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Report

Medicaid Premiums & Work Requirements: A Prescription for Higher Costs and Lower Health Insurance Coverage

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November 2017

Abstract

Recent proposals to impose work and premium requirements on Medicaid beneficiaries pose a significant threat to health coverage for the most vulnerable Floridians. They would also add new costs and uncompensated care burdens for state and local governments, safety net providers and privately insured residents. Lawmakers should instead look to commonsense Medicaid policies with a track record of improving access to care.

Executive Summary

During the 2017 state legislative session, proposed legislation would have imposed work and premium requirements as conditions of Medicaid eligibility. Although the bill did not pass, the same or similar proposals are likely to re-emerge in 2018.

Decades of research and experience with other safety net programs show that these requirements, as conditions of Medicaid eligibility, run counter to the overall purpose of the program. Medicaid was created to provide low-income individuals and families access to health care services. Instead, these proposals would likely deter thousands of uninsured Floridians from initial enrollment and terminate eligibility for thousands of participants.

These requirements would also add significant new costs and uncompensated care burdens for state and local governments, safety net providers and privately-insured Floridians.

Proposed Medicaid work requirements are largely driven by false stereotypes. In fact:

- Most Medicaid recipients who can work are already working.

- Years of experience with the Temporary Assistance for Needy Families (TANF) program, including Florida's program, demonstrate that Medicaid work requirements would not result in long-term stable employment for most participants or lift them out of poverty.

- Medicaid coverage enables people to work or seek work because they can stay healthy or address health problems, which are often barriers to employment.

- While the 2017 legislation exempted certain categories of beneficiaries from work requirements, such as people with disabilities, research shows that exemptions are costly to implement and not effective in protecting vulnerable participants.

- Women, minorities, people with limited education and those with serious health problems particularly risk losing coverage due to work requirements.

Likewise, decades of research show that Medicaid premiums have deterred enrollment and resulted in loss of coverage. For example:

- In Florida, Medicaid financial eligibility is extremely restrictive; most participants are very low-income and struggle to afford minimal basic necessities.

- Florida passed a Medicaid premium requirement in 2012, which was never implemented. One study projected that 800,000 children and their parents would have been dropped from the program because they could not afford a $10 monthly premium.

- Premiums cause more people to cycle on and off the program. This cycling increases administrative costs and increases the average cost of care because healthier people are less likely to re-enroll after cancellation.

- Premiums result in more uninsured families, which increases uncompensated care costs. These costs are shifted to state and local government, as well as health care providers.

Florida has made great progress reducing the number of uninsured, a steady decline from 20 percent in 2013 to 12.5 percent in 2016. Adding premium and work requirements to Medicaid eligibility would be a step backwards, having the harshest impacts on children in low-income families and their parents.

The Purpose of Medicaid

The starting point for evaluating proposed changes to the Medicaid program is to look at its overarching purpose, as delineated in Section 1901 of 42 U.S.C. 1396, which is to:

> "furnish (1) medical assistance on behalf of families with dependent children and of aged, blind or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care."[1]

Medicaid's "core mission is to provide comprehensive health care coverage to low income people so they can get the health care services they need."[2]

Florida Medicaid Basics

Federal law guarantees coverage for all Floridians who qualify and requires a minimum level of services and consumer protections to meet the special needs of this vulnerable population.[3] Required services include hospital, physician, nursing home and pregnancy-related services, as well as child health check-ups and treatment services for children and youth. This coverage incorporates more than 4 million Floridians, mainly children (59.1 percent), followed by adults — parents, caretakers and young adults 19-20 (19.8 percent) — persons with disabilities (13.3 percent) and seniors (7.8 percent).[4]

Medicaid is supported by state and federal funds and is jointly administered by the Florida Agency for Health Care Administration (AHCA) and the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). While AHCA is the "single state agency" designated for overall responsibility of administering Florida's Medicaid program, the Florida Department of Children and Families (DCF) is the state agency responsible for making Medicaid eligibility determinations.[5]

The federal government pays over 60 percent of program costs. Total 2017-18 funding for Medicaid in Florida is $26.4 billion.[6]

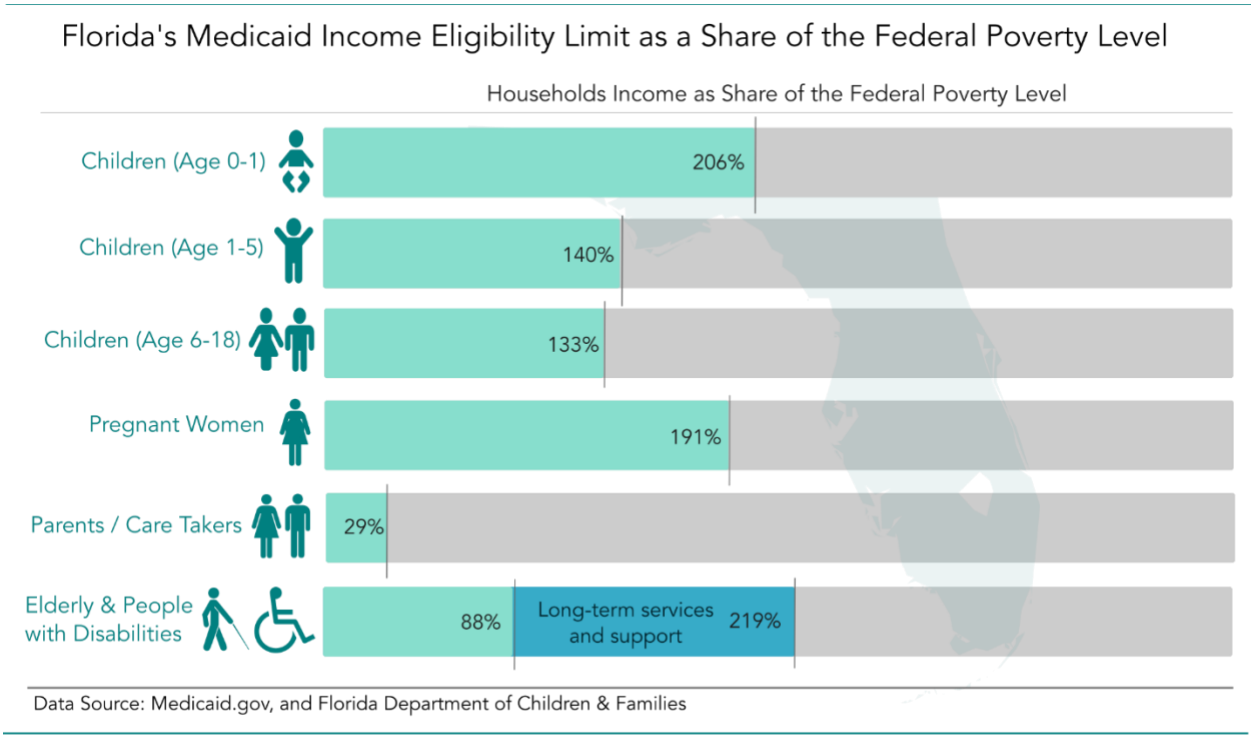
Florida Medicaid Eligibility Criteria

Federal law establishes four requirements that an individual must meet to obtain coverage. The individual must:

- be a U.S. citizen or a "qualified immigrant" who is lawfully present in the U.S.;
- be a resident of the state where s/he is applying for Medicaid;
- fit within a covered population group (e.g., children, people with disabilities); and
- have income at or below financial eligibility limits. [7]

Table 1 shows the major Florida Medicaid populations and their varying income eligibility limits. Most Florida Medicaid beneficiaries have income at or below the federal poverty level (FPL).[8] Thousands are in deep poverty, calculated as 50 percent or less of the FPL or lower. For many, participation in the program is very brief, resulting from immediate financial circumstances such as loss of a job. For others, participation is longer term due to catastrophic illness or disability.[9]

Since Florida has not opted to expand its Medicaid program as allowed under the Affordable Care Act (ACA), more than 500,000 childless, non-disabled Florida adults aged 18-64 who live in poverty cannot qualify for Florida Medicaid.[10] Only a small segment of "able-bodied" adults are currently on Medicaid, primarily pregnant women and parents/caretakers of minor children in deep poverty. Deep poverty is considered 29 percent of the federal poverty level, or less, up to $594.50 per month for a family of four.



The Medicaid Act does not include a requirement for applicants or beneficiaries to be working or seeking work as a condition of qualifying for Medicaid coverage. Nor does federal law require payment of premiums as a condition of eligibility. Multiple courts have recognized that states cannot add additional Medicaid eligibility requirements that are not permitted under federal Medicaid law.[11]

State Efforts to Require Medicaid Work and Premium Eligibility Requirements

During the 2017 state legislative session, legislation was introduced--House Bill (HB) 7117[12]-- that would have required AHCA to seek approval from the federal government to impose Medicaid work requirements and payment of premiums as conditions of eligibility. The rationale was to encourage people to work and "have skin in the game."[13]

Proposed work requirements were to be consistent with those in Florida's Temporary Assistance to Needy Families (TANF) program- a program providing temporary cash assistance to very low- income families. Exemptions from these requirements included, but were not limited to: Medicaid Long-Term Care program enrollees; people receiving disability benefits; children; single parents of children under 3 months; and people who have "diligently" tried to comply but who face "extraordinary" barriers to employment. AHCA projected that about 385,945 Medicaid recipients would be subject to work requirements.[14]

The bill, if enacted, would have also required enrollees with incomes between 50-100 percent of the FPL ($1,025 -$2,050 per month for a family of four) to pay a $10 monthly premium, and those above 101 percent of the FPL ($2070 per month for a family of four) to pay $15 per month. Families could be charged a premium for each covered household member, including each child.

However, DCF was given discretion to waive the premium "for hardship as defined by agency rule or upon successful completion of a health behavior program administered by their managed care plan." These programs are intended to reward healthy behaviors, and include smoking cessation, weight loss and alcohol or substance abuse recovery programs. These programs are currently voluntary.[15, 16]

In addition, a payment grace period of 60 days was included in the bill, but if premiums were not paid within the grace period, beneficiaries would be locked out of the program for 12 months.

On the fiscal impact of HB 7117, the House Health and Human Services Committee Staff Analysis[17] notes:

> The total amount of premiums will be impacted by waivers for hardship and waivers for successful completion of healthy behaviors…. ***The bill may have significant indeterminate, negative fiscal impact on [the Department of Children and Families-DCF] to administer the premium collections required by the bill***. ***DCF may also have significant, indeterminate, negative fiscal impact related to the bill's imposition of work requirements on Medicaid recipients***: DCF as part of its eligibility functions, would refer Medicaid recipients to [CareerSource work programs], track work participation, and take action for recipient failure to comply…. ***Implementation will likely require additional budget authority for DCF***… *[emphasis added]*

After stripping out the premium requirements, the House passed HB 7117, but it was not passed by both chambers in identical form.[18]

Notably, the Florida Legislature passed a similar law in 2011, HB 7107.[19] It conditioned Medicaid eligibility upon payments of monthly $10 premiums for nearly all Medicaid beneficiaries. Like the 2017 proposal, proponents stated that the motivation was philosophical, not budgetary. It was intended to ensure that everyone pays a portion of their health care.[20] Implementation of the bill was subject to federal approval. No approval was granted.

Federal Efforts to Require Medicaid Work and Premium Eligibility Requirements

Recent Congressional leadership bills to repeal and replace the ACA[21] have included provisions giving states an option to incorporate work and premium requirements as a condition of Medicaid eligibility. Additionally, a Medicaid work requirement as a state option is included in the Trump Administration's proposed 2018 budget.[22] To date, Congress has not passed any laws allowing states to impose these requirements.

Individual states are trying to implement work and premium requirements through section 1115 Medicaid waivers. These waivers allow states to carry out "an experimental, pilot or demonstration project which, in the judgment of the Secretary [of HHS], is likely to assist in promoting the objectives of [Medicaid]."[23] The HHS Secretary can waive certain federal requirements that states are otherwise required to follow to qualify for federal matching funds.

Historically, HHS has used the general criteria listed below to determine if section 1115 proposals promote the objectives of the Medicaid Act. The proposals must:[24]

- Increase and strengthen overall coverage of low-income individuals in the state;
- Increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- Improve health outcomes for Medicaid and other low-income populations in the state; or
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations must also be "budget neutral," meaning that during the project (no more than five years at the outset), they should not require additional federal funding specific to the waiver.

These criteria affirm that it is inconsistent with the objectives of the Medicaid Act to "cause fewer people to get or retain coverage or make it harder to obtain necessary health care."[25] Additionally, waivers are not intended to test models or policies already shown to limit coverage and access to care.[26]

Although federal CMS has consistently rejected state waiver requests to condition Medicaid eligibility on work requirements or payment of premiums, a March 14, 2017 letter[27] from then HHS Secretary Price to state governors signaled a possible attempt to change this position.

Seven states (Arkansas, Indiana, Kentucky, Maine, New Hampshire, Utah, Wisconsin) have submitted waiver requests to require work as a condition of eligibility. Four states (Indiana, Kentucky, Maine, Wisconsin) are seeking waivers to charge monthly premiums for persons below poverty level.[28]

Medicaid work and premium requirements result in more uninsured Floridians and state administrative costs, but do not ameliorate poverty

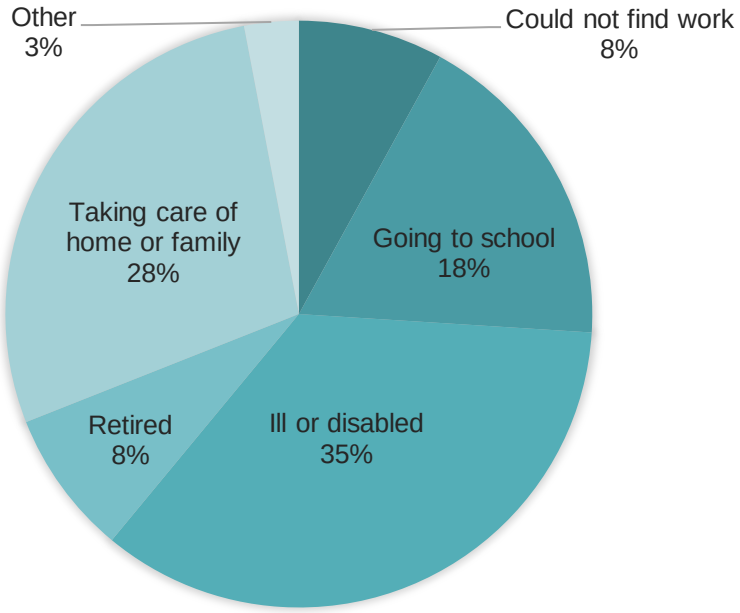
Work requirements

Medicaid work requirements are a solution in search of a problem. **Research shows that most Medicaid recipients who can work are already working**. In Florida, 73 percent of Medicaid beneficiaries who are non-elderly and not receiving Supplemental Security Income (SSI) are in a working family and 52 percent are working themselves.[29] Nationally, nearly half of working Medicaid recipients are employed by small firms and many are not likely to have access to insurance through their jobs. Most of those not working report major impediments to their ability to work, including illness, disability, being a caregiver or unemployment while looking for work.

Of the 11 million potentially affected enrollees nationally, certain populations are particularly at risk of losing coverage due to work requirements. Among the participants at risk of losing Medicaid:[30]

- Almost two-thirds (63 percent) are women.
- Slightly more than half are racial and ethnic minorities, while 44 percent are non-Hispanic whites.
- About 30 percent lack a high school diploma, and another 30 percent have a diploma, but no postsecondary courses, limiting their employment prospects.
- Almost half (46 percent) have serious health problems, even though they do not get Supplemental Security Income (SSI) or Social Security Disability Insurance due to very restrictive eligibility requirements. These health problems include illnesses such as diabetes, arthritis, cancer, heart disease or mental illness (36 percent), or being in self-reported fair or poor health (10 percent).

Reasons for not working among non-SSI, adult Medicaid Enrollees (2015)



Source: Garfield, R. & Rudowitz, R. (2017). Understanding the Intersection of Medicaid and Work, Figure 4. Kaiser Family Foundation.

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Based on state experience with the TANF Program, Medicaid work requirements will push participants deeper into poverty, not lift them out

In 1996 Congress created the TANF block grant program as part of a federal effort to reform welfare. TANF provides temporary cash assistance for very low- income families. In return, recipients are expected to prepare for and seek employment with the help of education and training, transportation, employer subsidies, hiring fairs and employability coaching. The goal is to provide supports necessary to move people from unemployment or underemployment to jobs that enable economic self-sufficiency.[31]

Extensive research on TANF work requirements concludes that the requirements do not increase self-sufficiency, do little to increase stable, long-term employment and do not decrease poverty. Families that lose the program's cash assistance are pushed deeper into poverty.[32]

Florida's experience with TANF work requirements, the model proposed in HB 7117, is consistent with these findings. In 2015, only 12.3 percent of closed Florida TANF cases resulted from employment. In part, the low placement rate is a function of Florida's minimal investment

supporting work and work-related activities-- only 6 percent of its total TANF block grant dollars.[33]

The TANF work requirement applied to 48,000 recipients. If enacted, HB 7117 would have applied the requirement to almost 386,000 Medicaid participants. As noted in the House Staff Analysis for the bill, the expanded population would likely have a significant negative fiscal impact and require additional state dollars for administration.

Exemptions from work requirements don't work in practice and increase state costs

Although HB 7117 exempted certain groups from work requirements, examining TANF and Supplemental Nutritional Assistance Program (SNAP) populations shows that these exemption procedures do not work in practice. Participants have difficulty understanding the exemptions, are unable to comply with burdensome paperwork and verification requirements and have problems getting transportation to appointments required for getting the exemptions.[34] In practice, the intended "protected" categories of recipients (e.g., people with disabilities) are more likely to lose benefits than other individuals.[35]

For example, roughly one in five SNAP participants has a disability, but does not receive disability benefits, and many of these individuals are not exempted from the SNAP work requirement.[36] A study in Franklin County, Ohio, found that one-third of individuals referred to a SNAP employment and training program to keep their benefits reported a physical or mental limitation, and 25 percent of these individuals indicated that the condition limited their daily activities. Additionally, almost 20 percent of the individuals had filed for federal disability benefits within the previous two years.[37]

Further, states are often not prepared to correctly identify and exempt these individuals. When Georgia's SNAP work requirement waiver expired in 2016, the state found that 62 percent of nearly 12,000 individuals subject to the requirement were dis-enrolled after just three months.[38] State officials acknowledged that hundreds of enrollees had been wrongly classified as "able-bodied" when in fact they were unable to work.[39]

While well-intentioned, HB 7117 adds even more administrative costs to implementation. It gives the state highly selective discretion on application of work requirements by exempting people who have "diligently" tried to comply but who face "extraordinary" barriers to employment. Not only would such a standard require additional administrative resources to make exemption determinations, but its impact could vary by subpopulation or community, and increase the potential for discriminatory application.[40]

Blocking access to care through work requirements gets it exactly backwards. Medicaid coverage enables previously uninsured individuals with unmet health problems to get the care necessary to obtain and maintain employment.[41] More than half of individuals enrolled in Medicaid expansion in Ohio reported that Medicaid coverage has made it easier to continue

working. For those not working, three-quarters reported that Medicaid made it easier for them to look for a job.[42]

Premium requirements

Medicaid premiums will deter enrollment and lead to loss of coverage

Affordable care is key to Medicaid recipients being able to access care. Thus, cost-sharing protections in the Medicaid program have been tailored to meet the realities of beneficiaries' dire financial circumstances. Specifically, Congress has enacted provisions that generally prohibit Medicaid premiums for individuals with income below 150 percent of the FPL.[43]

Most Florida Medicaid participants live in households below or slightly above the FPL.[44] They struggle to afford basic necessities, such as housing, food and child care. A bare-minimum household survival budget in Florida is $4,488 per month for a household of three, significantly more than the FPL of $1,702 per month.[45]

A large body of research over several decades shows that premiums deter enrollment in both Medicaid and the Children's Health Insurance Program (CHIP). They also increase disenrollment and shorten how long people remain enrolled. The lowest income people are more likely to become uninsured if disenrolled.[46]

Premium effects may also vary by factors other than income. For example, some research suggests that increases in Medicaid and CHIP premiums may have larger effects on coverage for children of color and among children whose families have lower levels of educational attainment.[47]

Nearly two decades ago, federal CMS approved multiple Medicaid demonstrations that charged premiums for limited-service benefit packages intended for non-elderly adults. For example, Oregon charged sliding scale premiums to enrollees below poverty level with a maximum of $20 per month and implemented a lock-out for nonpayment. In the first year, enrollment dropped by nearly half for the affected population.[48] Other states, including Washington, Rhode Island, Maryland, Vermont, and Utah also experienced substantial disenrollment after implementing premiums or enrollment fees on lower-income individuals.[49]

A more recent study focused on premium requirements in the Healthy Indiana Plan waiver program for Medicaid expansion adults with incomes below 138 percent of the FPL.[50] If payments are not made, enrollees with income above the poverty line are disenrolled from the program altogether and locked out for 6 months. Members below the poverty level are moved to another plan with fewer benefits and co-pays. The study found that during the first 21 months of the program, 55 percent of eligible individuals either did not make their initial payment or missed a payment. A survey of the people who never enrolled or were kicked off the program due to non-payment of the premium reveals that most ended up going without coverage of any kind.[51]

Research and experience focused on Florida is consistent with national research findings

A Florida-specific study projected the impact of a $10 per month per enrollee Medicaid premium eligibility requirement that was passed by the Florida Legislature in 2011. The proposal covered nearly all Medicaid recipients, including children. The study concluded that this proposal "could result in 800,000 Florida children and parents — the majority of them in very-low income families — leaving Florida Medicaid and losing access to health care coverage because they cannot afford the premium." [52] Children would bear the brunt of these losses since they are the largest group enrolled in the Medicaid program. This study applied an Urban Institute model showing that even a premium as low as 1 percent of family income would lead to 1 in 6 families dropping coverage, while a premium of 3 percent is estimated to reduce participation by half.[53]

The Florida Healthy Kids (FHK) program- the largest component of Florida CHIP- covers children with household income higher than Medicaid income limits (above 138 percent of the FPL). Unlike Medicaid, FHK charges monthly premiums to enroll and stay on the program. The lowest income families are charged a premium of $15 per month.

Notably, thousands of children lose coverage each month due to non-payment of premiums. In 2012, FHK estimated that an average of about 6,500 children were disenrolled each month due to nonpayment of premiums.[54] Most recently FHK reviewed disenrollment data in the 48 counties affected by Hurricane Irma. Under normal circumstances, FHK reported that just in those counties about 4,200 children are disenrolled each month due to non-payment of premiums.[55]

Thousands more children are unable to obtain coverage in the first place due to non-payment of premiums. During calendar year 2015, 33,849 Florida children were denied CHIP coverage because their applications expired due to non-payment of premiums.[56] Only seven states (including Florida) charge CHIP premiums for families below 150 percent of the FPL, and Florida's premiums remain high compared to other states.[57] The recent transition of a group of school-aged children (age 6-18) from FHK to Medicaid is particularly instructive on the impact of premiums on CHIP/Medicaid enrollment. These children are referred to as the "stair-step children," reflecting the uneven Medicaid income eligibility for younger and older children prior to 2014. Younger children could qualify for Medicaid at a higher income level — 138 percent of the FPL — while their siblings did not. The ACA changed that by aligning Medicaid income eligibility for all children/youth whose families earn below 138 percent of the FPL.

Thus, effective January 1, 2014, more than 72,000 children between the ages of 6 and 18 enrolled in FHK with a premium requirement were transferred to the Medicaid program with no premium requirement.[58] With no premium requirement, there was a dramatic increase in enrollment in this coverage category. By December 31, 2014, 103,201 children were enrolled in this coverage category and by December 31, 2015, the number jumped to 122,070 – a more than 18 percent increase.[59]

Premiums will increase state administrative costs and shift more uncompensated care burdens to providers and local governments

Premium requirements will increase churn in Medicaid, that is, people cycling on and off depending on whether they can afford to pay the monthly premium. Churn adds to state administrative costs. Moreover, the average cost of care for those who remain in the program increases because healthier people are more likely to go off the program when other competing needs (e.g., food, rent) take priority.[60]

The imposition of Medicaid premiums would likely lead to greater numbers of uninsured Floridians. More uninsured would have a ripple effect on the broader health care landscape. The uninsured are more likely to rely on costly emergency room and inpatient hospital care because they cannot access primary and preventive care. This reliance triggers more uncompensated care costs, costs which are shifted to private payors and throughout the health care system.[61]

Conclusion

Florida has made great progress reducing the number of uninsured- a steady decline from 20 percent in 2013 to 12.5 percent in 2016.[62] Medicaid has significantly contributed to this decline, providing coverage for more than 4 million Floridians. But 2.6 million Floridians remain uninsured. [63] The state's uninsured rate is one of the highest in the South and significantly higher than the national average. [64]

Decades of research findings are overwhelming- work requirements and premiums would likely end Medicaid coverage for thousands and prevent many more from enrolling. This would have a disproportionate impact on children and struggling Florida families who have no other access to health coverage. These eligibility requirements would also add new significant and burdensome costs for the state and Florida taxpayers.

Adding work and premium requirements as conditions of Medicaid eligibility makes no sense from either a public health or fiscal perspective. Struggling Florida families and taxpayers need commonsense Medicaid policies with a track record of promoting widespread access to health care.

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