HHS Approves Harmful Section 1115 Waiver in Indiana: Effects on People with Disabilities

By David Machledt

Earlier today, HHS approved an extension of the "Healthy Indiana Plan 2.0" section 1115 waiver.[1] This approval allows Indiana to continue to ignore numerous critical and long-standing Medicaid protections for eligible Hoosiers. It both extends existing waivers and adds new waivers that will worsen the problems caused by the current program.

The project will continue to reduce or eliminate access to Medicaid for low-income Hoosiers. Indiana's own independent evaluator already reported substantial barriers to coverage and care for low-income Hoosiers due to premiums and lockouts in the state's existing waiver. This approval doubles down on those provisions and adds more red tape, including a work requirement. All told, hundreds of thousands of Hoosiers living below the poverty level or nearly in poverty will be hurt by this 1115 project, and tens of thousands will lose coverage.[2]

Under the law, HHS may only approve section 1115 proposals that are valid experiments likely to promote the objective of Medicaid — to help *furnish* health services to low-income individuals. Indiana's approved extension, in contrast, will undoubtedly harm low-income Hoosiers, making it harder to access needed services and stay covered.

Indiana's extended waiver mostly applies to adults in the Medicaid expansion, a catchall group that includes millions of people with disabilities as well as low-wage workers, parents, and other caretakers. In Ohio, about one in five newly eligible expansion enrollees had claims histories that correspond to a serious disability. Other studies show about 3 in 10 expansion enrollees live with behavioral health conditions.

A typical expansion enrollee could be, for example:

- a young adult injured in a crash who is still in the lengthy process of obtaining a formal disability determination from the Social Security Administration (SSA);
- a coal miner with lung disease who lost his health and pension benefits when his employer filed for bankruptcy; or
- a person with bipolar disorder who may not meet Medicaid's strict disability definition but needs medications to function effectively and hold down a job.

Many of the approved provisions will impact everyone in the HIP demonstration, including people with disabilities and parents and caretakers. First, the state has to screen enrollees to identify who should be exempt from certain policies based on a disability or medical frailty. This process increases administration costs, complicates enrollment, and, based on the number who currently qualify, likely leaves many people with significant disabilities out. Second, even those who qualify for exemptions due to disability or medical frailty must document and update their status, a process that increases red tape and makes it harder for people with disabilities to get covered and stay covered.

Taken together, these changes will make it harder for people with disabilities to get the supports and services they need. Numerous studies of Temporary Assistance for Needy Families (TANF) programs have found that participants with physical and mental health issues are more likely to be sanctioned for not completing the work requirements.[3] Other studies of work requirements in the Supplemental Nutrition Assistance Program (SNAP) have suggested that states regularly fail to exempt many of the nearly 20% of all SNAP participants who have a disability but receive no disability benefits.[4] These are lessons that Indiana has ignored in seeking this punitive new requirement.

The **new** features of Indiana's new program that most impact people with disabilities are:

Work requirements for enrollees to maintain access to Medicaid coverage. Beginning next year, Indiana will suspend or discontinue Medicaid eligibility for parents and adults in its Medicaid expansion program who do not meet "community engagement" (work) requirements or qualify for an exemption. Only two years ago, HHS reviewed the possibility of work requirements in Medicaid through 1115 demonstrations and concluded the agency lacks the legal authority to approve such waivers.

- These requirements are based on the false premise that Medicaid beneficiaries do not work. To the contrary, nearly 4 in 5 adult Medicaid enrollees live in a working household, and 60 percent are working themselves. Almost all of those not working have a disabling condition, are caring for a child or an older adult who needs help, or are students or retirees. Yet this new work requirement forces everyone to jump through more hoops to maintain access to needed medical care through Medicaid.
- Work requirements create more red tape for all Medicaid enrollees, *including people with disabilities who might be exempt on paper*. All HIP 2.0 enrollees will be required to prove they are working or exempt. Every exemption requires someone to fill out a form, complete a screen, or any number of other requirements that add red tape and make it harder to stay enrolled. Many people will not even know they have to file paperwork, others will struggle to get the verification documents. This adds bureaucratic costs for individuals and the state.
- Adult enrollees who care for a non-dependent relative, such their aging parent, are not exempt. Rather, these caregivers will have to document their caregiving hours works and count them toward fulfilling the work requirement, which will add significant burden to continue their own coverage.
- Experience shows that, if provided adequate supports, many people with disabilities build successful careers. But it takes significant investment and adequate supports – from personal care to appropriate wheelchairs to necessary employer accommodations. In contrast, Indiana's 1115 waiver identifies no added resources or initiatives for employment supports that facilitate work. It simply takes away coverage from those who cannot comply.

More coverage lock-outs. Many individuals who fail to file renewal paperwork on time will be disenrolled and locked out of Medicaid for 3 months. Outreach and notice for the renewal process is often lacking. It can be especially challenging for some people with disabilities who require accommodations, such as large print or screen readable electronic documents. No one should lose essential coverage simply due to administrative snafus. And locking people out of coverage directly contradicts the objective of Medicaid – to furnish coverage.

- Even if enrollees correct paperwork or payment errors, they still face coverage lockouts. This may be true even if individuals are in the middle of cancer treatment or have an ongoing critical health need, such as kidney dialysis, unless they are able to qualify for an exemption.

In addition to these new policies, CMS has extended **existing** waivers for policies that add roadblocks to coverage and make accessing care more complicated:

Waiting periods for enrollment. Under Medicaid law, states must promptly enroll every eligible applicant. However, Indiana will subject some applicants living in poverty to a waiting period of up to two months before they are enrolled if they do not make an initial payment to begin coverage. People with disabilities with immediate care needs may not be properly screened and will end up stuck in this waiting period with no access to care.

Premiums with terminations and lockouts for nonpayment. Medicaid law prohibits premiums for Medicaid enrollees with incomes under 150% of the federal poverty level, including anyone eligible through the adult Medicaid expansion. HHS has allowed Indiana to charge premiums to these individuals *and* terminate and lock out a subset of enrollees with incomes above poverty level if they do not keep up with payments. Evidence from the state's own independent evaluator shows that nearly 3 in 10 eligible applicants facing mandatory premiums either lost coverage or never fully enrolled due to the premium payment.[5] There is nothing experimental about charging premiums or locking people out, and the known outcome contradicts the objectives of Medicaid. Moreover, people with disabilities eligible through Medicaid expansion could easily lose coverage when not flagged by the state's medical frailty screen.

Retroactive coverage eliminated. Many eligible individuals apply for Medicaid *after* an accident or serious illness that requires urgent treatment. Federal law requires states to provide retroactive coverage so treatment received prior to enrollment is covered.

- Retroactive coverage helps protect consumers and medical providers (such as hospitals) from bankruptcies due to expensive, uninsured care. People with chronic conditions and the medically frail, who are more likely to be hospitalized or require emergency care, are strongly impacted by this waiver but are not exempt under the approval
- Indiana's waiver seeks to save the state money by reducing access to care and shifting costs onto low-income families. Indiana's proposal suggested that retroactive coverage encourages low-income people to avoid coverage until they are sick, but this defies common sense. In reality, few low-income individuals even know retroactive coverage is available, so this is likely no deterrent to enrollment.

Nonemergency medical transportation eliminated. For some enrollees, the Indiana waiver eliminated transportation services. Evaluations of similar waivers in Iowa show that this benefit cut reduces access to care, particularly for people of color and people with health problems or disabilities (even with an exemption in place). This waiver has no experimental value.

Additional Issue Briefs can be found below:

- ***HHS Approves Harmful 1115 Waivers in Indiana – Including Work Requirements, Lockouts, and Waiting Periods***
- ***Indiana's Section 1115 Medicaid Waiver & Its Impact on Health Equity***
- ***HHS Approves 1115 Waiver in Indiana – Harming Medicaid Enrollees Who Need Reproductive Health Services***
- ***HHS Approves Harmful Section 1115 Waiver in Indiana: Effects on People with Disabilities***

[1] Centers for Medicare and Medicaid Services, Healthy Indiana Program Health Approval Letter and Special Terms and Conditions (Feb. 1, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf.
[2] Indiana's actuary estimates that about 25,000 people will lose coverage due to the work requirement alone. This does not include people who lose coverage due to administrative problems verifying their exemption or their employment hours. See Milliman's report in Indiana's § 1115 application, at page 75-76 of the application PDF (July 20, 2018), at https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa5.pdf.
[3] *See, e.g.,* Yeheskel Hasenfeld et al., *The Logic of Sanctioning Welfare Recipients: An Empirical Assessment*, Departmental Paper, University of Pennsylvania School of Social Policy and Practice (2004), https://repository.upenn.edu/cgi/viewcontent.cgi?article=1028&context=spp_papers.
[4] *See*, Michael Morris et al., Burton Blatt Inst. at Syracuse Univ., *Impact of the Work Requirement in Supplemental Nutrition Assistance (SNAP) on Low-Income Working-Age People with Disabilities*, 4, 14 (2014).
[5] Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, ii (Mar. 31, 2017).