CLASP
policy solutions that work for low-income people

June 23, 2017

Family and Social Services Administration
Office of Medicaid Policy and Planning
402 West Washington Street
Indianapolis, Indiana 46204

Re: Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application

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. In particular, 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.

CLASP submits the following comments in response to *the Amendment Request to Healthy Indiana Plan (HIP) Section 1115 Waiver Extension Application* and raises serious concerns about its impact on the coverage and health outcomes of low-income Medicaid beneficiaries in Indiana. The state claims that it seeks to support low-income people in their work and education goals but acknowledges that there is "conflicting data" from research on the relationship between employment and health outcomes, and provides no evidence that the existing voluntary Gateway to Work program has had any impact on participants' employment outcomes. By contrast, the state's own estimates are that nearly 25,000 beneficiaries will fail to participate in the required activities and will therefore lose health insurance coverage. 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."[1] This waiver is therefore inconsistent with the Medicaid purpose of providing medical assistance and improving health, and should be withdrawn. Moreover, losing health coverage will also make achieving work and education goals significantly more difficult for beneficiaries.

In addition, we express our concern that this waiver amendment has been submitted to CMS before the end of the public comment period. This displays bad faith and a lack of sincere interest in public input. While the previous waiver extension proposal was open for public comment, it did not include the mandatory work requirement. This is not a trivial amendment to the previous proposal, and submitting it without waiting for input makes a mockery of the public input process.

Indiana offers no evidence that Gateway to Work is effective

Implemented in 2015, the Gateway to Work program was designed to promote employment among HIP participants. According to the independent evaluation of the HIP waiver, in response to more than

300,000 letters about the program, the state received only about 3,200 phone inquiries and fewer than 600 Gateway to Work orientations took place.[2] Clearly, the overwhelming majority of HIP participants do not believe that Gateway to Work will offer them any services of value.

Moreover, neither the evaluation nor the waiver amendment offer any evidence that the people who do participate in Gateway to Work have improved their employment outcomes. Indiana should continue the evaluation of the current voluntary program, and focus on making it an impactful program.

Yet despite no evidence that the program works, Indiana proposes to expand this small program to a much larger population, and make it mandatory for an estimated 30% of HIP participants. This means that tens of thousands of people will be denied Medicaid health coverage. The state's own estimates are that nearly 25,000 beneficiaries will fail to participate in the required activities and will therefore lose health insurance coverage – this may well be an underestimate of those who will be sanctioned, based on the track record of confusion associated with previous provisions in HIP and the likelihood of problems in documenting or verifying participation.

This type of experiment has been tried before, and the results are clear. Overall, the evidence from many rigorous evaluations of welfare-to-work programs shows that employment increases among recipients subject to work requirements were modest and faded over time. Even among those who found work, stable employment at a living wage was rare, and the vast majority remained poor.[3] If approved, the main consequence of work requirements in Medicaid would be that people will lose access to health coverage, as discussed below.[4]

The waiver application requests federal matching costs for Gateway to Work. This represents a huge shift of funds away from providing health care and into a new bureaucracy designed to enforce participation. The state estimates that it will spend—and wants federal reimbursement for—approximately $90 per month per enrolled member, for "costs for providing orientation, assessment, job skills training, job search assistance, and tracking member progress." This would represent a huge shift of funds away from providing health care and into a new bureaucracy designed to enforce participation. Medicaid's purpose is not to fund job training, but to provide medical assistance.

At the same time, this estimated funding level is too low to provide anything but an ineffective, low-touch job search program that primarily serves as an additional hoop for beneficiaries to jump through. If Indiana intended to offer meaningful job training and work support services that would truly improve participants' ability to find and keep jobs that provide health benefits, it would need significantly more investment in the program. This figure underscores that this provision is unlikely to increase participants' employability.

As a reference point, in the state plan for Indiana's SNAP Employment and Training program, which is operated by the same vendor as Gateway to Work, the state indicates that it will pay $215 for each completed orientation and assessment, and $25 for each no-show.[5] For perspective, the average cost of a training voucher provided through workforce development programs is approximately $3,500 to $4,000.[6] Moreover, in the most recent year for which data are available, Indiana provided training for only 3,388 adults through the Workforce Investment Act (WIA)[7]. Funding under the workforce system is capped and falls vastly short of what is needed to serve all workers who need training, meaning that the Gateway to Work program cannot expect that the workforce system will fund training for Medicaid beneficiaries. If Indiana is serious about improving the employment outcomes for HIP participants, it would be far better to invest these funds in meaningful training for HIP participants who want it, rather than in a punitive and ineffective job search program.

Many Medicaid participants will lose coverage, including individuals with work limitations

A recent Kaiser Family Foundation study found that the overwhelming majority of non-working Medicaid recipients are ill or disabled, attending school, caring for other, or seeking work. Many Medicaid beneficiaries work—in fact, the state estimates that 32% of HIP participants will be exempted from this requirement because they are already working 20+ hours per week. But for low-wage workers, employer-sponsored insurance is often either not offered or is prohibitively expensive. Even if unemployed Medicaid recipients obtain jobs, they are highly likely to continue to need health coverage through Medicaid.

The Kaiser Family Foundation (KFF) study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI benefits—reported illness or disability as their primary reason for not working.[8] People with chronic conditions that impact their ability to work but do not qualify them for disability benefits will be at high risk of losing access to care. Chronic conditions are, by definition, not time-limited and often impact individuals for extended periods. While the proposal states that the work requirement will not apply to beneficiaries who are medically frail or who have a certified temporary illness or incapacity, the evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits.

For example, even though individuals who were unable to work should have been exempted, one study from Franklin County, OH, found that one third of the individuals referred to a SNAP employment program in order to keep their benefits reported a physical or mental limitation, 25% of whom indicated that the condition limited their daily activities. Additionally, nearly 20% of the individuals had applied for SSI or SSDI within the previous 2 years.[9]

Similarly, repeated studies of TANF programs have found that clients with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirements.[10] Such clients may not understand what is required of them, or may find it difficult to complete paperwork or travel to appointments to be assessed for exemptions. Precisely those who need health care the most will struggle to meet the requirement that exemptions for short-term incapacities and for caregivers be renewed every two months. Simply the burden of understanding the requirements and documenting their exemption is likely to 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.[11] These beneficiaries are highly likely to be locked out of coverage, with severe consequences for their health.

Conditioning Eligibility on Participation will Make People Sicker and Increase Health Care Costs

If individuals do not participate in Gateway to Work, their HIP eligibility will be terminated until they have completed a full month of their work requirement. These individuals will likely become uninsured once terminated from Medicaid. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[12] Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. When beneficiaries re-enroll in Medicaid, they will be sicker and have higher health care needs. Public programs will end up spending more to bring these beneficiaries back to health.

In addition, 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.[13]

These now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

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.[14] 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.[15]

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.[16] 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.[17]

Administrative Complexity

Tracking exemptions and participation for every beneficiary will add significant complexity and cost to the administration of the Medicaid program. One of the key lessons of the Work Support Strategies initiative is that every time that a client needs to bring in a verification or report a change, both the administrative burden on caseworkers and the likelihood that clients will lose benefits increase. In many cases, clients remain eligible and will reapply, but this is still costly to families (who lose benefits) as well as to the agencies that have to process additional applications. The WSS states found that that reducing administrative redundancies and barriers increased workers' efficiency and also helped with federal timeliness requirements. An administrator in Idaho reported that unnecessary reevaluations wasted caseworkers' time and confused families. A Colorado WSS team member reflecting on their former processes noted "it was crazy-making for us... it was a constant workload for all of us." Adding new complicated requirements to Medicaid eligibility, including determining exemptions and tracking the hours of work, which often vary from month to month, would be a major step in the wrong direction.

Under this proposal, Indiana will need to develop a whole new system to determine whether a beneficiary qualified for an exemption that month, track hours per week of qualifying work activities, and send appropriate notices to clients. While Indiana estimates that nearly one-third of HIP enrollees will qualify for an exemption based on employment, all of these enrollees will need to report data on their hours of work in order to qualify for that exemption. (Data collected for unemployment insurance purposes includes quarterly earnings, but does not capture month-to-month fluctuations or hours of work.) This is a massive administrative burden for workers, employers, and the state. Far more workers will have to report their hours of work than will participate in Gateway to Work activities.

This is particularly burdensome because workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week to week.[18] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[19] both industries well known for their variable and seasonal hours of employment. Individuals with variable hours of employment may also lose coverage if they fail to keep up with the requirement to document their hours

of employment.[20]

This waiver proposal adds even another layer of complexity by phasing in the number of hours a week that an individual must participate in work activities based on length of enrollment. These requirements will be confusing for participants and add another level of administrative burden on the state. Early evaluations of HIP indicate that the implementation of the various policies and requirements has created confusion and delays in effectuating coverage.[21] Given that Indiana has chosen to go to tiered income levels for POWER Account contributions to "ease administrative burden on the State from both a systems and member communication perspective," it seems deeply contradictory to implement a new set of provisions that will massively increase the administrative burden.

Thank you for your consideration of these comments.

If you have any questions, please contact Elizabeth Lower-Basch at elowerbasch@clasp.org or (202) 906-8013.

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