



June 26, 2020

VIA ELECTRONIC SUBMISSION

U.S. Department of Health and Human Services

Attn: Centers for Medicare and Medicaid Services

Re: Oklahoma SoonerCare 2.0 Healthy Adult Opportunity Section 1115
Demonstration Application

The Institute for Policy Integrity at New York University School of Law¹ respectfully submits the following comments to the Centers for Medicare and Medicaid Services (“CMS”) regarding the Oklahoma Health Care Authority’s (“OHCA”) application for a section 1115 waiver authorizing the SoonerCare 2.0 Medicaid demonstration (“SoonerCare 2.0”).² Policy Integrity is a non-partisan think tank dedicated to improving the quality of government decision-making through scholarship in the fields of administrative law, economics, and public policy.

Our comments focus on serious flaws in OHCA’s application. Specifically, we note that:

- OHCA’s application is incomplete and should be returned for correction;
- SoonerCare 2.0 will not “promot[e] the objectives” of the Medicaid program and thus does not qualify for a section 1115 waiver;³
- SoonerCare 2.0’s work requirement will impose health and administrative costs that are unlikely to be justified by any corresponding benefits; and
- SoonerCare 2.0’s cost-sharing measures will impose health and administrative costs that are unlikely to be justified by any corresponding benefits.

I. OHCA’s application is incomplete and should be returned for correction

Pursuant to CMS’s own regulations, a state’s section 1115 waiver application is not considered “complete” and ready for CMS review unless it includes eight required elements.⁴ OHCA’s application, however, fails to include at least two of these elements. Specifically, OHCA’s application does not (1) include “[a]n estimate of the expected increase or decrease . . . in annual

¹ This document does not purport to present New York University School of Law’s views, if any.

² Okla. Health Care Authority, SoonerCare 2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application 2 (Mar. 18, 2020) [hereinafter OHCA SoonerCare 2.0 HAO Application].

³ Social Security Act, 42 U.S.C. § 1315(a).

⁴ 42 C.F.R. § 431.412(a)(1)(i)-(viii).

aggregate expenditures,”⁵ or (2) contain accurate “[c]urrent enrollment data . . . and enrollment projections.”⁶ As a result, the application is not appropriately poised for CMS review and should be returned to OHCA for correction.

First, OHCA’s application does not include “[a]n estimate of the expected increase or decrease . . . in annual aggregate expenditures.”⁷ As explained in a letter to CMS from the Center for Children and Families at the Georgetown University Health Policy Institute and the Center on Budget and Policy Priorities, although OHCA’s application provides aggregate expenditure data for the first year of the demonstration program, OHCA “makes no adjustments to its estimated expenditures for demonstration years 2 through 5, essentially providing no estimates for the final three demonstration years.”⁸ OHCA further errs by failing to provide any “with- and without-demonstration projections for aggregate expenditures.”⁹ These flaws not only violate 42 C.F.R. § 431.412(a)(1)(iii), but also “prevent[] [the] public from understanding whether federal Medicaid payments to the state will change over the course of the demonstration, and if so, whether they will increase or decrease and by how much.”¹⁰ Absent this critical information, the public is denied a meaningful opportunity to comment on OHCA’s proposal.

Second, OHCA’s application does not contain accurate enrollment data and enrollment projections.¹¹ On March 6, 2020, OHCA submitted a state plan amendment “to add adult[s] ages 19-64 with income up to 133% of FPL as a covered population effective July 1, 2020.”¹² However, in June 2020, Oklahoma withdrew its expansion plan, “[c]iting a lack of funding.”¹³ Oklahoma Governor Kevin Stitt noted that as a result of “the widespread unemployment due to the pandemic[,] . . . far more people would be eligible for coverage under expanded Medicaid,” which would impose “a financial cost that would be significantly higher than the state had initially projected.”¹⁴ Therefore, Governor Stitt chose to veto a bill that would have provided funding for the expanded Medicaid program.¹⁵ OHCA’s section 1115 waiver application, however, is still premised on the notion that, a year prior to implementation of SoonerCare 2.0, Medicaid will be expanded in Oklahoma.¹⁶ As a result, the application’s estimates of SoonerCare 2.0’s incremental effects on enrollment are undeniably inaccurate.

⁵ *Id.* § 431.412(a)(1)(iii).

⁶ *Id.* § 431.412(a)(1)(iv).

⁷ *Id.* § 431.412(a)(1)(iii).

⁸ Letter from Joan Alker, Exec. Dir., Ctr. for Children & Families, & Judith Solomon, Senior Fellow, Ctr. on Budget & Policy Priorities, to Seema Verma, Adm’r Ctrs. for Medicare & Medicaid Servs. (May 1, 2020), *available at* <https://ccf.georgetown.edu/wp-content/uploads/2020/05/SoonerCare-2.0-Letter-5-1.pdf>.

⁹ *Id.*

¹⁰ *Id.*

¹¹ 42 C.F.R. § 431.412(a)(1)(iv).

¹² OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 17; *see also* Press Release, Okla. Health Care Authority, OHCA Submits State Plan Amendment to Increase the Eligibility of the SoonerCare Population (Mar. 6, 2020), <http://www.okhca.org/about.aspx?id=24560>.

¹³ Rebecca Pifer, *Citing Lack of Funding, Oklahoma Withdraws Planned July 1 Medicaid Expansion*, HEALTH CARE DIVE (June 1, 2020), <https://www.healthcaredive.com/news/citing-lack-of-funding-oklahoma-withdraws-planned-july-1-medicaid-expansio/578875>.

¹⁴ Louise Norris, *Oklahoma and the ACA’s Medicaid Expansion*, HEALTHINSURANCE.ORG (June 1, 2020), <https://www.healthinsurance.org/oklahoma-medicaid/#withdraw>.

¹⁵ *Id.*

¹⁶ *See* OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 17.

Indeed, even absent Oklahoma’s withdrawal of its state plan amendment, OHCA’s enrollment data and projections would be inaccurate due to the increase in unemployment resulting from COVID-19. As Governor Stitt himself noted, the increased unemployment rates “will not only increase the number of individuals currently enrolled in Medicaid, but will also increase the number of potential enrollees in the expanded population.”¹⁷ Because the enrollment data and projections that OHCA has included in its application are no longer accurate, the application is incomplete and thus unready for CMS review.

II. SoonerCare 2.0 will not promote the objectives of the Medicaid program and thus does not qualify for a section 1115 waiver

To approve a section 1115 demonstration, the Secretary of Health and Human Services must find that it “promot[es] the objectives” of the Medicaid program.¹⁸ Although the Social Security Act does not further define Medicaid’s “objectives,” courts have clarified that “the primary objective of Medicaid is to provide access to medical care.”¹⁹ Rather than advance this goal, SoonerCare 2.0 will erect barriers to care and, in turn, create conditions that may worsen health outcomes. Accordingly, the demonstration cannot be approved.

As explained in Section I, OHCA’s application is incomplete and should be returned. If, however, CMS chooses to proceed with considering the application, the appropriate comparison for purposes of assessing impacts on access to care is between an expansion of Medicaid coverage *without* SoonerCare 2.0’s reforms and an expansion of Medicaid coverage *with* SoonerCare 2.0’s reforms, since this is what the state expressly proposed and analyzed in its application.²⁰

Measured against the appropriate baseline, SoonerCare 2.0 will decrease access to care, as OHCA itself acknowledges.²¹ Specifically, OHCA projects that, under the proposed demonstration program, Medicaid “take-up” rates among the HAO population will be “reduced by 5%” due to “the effect of premiums and community engagement requirements.”²²

Others states’ experiences with imposing work requirements and cost-sharing measures akin to those in SoonerCare 2.0 suggest that the coverage loss associated with these provisions will be

¹⁷ Tres Savage, *Gov. Stitt Vetoes Hospital Fee for Medicaid Expansion*, NONDOC (May 21, 2020), <https://nondoc.com/2020/05/21/stitt-vetoes-hospital-fee-for-medicaid-expansion>.

¹⁸ Social Security Act, 42 U.S.C. § 1315(a); *see also About section 1115 Demonstrations*, MEDICAID.GOV, <https://www.medicaid.gov/medicaid/section-1115-demonstrations/about-section-1115-demonstrations/index.html>.

¹⁹ *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020); *see also Price v. Medicaid Dir.*, 838 F.3d 739, 743 (6th Cir. 2016) (“Through Medicaid, the federal government gives money to the States for the purpose of paying the medical costs of people ‘whose income and resources are insufficient to meet the costs of necessary medical services[.]’”); *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (“The primary purpose of Medicaid is to enable states to provide medical services to those whose ‘income and resources are insufficient to meet the costs of necessary medical services Congress expressly intended that the provision of medical services be administered by the state ‘in a manner consistent with simplicity of administration and the best interests of the recipients.’”) (citations omitted).

²⁰ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 17–20.

²¹ *Id.* at 18.

²² *Id.*

even greater than OHCA predicts.²³ In Arkansas, as of January 2019, 18,164 individuals had lost coverage since the state imposed work requirements in June 2018.²⁴ In Kentucky, the state “estimated in its application that about 95,000 people . . . could disenroll from Medicaid as a result of [work] requirements” over the course of a four-year period.²⁵ And in New Hampshire, the imposition of work requirements was projected to spur a massive decline in coverage; “between 30 percent and 45 percent of the [] low-income adults subject to the work requirements” in the state were deemed “likely be terminated within one year” due to inability to meet the work requirements or “difficulty completing the necessary paperwork.”²⁶

OHCA appears to believe that the harms associated with SoonerCare 2.0’s coverage losses will be outweighed by the program’s alleged benefit, such as the promotion of positive health outcomes associated with employment and the preparation of beneficiaries for transition to private insurance.²⁷ But even if this were true—and, as discussed in subsequent sections of this letter, it is very likely not—case law makes clear that the Secretary cannot justify the grant of a coverage-reducing section 1115 waiver by citing benefits of the proposed demonstration that are not direct objectives of the Medicaid program itself.

For example, in *Gresham v. Azar*, the court considered the Secretary’s approval of a section 1115 demonstration in Arkansas. There, the Secretary concluded that work requirements and limits to retroactive coverage “were ‘likely to assist in improving health outcomes’ and ‘incentivize beneficiaries to engage in their own health care.’”²⁸ The U.S. Court of Appeals for the D.C. Circuit, however, found the Secretary’s decision arbitrary and capricious, because it was based on his belief that “the demonstrations would assist in promoting an entirely different set of objectives than . . . the principal objective of Medicaid,” which “indisputably” was “providing health care coverage.”²⁹

²³ See, e.g., Jennifer Wagner & Jessica Schubel, *States’ Experiences Confirming Harmful Effects of Medicaid Work Requirements*, CTR. ON BUDGET & POLICY PRIORITIES (Oct. 22, 2019), <https://www.cbpp.org/health/states-experiences-confirming-harmful-effects-of-medicaid-work-requirements>.

²⁴ Jennifer Wagner, *Medicaid Coverage Losses Mounting in Arkansas from Work Requirement*, CTR. ON BUDGET & POLICY PRIORITIES (Jan. 17, 2019), <https://www.cbpp.org/blog/medicaid-coverage-losses-mounting-in-arkansas-from-work-requirement>; see also Benjamin Sommers et al., *Medicaid Work Requirements: Results from the First Year in Arkansas*, 381 N. ENG. J. MED. 1073 (Sept. 2019), <https://www.nejm.org/doi/pdf/10.1056/NEJMSr1901772?articleTools=true>; Robin Rudowitz et al., *February State Data for Medicaid Work Requirements in Arkansas*, KFF (Mar. 2019), <http://files.kff.org/attachment/State-Data-for-Medicaid-Work-Requirements-in-Arkansas>.

²⁵ Sara R. Collins et al., *The Potential Implications of Work Requirements for the Insurance Coverage of Medicaid Beneficiaries: The Case of Kentucky*, THE COMMONWEALTH FUND (2018), <https://www.commonwealthfund.org/publications/2018/oct/kentucky-medicaid-work-requirements> (“Work requirements present a serious risk — some Medicaid enrollees will not be able to meet the requirements and will lose their coverage.”).

²⁶ Leighton Ku & Erin Brantley, *New Hampshire’s Medicaid Work Requirements Could Cause More Than 15,000 to Lose Coverage*, THE COMMONWEALTH FUND (May 9, 2019), <https://www.commonwealthfund.org/blog/2019/new-hampshires-medicaid-work-requirements-could-cause-coverage-loss>; see also Letter from Jeffrey A. Meyers, Comm’r N.H. Dep’t of Health & Human Servs. to Gov. Christopher T. Sununu et al. (July 8, 2019), <https://www.dhhs.nh.gov/medicaid/granite/documents/ga-ce-findings.pdf>.

²⁷ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 6–7.

²⁸ *Gresham v. Azar*, 363 F. Supp. 3d 165, 172 (D.D.C. 2019), *aff’d*, 950 F.3d 93 (D.C. Cir. 2020).

²⁹ *Gresham v. Azar*, 950 F.3d 93, 99 (D.C. Cir. 2020).

Allowing implementation of SoonerCare 2.0, which OHCA admits will result in coverage losses, would similarly “prioritize non-statutory objectives to the exclusion of the statutory purpose” and is thus impermissible.³⁰

III. SoonerCare 2.0 will impose health and administrative costs that are unlikely to be justified by any corresponding benefits

As discussed *supra* in Section II, case law precludes the Secretary from relying on secondary objectives, like the promotion of positive health outcomes associated with employment and the preparation of beneficiaries for transition to private health insurance, as justification for approving a section 1115 demonstration that will reduce access to coverage. But even if such effects *were* permissible grounds for granting a section 1115 waiver, the Secretary could not reasonably conclude that SoonerCare 2.0 will yield them at levels sufficient to justify the program’s substantial health and administrative costs.

Because section 1115 waiver decisions are subject to arbitrary and capricious review under the Administrative Procedure Act (“APA”), costs are undoubtedly relevant to the Secretary’s consideration of OHCA’s application.³¹ Under the APA, a waiver grant can be set aside if the Secretary fails to “examine the relevant data” or “consider an important aspect of the problem.”³² And as the Supreme Court explained in *Michigan v. EPA*, “[a]gencies have long treated cost as a centrally relevant factor when deciding whether to regulate.”³³ Furthermore, relevant costs “include[] more than the expense of complying with regulations”; rather, “any disadvantage could be termed a cost.”³⁴ Accordingly, granting OHCA’s application without giving adequate consideration to SoonerCare 2.0’s considerable health and administrative costs would constitute an arbitrary and capricious use of the Secretary’s authority.³⁵

A. The Secretary cannot reasonably conclude that SoonerCare 2.0’s work requirement is cost-benefit justified

SoonerCare 2.0 will require non-exempt beneficiaries between 19 and 60 “to provide verification of participation in at least an average of 80 hours per month” of employment or another

³⁰ *Id.* at 104.

³¹ *Stewart v. Azar*, 313 F. Supp. 3d 237, 256 (D.D.C. 2018) (“Indeed, ‘[e]very court which has considered the issue has concluded that’ the Secretary’s section 1115 authority is ‘subject to APA review.’”). *See also* *Beno v. Shalala*, 30 F.3d 1057, 1067 & n.24 (9th Cir. 1994) (noting that “[e]very court which has considered the issue has concluded that § 1315(a) waivers are subject to APA review” and citing to a string of cases reaching the same conclusion).

³² *Motor Vehicle Mfrs. Ass’n v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983) (internal quotation marks omitted).

³³ *Michigan v. EPA*, 135 S. Ct. 2699, 2707–08 (2015); *see also* *Mingo Logan Coal Co. v. EPA*, 829 F.3d 710, 732–33 (D.C. Cir. 2016) (Kavanaugh, J., dissenting) (“As a general rule, the costs of an agency’s action are a relevant factor that the agency must consider before deciding whether to act.”).

³⁴ *Michigan v. EPA*, 135 S. Ct. at 2707–08.

³⁵ *See, e.g.,* *Competitive Enter. Inst. v. Nat’l Highway Traffic Safety Admin.*, 956 F.2d 321, 326–27 (D.C. Cir. 1992) (remanding fuel-efficiency rule due to agency’s failure to consider indirect safety costs); *Corrosion Proof Fittings v. EPA*, 947 F.2d 1201, 1225 (5th Cir. 1991) (striking down rule for failure to consider indirect safety effects of substituting asbestos-free car brakes); *see also* *Nat’l Ass’n of Home Builders v. EPA*, 682 F.3d 1032, 1040 (D.C. Cir. 2012) (when agency relies on a cost-benefit analysis to support its rulemaking, “a serious flaw undermining that analysis can render the rule unreasonable”).

“community engagement” activity.³⁶ For purposes of assessing the potential costs and benefits of this work requirement, the population of affected beneficiaries may be considered in four groups: (1) individuals who are currently unemployed and will remain unemployed despite the work requirement, thus jeopardizing their access to Medicaid coverage; (2) individuals who are currently unemployed but will successfully qualify for an exemption from the work requirement; (3) individuals who are already employed; and (4) individuals who are currently unemployed but will take on employment (or other qualifying activities) in response to the work requirement.

For individuals who are currently unemployed and will remain unemployed, the work requirement is a barrier to health care and does not provide any benefits. For the second category—individuals who qualify for and obtain an exemption—the work requirement provides no benefit but imposes administrative burdens. For the third category—individuals who are already employed—the work requirement provides no benefit but imposes administrative burdens and may lead to loss of coverage. Finally, for the fourth category—individuals who are currently unemployed but who will take on employment in response to the work requirement—such employment is unlikely to be welfare-enhancing.

Because the benefits provided by SoonerCare 2.0’s work requirements are unlikely to justify their substantial costs—and, for many Medicaid beneficiaries, will impose costs without *any* potential benefit—the Secretary cannot reasonably approve OHCA’s application.

1. For many currently unemployed individuals, meeting SoonerCare 2.0’s work requirement will prove too burdensome

For a variety of reasons, many currently unemployed individuals are unlikely to satisfy SoonerCare 2.0’s work requirement and will lose coverage, experience decreased access to care, and endure worsened health outcomes as a result. Some of these individuals may find that compliance is net costly due to associated opportunity or administrative costs. Other may be unable to satisfy the requirements due to physical and/or mental health conditions. And even if some of those conditions should exempt the affected individuals from work requirements, navigating the administrative process for securing an exemption may prove too difficult.

If an individual is currently unemployed, it may be because they determined that available employment opportunities are not net beneficial. Available jobs may not, for example, pay a sufficient wage to justify associated transportation and child-care costs, or may involve dangerous working conditions.³⁷ Because employment will not be welfare-enhancing for these individuals, they may remain unemployed despite a work requirement and thus lose access to Medicaid coverage. Furthermore, although SoonerCare 2.0 permits beneficiaries to meet its work

³⁶ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 11.

³⁷ See Tarani Chandola, *Is Having Any Job at All Better for Your Health and Wellbeing than Being Unemployed?*, UNIV. OF MANCHESTER: POLICY@MANCHESTER BLOGS (Aug. 15, 2017), <http://blog.policy.manchester.ac.uk/posts/2017/08/is-having-any-job-at-all-better-for-your-health-and-wellbeing-than-being-unemployed>; Joe Stafford, *Having a Bad Job Can Be Worse for Your Health Than Being Unemployed*, UNIV. OF MANCHESTER (Aug. 11, 2017), <https://www.manchester.ac.uk/discover/news/having-a-bad-job> (noting that “researchers found evidence that formerly unemployed adults who moved into poor quality jobs had elevated risks for a range of health problems, compared to adults who remained unemployed”); Alex Ekong, *Having a Bad Job Is Bad for Your Mental Health*, DEBUT (2018), <https://debut.careers/insight/a-bad-job-is-worse-than-unemployment>.

requirement through volunteer work and educational programs,³⁸ some may determine that the opportunity costs of these unpaid compliance options are also too high to justify.

Other beneficiaries may find it not just too costly but entirely infeasible to comply with a work requirement, because they “face significant employment barriers that work requirements do not address,” such as “physical and mental health conditions, addiction, low educational attainment, limited work experience, criminal histories that impede hiring, domestic violence, [] lack of affordable reliable childcare,” and speaking a first language other than English.³⁹ And while some of these circumstances may qualify affected individuals for an exemption under the Oklahoma plan, the beneficiaries may nevertheless find it too difficult to navigate the associated administrative process.⁴⁰ Indeed, a “recent Kaiser Family Foundation analysis [found] that the large majority of those likely to lose coverage due to work requirements are working people and people who should be eligible for exemptions, but who lose coverage due to administrative burdens or red tape.”⁴¹

As a result, SoonerCare 2.0’s work requirement “will cause many low-income adults to lose health coverage, including people who are . . . unable to work due to mental illness, opioid or other substance use disorders, or serious chronic physical conditions, but who cannot overcome various bureaucratic hurdles to document that they . . . qualify for an exemption.”⁴² These individuals will, in turn, have lesser access to care and risk worsened health outcomes.⁴³

2. Individuals who are already employed will not benefit from the work requirement but will bear administrative costs and may lose coverage

Beneficiaries who are already employed will not secure jobs in response to SoonerCare 2.0’s work requirement. As a result, imposing the requirement on these individuals will generate no benefit. The requirement will, however, create administrative burdens for these beneficiaries, as they will now have to *document* their employment.⁴⁴ Indeed, some employed beneficiaries will

³⁸ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 11-12.

³⁹ MaryBeth Musumeci & Julia Zur, *Medicaid Enrollees and Work Requirements: Lessons From the TANF Experience*, KFF (Aug. 18, 2017), <https://www.kff.org/medicaid/issue-brief/medicaid-enrollees-and-work-requirements-lessons-from-the-tanf-experience> (noting that “many adults receiving Medicaid often face barriers to employment, similar to those experienced by TANF enrollees”).

⁴⁰ The state will also bear an administrative burden in tracking and compiling all of the submitted documentation and utilizing this information to enforce SoonerCare 2.0’s eligibility requirements. *See id.* (noting that “Medicaid work requirements can create additional administrative complexity and costs for states[,]” since states must “devote their already limited staff and resources to tracking work program participation” or they must “incur the additional cost of contracting out that function”).

⁴¹ *See* Hannah Katch et al., *Taking Medicaid Coverage Away From People Not Meeting Work Requirements Will Reduce Low-Income Families’ Access to Care and Worsen Health Outcomes*, CTR. ON BUDGET & POLICY PRIORITIES (Aug. 13, 2018), <https://www.cbpp.org/research/health/taking-medicaid-coverage-away-from-people-not-meeting-work-requirements-will-reduce>; *see also* Rachel Garfield et al., *Implications of a Medicaid Work Requirement: National Estimates of Potential Coverage Losses*, KFF (June 27, 2018), <https://www.kff.org/medicaid/issue-brief/implications-of-a-medicaid-work-requirement-national-estimates-of-potential-coverage-losses>.

⁴² Katch et al., *supra* note 41.

⁴³ *Id.*

⁴⁴ *See* Garfield et al., *supra* note 41 (noting that Medicaid work requirements “will primarily affect people already working or exempt non-workers by imposing new reporting requirements to document either their compliance or exemption with the rules regarding work”).

lose coverage due to failure to satisfy reporting requirements.⁴⁵ Self-employed workers, for example, may find it difficult to supply proof of their working hours.⁴⁶ And workers in industries with highly variable hours, such as food service and construction, may be unable to consistently meet SoonerCare 2.0's 80-hour-per-month threshold.⁴⁷ Thus, for already employed beneficiaries, a work requirement is undoubtedly net costly.

3. Individuals who become employed in order to satisfy SoonerCare 2.0's work requirement are unlikely to experience improved health outcomes or other benefits that justify the requirement's costs

Even currently unemployed beneficiaries who take jobs in response to SoonerCare 2.0's work requirement are unlikely to enjoy the benefits that OHCA anticipates, such as higher incomes that will enable them to transition to private insurance coverage.⁴⁸

Research suggests that in the context of the Temporary Assistance for Needy Families ("TANF") program, enrollees subject to work requirements "work in low wage jobs and remain poor despite being employed."⁴⁹ Moreover, TANF "enrollees who were required to participate in a work program [have] incomes comparable to those who [are] not required to do so."⁵⁰

SoonerCare 2.0's work requirement is likely to have a similar result. If the jobs taken by beneficiaries provide neither employer-sponsored insurance nor sufficient income to purchase individual insurance, beneficiaries will not be able to transition to private insurance plans as OHCA envisions.

Nor can beneficiaries who secure jobs be expected to have better health outcomes solely by virtue of being employed. OHCA notes that "employed individuals are healthier than those who are not employed,"⁵¹ but correlation is not causation; the mere fact that employment and health/positive health outcomes are correlated does not mean that employment improves health. On the contrary, having a low-quality job, merely for the sake of being employed or meeting the work requirements imposed by a program such as SoonerCare 2.0, has been shown to cause *worse* health outcomes than unemployment.⁵² Thus, even for individuals who transition from

⁴⁵ Katch et al., *supra* note 41; *see also* Garfield et al., *supra* note 41 ("Disenrollment among those who may still be eligible but experience challenges in complying with administrative reporting requirements may be considered an 'unintended' negative consequence of implementing [work requirements].").

⁴⁶ Katch et al., *supra* note 41, at 6.

⁴⁷ *Id.* at 7 ("Among low-income working adults who could be subject to Medicaid work requirements, 46 percent worked fewer than 80 hours at least one month out of the year.").

⁴⁸ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 57 (hypothesizing that "SoonerCare 2.0 members subject to community engagement requirements will transition out of Medicaid due to increased income at a greater rate than Medicaid members not subject to the requirements").

⁴⁹ Musumeci & Zur, *supra* note 39; *see also* Gayle Hamilton et al., *National Evaluation of Welfare-to-Work Strategies: How Effective are Difference Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs*, MANPOWER DEMONSTRATION RES. CORP. (Dec. 2001), http://www.mdrc.org/sites/default/files/full_391.pdf (summarizing "the long-term effects of 11 mandatory welfare-to-work programs on welfare recipients and their children").

⁵⁰ Musumeci & Zur, *supra* note 39.

⁵¹ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 138.

⁵² *See* Chandola, *supra* note 37.

unemployment to employment, SoonerCare 2.0's work requirement is unlikely to generate benefits that justify its substantial costs.

B. The Secretary cannot reasonably conclude that SoonerCare 2.0's cost-sharing requirements are cost-benefit justified

Under SoonerCare 2.0, OHCA intends to implement cost-sharing measures, including monthly premiums⁵³ and an \$8 copay for non-emergency emergency department visits.⁵⁴ Yet research indicates that premiums and copays impose substantial costs on beneficiaries that are not justified by accompanying benefits such as improved health outcomes or more efficient allocation of health care resources. Accordingly, the Secretary cannot reasonably approve OHCA's application.

1. SoonerCare 2.0's premiums are likely to reduce access to health care and worsen health outcomes without generating a commensurate benefit

Rather than expanding access to care and enhancing health outcomes, “[p]remiums serve as a barrier to obtaining and maintaining Medicaid . . . coverage among low-income individuals.”⁵⁵ This is true even if the required payments are relatively small. For example, “increasing Medicaid premiums from 0 to 10 dollars per month has been shown to decrease continuous enrollment by 1.4 months and reduce rates of full year enrollment by 12% for both children and adults.”⁵⁶

OHCA relies on the Lewin Group's study of beneficiaries in Indiana who were required to pay premiums to assert that “making regular monthly premiums may lead to better health outcomes for members.”⁵⁷ It claims that Indiana “members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher prescribed drug adherence, and lower emergency room use than those who did not.”⁵⁸ However, Indiana's experience with cost-sharing measures is not the unalloyed success that OHCA suggests. Notably, after implementing premiums, Indiana failed to meet its enrollment goals.⁵⁹ Additionally, in a review of the Lewin Group's report and the accompanying data, the Kaiser Family Foundation found that “more than

⁵³ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 8 (“SoonerCare members will be required to make sliding scale flat rate monthly premium payments.”).

⁵⁴ *Id.* at 3 (noting that OHCA intends to “disincentivize inappropriate use of the emergency room with an \$8 copay for non-emergency use of the ER”).

⁵⁵ Samantha Artiga et al., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings*, KFF (June 1, 2017), <https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/view/print>.

⁵⁶ *Cost Sharing in Medicaid*, MARCH OF DIMES (June 2015), <https://www.marchofdimes.org/materials/Cost-Sharing-in-Medicaid-Issue-Brief-June-2015.pdf>; see also Laura Dague, *The Effect of Medicaid Premiums on Enrollment: A Regression Discontinuity Approach*, 37 J. HEALTH ECON. 1 (May 17, 2014) (finding that “an increase in the premium from 0 to 10 dollars per month results in 1.4 fewer months enrolled and reduces the probability of remaining enrolled for a full year by 12 percentage points, but other discrete changes in premium amounts do not affect enrollment or have a much smaller effect”).

⁵⁷ OHCA SoonerCare 2.0 HAO Application, *supra* note 2, at 8.

⁵⁸ *Id.*

⁵⁹ Jake Harper, *Indiana's Claims About Its Medicaid Experiment Don't All Check Out*, NPR (Feb. 24, 2017), <https://www.npr.org/sections/health-shots/2017/02/24/516704082/indiana-s-claims-about-its-medicaid-program-dont-all-check-out>.

half (55%) of all of those eligible to pay premiums under [Indiana’s plan] during the first two years of implementation failed to do so, resulting in negative consequences.”⁶⁰

Oregon’s experience with premiums similarly undercuts OHCA’s suggestion that they improve health.⁶¹ A study analyzing Oregon’s Medicaid program examined differences in enrollment and health outcomes between Oregon’s “Standard” and “Plus” plans. Under the “Standard” program, Oregon “increased premiums, raised cost sharing, and imposed rigid premium payment deadlines for members.”⁶² These new financial burdens were not imposed on members in the “Plus” program.⁶³ The study found that the difference in the two programs’ designs “was a key factor driving a 77 percent disenrollment rate in the Standard program, from a high of 104,000 enrollees in February 2003 to just 24,000 by the end of the study period, November 2005.”⁶⁴ Individuals “who were in the Standard plan when the reduced benefits and higher member costs went into effect were also nearly twice as likely to have unmet health care needs compared to those in the Plus plan.”⁶⁵

Thus, SoonerCare 2.0’s premiums are likely to impose health costs by reducing access to care. And these costs are unlikely to be justified by any corresponding benefit, such as the more efficient use of health care resources. In fact, because cost-sharing initiatives like premiums have been shown to reduce the “use of preventive services and prescription drugs, as well as chronic disease management,” they “could ultimately *increase* overall health care costs if individuals delay care until more expensive treatment is required.”⁶⁶

2. SoonerCare 2.0’s \$8 copay for non-emergency visits to the emergency room will impose administrative and other costs without discouraging such visits

Implementation of SoonerCare 2.0’s \$8 copay for non-emergency emergency department visits will impose administrative costs on the state, medical providers, and beneficiaries. The state and medical organizations, such as hospitals, will spend time and resources determining which visits do not qualify as emergencies and which beneficiaries are subject to the copay. Beneficiaries, meanwhile, will experience transaction costs associated with making payments or demonstrating that they are financially unable to do so and therefore exempt.

These costs almost certainly outweigh the benefits OHCA hopes to obtain. OHCA assumes that imposing the copay will reduce nonessential use of emergency rooms, thus freeing up resources

⁶⁰ Robin Rudowitz, MaryBeth Musumeci & Elizabeth Hinton, *Digging Into the Data: What Can We Learn from the State Evaluation of Healthy Indiana (HIP 2.0) Premiums*, KFF (Mar. 2018), <http://files.kff.org/attachment/Issue-Brief-Digging-Into-the-Data-What-Can-We-Learn-from-the-State-Evaluation-of-Healthy-Indiana-HIP-20-Premiums>.

⁶¹ See Bill J. Wright et al., *Raising Premiums and Other Costs for Oregon Health Plan Enrollees Drove Many to Drop Out*, 29(12) HEALTH AFF. (MILLWOOD) 2311 (Dec. 2010), available at <https://pubmed.ncbi.nlm.nih.gov/21134935>.

⁶² *Id.* at 2311.

⁶³ *Id.*

⁶⁴ *Id.*

⁶⁵ *Id.*

⁶⁶ *Cost Sharing in Medicaid*, *supra* note 56 (emphasis added).

for more efficient allocation.⁶⁷ However, research has shown that Medicaid enrollees in states that increased copays for non-emergency emergency department visits did not respond by making fewer such visits.⁶⁸ Furthermore, even if copays could discourage non-emergency visits, that discouragement might result in worsened health outcomes if deterred patients instead pursued less effective care or chose to forgo care altogether. Thus, the Secretary cannot reasonably conclude that the benefits of OHCA’s proposed copay justify its administrative costs.

Conclusion

OHCA’s section 1115 waiver application, as currently submitted, is incomplete and should be returned for correction. If CMS nevertheless proceeds with consideration of the application, the application should be denied because SoonerCare 2.0 will frustrate Medicaid’s primary goal of providing health coverage for vulnerable and low-income individuals. And even if it were permissible to rely on secondary objectives like the promotion of positive health outcomes associated with employment or the preparation of beneficiaries for transition to private insurance as grounds for granting a waiver that reduces coverage, the Secretary could not reasonably conclude that SoonerCare 2.0 will yield these alleged benefits at levels sufficient to justify its substantial health and administrative costs.

Respectfully,

Jack Lienke, Regulatory Policy Director
Julia Paranyuk, Summer Law Clerk

Institute for Policy Integrity

⁶⁷ OHCA SoonerCare 2.0 Application, *supra* note 2, at 54 (noting that a “goal” of the program is to “[s]trengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making” and hypothesizing that “[i]mplementation of an \$8 copay for non-emergency use of the ER will reduce non-emergency use of the ER”).

⁶⁸ Karoline Mortensen, *Copayments Did Not Reduce Medicaid Enrollees’ Nonemergency Use of Emergency Departments*, 29:9 HEALTH AFFAIRS 1643, 1648 (Sept. 2010); *see also* Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015), <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2091743> (concluding that “[g]ranted states permission to collect copayments for nonurgent visits under the DRA did not significantly change ED or outpatient medical provider use among Medicaid beneficiaries.”).