Submitted electronically via ***medicaid.gov***.

January 16, 2020

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration

Dear Secretary Azar,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. CLASP submits the following comments in response to the proposed Nebraska Medicaid Section 1115 Heritage Health Adult Expansion Demonstration and raises serious concerns about the effects of the waiver, as proposed, on the health outcomes of Medicaid beneficiaries in Nebraska.

This waiver proposes to expand Medicaid coverage for adults up to 138% of the Federal Poverty Level (FPL) but it imposes restrictive conditions and a significant paperwork burden on the enrollees to receive and maintain comprehensive health insurance. Specifically, the waiver proposes to give comprehensive "Prime Medicaid" *only* to beneficiaries who meet certain criteria—including work requirements. The waiver proposal also eliminates retroactive eligibility in the state's Medicaid program for all enrollees except pregnant women, children, dual eligibles and individuals in a nursing facility. The proposal runs counter to the will of Nebraskans who voted for expansion without work requirements. CLASP opposes the provisions of this waiver and urges the Centers for Medicare and Medicaid Services (CMS) to immediately reject this proposal. Instead, the state should do a straight expansion of comprehensive Medicaid services to all adults under 138% of FPL.

Comprehensive Benefits Contingent On Burdensome Requirements

While all enrollees will receive basic health care services, under this waiver proposal, only certain people will be able to access comprehensive coverage. Nebraska proposes to make comprehensive coverage—known as Prime Medicaid, contingent on enrollees completing burdensome administrative tasks every six months.

Only enrollees who receive Prime Medicaid will have access to vision and oral health coverage, as well as

over-the-counter medications. Certain categories of beneficiaries will automatically receive Prime Medicaid, including medically frail populations; young adults age 19-20; and women who are pregnant and eligible under the expansion. All other adults who receive coverage under this waiver will be required to participate in certain initiatives and activities in order to *earn* and then maintain Prime Medicaid. To qualify for Prime Medicaid, an enrollee must:

- Participate in case and care management (including completing a health risk screening and a social determinants of health assessment; and must fill medications routinely);
- Complete an annual health visit;
- Select a primary care provider;
- Not miss three or more scheduled appointments;
- Notify the state of any changes in your status;
- Maintain employer-sponsored health coverage; and
- In year 2, participate in work/community engagement.

Taken together, these activities represent a significant burden on enrollees which can have a negative impact on their ability to qualify for Prime Medicaid. CLASP has deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where work reporting requirements have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care. States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act.[1] A waiver that does not promote the provision of health care would not be permissible.

This proposal's attempt to transform Medicaid and reverse its core function will result in individuals losing needed coverage for oral and vision services, poor health outcomes, and higher administrative costs. There is an extensive and strong literature that shows, as a recent New England Journal of Medicine review concludes "Insurance coverage increases access to care and improves a wide range of health outcomes."[2] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be rejected. Moreover, losing access to medically necessary oral and vision services will also make achieving work and education goals significantly more difficult for beneficiaries.

Oral and Vision Services Are Part of Comprehensive Coverage

CLASP strongly opposes the creation of a tiered Medicaid program and conditioning a *comprehensive*

benefits package on meeting these bureaucratic conditions. Oral health and vision are critical components of an individual's overall health and prevent other costly health problems and supports social interaction, mobility and work readiness.

The converse is also true, individuals with poor oral and vision health put their overall health and wellbeing at risk—in both the short term and over the lifespan. Poor oral health can impact people's ability to eat, get and keep a job, interact socially. Poor appearance resulting from dental problems can contribute to social isolation, lower wages and loss of self-esteem.[3] Low vision and blindness have dramatic impacts on individuals—as well as their families and communities. Individuals experiencing vision problems experience barriers to work; limitations in transportation and mobility; and social isolation. Employed adults lose more than 164 million hours of work each year due to oral health problems or dental visits.[4]

Both oral health and eye disorders/vision loss are correlated with other chronic conditions; and dental diseases in particular can quickly develop life-threatening complications if they are not quickly treated. For example, there is a correlation between diabetes and eye disease; diabetes-related eye diseases can cause individuals significant vision problems and even blindness.[5] There is also a connection between uncontrolled diabetes and serious periodontal disease; untreated periodontal diseases makes it more difficult to control diabetes and can lead to significant complications.[6]

Poor oral health can also lead to a range of other chronic conditions. The data linking dental infections to increased risk of cardiovascular disease is clear: poor oral health appears to worsen blood pressure control and interferes with hyper tension treatment.[7] Periodontitis has been linked to premature birth and low birthweight[8]. For individuals with disabilities, prevalent chronic conditions that have known oral health connections include depression, diabetes, and kidney diseases;[9] and individuals with epilepsy and autism spectrum disorders may experience lifelong direct oral health consequences.[10]

There are direct economic impacts of poor oral and vision health. A recent study of hospital emergency department (ED) visits by adults for chronic dental conditions in Maryland found that in 2016 alone, more than 22,000 adults covered by Medicaid visited hospital EDs for their dental conditions. Medicaid paid nearly $10 million for those ED visits, in addition to $1.4 million for adults who required hospitalization for their dental needs.[11] An estimate from NORC on behalf of Prevent Blindness America estimates the total economic burden of eye disorders and vision loss to be $139 billion, based on the 2011 U.S. population in 2013 dollars.[12]

One key factor in oral and vision health is access to health care. Lack of access to oral health and vision services put individuals at greater risk of poor health outcomes. Low-income individuals and communities of color are less likely to have access to and/or receive oral health services[13], and the low-income population is more likely to experience oral diseases[14].

Despite the huge health care and economic impacts of poor oral and vision health, and despite the high level of need for oral and vision services among low-income individuals, this proposal will deny oral and vision services to otherwise-qualified Medicaid enrollees unless they participate in a range of burdensome and unsustainable activities.

Prime Medicaid Eligibility Contingent on Work Requirements in Year 2

CLASP strongly opposes work requirements as a condition of eligibility for Medicaid. Below we provide additional comments that focus on the Year 2 Work Requirement as part of the eligibility for Prime Medicaid.

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements

CLASP does not support Nebraska's proposal to take away certain health benefits from individuals who do not meet new work requirements. CLASP strongly opposes work requirements for Medicaid beneficiaries and urges CMS to reject this request. Work requirements—and withholding benefits for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to coverage, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs.

While the purported goal of this provision is to promote work, the reality is that denying access to oral and vision care creates obstacles for individuals to getting and maintaining work. People must be healthy in order to work, and consistent access to oral health and vision services is vital to being healthy enough to work.[15] Making oral and vision health services more difficult to access could have the exact opposite effect on employment that supporters of work requirements claim to be pursuing.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Lead to Employer-Sponsored Insurance

The waiver request assumes that if participants become employed, they will be able to transition to affordable employer-sponsored insurance (ESI). Unfortunately, this is simply not the reality of many jobs in America. Only 49 percent of people in this country receive health insurance through their jobs—and only 16 percent of poor adults do so.[16] The reality is that many low-wage jobs, particularly in industries like retail and restaurant work, do not offer ESI, and when they do, it is not affordable.[17] In fact, in 2017, only 24 percent of workers with earnings in the lowest 10 percent of wages were offered employer insurance, and only 14 percent actually received coverage under in their employer offered insurance.[18] People working multiple part-time jobs or in the gig economy are particularly unlikely to have access to ESI.

A recent study by the Urban Institute provides additional evidence in New Hampshire – a state that was recently approved to move forward with their work reporting requirement. The paper found that New Hampshire residents who could lose Medicaid under work reporting requirements will likely face limited and costly employer-sponsored insurance options. In particular, researchers found that less than one in ten part-time private-sector employees in New Hampshire were eligible for employer-sponsored coverage and just over half of full-time employees at firms with fewer than 50 employees were eligible for employer-sponsored coverage in 2017. Additionally, annual employee contributions for a single-coverage plan would represent 12.5 percent of annual income for a minimum-wage, full-time worker and 25.0 percent of annual income for a minimum-wage, part-time worker— more than ten times the percentage premium limit in the Marketplace for individuals earning 100 percent of the federal poverty level.[19]

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Grow

Government Bureaucracy and Increase Red Tape

Taking away benefits—and shifting enrollment between Basic and Prime Medicaid—from Medicaid enrollees who do not meet new work requirements in Year 2 would add new red tape and bureaucracy to the program and only serve as a barrier to health care for enrollees. Tracking work hours, reviewing proof of work, and keeping track of who is and is not subject to the work requirement is a considerable undertaking that will be costly and possibly require new technology expenses to update IT systems. What's more, the waiver proposes that the eligibility redeterminations for Prime Medicaid happen every six months.

One of the key lessons of the Work Support Strategies initiative is that every time a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that must process additional applications. The WSS states found that reducing administrative redundancies and barriers used workers' time more efficiently and helped with federal timeliness requirements. As a result of Nebraska's new administrative complexity and red tape, ***eligible*** people will lose their Prime status because the application, enrollment, and on-going processes to maintain coverage are too cumbersome.

Recent evidence from Arkansas' implementation of work reporting requirements confirms that bureaucratic barriers for individuals who already work or qualify for an exemption will lead to disenrollment. More than 18,000 beneficiaries lost coverage before the program was suspended by a federal judge, likely becoming uninsured because they didn't report their work or work-related activities.[20] As reported by the Center on Budget and Policy Priorities, many of those who failed to report likely didn't understand the reporting requirements, lacked internet access or couldn't access the reporting portal through their mobile device, couldn't establish an account and login, or struggled to use the portal due to disability.[21] The recent study looking at the Arkansas program found that "work requirements have substantially exacerbated administrative hurdles to maintaining coverage." The study found a reduction in Medicaid of 12 percent, even though more than 95% of those who were subject to the policy already met the requirement or should have been exempt.[22]

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Do Not Reflect the Realities of Our Economy

Proposals to take health benefits away from Medicaid enrollees who do not work a set number of hours do not reflect the realities of today's low-wage jobs. For example, seasonal workers may have a period of time each year when they are not working enough hours to meet a work requirement and as a result will churn on and off Medicaid Prime during that time of year. Or, some may have a reduction in their work hours at the last minute and therefore not meet the minimum number of hours needed to retain Medicaid. Many low-wage jobs are subject to last-minute scheduling, meaning that workers do not have advance notice of how many hours they will be able to work.[23]

Nebraska's proposal to require 80 hours of work per month throughout the entire year in order to qualify for Prime Medicaid does not represent the reality of low-wage work. An analysis by the Urban Institute of Kentucky's similar proposal found that an estimated 13 percent of nondisabled, nonelderly working

Medicaid enrollees who do not appear to qualify for a student or caregiver exemption in Kentucky's Medicaid program could be at risk of losing Medicaid coverage at some point in the year under the work requirements because, despite working 960 hours a year, they may not work consistently enough throughout the year to comply with the waiver.[24] Additional analysis from the Urban Institute shows that Medicaid enrollees who would potentially be subject to work reporting requirements are more likely to face barriers to employment, compared with privately insured adults. The analysis found that half of nonexempt Medicaid enrollees nationally reported issues related to the labor market or nature of employment, such as difficulty finding work and restricted work schedules, as reasons for not working more, and over one-quarter reported health reasons.[25]

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Will Harm Persons with Illness and Disabilities

Many people who are unable to work due to disability or illness are likely to lose Prime Medicaid because of the Year 2 work requirement. A Kaiser Family Foundation study found that 36 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working. Additional research from the Kaiser Family Foundation shows that people with disabilities were particularly vulnerable to losing coverage under the Arkansas work reporting requirements, despite remaining eligible.[26]

And, an Ohio study found that one-third of the people referred to a SNAP employment program that would allow them to keep their benefits reported a physical or mental limitation. Of those, 25 percent indicated that the condition limited their daily activities,[27] and nearly 20 percent had filed for Disability/SSI within the previous two years. Additionally, those with disabilities may have a difficult time navigating the increased red tape and bureaucracy put in place to administer a work requirement. The result is that many people with disabilities will, in fact, be subject to the work requirement and be at risk of losing health coverage.

Proposals to Take Health Benefits Away from Individuals Who Do Not Meet New Work Requirements Will Have a Disparate Impact on Communities of Color

CLASP strongly opposes the proposal due to its disproportionate impact on communities of color. As discussed in more detail in the sections that follow, many people of color face employment challenges and, under the proposed policy, would be disadvantaged in being able to gain oral and vision benefits through Prime Medicaid.

Employment discrimination limits access to the workforce for many people of color: Studies show that racial discrimination remains a key force in the labor market.[28] In a 2004 study, "Are Emily and Greg more employable than Lakisha and Jamal: A Field Experiment on Labor Market Discrimination," researchers randomly assigned names and quality to resumes and sent them to over 1,300 employment advertisements. Their results revealed significant differences in the number of callbacks each resume received based on whether the name sounded white or African American. More recent research indicates that this bias persists. A study from 2013 submitted fake resumes of nonexistent recent college graduates through online job applications for positions based in Atlanta, Baltimore, Portland, Oregon, Los Angeles, Boston, and Minneapolis. African-Americans were 16% less likely to get called in for an interview.[29] Similarly, a 2017 meta-analysis of field experiments on employment discrimination since 1989 found that

white Americans applying for jobs receive on average 36% more callbacks than African Americans and 24% more callbacks than Latinos.[30]

Hispanic and Black workers have been hardest hit by the structural shift toward involuntary part-time work: Despite wanting to work more, many low-wage workers struggle to receive enough hours from their employer to make ends meet. A report from the Economic Policy Institute found that 6.1 million workers were involuntary part-time; they preferred to work full-time but were only offered part-time hours. According to the report, "involuntary part-time work is increasing almost five times faster than part-time work and about 18 times faster than all work."[31] Hispanic and Black workers are much more likely to be involuntarily part-time (6.8 percent and 6.3 percent, respectively) than their White counterparts, of whom 3.7 percent work part time involuntarily. And Black and Latino workers are a higher proportion of involuntary part-time workers, together representing 41.1 percent of all involuntary part-time workers. The greater amount of involuntary part-time employment among Black and Hispanic workers is primarily due to their having greater difficulty finding full-time work and more often facing work conditions in which hours are variable and can be reduced without notice.[32]

People of color are more likely to live in neighborhoods with poor access to jobs: In recent years, majority-minority neighborhoods have experienced particularly pronounced declines in job proximity. Proximity to jobs can affect the employment outcomes of residents and studies show that people who live closer to jobs are more likely to work.[33] They also face shorter job searches and fewer spells of joblessness.[34] As residents from households with low-incomes and communities of color shifted toward suburbs in the 2000s, their proximity to jobs decreased. Between 2000 and 2012, the number of jobs near the typical Hispanic and Black resident in major metropolitan areas declined much more steeply than for white residents.[35]

Due to overcriminalization of neighborhoods of color, people of color are more likely to have previous histories of incarceration, which in turn limit their opportunities: People of color, particularly African Americans and Latinos, are unfairly targeted by the police and face harsher prison sentences than their white counterparts.[36] After release, formerly incarcerated individuals fare poorly in the labor market, with most experiencing difficulty finding a job after release. Research shows that roughly half of people formerly incarcerated are still unemployed one year after release.[37] For those who do find work, it's common to have annual earnings of less than $500.[38] Further, during the time spent in prison, many lose work skills and are given little opportunity to gain useful work experience.[39] People who have been involved in the justice system struggle to obtain a driver's license, own a reliable means of transportation, acquire relatively stable housing, and maintain proper identification documents. These obstacles often prevent them from successfully re-entering the job market and are compounded by criminal background checks, which further limit access to employment.[40] A recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[41]

Further, work reporting requirements are part of a long history of racially-motivated critiques of programs supporting basic needs. False race-based narratives have long surrounded people experiencing poverty, with direct harms to people of color. For decades these narratives have played a role in discussions around public assistance benefits and have been employed to garner support from working-class whites.[42] Below are a few examples of the relationship between poverty, racial bias, and access to basic needs programs.

- When the "Mother's Pension" program was first implemented in the early 1900s, it primarily served white women and allowed mothers to meet their basic needs without working outside of the home. Only when more African American women began to participate were work reporting requirements implemented.[43]
- Between 1915 and 1970, over 6 million African Americans fled the south in the hope of a better life. As more African Americans flowed north, northern states began to adopt some of the work reporting requirements already prevalent in assistance programs in the South.[44]
- As civil rights struggles intensified, the media's portrayal of poverty became increasingly racialized. In 1964, only 27 percent of the photos accompanying stories about poverty in three of the country's top weekly news magazines featured Black subjects; by 1967, 72 percent of photos accompanying stories about poverty featured Black Americans.[45]
- Many of Ronald Reagan's presidential campaign speech anecdotes centered around a Black woman from Chicago who had defrauded the government. These speeches further embedded the idea of the Black "welfare queen" as a staple of dog whistle politics, suggesting that people of color are unwilling to work.[46]
- In 2018, prominent sociologists released a study looking at racial attitudes on welfare. They noted that white opposition to public assistance programs has increased since 2008 — the year that Barack Obama was elected. The researchers also found that showing white Americans data suggesting that white privilege is diminishing led them to express more opposition to spending on basic needs programs. They concluded that the "relationship between racial resentment and welfare opposition remains robust."[47]

Prime Medicaid Eligibility Contingent on Not Missing Three Appointments, Participating in Case or Care Management, Attending an Annual Health Visit, and Choosing a Primary Care Provider

The proposed waiver will deny Prime Medicaid to beneficiaries who miss three or more scheduled appointments or do not actively participate in case or care management, attend an annual health visit, and choose a primary care provider. This policy places all the burden on the beneficiary and fails to acknowledge the challenges faced by low-income beneficiaries, including unpredictable shift work, challenges with reliable child care, lack of reliable transportation or the challenges of public transportation.[48] Under this policy, a Medicaid recipient could be forced to choose between losing their job (when they are unexpectedly required to work additional hours) and getting the oral and vision health services they need to maintain their health—and their jobs.

In addition, evidence from states that have created incentives for various health-related behaviors under Medicaid shows at best, only moderate levels of participation in the designated activities.[49] A synthesis of the literature finds a consistent challenge in simply communicating information about the programs to participants, and that "most surveyed beneficiaries report low to moderate awareness about the existence of the incentive programs or how they work."[50] Along with similar results from the work reporting requirements implemented in Arkansas, this suggests that many people will be denied Prime Medicaid because they did not understand what they needed to do to retain benefits.

Removing Conditions Around Existing Retroactive Coverage Does Not Further the Objectives of the Medicaid Program

Nebraska's proposal would remove conditions around retroactive coverage which would allow the state

to waive the statutory provision requiring that Medicaid reimburse medical costs incurred by Medicaid beneficiaries for up to three months before they apply if they were eligible during the retroactive period. This waiver provision would apply to all Medicaid enrollees in the state except for pregnant women and children ages 0-18, beneficiaries dually-enrolled in Medicare and Medicaid, and recipients who are residing in a nursing facility.

Retroactive coverage, which has been a feature of Medicaid since 1972, helps prevent medical bankruptcy and provides financial security to vulnerable beneficiaries by making Medicaid payments available for expenses incurred during the three-month period before application if the beneficiary was eligible for Medicaid during that period. Data from Indiana show how important retroactive coverage is for low-income parents in the state who incurred costs prior to enrollment. Medicaid paid $1,561 on average on behalf of parents who incurred medical costs prior to enrolling in Medicaid.[51] Eliminating retroactive eligibility would instead lead to increased financial insecurity and instability for low-income families and higher uncompensated care costs for Medicaid providers.

As the court recognized in vacating approval of Kentucky's first waiver, the primary objective of Medicaid is to provide affordable coverage, including when an individual moves in and out of the program, or is sick and otherwise eligible for Medicaid. Taking months of coverage away from people and exposing them to financial harm does not promote the objectives of Medicaid. Without retroactive coverage, parents may go without needed medical care and incur significant medical debt for care they receive prior to the effective date of enrollment. Research shows that children's development can be negatively affected by issues resulting from poverty, such as toxic stress.[52]

In addition to helping individuals get the care they need, retroactive coverage ensures the financial stability of hospitals and other safety net providers as it allows them to be reimbursed for care they have provided during the three-month period that would otherwise have gone as uncompensated care, helping them meet their daily operating costs and maintain quality of care. Under waivers that eliminate retroactive coverage, a hospital would no longer get paid for, say, providing an emergency appendectomy or setting a broken bone for adults who are uninsured but Medicaid-eligible at the time of their accident, increasing the hospital's uncompensated care costs.

Conclusion

For all the reasons laid out above, CMS should reject Nebraska's waiver application. If Nebraska is serious about encouraging work and helping people move into jobs that allow for self-sufficiency (and affordable ESI) the state would be committed to expanding Medicaid to 138% of the Federal Poverty Level for all elgibible adults, as demanded by the voters of Nebraska.

Our comments include citations to supporting research and documents for the benefit of CMS in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks, and we request that these, along with the full text of our comments, be considered part of the formal administrative record on this proposal.

Thank you for considering CLASP's comments. Contact Elizabeth Lower-Basch (**elowerbasch@clasp.org**) and Renato Rocha (**rrocha@clasp.org**) with any questions.

All sources accessed January 2020.

[1] Jane Perkins, "Section 1115 Demonstration Authority: Medicaid Act Provisions That Prohibit a Waiver," *National Health Law Program*, 2017, **http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-demonstration-authority-medicaid-provisions-that-prohibit-waiver#.WhRlBFWnHIU**.
[2] Benjamin D. Sommers, M.D., Ph.D., Atul A. Gawande, M.D., M.P.H., and Katherine Baicker, Ph.D., "Health Insurance Coverage and Health — What the Recent Evidence Tells Us," *New England Journal of Medicine*, July 2017, **http://www.nejm.org/doi/full/10.1056/NEJMsb1706645**.
[3] "U.S. Department of Health and Human Services Oral Health Strategic Framework, 2014–2017," *U.S. Department of Health and Human Services Oral Health Coordinating Committee*, March-April 2016, **https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4765973/**.
[4] "Oral Health: Can Access to Services Be Improved," *Georgetown University Health Policy Institute*, n.d., **https://hpi.georgetown.edu/oralhealth/**.
[5] "Diabetes + Your Eyes," *Prevent Blindness*, 2019, **https://www.preventblindness.org/diabetes-related-eye-disease**.
[6] "Diabetes and Periodontal Disease," *American Academy of Periodontology*, n.d., **https://www.perio.org/consumer/gum-disease-and-diabetes.htm**.
[7] "Poor Oral Health Linked to Higher Blood Pressure, Worse Blood Pressure Control," *American Heart Association*, October 2018, **https://newsroom.heart.org/news/poor-oral-health-linked-to-higher-blood-pressure-worse-blood-pressure-control**.
[8] "Oral Health: A Window to Your Overall Health," *Mayo Clinic*, June 2019, **https://www.mayoclinic.org/healthy-lifestyle/adult-health/in-depth/dental/art-20047475**.
[9] Cheryl Fish-Parcham, "Improving Access to Oral health Care for Adults with Disabilities Can Improve Their Health and Well-Being," *Families USA*, September 2019, **https://familiesusa.org/wp-content/uploads/2019/10/OH_Oral-Health-and-People-with-Disabilities_IssueBrief.pdf**.
[10] Ibid.
[11] Cheryl Fish-Parcham, "Treating Pain Is Not Enough: Why States' Emergency-Only Dental Benefits Fall Short," *Families USA*, July 2018, **https://familiesusa.org/wp-content/uploads/2019/09/OH_Emergency-Oral-Health_Issue-Brief.pdf**.
[12] John Wittenborn and David Rein, "Cost of Vision Problems: The Economic Burden of Vision Loss and Eye Disorders in the United States," *Prevent Blindness America*, June 2013, **https://www.preventblindness.org/sites/default/files/national/documents/Economic%20Burden%20of%20Vision%20Final%20Report_130611_0.pdf**.
[13] Ibid., 4.
[14] Ibid., 4.
[15] Jessica Gehr and Suzanne Wikle, *The Evidence Builds: Access to Medicaid Helps People Work*, Center for Law and Social Policy, February 2017, **https://www.clasp.org/publications/fact-sheet/evidence-builds-access-medicaid-helps-people-work**.
[16] "Health Insurance Coverage of the Total Population," Kaiser Family Foundation, 2016, **https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&sortModel= percent7B percent22colId percent22: percent22Location percent22, percent22sort percent22: percent22asc percent22 percent7D**; "Health Insurance Coverage of Adults 19-64 Living in Poverty (under 100 percent FPL)," Kaiser Family Foundation, 2016, **https://www.kff.org/other/state-indicator/poor-adults**.
[17] Brynne Keith-Jennings and Vincent Palacios, "SNAP Helps Millions of Low-Wage Workers," Center on Budget and Policy Priorities, May 2017, **http://www.cbpp.org/research/food-assistance/snap-helps-millions-of-low-wage-workers**.
[18] Bureau of Labor Statistics, "Table 2. Medical Care Benefits: Access, Participation, and Take-up Rates," *U.S. Department of Labor*, December 2017, **https://www.bls.gov/news.release/ebs2.t02.htm**.
[19] Emily M. Johnston, Anuj Gangopadhyaya, Genevieve M. Kenney, et al., "New Hampshire Residents Who Lose Medicaid Under Work Requirements Will Likely Face Limited Employer-Sponsored Insurance Options," *Urban Institute*, May 2019, **https://www.urban.org/urban-wire/new-hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options?cm_ven=ExactTarget&cm_cat=HPC+-+05.30.2019&cm_pla=All+Subscribers&cm_ite=https%3a%2f%2fwww.urban.org%2furban-wire%2fnew-hampshire-residents-who-lose-medicaid-under-work-requirements-will-likely-face-limited-employer-sponsored-insurance-options&cm_lm=swikle@clasp.org&cm_ainfo=&&utm_source=%20urban_newsletters&&utm_medium=news-HPC&&utm_term=HPC&&**.
[20] Jennifer Wagner, "Commentary: As Predicted, Arkansas' Medicaid Waiver Is Taking Coverage Away from People," *Center on Budget and Policy Priorities*, June 2019, **https://www.cbpp.org/health/commentary-as-predicted-arkansas-medicaid-**

waiver-is-taking-coverage-away-from-eligible-people.

[21] Jennifer Wagner, "Commentary: As Predicted, Eligible Arkansas Medicaid Beneficiaries Struggling to Meet Rigid Work Requirements," *Center on Budget and Policy Priorities*, July 2018, **https://www.cbpp.org/health/commentary-as-predicted-eligible-arkansas-medicaid-beneficiaries-struggling-to-meet-rigid**.

[22] Ibid., 10.

[23] Liz Ben-Ishai, "Volatile Job Schedules and Access to Public Benefits," *Center for Law and Social Policy*, September 2015, **https://www.clasp.org/sites/default/files/public/resources-and-publications/publication-1/2015.09.16-Scheduling-Volatility-and-Benefits-FINAL.pdf**.

[24] Anuj Gangopadhyaya, Emily M. Johnston, Genevieve M. Kenney, et al., "Kentucky Medicaid Work Requirements: What are the Coverage Risks for Working Enrollees," *Urban Institute*, August 2018 **https://www.urban.org/research/publication/kentucky-medicaid-work-requirements-what-are-coverage-risks-working-enrollees**.

[25] Michael Karpman, "Many Adults Targeted by Medicaid Work Requirements Face Barriers to Sustained Employment," *Urban Institute*, May 2019, **https://www.urban.org/research/publication/many-adults-targeted-medicaid-work-requirements-face-barriers-sustained-employment**.

[26] MaryBeth Musumeci, "Disability and Technical Issues Were Key Barriers to Meeting Arkansas' Medicaid Work and Reporting Requirements in 2018," *Kaiser Family Foundation*, June 2019, **https://www.kff.org/medicaid/issue-brief/disability-and-technical-issues-were-key-barriers-to-meeting-arkansas-medicaid-work-and-reporting-requirements-in-2018/**.

[27] "Comprehensive Report: Able-Bodied Adults Without Dependents," *Ohio Association of Foodbanks*, 2015, **http://admin.ohiofoodbanks.org/uploads/news/ABAWD_Report_2014-2015-v3.pdf**.

[28] Robert Manduca, "Income Inequality and the Persistence of Racial Economic Disparities," *Sociological Science*, March 2018, **https://www.sociologicalscience.com/download/vol-5/march/SocSci_v5_182to205.pdf**.

[29] Brett Arends, "In Hiring, Racial Bias is Still a Problem. But Not Always for Reasons You Think," *Fortune*, November 2014, **http://fortune.com/2014/11/04/hiring-racial-bias/**.

[30] Lincoln Quillian, Devah Pager, Ole Hexel, et al., "Meta-Analysis of Field Experiments Shows No Change in Racial Discrimination in Hiring over Time," *Proceedings of the National Academy of Sciences of the United States of America*, October 2017, **https://doi.org/10.1073/pnas.1706255114**.

[31] Lonnie Golden, "Still Falling Short on Hours and Pay," *Economic Policy Institute*, December 2016, **http://www.epi.org/publication/still-falling-short-on-hours-and-pay-part-time-work-becoming-new-normal/**.

[32] Ibid.

[33] Scott W. Allard and Sheldon Danziger, "Proximity and Opportunity: How Residence and Race Affect the Employment of Welfare Recipients," *Housing Policy Debate*, September 2000, **https://pdfs.semanticscholar.org/4936/dfd925b78d9e81f8d5d44b95b6a15f8ba0ab.pdf**.

[34] Elizabeth Kneebone and Natalie Holmes, "The Growing Distance Between People and Jobs in Metropolitan America," *The Brookings Institution*, March 2015, **https://www.brookings.edu/research/the-growing-distance-between-people-and-jobs-in-metropolitan-america/**.

[35] Ibid.

[36] Jamal Hagler, "8 Facts You Should Know About the Criminal Justice System and People of Color," *Center for American Progress*, May 2015, **https://www.americanprogress.org/issues/race/news/2015/05/28/113436/8-facts-you-should-know-about-the-criminal-justice-system-and-people-of-color/**.

[37] Adam Looney and Nicholas Turner, *Work and Opportunity Before and After Incarceration*, The Brookings Institution, March 2018, **https://www.brookings.edu/research/work-and-opportunity-before-and-after-incarceration/**; Joan Petersilia, *When Prisoners Come Home: Parole and Prisoner Reentry,* Chicago, Ill: University of Chicago Press, 2003, **https://www.amazon.com/When-Prisoners-Come-Home-Prisoner/dp/0195386124**; Jeremy Travis, *But They All Come Back: Facing the Challenges of Prisoner Reentry,* Washington, D.C.: Urban Institute Press, 2005, **https://www.amazon.com/But-They-All-Come-Back/dp/0877667500**.

[38] Thomas Ahearn, "Survey Finds 96 Percent of Employers Conduct Background Screening," *Employment Screening Resources*, August 2017, **http://www.esrcheck.com/wordpress/2017/08/03/survey-finds-96-percent-of-employers-conduct-background-screening/**.

[39] Christy Visher, Sara Debus, and Jennifer Yahner, *Employment after Prison: A Longitudinal Study of Releasees in Three States*, Urban Institute, October 2008, **https://www.urban.org/sites/default/files/publication/32106/411778-Employment-after-Prison-A-Longitudinal-Study-of-Releasees-in-Three-States.PDF**.

[40] Marina Duane, Nancy La Vigne, Mathew Lynch, et al., *Criminal Background Checks: Impact on Employment and Recidivism*,

Urban Institute, March 2017, **https://www.urban.org/sites/default/files/publication/88621/2017.02.28_criminal_background_checks_report_finalized_blue_dots_1.pdf**.

[41] Ibid., 38.

[42] Josh Levin, "She Used 80 Names: The Real Story of Linda Taylor, America's Original Welfare Queen," *Slate*, December 2013, **http://www.slate.com/articles/news_and_politics/history/2013/12/linda_taylor_welfare_queen_ronald_reagan_made_her_a_notorious_american_villain.html**.

[43] Rachel Black and Aleta Sprague, "Republicans' Fixation on Work Requirements is Fueled by White Racial Resentment," *Slate*, June 2018, **https://slate.com/human-interest/2018/06/trump-administrations-fixation-on-work-requirements-for-snap-benefits-is-part-of-a-long-racist-policy-history.html**.

[44] Kali Grant, Funke Aderonmu, Sophie Khan, et al., *Unworkable and Unwise: Conditioning Access to Programs that Ensure a Basic Foundation for Families on Work Requirements*, Economic Security and Opportunity Initiative at Georgetown Law, February 2019**, http://www.georgetownpoverty.org/issues/tax-benefits/unworkable-unwise/**.

[45] Rachel Black and Aleta Sprague, "The Rise and Reign of the Welfare Queen," *New America*, September 2016, **https://www.newamerica.org/weekly/edition-135/rise-and-reign-welfare-queen/**.

[46] Gene Demby, "The Truth Behind the Lies of the Original 'Welfare Queen'," *NPR*, December 2013, **https://www.npr.org/sections/codeswitch/2013/12/20/255819681/the-truth-behind-the-lies-of-the-original-welfare-queen**.

[47] Rachel Wetts and Robb Willer, "Privilege on the Precipice: Perceived Racial Status Threats Lead White Americans to Oppose Welfare Programs," *Social Forces*, December 2018, **https://academic.oup.com/sf/article/97/2/793/5002999**.

[48] "Commuting to Fulfill Work-Requirements is a Part-Time Job*," *Center for the Study of Social Policy*, June 2019, **https://cssp.org/wp-content/uploads/2019/05/Commuting-to-Fulfill-Work-Requirements-INFOGRAPHIC-ONLY.pdf**.

[49] Kara Contreary and Rachel Miller, *Incentives to Change Health Behaviors: Beneficiary Engagement Strategies in Indiana, Iowa, and Michigan*, Medicaid.gov, August 2017, **https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/incentives-to-change-health-behaviors.pdf**.

[50] Rob Saunders, Madhu Vulimiri, Mark Japinga, et al., *Are Carrots Good for Your Health? Current Evidence on Health Behavior Incentives in the Medicaid Program*, Duke Margolis Center for Health Policy, June 2018, **https://healthpolicy.duke.edu/sites/default/files/atoms/files/duke_healthybehaviorincentives_6.1.pdf**.

[51] July 29, 2016 letter from the Centers of Medicare and Medicaid Services to the state of Indiana, available at **https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf**.

[52] American Academy of Pediatrics: Council on Community Pediatrics, "Poverty and Child Health in the United States," *Pediatrics,* April 2016, **http://pediatrics.aappublications.org/content/pediatrics/early/2016/03/07/peds.2016-0339.full.pdf**.