SECTION 1115 WAIVERS: SUCCESS FOR MEDICAID IN MICHIGAN AND INDIANA

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INTRODUCTION

Medicaid is a national program that provides health insurance to low-income people.[1] The federal government provides level of care standards for states, matches funds, and allows states the ability to design and administer their own programs under the Medicaid umbrella.[2] States have the flexibility to determine which populations and services to cover, as well as methods for paying providers.[3] Under conventional Medicaid, four main groups gain coverage: "infants and children; pregnant women, parents, and other nonelderly adults; individuals of all ages with disabilities; and very low-income seniors, most of whom are also covered by Medicare."[4] Traditionally, "most low-income adults did not qualify for Medicaid because income eligibility for parents was very limited in most states . . . and federal law excluded adults without dependent children from the program."[5] However, the Affordable Care Act (ACA) provided federal funding to expand Medicaid "to nonelderly adults with income up to 138% federal poverty level (FPL)."[6] The ACA

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1. *Medicaid Pocket Primer*, KAISER FAMILY FOUND. (June 9, 2017), http://kff.org/medicaid/fact-sheet/medicaid-pocket-primer [https://perma.cc/4H3M-T5A4]. Medicaid pays the health care expenses for more than 74.5 million people nationally. *Affordable Care Act Medicaid Expansion*, NAT'L CONFERENCE OF STATE LEGISLATURES, http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx [https://perma.cc/Y8TS-W4FQ] [hereinafter *Medicaid Pocket Primer*].

2. *Id.*

3. *Id.*

4. KAISER FAMILY FOUND., FIVE KEY QUESTIONS AND ANSWERS ABOUT SECTION 1115 MEDICAID DEMONSTRATION WAIVERS EXECUTIVE SUMMARY 1–2 (2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf [https://perma.cc/LGD8-AXYR] [hereinafter SECTION 1115 MEDICAID DEMONSTRATION WAIVERS].

5. *Id.*

6. *Id.* The federal poverty level is a measure of income issued by the Department of Health and Human Services. The measure is used to determine eligibility for certain programs and benefits. U.S. Ctrs. for Medicare & Medicaid Servs., *Federal Poverty*

also sought to streamline "Medicaid eligibility and enrollment and [give] states new options and funding for delivery system innovation, including expanded options for community-based long-term care."[7] Under *NFIB v. Sebelius*, "the ACA Medicaid expansion is effectively optional for states" (even though Congress intended it to be mandatory).[8]

The federal government also issues Section 1115 waivers, which give states further flexibility with Medicaid. The waiver provides states with an opportunity to try innovative coverage approaches that do not necessarily meet federal program requirements.[9] For example, states could implement broad changes in eligibility, cost sharing, and provider payments,[10] as long as the Secretary of Health and Human Services (the "Secretary") determines that the initiative is an "experimental, pilot, or demonstration project that is likely to assist in promoting the objectives

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Level (FPL), HEALTHCARE.GOV, https://www.healthcare.gov/glossary/federal-poverty-level-FPL [https://perma.cc/74BT-PLG6].

7. *Medicaid Pocket Primer*, *supra* note 1.

8. SECTION 1115 MEDICAID DEMONSTRATION WAIVERS, *supra* note 4, at 1–2; *see* National Federation of Independent Business v. Sebelius, 567 U.S. 519, 587 (2012) (construing the Medicaid expansion provision of the Affordable Care Act as non-mandatory in order to avoid striking it down as unconstitutional). In January 2017, 32 states, including the District of Columbia, expanded Medicaid and 19 states had not. In the non-expansion states, a "coverage gap" exists where people's income exceeds the state cutoff for Medicaid but it is too low to qualify for subsidies for private coverage provided under the ACA. Despite the 19 states that have not expanded Medicaid, the optional expansion has contributed to a decline in the uninsured rate among nonelderly individuals from 16.6 percent in 2013 to 10 percent in 2016. *Medicaid Pocket Primer*, *supra* note 1.

9. SECTION 1115 MEDICAID DEMONSTRATION WAIVERS, *supra* note 4, at 1–2. The Federal core requirements include coverage for certain groups—pregnant women, children, elderly individuals, parents, and individuals with disabilities up to specific income levels—and maintenance of eligibility and enrollment policies that are not any more restrictive than those in place at the time the ACA was enacted. States are required to provide enrollees with a "core set of mandatory benefits" and certain cost sharing protections to receive federal funding. These mandatory benefits include amongst others: physician services, laboratory and x-ray services, nursing facility and home health services for those who qualify, smoking cessation services for pregnant women. Optional services include amongst others: prescription drugs, physical therapy, inpatient psychiatric care for individuals under 21, and hospice services. While states are able to largely determine provider payments, the federal government requires them to be "consistent with efficiency, economy, quality, and access [as well as] safeguard against unnecessary utilization." KAISER COMM'N ON MEDICAID & THE UNINSURED, FEDERAL CORE REQUIREMENTS AND STATE OPTIONS IN MEDICAID: CURRENT POLICIES AND KEY ISSUES 8 (2011), https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8174.pdf [https://perma.cc/FA33-FWQ4] [hereinafter FEDERAL CORE REQUIREMENTS AND STATE OPTIONS].

10. SECTION 1115 MEDICAID DEMONSTRATION WAIVERS, *supra* note 4, at 1–2.

of the program."[11] Additionally, there is an understanding in the Department that within the Section 1115 waiver policy, "federal costs under a waiver must not exceed what federal costs would have been for that state without the waiver, as calculated by the administration."[12] States apply for a Section 1115 waiver, which is approved "at the discretion of the Secretary of Health and Human Services."[13] The Secretary, does not have the authority to waive certain elements such as "the federal matching payment system for states, or requirements that are rooted in the Constitution such as the right to a fair hearing."[14] Generally, a waiver is approved for a five-year period and must be renewed thereafter.[15] The purpose of this waiver is to allow innovation within states so that they can research and test out projects, in order to learn about new approaches to program design and administration.[16] The waiver has become an increasingly popular device for states that want to innovate and get expansion funds but do not want to follow all federal requirements.[17]

This Essay will examine two states that have employed Section 1115 waivers to implement innovative models of Medicaid expansion: Michigan and Indiana. Both states are in the same geographic region and have utilized similar mechanisms with their waivers. However, their outcomes differ in both implementation strategies and success rates. The Indiana plan is of particular interest because it was designed by Seema Verma, the newly appointed Administrator of the Centers for Medicaid and Medicare Services (CMS). Consequently, Indiana's version of Medicaid expansion and its performance to date provide valuable insight into where Medicaid may be headed under the Trump Administration.

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11. *Section 1115 Medicaid Demonstration Waivers: A Look at the Current Landscape of Approved and Pending Waivers*, KAISER FAMILY FOUND. (Sept. 13, 2017), https://www.kff.org/medicaid/issue-brief/section-1115-medicaid-demonstration-waivers-a-look-at-the-current-landscape-of-approved-and-pending-waivers [https://perma.cc/UD2V-6FG8] [hereinafter *Current Landscape*].

12. *Id.*

13. FEDERAL CORE REQUIREMENTS AND STATE OPTIONS, *supra* note 8, at 8.

14. *Id. See generally* Mathews v. Eldridge, 424 U.S. 319 (1976).

15. FEDERAL CORE REQUIREMENTS AND STATE OPTIONS, *supra* note 8, at 8.

16. *Id.*

17. As of September 2017, thirty-three states had forty-one approved Section 1115 waivers. However, some states have multiple waivers and some states have comprehensive waivers that fall into multiple categories. *Current Landscape*, *supra* note 11.

MEDICAID EXPANSION IN MICHIGAN

Michigan expanded Medicaid to create the consumer-driven Healthy Michigan Plan.[18] The plan garnered bipartisan support and was implemented via two Section 1115 waivers. The first waiver was approved in 2013 and focused on a cost-sharing plan that would be connected to a Health Savings Account (HSA).[19] The second waiver, approved in April of 2016, sought to extend the original waiver's Medicaid expansion strategies, such as expansion of care and co-payments for medical services.[20]

The waivers expand coverage to childless adults from ages nineteen to sixty-four from 0% to 138% FPL through the existing Healthy Michigan managed care plan.[21] The plan requires two payments: co-payments for medical services and monthly payments into a HSA.[22] An individual's payments into their HSA are "based on their average co-payments for services used [over] the previous six months."[23] There is an additional requirement for those within the 100–138% FPL bracket—they must pay "monthly premiums up to 2% of income" into their HSAs.[24] However, beneficiaries cannot lose coverage or face denial of services due to failure to pay co-pays or premiums.[25] Michigan reserves the right to recoup the missed payments from two sources: state income tax refunds or lottery winnings.[26] Under the first waiver, the total cost-sharing and premiums originally could not exceed 5% of household

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18. Louis Norris, *Michigan and the ACA's Medicaid expansion*, HEALTHINSURANCE.ORG (Jan. 5, 2017), https://www.healthinsurance.org/michigan-medicaid [https://perma.cc/M325-VLNN].

19. Marianne Udow-Phillips et. al, *Medicaid Expansion in Michigan: The Second CMS Waiver,* HEALTH AFFAIRS BLOG (Jan. 5, 2016), http://healthaffairs.org/blog/2016/01/05/medicaid-expansion-in-michigan-the-second-cms-waiver [https://perma.cc/H5EG-3WLV]. A Health Savings Account is "a type of savings account that allows you to set aside money on a pre-tax basis to pay for qualified medical expenses." U.S. Ctrs. for Medicare & Medicaid Servs., *Health Savings Account (HSA)*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/health-savings-account-HSA [https://perma.cc/U38Y-DJDM].

20. *Id.*

21. Marianne Udow-Phillips et. al, *supra* note 19.

22. *Id.*

23. *Id.*

24. *Id.*

25. *Id.*

26. MaryBeth Musumeci et. al, *An Early Look at Medicaid Expansion Waiver Implementation in Michigan and Indiana*, KAISER FAMILY FOUND. (Jan. 2017), http://kff.org/medicaid/issue-brief/an-early-look-at-medicaid-expansion-waiver-implementation-in-michigan-and-indiana [https://perma.cc/78JC-TY3C].

income; however, this was raised to 7% under the second waiver.[27] HSA contributions can be reduced through participation in certain healthy behaviors such as scheduling a preventative health visit with a primary care physician or smoking cessation.[28] Compliance "results in a 50% reduction in future premiums for those above poverty and a $50 gift card for those below poverty [level]."[29]

There are two types of coverage available under Michigan's Medicaid expansion: Medicaid managed care (the Healthy Michigan Plan) or Medicaid premium assistance for Marketplace coverage through a Qualified Health Plan (QHP).[30] Beneficiaries who opt into the managed care program "will be required to complete a healthy behavior" within a year or will have to transition to a QHP.[31]

Healthy Michigan Plan enrollment has vastly exceeded expectations. As of August 2015, 576,624 people were enrolled, and a large mass of participants were below 100% FPL.[32] Enrollees participate "in the program's health risk assessment component at more than twice the rate of enrollees in a typical private health insurance plan (14% compared to 6% per state figures)."[33] All individuals between 100% and 138% FPL must work with physicians on certain health improving strategies, such as smoking cessation, or get coverage through QHPs.[34] "[T]he proportion of primary care practices willing to accept new Medicaid patients in Michigan has increased from 49% to 55% since the launch of the Healthy Michigan Plan."[35] Additionally, as of February

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27. *Id.*; Marianne Udow-Phillips et. al, *The Medicaid Expansion Experience in Michigan,* HEALTH AFFAIRS BLOG (Aug. 28, 2015), http://healthaffairs.org/blog/2015/08/28/michigan-the-path-to-medicaid-expansion-in-a-republican-led-state [https://perma.cc/8B5G-KP8P].

28. Udow-Phillips et. al, *supra* note 19.

29. Musumeci et. al, *supra* note 26.

30. Udow-Phillips et. al, *supra* note 19.

31. *Id.* Healthy behavior activities include completing an annual check-up with one's primary care physician, completing a health risk assessment, and agreeing to stay healthy or work on getting healthier. MICH. DEP'T OF HEALTH & HUMAN SERVS., THE HEALTHY MICHIGAN PLAN HANDBOOK (2016), https://www.michigan.gov/documents/mdch/Healthy_Michigan_Handbook_Final_447363_7.pdf [https://perma.cc/SD9Q-WXCT]; *Healthy Michigan Plan Frequently Asked Questions*, MICHIGAN DEP'T OF HEALTH & HUMAN SERVS., http://www.michigan.gov/mdhhs/0,5885,7-339-71547_2943_66797-325160--,00.html [https://perma.cc/LCF7-FCPN].

32. Udow-Phillips et. al, *supra* note 19. It was projected that throughout the entire year of 2014, 322,000 low-income adults ages nineteen to 64 would enroll in the Healthy Michigan Plan. Within the first 100 days of implementation, that amount was met. John Z. Ayanian et. al, *Launching the Healthy Michigan Plan—The First 100 Days*, 371 NEW ENG. J. OF MED. 1573–75 (2014).

33. *Id.*

34. Udow-Phillips et. al, *supra* note 19.

35. Udow-Phillips et. al, *supra* note 27.

2015, more than half of enrollees had been to a primary care physician, and 17% had used preventive care services.[36] Many stakeholders, such as government officials and participants, throughout Michigan have been pleased with the extent of improved coverage and access.[37]

MEDICAID EXPANSION IN INDIANA

Using a Section 1115 waiver, Indiana replaced their traditional Medicaid program for able-bodied adults with the Healthy Indiana Plan (HIP).[38] Recognized at the time of approval as the most significant departure from the traditional model of Medicaid,[39] HIP is a truly consumer-driven approach. In 2015, a second Section 1115 waiver was approved, which established HIP 2.0.[40] HIP expands coverage to different categories of adults: working parents between 24 and 138% FPL, jobless parents from 18 to 138% FPL, and childless adults from 0 to 138% FPL. The plan has four main features: a high deductible plan paired with a Personal Wellness and Responsibility (POWER) Account (similar to a HSA), HIP Plus, HIP Basic, and cost and quality comparison by patients.

The POWER Account is modeled off of a traditional HSA. HIP 2.0 enrollees have $2,500 limits on their POWER Accounts, which are "funded annually by a combination of deposits by the state and premiums" required from enrollees.[41] "Premiums are 2% of income for all waiver beneficiaries," with the exception of those within 0 to 5% FPL, who pay a flat $1.00 per month.[42] The accounts are "coupled with a high deductible health plan," which covers health care costs when the POWER Account is fully spent.[43] Seventy-percent of HIP members

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36. *Id.*

37. *Id.*

38. Seema Verma & Brian Neale, *Healthy Indiana 2.0 Is Challenging Medicaid Norms,* HEALTH AFFAIRS BLOG (Aug. 29, 2016), http://healthaffairs.org/blog/2016/08/29/healthy-indiana-2-0-is-challenging-medicaid-norms [https://perma.cc/NG64-DXFK].

39. *Id.*

40. Judith Solomon, *Indiana Medicaid Waiver Evaluation Shows Why Kentucky's Medicaid Proposal Shouldn't Be Approved*, CTR. ON BUDGET & POL'Y PRIORITIES (Aug. 1, 2016), http://www.cbpp.org/research/health/indiana-medicaid-waiver-evaluation-shows-why-kentuckys-medicaid-proposal-shouldnt-be [https://perma.cc/M84T-Z7EN].

41. *Id.* "Native Americans and pregnant women are exempt from POWER Account contributions." LEWIN GRP., INDIANA HEALTHY INDIANA PLAN 2.0: INTERIM EVALUATION REPORT 1 (2015), https://www.medicaid.gov/medicaid-chip-program-information/by-topics/waivers/1115/downloads/in/healthy-indiana-plan-2/in-healthy-indiana-plan-support-20-interim-evl-rpt-07062016.pdf [https://perma.cc/RS8Y-5CK3].

42. Musumeci et. al, *supra* note 26.

43. *Id.*

make POWER Account contributions, and 85% of those who contribute are below the poverty line.[44]

Two main plans provide Medicaid coverage: HIP Plus and HIP Basic. HIP Plus is advertised as superior to HIP Basic.[45] This plan includes benefits such as dental and vision coverage as well as free preventative care.[46] The only way to maintain membership in HIP Plus is to consistently pay premiums into the POWER Account. Otherwise, Medicaid members are put on HIP Basic, which is much more limited (i.e. does not cover dental or vision services) and requires co-payments for most services.[47] For example, a jobless parent between the ages of 19 and 64 with an income of $16,401.60 (137% of the FPL) would pay a $328.03 premium per month for enrollment in HIP. This individual would need to contribute that premium into their POWER Account each month in order to remain in the Plus plan; otherwise they will be moved down to the Basic plan. Members can roll over a portion of unused funds from their POWER Account (depending on how much the member contributed to the account during the year) to the next benefit year, which helps reduce future contributions.[48]

HIP 2.0 provides preventive care at zero cost to enrollees, as "members are not required to make co-payments or use POWER Account funds to pay for services."[49] Anyone who is enrolled in HIP Plus and goes to a doctor for a preventive care visit receives a "POWER Account rollover, which reduces the amount of required member contributions during the next benefit period."[50] While this provides a cost-incentive for members to receive preventive care, a majority of those surveyed were unaware that the visit would be at no cost to the enrollee.[51]

HIP 2.0 also has a "State Plan" for more vulnerable populations.[52] Members are subject to the same cost-sharing incentives as the regular

44. *Id.*

45. LEWIN GRP., *supra* note 41 at 1.

46. *Id.*

47. *Id* at 2.

48. *Id.*

49. *Id.* at 3.

50. *Id.* at 4.

51. LEWIN GRP., *supra* note 41, at 4. Lack of awareness for preventive care is not unique to HIP 2.0 as previous surveys for HIP 1.0 and a survey of non-group health insurance enrollees also showed a large proportion of members with a "lack of awareness about rules for coverage regarding preventive services." *Id.*

52. *Id.* at 8. Vulnerable populations include the "medically frail, Transitional Medical Assistance participants, Section 1931 low-income parents and caretakers, and low-income 19–20 year olds." *Id.* at 9.

plan members; however, they are eligible for enhanced coverage regardless of whether they are enrolled in Basic or Plus.[53]

HIP 2.0 is based on a consumer-driven approach. The POWER Account is the paramount example of this. The underlying theory of the POWER Account payments is that they will evoke personal investment and engagement by the enrollee in his or her own healthcare.[54] Since citizens contribute their own dollars into the plan, the idea is that they will be more cost conscious because they have "skin in the game." To further this goal, the program distributes monthly statements that detail the cost of services received, so that each person can be mindful and seek out lower-cost alternatives with a physician.[55] Approximately 40% of "HIP Plus members check the balance of their POWER Account at least once a month, and one in four members ask their providers about the cost of care."[56]

Unlike Michigan, failure to make contributions into Indiana's POWER Account as a HIP Plus member has consequences. A failure to make required contributions on time or within a sixty-day grace period will drop a member that is below the poverty line to HIP Basic.[57] A member who is above the poverty line will be dropped from HIP Plus completely and must wait six months to re-enroll.[58] Program designers assume that the incentive to stay in the superior HIP Plus will motivate people to avoid falling back into HIP Basic.[59] The incentives seem to be successful thus far: 70% of HIP members make POWER Account contributions, and 92% of members who make their first POWER Account contribution keep making contributions.[60]

INDIANA: PRECURSOR TO THE FUTURE OF MEDICAID?

Indiana's Medicaid expansion program under its Section 1115 waiver is particularly instructive because it was designed by Seema Verma, who now directs the Centers for Medicare and Medicaid Services. Therefore, the Indiana model may serve as a template for widespread changes CMS could make in the Trump administration. However, this only signals one potential change to Medicaid; the ACA contains thousands of statements that contain the phrase "the secretary

53. *Id.* at 8.
54. Verma & Neale, *supra* note 38.
55. *Id.*
56. *Id.*
57. *Id.*
58. *Id.*
59. *Id.*
60. Verma & Neale, *supra* note 38.

shall,"[61] which gives DHS wide-ranging power throughout the ACA to shape health care programs and reforms.[62] Former Secretary Price stated that he would use this power to exercise his own discretion to vastly change the way that healthcare operates in this country.[63] For example, this department is responsible for the actual creation and maintenance of the HealthCare.Gov website and the establishment of federally run exchanges in struggling states.[64] Most relevant to this Essay is the Secretary of Health and Human Services and Verma's control over an added branch of the CMS under the ACA, the Center for Medicare and Medicaid Innovation, which is designed to test and implement changes in the actual delivery and payment for healthcare in the county.[65]

The Secretary could allow other states to implement programs similar to Indiana's; therefore, even absent use of administrative discretion, we could see Medicaid change dramatically during President Trump's term. Many members of the Republican Party have vehemently opposed the ACA as well as the optional Medicaid expansion. If Medicaid expansion and Section 1115 waivers remain intact, incorporating the features of Indiana's waiver would almost guarantee CMS's ultimate approval of the waiver as well as expansion funds.

Perhaps HHS will loosen the requirements for Medicaid altogether and allow initiatives such as premium payments and HSAs to become a central part of Medicaid for the traditionally covered populations mentioned above. Many states have already shown interest in including Indiana's cost-sharing incentives in their own Section 1115 waiver

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61. Vann R. Newkirk II, *Tom Price's Healthcare Agenda,* THE ATLANTIC (Nov. 30, 2016), https://www.theatlantic.com/politics/archive/2016/11/tom-price-secretary-hhs-policy/509159 [https://perma.cc/3U5Q-ZASB].

62. *Id. See generally* TEVI TROY, "THE SECRETARY SHALL": HOW THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT WILL AFFECT DOCTORS (HUDSON INST., 2012), https://www.hudson.org/content/researchattachments/attachment/1034/secshalltroy--052212web.pdf [https://perma.cc/7M29-RCCU]; *see As HHS secretary, Tom Price has significant powers to change health care*, PBS NEWS HOUR (Feb. 10, 2017), https://www.pbs.org/newshour/show/hhs-secretary-tom-price-significant-powers-change-health-care [https://perma.cc/Y7E2-4ZV2]; Anna Maria Barry-Jester, *The Future of Obamacare Is In Trump's Hands*, FIVETHIRTYEIGHT (Mar. 25, 2017), https://fivethirtyeight.com/features/the-future-of-obamacare-is-in-trumps-hands [https://perma.cc/9YFD-CDLD] (noting that former Secretary Price pulled funding for advertisements promoting ACA enrollment, which funding is fully under his discretion).

63. Barry-Jester, *supra* note 62; @SecPriceMD, TWITTER (Mar. 17, 2017, 11:25 AM), https://twitter.com/SecPriceMD/status/842758846816964608 [https://perma.cc/32MC-SAYS].

64. Barry-Jester, *supra* note 62

65. *Id.*

applications.[66] The Trump Administration, shortly after the confirmation of Verma in early 2017, signaled their support for Section 1115 waivers that would incorporate more significant cost sharing than the Obama Administration previously approved.[67] Former Secretary Price and Verma both indicated support for a work requirement, which those on the left oppose. For example, the Obama administration previously declined waiver requests that included a work requirement.[68] Early data indicate that members contribute regularly to their POWER Accounts but beneficiaries and providers still do not have a strong understanding of the rules and policies.[69] CMS is unlikely to mandate these policies for each state because Republicans generally favor fewer federal requirements and more state flexibility. Therefore, it is more likely that states will opt to utilize these techniques, but will not be obligated to do so.

Unfortunately, even very low premiums can be unaffordable for low-income populations, so this additional financial strain deters some eligible people from enrolling.[70] It has been challenging to assess the affordability of premiums in Indiana because it is difficult to track and adjust premium payment amounts for populations that have fluctuating incomes. It is also difficult to track individuals who receive extra help from third parties to pay premiums.[71]

CONCLUSION

Both Michigan and Indiana implemented a consumer-driven approach with their Section 1115 waivers for the common purpose of facilitating cost-sharing by beneficiaries and the government. Michigan's program shares some basic similarities with Indiana's, such as HSAs and enrollee payment contribution, but there are some differences as to how each of these mechanisms are executed. Overall, Michigan implemented a far less drastic change to traditional Medicaid in comparison to Indiana. The approval of HIP 2.0 in Indiana suggests that it may be used as a guide for future policy and Section 1115 waiver

66. Musumeci et. al, *supra* note 26.

67. Tami Luhby & Jen Christensen, *Trump Administration Open to Making Some Medicaid Recipients Work, Pay Premiums,* CNN MONEY (Mar. 15, 2017), http://money.cnn.com/2017/03/15/news/economy/medicaid-premiums-work-trump [https://perma.cc/GC6J-YANA].

68. *Id.* (Judy Solomon from the Center on Budget and Policy Priorities states, "from welfare reform we have plenty of good evidence that work requirements don't often lead to long-term employment.").

69. *Id.*

70. *Id.*

71. *Id.*

approval as long as its architect, Seema Verma, oversees CMS. Indiana's results over the course of the next few months and year will be helpful to predict what nationwide Medicaid results could look like in the years ahead.