CLASP

Policy solutions that work for low-income people

March 20, 2020

The Honorable Alex Azar, Secretary
U.S. Departemtn of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Re: Healthy Indiana Plan Demonstration Extenstion Request

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 Indiana's section 1115 demonstration project known as the Healthy Indiana Plan (HIP), and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Indiana.

These comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver 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.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. Many work in low-wage jobs where employer-sponsored health care is not offered or is prohibitively expensive. Only 24 percent of the lowest 10 percent of earners has access to employer insurance (just 13 percent enroll), and among the lowest 25 percent of earners only 36 percent are offered employer insurance (just 21 percent enroll).[1] In fact, only 18 percent of poor adults receive health insurance through their jobs[2] and, according to recent a recent survey by the Bureau of Labor Statistics, low-wage workers pay more for employer-provided medical care benefits than higher-wage workers.[3]

Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications.

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.[4] 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, 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."[5] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health and should be rejected. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

During this time of the COVID-19 pandemic, CLASP asks CMS to automatically stop the consideration of any waiver, such as Indiana's request, that will create additional barriers to care. The stakes are so high at this time, all resources should be redirected to enrolling people in Medicaid and ensuring Indianans have access to care.

The Social Security Act Limits Extensions of Section 1115 Demonstration Projects to Three Years

Section 1115 of the Social Security Act (the "Act") allows the Secretary to approve state demonstration projects that promote the objectives of Medicaid. The statute is silent on the length of initial approvals although demonstrations are generally approved for no more than five years. In contrast, subsections (e) and (f) of section 1115 are clear that initial and subsequent extensions of an approved demonstration are limited to three-year periods.

Despite the clear direction from Congress that extensions be limited to periods no longer than three years, the Centers for Medicare & Medicaid Services (CMS) issued guidance in November 2018, stating that CMS "may approve the extension of routine, successful, non-complex section 1115(a) waiver and expenditure authorities in a state for a period up to 10 years." Indiana claims a ten-year extension is justified "based on the long-tenure and demonstrated success of HIP."

Section 1115 clearly prohibits an extension of HIP for longer than three years, so Indiana's request for a ten-year extension cannot be approved. Absent a statutory prohibition on extensions longer than three years, Indiana's 10-year extension request would still have to be denied under CMS' policy, because as shown below it is very far from being a "successful, non-complex" demonstration. Over the course of the demonstration, its features have been shown to limit participation in coverage and make it harder to get care.

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

CLASP does not support Indiana's proposal to take away health coverage from individuals who do not meet new work requirements. Our comments that follow focus on the harmful impact the proposed work requirements will have on low-income Indianans and the state.

Indiana's work requirement launched in 2019, but the state suspended implementation after it was challenged in a lawsuit, which is still pending. Given the appeals court decision in *Gresham v. Azar,* finding Arkansas' work requirement did not promote the objectives of Medicaid, the Indiana plaintiffs' case is likely to be successful.

Work requirements lead to loss of coverage of eligible people who are already working or should be exempt, a result that can't be avoided. In Arkansas, more than 18,000 people — nearly 1 in 4 of those subject to work requirements — lost coverage over the course of just seven months. In New Hampshire, almost 17,000 people, or about 40 percent of those who would have been subject to work requirements, would have lost coverage had state policymakers not put the policy on hold. In Michigan, almost 80,000 people were at risk of losing coverage before a court put its policy on hold, with the state joining in the plaintiff's request.

Indiana appeared to be on a path similar to Arkansas, New Hampshire and Michigan, with small numbers of

people reporting work or work-related activities and large numbers of people at risk of losing coverage. According to the interim evaluation, while reporting was still voluntary, only one percent of those who would later be required to report had done so through June 2019.

Based on data in the interim evaluation, 97,000 beneficiaries would be required to compete work activities in order to remain enrolled in coverage. Applying Arkansas' coverage loss ratio of 23% would result in approximately 22,000 people in Indiana losing coverage. The appeals court decision clearly affirmed, "The district court is indisputably correct that the principal objective of Medicaid is providing health care coverage."[6] Indiana's request to extend its work requirement, which will result in the loss of coverage for thousands of beneficiaries is directly in contradition to the principal objective of Medicaid.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges CMS to reject this request, especially given the pending litigation and data from Arkansas. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, 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.

As the current COVID-19 pandemic demonstrates, people who are employed may lose their job – through no fault of their own – on any given day. Factors beyond a person's control dictate whether or not they are able to work, and in times of public health crises or natural disasters Medicaid is needed most to respond to the need.

In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of preventive and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Do Not Promote Employment

Creating a work requirement for Medicaid is misguided and short-sighted. Lessons learned from other programs demonstrate that work requirement policies are not effective in connecting people to living-wage jobs that provide affordable health insurance and other work support benefits, such as paid leave.[7] A much better focus for public policy is to develop skills training for jobs that are in high demand and pay living wages, help people get the education they need to climb their career ladder and foster an economy that creates more jobs.

Another consequence of a work requirement could be, ironically, making it harder for people to work. When additional red tape and bureaucracy force people to lose Medicaid, they are less likely to be able to work. People must be healthy in order to work, and consistent access to health insurance is vital to being healthy enough to work.[8] Medicaid expansion enrollees from Ohio[9] and Michigan[10] reported that having Medicaid made it easier to look for employment and stay employed. Further, recent analysis by the New York Times finds that young single mothers' participation in the labor force increased four percentage points more in states that expanded Medicaid in 2014 compared to those that didn't, providing evidence that if people don't lose their health insurance when they go to work, they are more likely to work.[11] Making Medicaid 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.[12] 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.[13] 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.[14] 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 tend 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.[15]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Grow Government Bureaucracy and Increase Red Tape

Taking away health coverage from Medicaid enrollees who do not meet new work requirements 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.

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 Indianas new administrative complexity and red tape, ***eligible*** people will lose their health insurance because the application, enrollment, and on-going processes to maintain coverage are too cumbersome

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

Proposals to take health coverage 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 the program 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 numbers 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.[16] This not only jeopardizes their health coverage if Medicaid has a work requirement but also makes it challenging to hold a second job. If you are constantly at the whim of random scheduling at your primary job, you will never know when you will be available to work at a second job.

Indiana'ss proposal to require 80 hours of work per month throughout the entire year for some families is

incredibly blind to the reality of low-wage work. An analysis by the Urban Institute found that Kentucky's proposal to take away health care from individuals who do not work a set number of hours does not align with the reality of some working enrollees' lives. Urban 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.[17] 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 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.[18]

Proposals to Take Health Coverage 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 coverage because of the work requirement. Many people are not able to work due to disability or disease but may not have an official disability diagnosis. . A Kaiser Family Foundation study found that about 30 percent percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI—reported illness or disability as their primary reason for not working.[19] 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.[20]

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,[21] 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 Coverage Away from Individuals Who Do Not Meet New Work Requirements are Likely to Increase Churn

Indiana'sproposal to take away health coverage from Medicaid enrollees who do not meet new work requirements is likely to increase churn. As people are disenrolled from Medicaid for not meeting work requirements, possibly because their hours get cut one week or they have primarily seasonal employment (like construction work), they will cycle back on Medicaid as their hours increase or the seasons change. People may be most likely to seek to re-enrollment once they need healthcare, and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

When the beneficiary re-enrolls in Medicaid aftera lapse in coverage, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[22] Public programs will end up spending more to bring these beneficiaries back to health.

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

We strongly oppose 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 maintain their Medicaid eligibility.

Racial income disparities persist in the United States: Due to persisting racial economic disparities and discrimination in hiring practices, average hourly wages for Black and Hispanic workers are substantially lower than their white counterparts.[23] In South Carolina in 2017, for adults age 18-64, the poverty rate of the general population is approximately 15%. That percentage is significantly higher for both Black Americans and Latinos who have an estimated poverty rate of 21% in South Carolina in 2017.[24] This makes it more likely that Black and Hispanic individuals will benefit from programs that support work by helping them access health coverage.

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.[25] 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.[26] 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.[27]

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 recent report[28] found that as many as 4 in 10 part-time wokers are generally underemployed, preferring more hours of work compared to the same or fewer hours. Certain groups are more likely to be underemployed, including Black and Latinx workers, workers in relatively lower wage occupations, workers in the lowest third of family incomes, and workers paid hourly.

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."[29] 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.[30]

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.[31] They also face shorter job searches and fewer spells of joblessness.[32] 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.[33]

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.[34] 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.[35] For those who do find work, it's common to have annual earnings of less than $500. Further, during the time spent in prison, many lose work skills and are given little opportunity to gain useful work experience.[36] 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.[37] A recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[38]

Further, work reporting requirements are part of a long history of racially-motivated critiques of programs supporting basic needs. They are premised on the very assumption that people do not want to work, and therefore should be coerced to work. More often than not, the implication is that certain people, specifically black people, do not want to work.[39] False race-based narratives have long surrounded people experiencing poverty, with direct harms to people of color. The painful irony is that Black people have worked more than any other group in American history.[40] As the historian Steven Hahn has written, "African Americans were more consistently a part of the nation's working class, over a more extended period of time, than any other social, ethnic, or racial group."[41] For Black women and men, slavery required full employment. For the century that followed, Black women worked significantly more than White women in formal, paid, employment, and their labor force participation has been higher ever since—only recently have White women caught up.[42] Despite these realities, narratives that question the work ethic of Black people have been consistently used to promote policies, such as work reporting requirements. These policies coerce low-wage labor that perpetuates economic and political power that inflates the social standing, of White people. [43]

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.[44] 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.[45]
- 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.[46]
- 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.[47]
- Many of Ronald Reagan's presidential campaign speech anecdotes centered around Linda Taylor, 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.[48] She had been charged of multiple crimes including, serial killing and child abductions and even passed as white for most of her life. However, the story of her welfare fraud spread like wildfire and although Linda Taylor's was absolutely an annomally, her story has been used to depict all public benefits reipients. [49]
- 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."[50]

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements Will Harm

Returning Citizens

Having a criminal record can make it extremely difficult to find a job and meet work requirements. Research shows that roughly half of returning citizens are still unemployed one year after release.[51] These individuals face many legal and social impediments to finding and retaining employment which can build stability and reduce the risk of recidivism. Taking away health coverage for not working a set number of hours per month only exacerbates this challenge. People with criminal records face many more legal barriers to employment such as occupational licensing bans that preclude them from obtaining even low skilled and entry level positions. Even an arrest record can be a long-term barrier to finding and keeping employment since many businesses conduct background checks; a recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.[52]

Indiana's proposal would subject returning citizens after only six months of release to work a set number of hours per month in order to be Medicaid eligible. Many people with criminal records need more time, training, and hands-on assistance to find adequate employment. Access to benefits, such as Medicaid can mean the difference between an individual successfully reintegrating into society, or recidivating.

Former foster youth are likely to lose coverage

The Affordable Care Act (ACA) included a provision to help improve the health of young adults who often have significant health care needs and are more likely to be uninsured than their peers –youth up to age 26 previously in foster care and enrolled in Medicaid. This provision was also intended to reduce disparities in access to health insurance between former foster youth and other young adults who can stay on their parents' private insurance until age 26.

For youth who enter into foster care, between 35 and 60 percent have at least one chronic or acute health condition that needs treatment.[53] The chronic health issues that impact youth involved in the foster care system continue to be problematic for youth who ultimately age out of the foster care system. Youth who have aged out of foster care are more likely than their general peers to have a health condition that limits their daily activities.[54] Despite the intention of the ACA and the evidence surrounding the health of these youth, Indiana'sproposal takes away health coverage from former foster youth who are older than 21 years of age and do not work a set number of hours per month, jeopardizing their general health and well-being over time.[55]

Monthly premiums would harm families in low-income households

Medicaid has strong affordability protections to ensure that beneficiaries have access to a comprehensive service package and protects beneficiaries from out-of-pocket costs, particularly those due to an illness.[56]

A large body of research shows that even modest premiums keep people from enrolling in coverage.[57] Individuals, particularly during period of unemployment or other financial hardship, may be unable to afford to make the payments. Low-income consumers have very little disposable income and often must make choices and stretch limited funds across many critical purchases. While Medicaid is designed to protect consumers against costs, this proposal adds another cost to their monthly budget.

Moreover, simply the burden of understanding the premium requirements and submitting payments on a regular basis may be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.[58] Finally, states or insurance companies may fail to process payments in a timely fashion, leading to benefit denials even for people who make the required payments.[59]

Unlike private health insurance, The reality of this proposal is that individuals have to write checks on a monthly basis to purchase coverage. The vast majority of people with private insurance receive it through their employers, and have their share of the premiums automatically withheld from their paychecks, without having to take any positive action. Moreover, one-quarter of households with incomes under $15,000 reported being "unbanked,"[60] which may create additional barriers to making regular payments.

We strongly encourage CMS to reject Indiana's request to continue premium payments in HIP. The interim evaluation submitted with Indiana's extension request confirms the findings of previous evaluations showing that HIP's structure has reduced participation, although it omits a key metric—how many people never enroll because they fail to pay a premium.

- The 2016 interim evaluation of HIP found that one-third of individuals who apply for HIP coverage and are found eligible are not enrolled, because they don't make a premium payment.[61] Despite this alarming finding, the current interim evaluation does not include data on people who never enrolled.
- A separate assessment of the POWER Accounts in 2017 found that 55 percent of eligible individuals either didn't make their initial payment or missed a payment. Of those who missed a payment, 44 percent said they couldn't afford the premium.[62]
- The interim evaluation accompanying Indiana's extension request shows that in 2018, almost 6,000 individuals were disenrolled from coverage for failure to pay initial premiums into HIP Plus, including individuals on HIP Basic whose incomes increased above the poverty line. (This does not include people who were never enrolled for non-payment as noted above.) An additional 5,500 individuals with HIP Plus benefits were disenrolled and locked out of coverage for six months for non-payment.

Indiana's experience is consistent with extensive research (including research from Medicaid demonstration projects conducted prior to the enactment of the Affordable Care Act (ACA)) showing that premiums significantly reduce low-income people's participation in health coverage programs. These studies show that the lower a person's income, the less likely they are to enroll and the more likely they are to drop coverage due to premium obligations. People who lose coverage most often end up uninsured and unable to obtain needed health care services.[63]

Indiana's premiums appear to be affecting overall enrollment, according to a study in *Health Affairs*.[64] Indiana's coverage gains under the ACA were smaller than in neighboring states like Illinois, Kentucky, Michigan, and Ohio, which also expanded Medicaid, but do not terminate coverage for people who fail to make premium payments or impose a waiting period before enrollment.

Moreover, Indiana's experiment is having a disparate impact on African Americans who, according to the current interim evaluation, are more likely to lose coverage than other participants. They also had a higher likelihood of moving from Plus to Basic coverage and were more likely to be enrolled in Basic, which as explained below likely led to lower utilization of care. Despite the evaluation's findings, the new application does nothing to address the negative effects the demonstration has had on African American beneficiaries.

The impact of Indiana's premiums will likely be exacerbated by the tobacco surcharge premium imposed on people who smoke. According to the evaluation, only one percent of people have had to pay the premium surcharge so far, because it is imposed after people self-identify as tobacco users over a 12-month period of enrollment with the same managed care organization. That number is likely to increase and likely lead to decreased participation in coverage and decreased use of care as people end up leaving HIP Plus for Basic.

As we wrote in earlier comments, the tobacco surcharge is not likely to have the desired effect of encouraging people to quit.[65] Evidence shows that a tobacco surcharge does not reduce tobacco use; rather, it has negative

side effects like reduced insurance take-up.[66]

Indiana's Evaluation Shows There is Nothing Left to Demonstrate

The state's own evaluation of its current demonstration confirms what previous research has shown: that premiums reduce coverage and that copayments reduce the use of medically necessary services by program beneficiaries. Indiana wants to extend its current demonstration for ten years, but as described below, the evidence is clear that premiums and copayments decrease participation and impede access to care – there is nothing left to demonstrate.

The extension request includes continuing the existing POWER Account structure, which provides two types of coverage: HIP Plus and HIP Basic depending on people's income and whether they pay premiums. People with incomes above the poverty line enroll in Plus and must pay a monthly premium or lose coverage. If people with incomes below the poverty line don't pay their premiums, they are moved from Plus to Basic, which offers fewer benefits and requires copayments for most forms of care.

Reports that Claim to Provide Supporting Evidence for Taking Away Health Insurance from People Who Don't Meet Work Requirements are Deeply Misleading

The White House Council on Economic Advisors (CEA) and the conservative Foundation for Government Accountability have released reports that provide a deeply misleading view of Medicaid and work requirements. Several analyses paint a picture of low-wage work that contradicts claims in the CEA report. These reports find that many people who need assistance from programs like Medicaid are working, but characteristics of low-wage jobs mean this population faces job volatility, higher unemployment and less stability in employment.[67]

The CEA report does not even address health insurance coverage and never mentions the well-known data showing that most Medicaid beneficiaries who can work do work. Further, when examining the share of Medicaid beneficiaries that work the CEA report chose to focus on one month (December 2013), which gives a much lower rate of employment than another report from the Kaiser Family Foundation that uses the same data set but looks at employment over the course of a year. It's also important to note that the Medicaid data cited in the report pre-dates the Medicaid expansion, which dramatically affects the composition of the caseload.

Additionally, the CEA and FGA reports consider all Medicaid beneficiaries who do not receive disability benefits as "able-bodied," ignoring data and research that show that substantial numbers of Medicaid beneficiaries who do not receive disability benefits face significant personal or family challenges that limit the amount or kind of work they can do. In reality, barriers to work are significant and common. Five million Medicaid beneficiaries have disabilities but do not receive disability benefits, meaning that they could be subject to work requirements under the Administration's guidance.[68] Moreover, large majorities of non-working Medicaid beneficiaries report that they are unable to work due to disability or illness, caregiving responsibilities, or because they are in school.[69]

Lastly and most notably, the CEA and FGA reports do not offer any actual evidence to support the claim that taking away health care or other basic supports from people who fail to work a minimum number of hours will cause them to work more. In fact, the report ignores the ample evidence, as cited earlier in these comments, that work supports such as Medicaid make it easier for people to work. While the FGA report alludes to "success" with work requirements in other programs, their analyses have been called out as flawed and misleading.[70]

Conclusion

The request by Indiana to increase bureacracy, decrease access to health insurance, and impose burdensome work reporting requirements on their residents seems particularly cruel and short sighted given our country's

current economic crisis amid the COVID-19 pandemic. Medicaid should be one of the first lines of defense in a national health emergency such as the current pandemic. Proposals such as this that limit access to care significantly decrease Medicaid's ability to respond to crises, which negatively impacts the health of those who should be insured by Medicaid and ultimately, as we are currently experience, the health of everyone in the community or country. While we believe Indiana's waiver request is never appropriate for approval by CMS, we assert that approving such requests at this time gravely endangers lives.

For all the reasons laid out above, CMS should reject Indianas waiver application. Our comments include citations to supporting research and documents for the benefit of the Centers for Medicare and Medicaid Services (CMS) in reviewing our comments. We direct CMS to each of the items cited and made available to the agency through active hyperlinks and as attachments, 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 Suzanne Wikle (**swikle@clasp.org**) or Renato Rocha (**rrocha@clasp.org**) with any questions.

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