FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

July 31, 2017

The Honorable Tom Price, Secretary
United States Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Submitted electronically via *Medicaid.gov*

Re: Comments on HIP 2.0 1115 Waiver Extension Amendment

Dear Secretary Price:

Families USA is grateful for the opportunity to comment on the state of Indiana's waiver amendment request to modify its existing waiver, Healthy Indiana Plan 2.0 (HIP 2.0). We likewise greatly appreciate the extension of the federal comment period to do so.

Families USA a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans.

We are strongly in support of Indiana's decision to accept federal funding to extend Medicaid to more low income parents and adults. However, that the extension amendment includes components that set extremely troubling precedents for the Medicaid program. The amendment as requested includes elements that are contrary to the objectives of the Medicaid program and that would greatly diminish Medicaid enrollees' ability to access health care.

Our concerns and suggestions are discussed in greater detail below. Many of these concerns can, and should, be addressed during the waiver amendment approval process.

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The Amendment request will add administrative complexity to an already burdensome system

We appreciate the amendment request's acknowledgement that administrative complexity can pose a barriers to coverage and care for enrollees and foist unnecessary costs onto state systems and taxpayers. Unfortunately, there are several components of the amendment which run contrary to the state's goal of streamlined and efficient administration.

a. Charging and collecting premiums poses a barrier to coverage for low income people and foists unnecessary administrative burden onto the state

Research shows that all premiums, whether a percentage of income or a fixed amount, add to administrative complexity.[1] In Arkansas, for example, the state spent $9 million to contract with a vendor to manage premium collection and individual accounts but only collected $426,500 in premiums.[2] The POWER account structure is already very complex and difficult for enrollees to navigate, as demonstrated by very low enrollee knowledge and understanding of how these accounts work (see discussion below.) Tiering copayments rather than tying them to a percentage of income will not reduce administrative burden in a meaningful way, nor will it address the complexity of the underlying structure of the accounts.

Adding a new complicated work requirement will create significant new administrative burden for the state as it attempts to track work participation among a population whose work status and hours fluctuate frequently. Evidence from states' experience with TANF shows that monitoring work requirements is expensive and results in more resources and time being spent on tracking work hours than providing services.[3] It will also produce a significant new complexity into ongoing review of Medicaid eligibility, a process that has been painstakingly simplified over decades of Medicaid policy. An overwhelming lesson of decades of Medicaid policy is that collection of significant additional information leads to a higher rate of "eligible

[1] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[2] Joseph Thompson, *et al.,* "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population," Arkansas Center for Health Improvement, June 27, 2017.

[3] Ladonna Pavetti and Liz Schott, Changes in TANF Work Requirements Could Make Them More Effective in Promoting Employment (Washington, DC: Center for Budget and Policy Priorities, February 2013), available online at http://www.cbpp.org/research/family-income-support/changes-in-tanf-work-requirements-could-make-them-more-effective-in.

but not enrolled". Implementation of a work requirement will certainly lead to many people who comply with the requirement losing coverage because of the inherent coverage losses involved in adding a significant new documentation requirement.

Indiana's stated goals in HIP 2.0 are to engage beneficiaries in their health and health care utilization through the POWER Account structure. The state should allow for a rigorous federal evaluation of the administrative costs of the existing premium structure, existing POWER accounts and an evaluation of the anticipated administrative costs of the proposed work requirement in an effort to not only assist the state in achieving maximum efficiency, but also providing information to other states that might wish to follow the Indiana model. It is particularly important that in any review of administrative costs that managed care data be made available.

Work requirements in the Medicaid program are an abuse of the Section 1115 Demonstration authority as they do not promote the objectives of the Medicaid program

We strongly oppose Indiana's proposal to add a work requirement to HIP 2.0. The amendment application would require HIP 2.0 members to work or volunteer at least 20 hours per week on average over eight months of eligibility, be enrolled in full time or part time education, engaged in job seeking or job training, or volunteering. Work requirements are antithetical to the core objective of the Medicaid program, which is to furnish medical assistance to eligible needy persons. A work requirement creates a new eligibility requirement and erects a barrier for otherwise statutorily eligible persons to access coverage and care. Furthermore, it is outside the Secretary's discretion to approve such a radical change to the program through an 1115 waiver. Rather, imposition of an entirely new eligibility criterion must be undertaken through the legislative process—and indeed Congress recently considered precisely such a change.

a. The mere fact of a relationship between employment and health status does not create a sufficient connection to legally justify Medicaid waiver authority that renders otherwise eligible people uninsured.

In its application, Indiana cites research linking employment to improved mental and physical health as a rationale for linking enrollees' financial obligations under Medicaid to hours worked. The cited research may be true, but that is not relevant. Medicaid is a health insurance program whose purpose it is to provide health insurance for eligible people. The mere presence of a link between an activity, in this case employment, and health does not create a sufficient connection to support a claim that making Medicaid coverage conditional on that activity

promotes the objectives of the Medicaid program. It does not matter how commendable the activities in question, or whether those activities have been shown to promote health and well-being. Conditioning eligibility for the Medicaid program on participation in activities that are outside of the purpose of the Medicaid program changes the nature of the program itself and is outside of the Secretary's authority under Section 1115 of the Social Security Act.

b. Work requirements will penalize many people who work but cannot establish work history, or people who face great obstacles to work, in a population that is primarily workers

Most people on Medicaid who can work, do so, and for people who face major obstacles to employment, harsh requirements such as limiting their eligibility for coverage will not help overcome them – indeed they are likely to have the opposite effect. Eight in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Two thirds of Medicaid enrollees that work do so forty hours per week or longer. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.[4]

c. Medicaid coverage itself can promote employment among enrollees. Predicating coverage on work can be counterproductive to the purported goal of the proposed work requirement.

From a practical standpoint, work requirements applied to health coverage get it exactly backwards and this policy will work against the goal of ensuring Medicaid enrollees are fully employed. Data from Ohio's Medicaid expansion found that providing access to Medicaid helps people maintain employment and seek employment. More than half of Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three quarters of unemployed Medicaid expansion enrollees looking for work reported that health coverage has made it easier to seek employment.[5]

d. Imposing a work requirement will not necessarily achieve the state's goal of moving people off Medicaid due to the lack of affordable health insurance available to workers

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[4] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/

[5] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the General Assembly" http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

in low wage jobs

The State's proffered reason to impose work requirements, namely to encourage work among unemployed enrollees to "reduce dependence on public assistance," does not take into account that most Medicaid enrollees work in industries- like retail, home health care and food service—that do not offer employer sponsored insurance. If they do offer coverage, many time it is not available to part time staff or it has unaffordable cost sharing or premiums for someone making poverty wages. Just 12 percent of workers earning the lowest 10 percent of wages had employer-provided health insurance in 2016.[6]

e. Requiring individuals to provide community service in order to meet their requirement and receive health care coverage is bad policy and may violate federal labor laws.

In most cases, in which Medicaid pays health care providers for services provided to Medicaid enrollees or purchases insurance coverage for enrollees, enrollees do not receive any payments from the program.[7] Enrollees may go many months without receiving any direct benefit from Medicaid (i.e., people do not use health services all the time, the need is often unpredictable, hence the rationale for insurance to protect one from unpredictable costs). Given the way Medicaid operates, the state's proposed work/community service requirement which amounts to requiring those without paying jobs to engage in unpaid work in exchange for health coverage. That is not only bad public policy—essentially requiring work in exchange for a non-monetary benefit—there is also the potential for labor market disruption. In communities with weak labor markets, "free labor" provided through community service work could displace paying jobs and have the effect of increasing the ranks of the unemployed and the poor. A work requirement will particularly hurt people who cannot find jobs because they live in an economically depressed area, particularly those in struggling rural economies or areas with high rates of unemployment and some cases force them into unpaid work.[8]

Additionally, it may be that laws not related to the Medicaid program would be violated by this proposed scheme. We urge CMS to solicit input from the Department of Labor regarding this aspect of Indiana's proposal. In addition to being contrary to Medicaid law, the community service/volunteer work requirement in the request may be in violation of the Fair Labor Standards Act.

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[6] The Center for Law and Social Policy, "Work Supports" (last accessed July 15, 2017) http://www.clasp.org/issues/work-supports

[7] Medicaid may pay enrollees directly for some long-term services and supports.

f. Suggested Alternative

We agree with the state that any work promotion program must be carefully designed so as not to have the unintended consequence of worsening health outcomes. There is an alternative approach to the work requirement requested that would not have the unintended consequence of worsening health outcomes and cutting people off from coverage, something that would be a consequence of a work requirement linked to eligibility. The foundation of this approach would be a full assessment of the existing Gateway to Work program, with program redesign as indicated by that assessment.

In its amendment application, the state notes that the current HIP 2.0 Gateway to Work program has not been successful at "connecting members to sustained employment." Before taking the radical step of adding a work requirement—which is in opposition to Medicaid's core purpose of providing health insurance to low-income people is likely to have the unintended consequence of worsening health outcomes, and may not promote long-term employment—we urge an in-depth assessment of the Gateway to Work program which looks at samplings of both urban and rural areas to ascertain why the current voluntary program is not working and changes that could make it more effective. It is incumbent upon the state and CMS to understand fully why the state's voluntary work promotion program isn't working as desired before taking the radical step of adding a work requirement.

Such a study would serve multiple purposes: It will help the state better understand the barriers to work that Medicaid enrollees confront and the best ways to truly address those barriers; it will help the state better understand whether removing health coverage as a penalty for not working would be likely to help address those barriers; it would be informative for other states that are considering a program comparable to Indiana's Gateway to Work or work requirements in Medicaid. We recommend such an assessment be completed prior to approval of any mandatory work requirement tied to eligibility and that the findings be used to evaluate any final work related program proposed by the state.

The impulse to revoke Medicaid benefits as a disincentive stems more from an ideological connection of Medicaid to "welfare" than from empirical analysis. From the study that we recommend, a truly evidence based program that supports and encourages work could be created. For example, is lack of transportation or childcare impeding a HIP 2.0 member's ability to work and, if so, how might the state offer appropriate supports? In Colorado, workforce participation was increased by a universal pre-K program.[9] If current Gateway to Work

[9] Arloc Sherman, Danilo Trisi and Sharon Parrot, "Various Supports for Low-Income Families Reduce Poverty and

participations are not finding "sustained" employment because they are being connected with jobs in industries that have fluctuating hours and schedules, such as seasonal retail, food service and home health care, is there a way for the state to work with employers to increase the availability of full time work? Research from other state work support programs might also be valuable as the state seeks to improve workforce participation among enrollees.

The application cites Indiana's growing economy and we share the state's optimism that increased economic activity will "lift all boats." For members living in economically depressed areas, particularly rural areas, we hope a study of the current voluntary Gateway to Work program could determine how work requirements affect individuals where employment is scarce and, in particular, the effect compulsory unpaid employment might have on these fragile economies (see discussion above).

CMS should not approve the state's request to ask a tobacco use question on its Medicaid application as it could dissuade eligible individuals from enrolling and represents unnecessary intrusion into enrollee health information

We have concerns with the Indiana renewal application and the amendment's request to ask individuals a tobacco usage question on their application to determine a tobacco use premium surcharge. We share the state's goal of reducing the rate of smoking by linking individuals to smoking cessation tools and other medical and social supports. However, this is best done in the context of the doctor patient relationship, not via a state form. Having such a question may deter eligible enrollees from seeking coverage and therefore being connected with appropriate smoking cessation support. We note in addition that CMS policy following on statutory changes to Title XIX over many years, culminating in 2010, has been to minimize or eliminate questions that are extraneous to eligibility determination as a critical tool in reducing the number of people eligible but not enrolled in Medicaid.

Conclusion

We continue to support the state's decision to accept federal funding and expand Medicaid to eligible Hoosiers up to 138 percent of the federal poverty level. However, as proposed, many elements of the extension amendment application work against the purposes of the Title XIX, namely, by tying Medicaid coverage to a work requirement and further complicating how the state will charge premiums to very low income individuals through what is already a complex, administratively burdensome individual account structure. The amendment as submitted would

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Have Long-Term Positive Effects on Families and Children" The Center on Budget and Policy Priorities (July, 2013) http://www.cbpp.org/research/various-supports-for-low-income-families-reduce-poverty-and-have-long-term-positive-effects

place current HIP 2.0 enrollees in a worse position than they are in now, making it more difficult for them to access and afford care, all while creating administrative burden and cost for the state and Indiana taxpayers.

Thank you for the opportunity to comment on this important program. Should you have any questions, please don't hesitate to contact Dee Mahan, Director of Medicaid Initiatives at dmahan@familiesusa.org or Andrea Callow, Associate Director of Medicaid Initiatives at acallow@familiesusa.org

Respectfully,

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