

CLASP

Policy solutions that work for low-income people

April 15, 2020

Oklahoma Health Care Authority
Federal Authorities Unit
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Re: SoonerCare2.0 Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application

Dear Oklahoma Health Care Authority,

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 Oklahoma's Sooner 2.0 Healthy Adult Opportunity (HAO) waiver application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of Medicaid beneficiaries in Oklahoma.

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 some 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 (WSS) 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.

CLASP notes that Oklahoma's waiver application was released in the midst of a global health pandemic. The COVID-19 pandemic has demonstrated the shortcomings of our current health insurance options across America, and has also highlighted the impact one person's health insurance status can have on an entire society's well-being. As we have come to learn, if people are hesitant to seek care because they are uninsured or cannot afford the cost-sharing provisions of their health insurance, they may not be treated until their illness has become severe, increasing risks for themselves and those around them. Therefore, CLASP strongly urges Oklahoma to proceed with their planned Medicaid expansion, as provided for through the State Plan Amendment submitted to the Centers for Medicare and Medicaid Services (CMS), and cease all plans to implement the provisions outlined in their Healthy Adult Opportunity (HAO) waiver application. As described below, the policy provisions sought in the HAO waiver – aside from the Medicaid expansion, which is separately addressed through the state plan amendment – will only serve to limit access to health insurance, and health care. These barriers to care

are unjust at any time, and that is only magnified during a global pandemic.

CLASP also notes that the maintenance of effort (MOE) required by states to receive the enhanced FMAP included in the Congressional response to COVID-19 prevents states from implementing many of the provisions that Oklahoma has asked permission to enact. As such, Oklahomans would be best served by the state withdrawing this waiver application and instead solely moving ahead with Medicaid expansion.

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 jobs² and, according to 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 Therefore, all aspects of this waiver other than the Medicaid expansion (which as separately been addressed through a State Plan Amendment) is 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.

Proposed Per Capita Cap is Fiscally Risky and Will Prevent Oklahoma from Using Medicaid to Respond to Economic Downturns

Oklahoma’s proposed financing structure through a per capita cap, and presumably through a block grant after two years of a per capita cap, as outlined in the Healthy Adult Opportunity (HAO) guidance from CMS, holds several risks for the state and is detrimental to Medicaid enrollees. Arbitrarily limiting the amount of federal dollars the state can receive to support the Medicaid program positions the state to have to either cut eligibility, benefits, or provider rates in the case of unexpected expenses. Certainly, the current COVID-19 pandemic provides a dramatic example of a time when the state would find it

detrimental to have a limit on federal funds, but even in times without pandemics, this approach is short sighted. New medications, an increase in health costs, or a particularly bad flu season are all situations that could leave the state spending more than anticipated and not receiving the federal funds they would be entitled to if not operating under an HAO waiver.

While it is not explicitly stated in Oklahoma's HAO waiver that the state intends to move from a per capita cap to an aggregate cap, based on Governor Stitt's remarks when CMS released the HAO guidance to states,⁶ it's a reasonable conclusion to draw that Oklahoma does in fact plan to transition to an aggregate cap after two years of expenditures are known. Doing so would pose several dangers to Medicaid enrollees and the state's fiscal health, including:

Cap allotments will not keep pace with health care spending. If Medicaid financing is changed to a block grant or per capita cap, there is a significant risk that Oklahoma will not receive enough funding to keep pace with the rising cost of health care while simultaneously continuing to provide the same coverage, benefits, and payments to providers. As a result, Oklahoma policymakers will be forced to decide how to make up the difference and/or Medicaid enrollees would lose services or eligibility. Erosion in Medicaid funding is detrimental not only to those without other affordable health care options, but also to doctors, other health care providers, hospitals, and nursing homes.

When the state encounters higher than anticipated expenditures they will likely cut benefits, provider rates, or other eligibility in order to stay within their projected per capita cap. While always a risky approach, it is particularly risky for Oklahoma because there is no historical expenditure data for the population that will be covered through the HAO waiver. CLASP notes that the referenced attachment B is not included in the application. Without these full enrollment and cost projections it is impossible to fully understand the state's approach to determining the projected costs.

Such as erosion is exactly what has happened with the Temporary Assistance for Needy Families (TANF) funding in Oklahoma since its inception as a block grant over 20 years ago. The TANF block grant amount allocated to each state was set based on their spending under the AFDC program and it has not been adjusted to reflect changes in state population or poverty rates.⁷ As a result, between 1997 and 2018, Oklahoma had a 38 percent decrease in the TANF block grant amount it received per the number of poor children in the state.⁸ In Oklahoma, TANF cash benefits to families with low incomes are below their nominal levels from 1996. Oklahoma is one of only four states in the nation where this is the case.⁹

Medicaid will no longer respond automatically to economic downturns. Shifting financial risk to states is especially damaging during economic downturns, as we are currently experiencing as the nation struggles with the COVID-19 pandemic. When state tax revenue drops during recessions, federal dollars can help alleviate state budget crises. One way federal dollars provide relief to states is through an enhanced FMAP rate for Medicaid. With the request of a per capita cap, that will presumably be converted to an aggregate cap, Oklahoma would likely lose out on significant federal dollars by not being included in an enhanced FMAP rate. The ability of Medicaid to respond to economic pressures preserves not only access to health care for those most in need, but also jobs at every level of the health care industry.

Oklahoma will be under pressure to cut benefits and reimbursements. Placing a limit on federal funding

sets the stage for Oklahoma to not receive the federal funds it needs to maintain its Medicaid program. This will force the state to make difficult decisions with serious repercussions for Oklahomans. Oklahoma will be left with no other options besides increasing their state Medicaid dollars to offset the federal losses, reducing benefits or eligibility, or cutting provider payments.

Pursuing a per capita cap for Medicaid, for the reasons outlined above, is a perilous pursuit at any time. Our nation's current situation battling the COVID-19 pandemic and the associated economic downturn provides a vivid example of why Oklahoma's waiver request is short sighted and hamstringing the state. While an extreme example, the COVID-19 crisis demonstrates that at any time, for unforeseen reasons, health care expenses can increase drastically or the economy can falter and leave people without access to employer-based insurance. Medicaid is designed to be a safety-net, providing care to people who are working hard but still struggling to make ends meet (many of which are currently deemed as "essential workers," such as child care providers), and to help people who are experiencing a loss of income and associated job and health insurance loss. Oklahoma's proposal positions the state's Medicaid program to come up short just as it's needed the most as a safety-net, particularly if the assumption is that an aggregate cap will replace the per capita cap after a set number of years.

The state's own projections show that enrollment under the demonstration will be less than if the demonstration was not approved. Furthermore, the state projects no change in enrollment or expenditures between years two and five of the demonstration. This seems implausible and without more accurate projections of enrollment and expenditures, the concerns described above are magnified.

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

CLASP does not support Oklahoma's proposal to take away health coverage from individuals who do not meet new work reporting requirements, as described on pages 11-16 of the application. Our comments that follow focus on the harmful impact the proposed work requirements will have on low-income Oklahomans and the state.

CLASP strongly opposes work requirements for Medicaid beneficiaries and urges Oklahoma to withdraw this request. Work requirements—and disenrollment for failure to comply—are inconsistent with the goals of Medicaid because they 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. 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.¹⁰ 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.¹¹ Medicaid expansion enrollees from Ohio¹² and Michigan¹³ 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.¹⁴ 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.¹⁵ 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.¹⁶ 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.¹⁷ 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.¹⁸

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, that 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 Oklahoma's new proposed 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. In the first seven months of Arkansas' work requirement implementation, over 18,000 beneficiaries lost coverage.¹⁹ That was about one quarter of everyone who was subject to the work requirement. Arkansas Medicaid beneficiaries have lost coverage since the state implemented its work requirements. 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.²⁰

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.²¹ 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.

Oklahoma's proposal to require 20 hours of work per week (after the phase in) 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.²² 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.²³

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. Although Oklahoma is proposing to exempt people with disabilities in reality, many people are not able to work due to disability or disease are likely to not receive an exemption due to the complexity of paperwork. 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.²⁴ 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.²⁵

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,²⁶ 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.

Disenrollment and lock out would lead to worse health outcomes, higher costs

Once terminated from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.²⁷

The impact of even short-term gaps in health insurance coverage has been well documented. In a 2003 analysis, researchers from the Urban Institute found that people who are uninsured for less than 6 months are less likely to have a usual source of care that is not an emergency room, more likely to lack confidence in their ability to get care and more likely to have unmet medical or prescription drug needs.²⁸ A 2006 analysis of Medicaid enrollees in Oregon found that those who lost Medicaid coverage but experienced a coverage gap of fewer than 10 months were less likely to have a primary care visit and more likely to report unmet health care needs and medical debt when compared with those continuously insured.²⁹

The consequences of disruptions in coverage are even more concerning for consumers with high health needs. A 2008 analysis of Medicaid enrollees in California found that interruptions in Medicaid coverage

were associated with a higher risk of hospitalization for conditions such as heart failure, diabetes, and chronic obstructive disorders. In addition to the poorer health outcomes for patients, these avoidable hospitalizations are also costly for the state.³⁰ Similarly, a separate 2008 study of Medicaid enrollees with diabetes who experienced disruptions in coverage found that the per member per month cost following reenrollment after a coverage gap rose by an average of \$239, and enrollees were more likely to incur inpatient and emergency room expenses following reenrollment compared to the period of time before the enrollee lost coverage.³¹

Proposals to Take Health Coverage Away from Individuals Who Do Not Meet New Work Requirements are Likely to Increase Churn

Oklahoma's proposal 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 reenrollment once they need healthcare, and be less likely to receive preventive care if they are not continuously enrolled in Medicaid.

Children will be harmed by proposal

It is important to recognize that limiting parents' access to health care will have significant negative effects on their children as well. Children do better when their parents and other caregivers are healthy, both emotionally and physically.³² Adults' access to health care supports effective parenting, while untreated physical and mental health needs can get in the way. For example, a mother's untreated depression can place at risk her child's safety, development, and learning.³³ Untreated chronic illnesses or pain can contribute to high levels of parental stress that are particularly harmful to children during their earliest years.³⁴ Additionally, health insurance coverage is key to the entire family's financial stability, particularly because coverage lifts the burdens of unexpected health problems and related costs. These findings were reinforced in a new study, which found that when parents were enrolled in Medicaid their children were more likely to have annual well-child visits.³⁵

Further, research shows that when parents have health insurance their children are more likely to have health insurance.³⁶ Oklahoma's proposal to disenroll Medicaid enrollees from health coverage for not meeting a work requirement will reduce the number of parents with health insurance, which the evidence suggests will lead to children becoming uninsured.

Support services will be inadequate

Child care is a significant barrier to employment for low-income parents. Many low-income jobs have variable hours from week to week and evening and weekend hours, creating additional challenges to finding affordable and safe child care. Oklahoma is proposing to only exempt parents if their children are younger than six years old. Finding affordable and safe child care for children is difficult and a barrier to employment, including for those who are not single parents. Requiring employment in order to maintain health care, but not providing adequate support services such as child care, sets a family up for a no-win situation.

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.³⁷ 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 2017.³⁸ 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.³⁹ 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.⁴⁰ 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.⁴¹

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 found that as many as 4 in 10 part-time workers are generally underemployed, preferring more hours of work compared to the same or fewer hours.⁴² 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.”⁴³ 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.⁴⁴

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.⁴⁵ They also face shorter job searches and fewer spells of joblessness.⁴⁶ 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.⁴⁷

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.⁴⁸ 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.⁴⁹ For those who do find work, it's common to have annual earnings of less than \$500.⁵⁰ Further, during the time spent in prison, many lose work skills and are given little opportunity to gain useful work experience.⁵¹ 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.⁵² A recent survey found that 96 percent of employers conduct background checks on job applicants that include a criminal history search.⁵³

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.⁵⁴ 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.⁵⁵ 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."⁵⁶ 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.⁵⁷ 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.⁵⁸

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.⁵⁹ 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.⁶⁰
- Between 1915 and 1970, over 6 million African Americans fled the south in the hope of a better life. As more African Americans moved north, northern states began to adopt some of the work reporting requirements already prevalent in assistance programs in the South.⁶¹
- 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.⁶²
- 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.⁶³
- 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.”⁶⁴

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.⁶⁵ 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.⁶⁶

Oklahoma’s proposal would subject returning citizens after only nine 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.

Monthly premiums would harm families in low-income households

Oklahoma's request to implement premiums and cost-sharing up to 5 percent of household incomes is much higher than families in this income range can reasonably afford.

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.⁶⁷ Medicaid generally prohibits premiums for Medicaid beneficiaries with income below 150% of the Federal Poverty Level (FPL). Nonetheless, HHS has recently approved waivers allowing a few states to test the effects of imposing premiums. These states have been allowed to apply mandatory premiums for individuals with incomes between 100-150% FPL and only voluntary premiums for individuals with incomes below 100% FPL. Furthermore, no Section 1115 waivers have been approved to date for any Medicaid population that include premiums as a condition of eligibility or coverage or coverage lock-outs for non-payment for those under 100% FPL.⁶⁸

CLASP strongly opposes this waiver proposal to require adults with incomes between the parent eligibility threshold and 100% of poverty to pay a monthly premium, going much further than HHS has previously permitted. Studies of the Healthy Indiana waiver, which required Medicaid recipients with incomes between 100 and 138% of FPL to pay a premium⁶⁹ or face disenrollment or lockout,⁷⁰ have found that it deters enrollment. About one-third of individuals who applied and were found eligible were not enrolled because they did not pay the premium.⁷¹

A large body of research shows that even modest premiums keep people from enrolling in coverage.⁷² 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.⁷³ 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.⁷⁴

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,"⁷⁵ which may create additional barriers to making regular payments.

We strongly encourage Oklahoma to eliminate its proposal to introduce premiums in Medicaid and to maintain Medicaid's strong affordability protections.

Delayed Effective Dates of Coverage is Unnecessary and Will Delay Care

Oklahoma is proposing to delay coverage up to 45 days after an application is *approved*. Such a delay in the effective date of coverage is unprecedented and unnecessary. The state's proposal to delay enrollment for people with no premium up to 45 days after the application is approved and a person is deemed eligible is nothing more than a tactic to delay providing care. The typical approach is for coverage to be effective immediately, with coverage paid for by fee-for-service before a new enrollee selects a managed care organization.

Likewise, the state's proposal to delay the effective date for those approved applicants who would have to pay premiums under this plan is still unnecessary and places people's health in peril. When coupled with the request to eliminate retroactive eligibility, people who have been deemed eligible will wait up to six weeks to become insured. This is unprecedented for Medicaid and will have detrimental effects on Oklahomans health, providers reimbursements, and public health.

Eliminating Retroactive Coverage Does Not Further the Objectives of the Medicaid Program

Oklahoma's proposal would eliminate 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.

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.⁷⁶ 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.⁷⁷

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, the state should reconsider their approach to redesigning Medicaid financing and crucial elements of Medicaid and withdraw their waiver application.

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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