second citation, a literature review on the effects of volunteering (defined as an act of free will), "did not find any consistent, significant health benefits arising through volunteering."[8] While the review found limited benefits on well-being and mental health among people who volunteer, it relied mostly on study cohorts that are aged 50 and over and notes that improved outcomes "may be limited to older volunteers" and may also decline as hours of volunteering increase.[9] Importantly, the authors also note that the results of the cohort studies were not confirmed by randomized studies which are the gold standard for determining the effectiveness of an intervention. In short, the evidence cited hardly supports, and more likely undermines, the value of state proposals that would mandate substantial "community engagement" as a mechanism to improve health outcomes.

Finally, CMS cites evidence for the largely uncontroversial point that higher income is associated with longer life expectancy. But the study CMS cites cautions that these relationships "should not be interpreted as causal effects of having more money because income is correlated with other attributes that directly affect health."[10] The very fact that people in poor health tend to make less money could easily explain much of the mortality/income gradient. Moreover, CMS offers no evidence or basis for its belief that imposing work requirements would lead to increased employment or higher income. In fact, repeated studies find that access to Medicaid benefits facilitates employment,[11] while evidence from TANF shows that punitive work requirements have little or no lasting effect on income and can actually increase severe poverty.[12]

Dated: January 11, 2018

LaDonna Pavetti

LaDonna Pavetti, Ph.D.

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[8] Jenkinson, et al., *Is volunteering a public health intervention? A systematic review and meta-analysis of the health and survival of volunteers* (2013).

[9] Jenkinson, et al.

[10] R. Chetty, M. Stepner, and S. Abraham et al., *The Association Between Income and Life Expectancy in the United States, 2001-2014,* 315 JAMA 1750, 1764 (2016).

[11] Renuka Tipirneni et al., Institute for Healthcare Policy and Innovation, University of Michigan, *Medicaid Expansion Helped Enrollees Do Better at Work or in Job Searches*, (2017), available at http://ihpi.umich.edu/news/medicaid-expansion-helped-enrollees-do-better-work-or-job-searches; Louija Hou et al., "Working Paper No. 22170: The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Well-Being," National Bureau of Economic Research, (2016), available at http://nber.org/papers/w22170; Ohio Dep't of Medicaid, *Ohio Medicaid Group VII Assessment: A Report to the Ohio General Assembly*, (2017), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[12] LaDonna Pavetti, Ctr. on Budget & Pol'y Priorities, *Work Requirements Don't' Cut Poverty, Evidence Shows* (2016); Sandra K. Danziger et al., *From Welfare to a Work-Based Safety Net: An Incomplete Transition*, 35 J. Pol'y Analysis & Management 231, 234 (2016); 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 (2001); Stephen Freedman et al., *National Evaluation of Welfare-to-Work Strategies: Two-year Impacts for Eleven Programs*, Manpower Development Research Corporation, (2000) http://www.mdrc.org/publication/evaluatingalternative-welfare-work-approaches.