September 25, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted electronically via Medicaid.gov

RE: Alabama Medicaid Workforce Initiative, Application for a Section 1115 Demonstration

Dear Ms. Verma:

As social scientists and scholars of health policy, we write to provide comments on Alabama Medicaid's Section 1115 Demonstration Application. In our professional opinion, the proposed Alabama Medicaid Workforce Initiative (AMWI), which will affect approximately 75,000 low-income Alabama residents, would not assist in promoting the "health and wellness objectives" of the Medicaid Act stated in 42 U.S.C. 1396-1, and reinforced by Centers for Medicare and Medicaid Services (CMS) guidance.[1] Moreover, contrary to CMS guidance, Alabama Medicaid's proposed hypotheses for evaluating AMWI will not allow the agency to "determine whether the demonstration is meeting its objectives."[2] Therefore, we strongly urge CMS to disapprove this waiver. We elaborate on each of these points below.

A substantial body of research exists to suggest that employment status has no causal relationship to health outcomes. Therefore, it is unlikely that AMWI would promote the objectives of the Medicaid Act.

The stated purpose of Medicaid is to enable each state, as far as is practicable, "to furnish medical assistance" to individuals "whose income and resources are insufficient to meet the costs of necessary medical services" and to provide "rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[3]
The Secretary of Health and Human Services may grant a Section 1115 Medicaid waiver only to experimental, pilot, or demonstration projects that are "likely to assist in promoting the objectives" of the Medicaid Act.[4] In its State Medicaid Director letter on work and community-engagement requirements, CMS notes that states "will need to link" requirements for work and community engagement to "those outcomes [producing improved health and well-being] and

[1] CMS, State Medicaid Director Letter SMD 18-002, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, January 11, 2018.
[2] Ibid.
[3] 42 U.S.C. 1396-1.
[4] 42 U.S.C. 1315(a).

ultimately assess the effectiveness of the demonstration in furthering the health and wellness objectives of the Medicaid program."[5]

In its waiver application, Alabama Medicaid proposes to require individuals in the Parent or Caregiver Relative (POCR) eligibility group who do not meet exclusion criteria to participate in 35 hours of employment-related activities per week, including employment, on-the-job training, job search and job-readiness activities, education, volunteer work, community service, or technical training. Individuals with a child under 6 years of age must participate in 20 hours of employment-related activities per week. If the demonstration is approved, approximately 75,000 recipients will be subject to these requirements. This will include individuals with family income at or below 13 percent of the federal poverty level (FPL).

There is little evidence to suggest that AMWI will promote the objectives of the Medicaid Act. Alabama Medicaid's application states that, "As CMS has explained, there is 'strong evidence that unemployment is generally harmful to health, including higher mortality; poorer general health; poorer mental health; and higher medical consultation and hospital admission rates.'" Yet the premise that employment improves health outcomes, advanced by CMS and reiterated in Alabama Medicaid's application, is not reflective of the state of knowledge in the medical and social sciences. Indeed, CMS's guidance misrepresents the findings of research it cites to establish a relationship between employment and health outcomes.[6] Four examples will suffice here:

A.) CMS guidance cites a 2016 *JAMA* study to support the claim that employment is associated with better health outcomes. [7] Yet the overall purpose of the study was to examine the trends in and sources of the socioeconomic gradient in life expectancy in the United States. On page 1759 of the study, the authors write: "Unemployment rates, changes in population, and changes in the size of the labor force (all measures of local labor market conditions) *were not significantly associated with life expectancy among individuals in the bottom income quartile* [emphasis added]."[8] The *JAMA* study thus appears to contradict CMS's premise that employment rates in lower-income populations will causally improve health. It is important to note that, while a link between social class status and health outcomes may exist, social class status should not be conflated with employment status. The groundbreaking Whitehall Studies conducted among tens of thousands of civil servants – all of whom were gainfully employed by the British government – demonstrated a higher rate of mortality among those with lower social class.[9] Indeed, the World Health Organization's Commission on the Social Determinants of Health cites a number of studies suggesting that in some occupations, employment is correlated with negative health outcomes, such as higher mortality rates

[5] CMS, State Medicaid Director Letter SMD 18-002, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, January 11, 2018.
[6] CMS, State Medicaid Director Letter SMD 18-002.
[7] Chetty R, Stepner M, Abraham S, et al. The association between income and life expectancy in the United States, 2001-2014. *JAMA*. 2016; 315(16):1750-1766
[8] Ibid.
[9] Marmot M., Stansfeld S, Patel C, et al. Health inequalities among British civil servants: the Whitehall II study. *Lancet* 1991; 337(8754): 1387-1393.

among temporary workers when compared to those engaged in permanent work.[10] Recently, scientists at the National Institute for Occupational Safety and Health recently documented an alarming cluster of black lung cases among coal miners in Kentucky, Virginia, and West Virginia. Because black lung is caused by workplace exposure to silica dust, it is clear that employment in coalmines, relative to unemployment, caused poor health outcomes in these cases.[11]

B.) CMS also cites a 2002 study published in the *International Journal of Epidemiology* to support the claim that "education…can lead to improved health by increasing health knowledge and healthy behaviors."[12] Yet the study cited does not examine health knowledge or healthy behaviors as outcomes. Rather, the study examines the long-term effects of social class status and unemployment on limiting long-term illness among the male working population in England and Wales. On page 338 of the study, the authors write: "In the fully adjusted model, unemployment at both time points, and membership of the most disadvantaged social classes at all three times, each retain the ability to predict ill-health 10 to 20 years after they have occurred." The authors conclude that: "Short term improvements in health inequality may not prove easy to obtain in areas of large scale de-industrialization, where many citizens have experienced two decades or more of economic hardship and its social consequences." These findings do not support the hypothesis that work requirements will causally improve health in Medicaid eligible populations.

C.) CMS cites a 2014 review article published in *Occupational and Environmental Medicine* to support the claim that there is a "protective effect of employment on depression and general mental health."[13] Yet on page 735 of that study, the authors note that they cannot establish a causal link between employment and health: "…the relationship between employment and health can be bi-directional. This means that the positive health effects of employment can be affected by the fact that healthier people are more likely to get and stay in employment." It is thus not clear that data support a hypothesis that employment causes improved mental health – in fact, it is just as reasonable to hypothesize that poor mental health causes unemployment. Further still, evidence suggests that work requirements can be negatively associated with physical and mental health. A recent study published in *Health Affairs* found that participants in a Florida welfare reform experiment whose benefits were conditioned on workforce participation had a 16 percent higher mortality rate than comparable recipients of welfare who were not subject to work stipulations (the control group).[14] Additionally, a 2008 study of TANF implementation among parents found that "strong emphasis on efforts to push welfare clients into low-wage employment may have adverse effects on the ways in which welfare programs affect low-income women's mental health outcomes." [15]

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[10] Commission on the Social Determinants of Health, *Closing the gap in a generation: health equity through action on the social determinants of health.* World Health Organization, 2008.
[11] Blackley D, Reynolds L, Short C, et al. Progressive Massive Fibrosis in Coal Miners From 3 Clinics in Virginia. *JAMA* 2018; 319(5): 500-501.
[12] CMS, State Medicaid Director Letter SMD 18-002.
[13] Ibid.
[14] Muennig, P., Rosen Z. and Wilde E. Welfare Programs That Target Workforce Participation May Negatively Affect Mortality. *Health Aff.* 32 (6): 1072–1077, 2013.
[15] Morris, P. Welfare Program Implementation and Parents' Depression. *Soc. Serv Rev* 2008; 82 (4): 602.

D.) In general, the empirical evidence is far more persuasive that ill health leads to reduced employment and earnings—and preventing people from accessing health insurance will worsen health. For example, a summary of existing research published in *Medical Care Research and Review* found that improving health would increase earnings by 15-20 percent.[16]A recent review of evidence published in the *New England Journal of Medicine* persuasively shows the generally positive impacts of having health insurance on health, especially depression, which has a significantly negative impact on labor force participation.[17]

The tenuous link between employment and health suggests that AMWI would not promote the objectives of the Medicaid Act. While Alabama Medicaid reiterates CMS's argument that employment improves health, the evidence suggests that it is equally plausible that mandated employment leads to poor health outcomes. Further, CMS's interpretation of the *JAMA* study assumes that safety-net programs with work requirements yield meaningful improvements in economic outcomes for participants. A variety of published studies caution against this. Research on the trajectory of TANF recipients after welfare reform suggests that despite "extensive work effort…job instability and limited upward mobility (i.e. transitions to good jobs) characterized the employment experiences of most respondents."[18] More generally, even people who find employment after the enactment of work requirements continue to experience significant and persistent material hardship.[19] Long-term studies of participation in 11 mandatory welfare-to-work programs nationwide suggest that participants in these programs experienced few economic gains. The programs led to individuals "replacing welfare and Food Stamp dollars with dollars from earnings and Earned Income Tax Credits (EITCs), but the programs did not increase income above the low levels of the control group."[20] Moreover, the rate of job finding among participants did not increase significantly when compared to the control group.

Recent research has also suggested that any gain in earnings among low-skilled individuals under TANF has been offset by significant losses in transfer income.[21] Employment effects of TANF are also racially disparate. Structural disparities and employment discrimination have

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[16] Hadley J. Sicker and poorer—The consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income. *Med. Care Res Rev* 2003; 60(2, suppl): 3S-75S.

[17] Sommers B, Gawande A, Baicker K. Health Insurance Coverage and Health—What the Recent Evidence Tells Us. *N Engl J Med* 2017; 377(6): 586-593.

[18] Johnson R, Corcoran M. The Road to Economic Self-Sufficiency: Job Quality and Job Transition Patterns after Welfare Reform. *J Pol Anal Manag* 2003; 22 (4): 615-639.

[19] Danziger S, Heflin C, Corcoran M, et al. Does it Pay to Move from Welfare to Work? *J Pol Anal Manag* 2002; 21 (4): 671-692.

[20] Hamilton G, Freedman S, Geentian L, 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. Washington, DC: US Department of Health and Human Services, Administration for Children and Families and Office of the Assistant Secretary for Planning and Evaluation; and US Department of Education, 2001.

[21] Bollinger C, Gonzlaez L, Ziliak J, Welfare reform and the level and composition of income. *Welfare Reform and its Long-Term Consequences for America's Poor*. Cambridge University Press, 2009: 59-103.

made it more difficult for African Americans receiving TANF to find work.[22] In general, TANF has not provided protection for individuals in poverty, especially during difficult-to-foresee economic downturns. A comparative analysis of the effects of safety-net programs on the cyclicality of poverty during the Great Recession shows that TANF had no statistically significant effect on poverty reduction.[23] Moreover, a recent comprehensive review of the evidence on TANF's effects on the health outcomes of participants to be "too mixed or even nonexistent."[24]

AMWI's work requirements would also impose burdens on individuals eligible for Medicaid that may put them at risk of losing access to healthcare.

The reporting requirements necessary to institute a work requirement present a substantial burden to beneficiaries. We have already seen from the early results coming out of Arkansas that access to the internet presents a unique issue for low-income beneficiaries, particularly those living in rural areas or places where there is less substantial infrastructure. When crafting Medicaid policy, it is important to consider that even minor requirements and barriers can cause people to fail to participate in programs even when they value and need the benefits involved.[25] People suffering from intense poverty tend to struggle more than others in overcoming such burdens.[26] Studies of health-specific programs reveal that additional administrative requirements result in large and sustained reductions in enrollment.[27]

A predictable outcome of the paperwork requirements of new mandates will be to lose individuals who need health insurance, contrary to the basic goals of Medicaid. New burdens will not just affect beneficiaries; they will also consume the time administrators could devote to helping beneficiaries. Because of the complexity of complying with work requirements, caseworkers devote more time to tracking and verifying participant work activities than

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[22] Hahn H, Pratt E, Allen E, et al. Work Requirements in Social Safety Net Programs: A Status Report of Work Requirements in TANF, SNAP, Housing Assistance, and Medicaid, Urban Institute, 2017.

[23] Bitler M, Hoynes H. The more things change, the more they stay the same? The safety net and poverty in the Great Recession. *J Labor Econ* 2016; 34(S1): S403-S444

[24] Ziliak J. *Temporary Assistance for Needy Families*, No. w21038. National Bureau of Economic Research, 2015.; See also: Kaestner R, Tarlov E. Changes in the welfare caseload and the health of low-educated mothers. *J Pol Anal Manag* 2006; 25(3): 623-643.

[25] Moynihan D, Herd P, Harvey H. Administrative Burdens: Learning, Psychological and Compliance Costs in Citizen-State Interactions. *J Pub Admin Res Theory* 2015; 25(1): 43-69.

[26] Mani A., Mullainathan S. Shafir, E, et al. Poverty impedes cognitive function. *Science* 2013; 341: 976-980.

[27] Dunkelberg A, O'Malley M. Children's Medicaid and SCHIP in Texas: Tracking the Impact of Budget Cuts. Washington, DC: Kaiser Commission on Medicaid and the Uninsured; 2004; Summer L, Mann C. Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies. Washington, DC: The Commonwealth Fund, 2006; Herndon JB, Shenkman EA, Bruce Vogel. The Impact of Renewal Policy Changes in the Florida Healthy Kids Program. Gainesville, FL: University of Florida, Institute for Child Health Policy, 2007; Haeder SF, Plein C. The Successes of Children's Health Insurance in West Virginia and the Challenges that Lie Ahead. Charleston, WV: West Virginia Kids Count; 2018.

connecting participants with work and support services.[28] Research suggests that such intensive and stringent administrative arrangements can create opportunities for caseworker discretion and lead to the unequal application of standards across racial groups.[29] Any resulting inequitable outcomes for AMWI would exacerbate already existing racial disparities in access to healthcare.[30]

In short, while Alabama Medicaid's Demonstration Application hypothesizes that: "increasing employment through employment and job training requirements, will improve health outcomes," it has provided little evidence to support a direct or indirect positive effect of employment on health outcomes. Given likely administrative burdens on the eligibility group, which may limit their access to medical care, AMWI would not promote the objectives of the Medicaid Act.

The hypotheses and evaluation plan Alabama Medicaid has described will not allow the state to evaluate whether AMWI furthers the objectives of the Medicaid Act or not.

CMS's guidance on work and community engagement requirements requires states to "evaluate health and other outcomes of individuals that have been enrolled in and subject to the provisions of the demonstration."[31] Where this guidance is concerned, there are two problems with Alabama Medicaid's application. First, Alabama Medicaid proposes to test five hypotheses concerning the effects of AMWI. Yet none of the five hypotheses contained in the demonstration application concerns the effects of AMWI on participants' health outcomes. This is troubling, especially given that Section 1115 waivers are required to further the objectives of the Medicaid Act. Moreover, given Congress's identification of the importance of evidence-based policymaking, waiver programs should be designed to provide evidence as to their purported effects.[32]

Second, Alabama Medicaid has not provided basic clarity on the measures and methods it will use to test its hypotheses. The Demonstration Application suggests that the state's evaluation will,

> measure [*sic*] these hypotheses…using wage and employment records available through the Department of Labor; internal system records regarding program terminations and transitional Medicaid; and surveys to determine the effect of changes on individuals who have left the program.

To understand whether the data will permit an effective evaluation of the demonstration, the agency must provide some details on the quality and comprehensiveness of its employment

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[28] Hahn H, Loprest P. Improving State TANF Performance Measures, Urban Institute (2011); Schott L, Pavetti L. Changes in TANF Work Requirements Could Make Them More Effective in Promoting Employment. Center on Budget and Policy Priorities (2013); Zedlewski S, Golden O. Next Steps for Temporary Assistance for Needy Families. Urban Institute (2011).

[29] Soss J, Schram S, Fording R. *Disciplining the Poor: Neoliberal Paternalism and the Persistent Power of Race* (University of Chicago Press, 2011).

[30] Andrews C. Unintended Consequences: Medicaid Expansion and Racial Inequality in Access to Health Insurance. *Health Soc Work* 2014; 39 (3): 131–33.

[31] CMS, State Medicaid Director Letter SMD 18-002.

[32] US Congress, House of Representatives, Foundations for Evidence-Based Policymaking Act of 2017, 115th Cong., 1st sess., H. Rept. 114-411,

records. Additionally, the agency should specify how these records treat domestic and seasonal employees as well as small-business owners, and whether the records will provide a basis for assessing differences in AMWI's effects across racial groups. The agency should also discuss how it would administer surveys and the specific survey instruments (e.g. Consumer Assessment of Healthcare Provides and Systems). Finally, in accordance with CMS guidance, the evaluation description should discuss how it would separate the intended outcomes of AMWI (e.g. share of participants enrolling in affordable employer-based insurance) from unintended, negative outcomes (e.g. share of participants losing insurance).

As AMWI is not likely to further the objectives of the Medicaid Act, CMS should disapprove this waiver.

Our review of the evidence here suggests that AMWI's proposed work and community engagement requirements are not likely to further the objectives of the Medicaid Act. At a minimum, the lack of an established causal link between employment and health suggests that requiring employment is not likely to enhance Alabama Medicaid's ability to furnish medical assistance to eligible recipients. Yet work requirements like those proposed here would be likely to create barriers to care for eligible participants. This is significant, given that non-elderly Medicaid participants have significantly better access to care than their uninsured peers.[33] A recent study of Tennessee's Medicaid program, TennCare, shows that disenrollment from Medicaid is associated with "significant decreases in health insurance and increases in cost-related barriers to care for low-income adults living in Tennessee."[34]

In its application, Alabama Medicaid provides no indication that it recognizes or that it will seek to reduce such unnecessary harms. Alabama's response to public comments regarding these harms is also perfunctory at best. Combined with the limited evidence of potential health benefits for recipients, and the absence of a clear evaluation plan, we are concerned that AMWI would not further the objectives of the Medicaid Act, with negative consequences for low-income Alabama residents. Therefore, we urge CMS to disapprove this waiver.

Thank you for the opportunity to provide these comments. Please contact us if you have any questions.

Sincerely,

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[33] Long S, Stockley K, Grimm E, Coyer C, National Findings on Access to Health Care and Service Use for Non-elderly Adults Enrolled in Medicaid, MACPAC Contractor Report 2, June 2012.
[34] Tarazi W, Green T, Sabik L Medicaid disenrollment and disparities in access to care: Evidence from Tennessee. *Health Serv. Res* 2017; 52(3): 1156-1167.

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