March 13, 2019

Chairman Dennis Lanz
Vice Chairman Edward Buttrey
Vice Chairman Gordon Pierson
House Committee on Children, Families, Health and Human Services
P.O. Box 200400
Helena, Montana 59620

Submitted by:
Nicole Huberfeld, J.D.

Sent via email to:
lydia.balian@mt.gov

RE: HB 425, The Keep Montana Healthy Act, Written Testimony

Dear Chairman Lanz, Vice Chairman Buttrey, Vice Chairman Pierson, and the honorable members of the House Human Services Committee:

I write to share my expertise, as it is relevant to House Bill 425, The Keep Montana Healthy Act, sponsored by Representative Mary Caferro. I am a Professor of Health Law, Ethics & Human Rights at Boston University School of Public Health and Professor of Law at Boston University School of Law. Before joining BU, I was a Professor of Law at the University of Kentucky College of Law and Bioethics Associate at UK College of Medicine. My research explores health law and constitutional law with a focus on health care reform, federalism in health care, and Medicaid. My work on Medicaid has been cited by the US Supreme Court, *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519 (2012), and other federal and state courts.

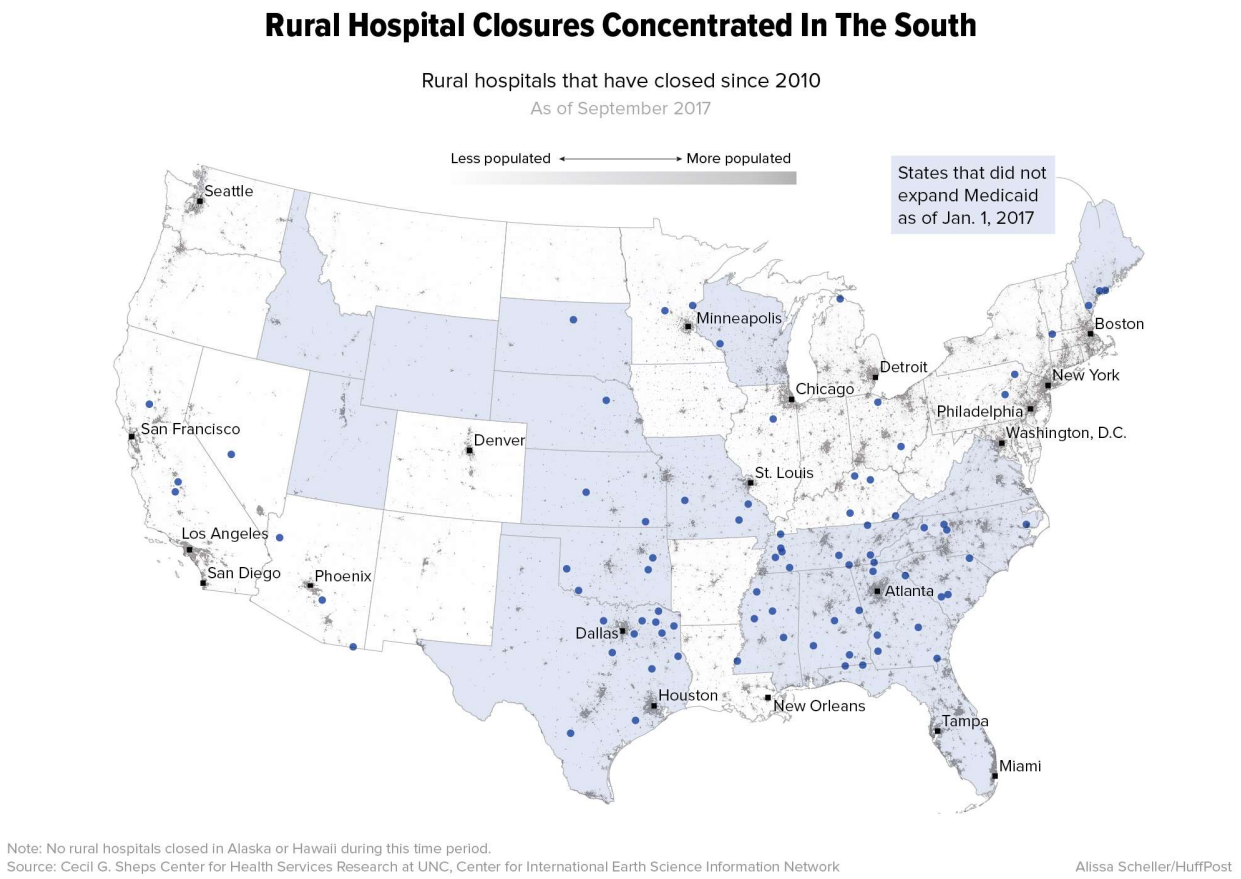
I strongly urge Montana to continue its Medicaid eligibility expansion, without work requirements, because the purpose of the Medicaid Act is to provide medical care to low-income people. Since 1965, federal law has invited states to "furnish medical assistance" to low-income people through the matching funds offered by the Medicaid program. Medicaid's legal purpose is to provide medical assistance, a goal that is contradicted by a policy that prevents coverage and, accordingly, access to care. In other words, the Medicaid Act ensures that the poor are protected against financial risk while providing access to necessary medical care because Medicaid pays for "medical assistance." Medicaid originally focused on those called the "deserving poor," but in 2010 the Patient Protection and Affordable Care Act (ACA) amended Medicaid to include childless, nonelderly adults earning up to 138% of the federal poverty level (FPL) (for one person, the FPL is $12,490 in 2019). The ACA ended the distinction between deserving and undeserving poor.

The Medicaid Act does not allow work requirements and implementing them can be expected to lead to lawsuits. Some states (like Montana) have established job search programs that assist low-income people such as Medicaid beneficiaries, which is lawful because the state encourages but does not require work as a condition of Medicaid eligibility. Mandatory work requirements are different because they create a barrier to enrollment. A federal court has held that Kentucky's work requirements were an unlawful exercise of the Secretary of the Department of Health and Human Services' authority, because Medicaid's language requiring states to "furnish medical assistance" means that states must *pay* for medical care, which is not the same as promoting "health," and which is contradicted by conditions on eligibility predicted to disenroll beneficiaries. New

litigation is pending in federal court, challenging Arkansas' work requirements and the re-approval of Kentucky's work requirements. More than 18,000 Arkansas Medicaid beneficiaries were disenrolled at the end of 2018 due to work reporting requirements, not because the beneficiaries were not working but because they did not know of the new rule or know how to report their work. This led an independent federal commission to ask the Secretary to cease all approvals for work requirements. Federal courts are not likely to uphold any states' work requirements because they contradict the purpose of the Medicaid Act.

Even if work requirements were lawful, low-income and part-time workers cannot get private health insurance coverage through work. Since the late 1980s, the percentage of persons enrolled in employer-sponsored health insurance has decreased steadily, especially among those earning less than 250% of the FPL [1]. In addition, individuals employed in low-wage and part-time jobs have rarely been offered health insurance benefits. As a result, the ACA created health insurance coverage for populations that had been unable to get insurance through work. Private insurance for individuals is sold through new health insurance exchanges, with tax credits given to persons who earn 100-400% of the FPL. For those who earn lower incomes, Medicaid eligibility was expanded. The overlap between Medicaid and subsidies for private insurance purchased on the exchanges ensures that the working poor, whose incomes vary throughout the year, would not go without health insurance. Without Medicaid, low-income workers will return to the pre-ACA days of working in jobs with no health insurance benefit, and those earning less than 100% of FPL will not be able to receive subsidies for individual insurance purchased on an exchange. No increase in employer-sponsored health insurance has occurred since the ACA was enacted for part-time or low-wage work. Data shows that Medicaid beneficiaries who can work do work, and most Medicaid beneficiaries are in households with at least one full-time worker [2]. Among the non-elderly who remain uninsured after the ACA, more than 70% work in jobs that do not offer health insurance benefits [3]. In other words, Medicaid beneficiaries disenrolled due to work requirements are not likely to gain private coverage elsewhere even if they do find new jobs.

Rural hospitals are more likely to remain open in states that have expanded Medicaid.
Rural hospitals have been closing throughout the last decade. This trend is related to characteristics of rural areas that affect both patients and health care providers. Rural residents are older, lower income, and less healthy than urban populations, and they suffer higher rates of disease and injury and more deaths from disease and injury. Rural residents are also less likely to work in industries that offer health insurance as an employment benefit, such as agriculture, mining, and retail. Combined with their lower-income status, rural patients are less likely to be able to pay for medical care in the absence of health insurance. The challenges facing rural patients in turn affect rural health care providers, which face higher rates of unpaid care and sicker patients. Hospitals bear the brunt of rural health disparities because they must provide emergency care for anyone who arrives in an emergency department under federal law (known as "EMTALA"). For rural health care providers, Medicaid expansion offers payment where none exists otherwise. Medicaid expansion has made a notable difference in keeping rural hospitals open as compared to non-expansion states, shown by the map below (with expansion states shaded in blue and non-expansion states in white) [4]:



In sum, I urge Montana legislators to continue Medicaid expansion, with no work requirements. Thank you very much for the opportunity to submit written testimony on this important issue.

Sincerely,

Professor Nicole Huberfeld
Boston University

References

[1] US Census Bureau, Income, Poverty, and Health Insurance Coverage in the United States: 2009. At: https://www.census.gov/prod/2010pubs/p60-238.pdf.
[2] Robin Rudowitz et al., *Understanding the Intersection of Medicaid and Work*, Jan. 5, 2018. At: https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.
[3] Kaiser Family Foundation, *Key Facts about the Uninsured*, Dec. 7, 2018. At: https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/.
[4] Relying on data from the Sheps Center for Health Services Research at UNC, this map illustrates that most rural hospital closures since 2010 have occurred in non-expansion states. At: https://www.huffingtonpost.com/entry/rural-hospitals-closure-georgia_us_59c02bf4e4b087fdf5075e38. Since the map was published, Maine expanded Medicaid, followed by Utah, Idaho, and Nebraska, all of which approved Medicaid expansion by voter ballot initiatives.