Laura Hermer
Professor of Law, Mitchell Hamline School of Law
Statement before the House Health and Human Services Reform Committee Regarding HF 3722
Saint Paul, MN
March 20, 2018

Thank you for the opportunity to testify in opposition to HF 3722.

Minnesota has a proud, bipartisan tradition of fostering the health and well-being of all its residents. For decades, it has creatively and iconoclastically sought solutions to the health care challenges facing its residents and health care system. While these efforts to invest in its residents' health have often not been easy, they have paid off. Minnesota now consistently ranks among the healthiest states in the nation.[1]

Minnesota has long sought to ensure the coverage of all its residents as a means to improve the well-being of its population. It is surprising and unfortunate, then, to see HF 3722 proposed, which, if enacted, would likely work against that tradition, and instead embrace the cookie-cutter approach currently suggested by the federal Centers for Medicare and Medicaid Services (CMS).

HF 3722 is a solution to a problem that doesn't really exist. The proposition that underlies HF 3722 is that non-disabled, non-elderly, adult Medical Assistance beneficiaries should be responsible citizens and work. But most of them do work. According to the Kaiser Family Foundation, nearly two-thirds of non-elderly, non-SSI, adult Medicaid beneficiaries are employed, many in industries like customer service, education, and agriculture. The vast majority of the remainder is disabled, taking care of family, or studying.[2]

Why, then, do people who work need Medical Assistance? According to the Department of Public Health's Minnesota Health Access Survey, less than half of all Minnesotans who earn less than 200% of the federal poverty level have access to employer-sponsored coverage, and only 65% of those employees take it up.[3] When one looks at the economics of the situation, it's not hard to see why this is the case. If lower-income Minnesotans were offered a health insurance policy through their employer, the cost of their policy would total roughly one-third to one-half of their gross annual wages. According to the State Health Access Data Assistance Center, an individual, employer-sponsored health insurance policy cost around $6,000 in Minnesota in 2016. A family plan cost nearly $17,000.[4] To offer such a costly benefit in addition to cash wages is unfeasible for most employers. What's more, even if an employer does offer

[1] *See, e.g.*, Commonwealth Fund, AIMING HIGHER: RESULTS FROM THE COMMONWEALTH FUND SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE 5 (2017), http://www.commonwealthfund.org/~/media/files/publications/fund-report/2017/mar/1933_radley_aiming_higher_2017_state_scorecard_final_v3_03_15_2017.pdf.
[2] Rachel Garfield, Robin Rudowitz, & Anthony Damico, *Understanding the Intersection of Medicaid and Work*, KAISER FAMILY FOUNDATION ISSUE BRIEF (Dec. 7, 2017), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.
[3] Minnesota Dep't of Health, MINNESOTA HEALTH ACCESS SURVEY, https://pqc.health.state.mn.us/mnha/PublicQuery.action (querying "Access to employer coverage for the non-elderly" and "access to employer coverage for the non-elderly by income" for 2015 and 2017).
[4] SHADAC, 50-STATE COMPARISON TABLES: EMPLOYER-SPONSORED INSURANCE, 2015 – 2016 (2017), http://www.shadac.org/sites/default/files/publications/All%20state%20tables_Final%209.8.17.pdf.

health insurance to a lower-wage employee, Minnesota employees must pay, on average, 25 – 30% of the premium for that coverage, and must pay, on average, around $2,000 for a single-coverage deductible.[5] All that must come out of their low cash wages.

For a single, non-elderly, non-disabled adult earning no more than about $16,000 – nearly the eligibility cutoff for Medical Assistance – the economics of those figures are untenable. If one must choose between getting money to use to pay for one's bare daily subsistence, versus paying for health insurance, money for subsistence will usually come first. This is the situation most adult, non-elderly, non-disabled Medical Assistance beneficiaries find themselves in. Their low wages help keep consumer prices low. As long as we want less expensive food, customer service, cleaning, and maintenance, part of the price we must pay as decent people in a decent society is to provide for the health care benefits of the working poor. To make the working poor either go without coverage or be treated like untrustworthy freeloaders in order to obtain and keep coverage is simply unethical. As Minnesotans, we can do better than that.

Unfortunately, that's not all that's wrong with HF 3722. The bill would waste taxpayer dollars while also making benefit retention for working beneficiaries needlessly difficult. First, the proposed work requirements and their exceptions would be unduly onerous for both beneficiaries and units of government to administer, with frequent and burdensome documentation requirements for beneficiaries and cumbersome and expensive administration of the same for the government. Second, as the guidance issued by CMS on January 11, 2018, expressly states, CMS will provide no federal Medicaid matching funds to states for job training programs, job placement assistance, and employment supports such as transportation and child care. Minnesota will nevertheless be required to provide such supports to all beneficiaries subject to the work requirements.[6] Thus, either the state would need to fund these services out of the anticipated savings from the reduction in coverage of Minnesotans for whom the burdensome hassle of documenting adherence and maintaining compliance will be too great, or the state would need to allocate additional taxpayer dollars to pay for those services.

HF 3722 wouldn't continue our state's history of fostering the health and welfare of all Minnesotans. Rather, if enacted, two primary results are likely: First, as anticipated by other states that have already received § 1115 waiver approval,[7] it would probably diminish the Medical Assistance rolls, even if it ultimately saves Minnesota no money in the process.[8] And second, it would stigmatize Medical Assistance with the undeserved taint of welfare dependency, rather than treating the program as a support that helps beneficiaries access the medical care they need so they can continue contributing to their families' livelihood and to the good of our economy and society.

Please vote no on HF 3722.

---

[5] *Id*.
[6] CMS, STATE MEDICAID DIRECTOR LETTER 18-002, at 7 (Jan. 11, 2018).
[7] *See, e.g*., Office of the Governor Bevin, KENTUCKY HEALTH PROGRAM § 1115 WAIVER APPLICATION, Attachment IV (2017) (estimating a total reduction of over one million member months over the five years of the waiver).
[8] Notably, the guidance from CMS expressly provides that "States will not be permitted to accrue savings from a reduction in enrollment that may occur as a result of using this section 1115 authority." CMS, *supra* note 5, at p. 8.