December 3, 2019

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RE: Georgia Section 1115 Demonstration Waiver Application

To Whom It May Concern:

As a social scientists and scholars of health policy, we write to provide comments on Georgia's proposed Medicaid Section 1115 Demonstration project, published on November 4, 2019.[1] This proposal will allow residents at or below the poverty line qualify for Medicaid coverage only if they meet a burdensome work requirement. Otherwise-eligible beneficiaries who don't work or engage in work-related activities for a minimum of 80 hours per month unless they qualify for an exemption from the requirement. These burdensome requirements, according to Georgia's own analysis, will create barriers to accessing the new Medicaid benefit for over 400,000 non-elderly Georgians living below 100% FPL.[2] In our professional opinion, the proposed waiver would not advance—and may ultimately undermine—Medicaid's goal of furnishing access to medical care, as stated in 42 U.S.C. 1396-1, and reinforced by Centers for Medicare and Medicaid Services (CMS) guidance.[3] Therefore, we strongly urge you to eliminate this element of the proposed waiver.

Imposing work requirements will not lead to improvements in health.

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."[4]

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.[5] 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 wellbeing] and ultimately assess the effectiveness of the demonstration in furthering the health

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[1] Georgia Section 1115 Demonstration Waiver Application, Department of Community Health, Posted on November 4, 2019

[2] While over 408,000 non-elderly uninsured adult Georgians have incomes below 100% FPL, Georgia's analysis suggests that only 50,000 people will enroll in Medicaid due to these requirements.

[3] CMS, State Medicaid Director Letter SMD 18-002, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, January 11, 2018.

[4] 42 U.S.C. 1396-1.

[5] 42 U.S.C. 1315(a).

and wellness objectives of the Medicaid program."[6] Georgia's proposed waiver will require beneficiaries to, as a condition of eligibility, certify each month that they are engaging in at least 80 hours per month of work or community-engagement activity.

Georgia's application argues that this amendment is intended to support the improvement of beneficiaries' health. This is at best a misleading characterization of the evidence cited in the application and is contradicted time and again by the published research literature. CMS's guidance to states on work and community engagement requirements—cited in Georgia's waiver— misrepresents the findings of research it cites to establish a relationship between employment and health outcomes.[7] Five examples will suffice here:

A) CMS guidance cites a 2016 *JAMA* study to support the claim that employment is associated with better health outcomes.[8] 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]."[9] 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.[10] 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 among temporary workers when compared to those engaged in permanent work.[11] 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

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[6] CMS, State Medicaid Director Letter SMD 18-002, RE: Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries, January 11, 2018.

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

[8] 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

[9] Id.

[10] Marmot M., Stansfeld S, Patel C, et al. Health inequalities among British civil servants: the Whitehall II study. *Lancet* 1991; 337(8754): 1387-1393.

[11] 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.

employment in coal mines, relative to unemployment, caused poor health outcomes in these cases.[12]

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."[13] 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."[14] 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).[15] 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."[16]

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

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[12] 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.

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

[14] Id.

[15] Muennig, P., Rosen Z. and Wilde E. Welfare Programs That Target Workforce Participation May Negatively Affect Mortality. *Health Aff.* 32 (6): 1072–1077, 2013.

[16] Morris, P. Welfare Program Implementation and Parents' Depression. *Soc. Serv Rev* 2008; 82 (4): 602.

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.[17] 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.[18] Further, none of the evidence presented by CMS can speak to the effective causal mechanism that would occur in the Medicaid waiver: forcing people into the workforce at the risk of losing their health insurance.

E) A 2019 study published in the *New England Journal of Medicine* reveals that Arkansas' implementation of work requirements within Medicaid resulted in statistically significant losses in insurance coverage losses with no significant change in the levels of employment. Specifically, coverage among the low-income Arkansas adult population ages 30–49 fell from 70.5 percent in 2016 to 63.7 percent following the implementation of work requirements.[19]

Work requirements are unlikely to improve individuals' earnings or financial stability.

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."[20] More generally, even people who find employment after the enactment of work requirements continue to experience significant and persistent material hardship.[21] 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."[22] Moreover, the rate of job finding among participants did not increase significantly when compared to the control group.

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[17] 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.

[18] 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.

[19] Sommers B, Goldman A, Blendon R, Orav EJ, Epstein A, Medicaid Work Requirements — Results from the First Year in Arkansas, *N Engl J Med* 2019, 10.1056/NEJMsr1901772.

[20] 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.

[21] 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.

[22] 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.

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.[23] Employment effects of TANF are also racially disparate. Structural disparities and employment discrimination have made it more difficult for African Americans receiving TANF to find work.[24] 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.[25] 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."[26]

Though the federal government strongly supports and consistently encourages work requirements, their rationale for doing so is both out of step with the core purpose of Medicaid and empirically ungrounded. The Council of Economic Advisers' (CEA) July 2018 report entitled, "Expanding Work Requirements in Non-Cash Welfare Programs" provides key examples on both counts.[27] The CEA report emphasizes improving "self-sufficiency," decreasing "dependency" and increasing employment.[28] The CEA report thus reflects the inattention to the statutory goals of Medicaid. Though the report mentions Medicaid over 150 times, it does not discuss healthcare or offer any evidence that work requirements will increase access to health benefits. Instead, it justifies work requirements in terms of enhanced labor force participation, relying primarily on the experience of TANF, a program with different goals from Medicaid, and established in statute with the deliberate goal of imposing work requirements in mind. The CEA report does not speak to the experience of those who lost benefits as a result of new requirements, but an analysis of a national sample of TANF exits found that administrative burdens helped explain reductions in TANF caseloads, and fell harder on those in extreme poverty.[29] The federal government's own justification for work requirements therefore reflects a disinterest in the statutory requirement for Medicaid to furnish medical assistance, or a concern

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[23] 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.
[24] 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.
[25] 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
[26] 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.
[27] The Council of Economic Advisers. July 2018. "Expanding Work Requirements in Non-Cash Welfare Programs." Executive Office of the President of the United States.
[28] Id., 17.
[29] Brodkin E, Majmundar M. Administrative Exclusion: Organizations and the Hidden Costs of Welfare Claiming. *J Pub Admin Res Theory* 2010; 20(4): 827-848.

about what will happen to those who struggle with the administrative burdens arising from the new work requirements.

The logic and evidence underlying the CEA report is also based on inaccurate and incomplete evidentiary claims. Drawing on 2014 data from the Survey of Income and Program Participation, the CEA report claims that 60 percent of non-disabled adult Medicaid beneficiaries "worked few if any hours each week."[30] Yet, recent data from the Current Population Survey (CPS) offers more nuanced insight into the employment circumstances that Medicaid beneficiaries face. Analyses of CPS data indicate that in 2016, 43 percent of non-elderly, non-disabled adult Medicaid beneficiaries worked full time.[31] Among the remaining 57 percent, 15 percent were out of work because of illness or poor health, 6 percent were attending school, 11 percent were not working due to caregiving and 19 percent worked part-time. That leaves just 6 percent of beneficiaries to whom work requirements would likely apply.[32] So, while the CEA report claims that "low employment rates of non-disabled working age recipients" necessitates policy intervention, available evidence runs counter to that supposition.[33] Finally, even the CEA report acknowledges that some beneficiaries will "experience negative effects."[34] The CEA notes that to address this, it is necessary to "support recipients overcoming barriers to employment (lack of access to childcare, mental illness or criminal records."[35] However, Georgia's work requirement includes no such provisions. Hence, the waiver application falls short even per the (empirically unsubstantiated) proposals laid out by the White House Council of Economic Advisers.

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

The proposed application states that the new program will help beneficiaries attain better health outcomes. However, a substantial body of research shows that even minor requirements and barriers can cause people to fail to participate in programs even when they value and need the benefits involved.[36] People suffering from intense poverty tend to struggle more than others in overcoming such burdens.[37] A simple example is the requirement to provide online

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[30] The Council of Economic Advisers. July 2018. "Expanding Work Requirements in Non-Cash Welfare Programs." Executive Office of the President of the United States, page 17.

[31] Garfield, Rachel, Robin Ruowidtz and MaryBeth Musumeci. June 2018. "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses." Kaiser Family Foundation Issue Brief.

[32] Garfield, Rachel, Robin Ruowidtz and MaryBeth Musumeci. June 2018. "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses." Kaiser Family Foundation Issue Brief.

[33] The Council of Economic Advisers. July 2018. "Expanding Work Requirements in Non-Cash Welfare Programs." Executive Office of the President of the United States, p. 1

[34] Id., 2.

[35] Id., 3.

[36] 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.

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

documentation to verify compliance with new mandates. Given that 30 percent of Medicaid adults report they never use a computer, 28 percent say they do not use the Internet, and 41 percent do not use email, it is unrealistic to expect that such a population will possess the technological literacy to navigate online documentation processes.[38]

Reporting burdens would fall hardest on low-income employees, where the labor market features frequent churning in and out of jobs, unstable hours, and a lack of easy access to documentation. For example, about 1 in 10 workers who earn $10 an hour transition from their jobs each month, compared to just 1 in 25 of those earning $25 an hour.[39] Lower-income employees therefore face additional burdens to maintain documentation of their work status. The informal nature of much of the service industry also places additional burdens on those working there.

One group of researchers has estimated the effects the new Medicaid work requirements, and the importance of administrative burdens. Using past restrictions on Medicaid as a basis, and assuming different scenarios in terms of how many beneficiaries would be exempt from the requirements, researchers at the Kaiser Family Foundation estimated that if the new work requirements were implemented nationally, it would cause between 1.4 million and 4 million people to lose Medicaid coverage. The scale of the effects is striking. So too is the reason why. Across four different scenarios, an average of 78% of those disenrolled will lose coverage not because they do not meet the new requirements, but because of the administrative burden that comes with the requirements.[40]

In addition to these studies, it is not apparent that Georgia has reviewed the effects of Arkansas' recent 1115 community-engagement waiver. As of December, over 18,000 Medicaid beneficiaries lost coverage due to failure to comply with work requirements.[41] In a November 8th letter to HHS Secretary Alex Azar, the Medicaid and CHIP Payment and Access Commission raised concern about these outcomes, which contradicted the claims of Arkansas' application.[42] Early analyses of implementation found that enrollees have not been contacted about new

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976-980.

[38] Garfield R, Rudowitz R, Musucemi M, Damico A, Implications of Work Requirement in Medicaid: What Does the Data Say, Kaiser Family Foundation, June 12, 2018, https://www.kff.org/medicaid/issue-brief/implications-of-work-requirements-in-medicaid-what-does-the-data-say/

[39] Bivens J, Fremstad S. 2018. Why Punitive Work-hours Tests in SNAP and Medicaid Would Harm Workers and do Nothing to Raise Employment. Economic Policy Institute. epi.org/151107

[40] Garfield, Rachel, Robin Rudowitz, and MaryBeth Musucemi. 2019 "Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses." Kaiser Family Foundation, June 27, Access at http://files.kff.org/attachment/Issue-Brief-Implications-of-a-Medicaid-Work-Requirement-National-Estimates-of-Potential-Coverage-Losses

[41] Rudowitz R, Musumeci M, Hall C, Year End Review: December State Data for Medicaid Work Requirements in Arkansas, Kaiser Family Foundation, January 17, 2019, https://www.kff.org/medicaid/issue-brief/state-data-for-medicaid-work-requirements-in-arkansas/

[42] Penny Thompson to Alex Azar, November 8, 2018, https://www.macpac.gov/wp-content/uploads/2018/11/MACPAC-letter-to-HHS-Secretary-Regarding-Work-Requirements-Implementation.pdf

requirements.[43] At minimum, Georgia must review the conditions that led to these outcomes and make clear plans to avoid them in the context of its own proposed waiver.

The proposed exemptions from work requirements are arbitrary.

Georgia's waiver application contains a list of exemptions from HELP work requirements. These exemptions are arbitrary and are at odds with the state's claims that work will cause health to improve. For example, if one did believe that work improved physical and mental health, then it would in fact be cruel to exempt pregnant and postpartum women – who are at risk of depression – from the work requirements. There is no justification for the child caretaker exemption. The age limit on caring for children is completely arbitrary, as it is unclear why caring for a child age 5 years and 11 months of age is different from caring for a child age 6 years and 1 month of age.

As the work requirements in Georgia's Section 1115 demonstration waiver are not likely to further the objectives of the Medicaid Act, the state should abandon this element of the application.

Our review of the evidence here suggests that Georgia's proposed Section 1115 demonstration waiver is unlikely to enhance participant health or wellbeing; financial stability; or access to health insurance coverage. On the contrary, the proposal may cause negative consequences for the health and wellbeing of individuals and families who already bear the burden of living in poverty. Given the preponderance of evidence suggesting that such work requirements have negative effects on program participation, it is unlikely to further the objectives of the Social Security Act, with negative consequences for low-income Georgia families. Therefore, we urge the state to abandon this element of the application.

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

Sincerely,

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[43] Musumeci M, Rudowitz R, Hall C, An Early Look at Implementation of Medicaid Work Requirements in Arkansas, October 8, 2018, https://www.kff.org/medicaid/issue-brief/an-early-look-at-implementation-of-medicaid-work-requirements-in-arkansas/

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