HHS Approves Harmful Section 1115 Waiver Project in Indiana – Including Work Requirements, Lockouts, and Waiting Periods

By David Machledt

HHS on Feb. 2 approved an extension with amendments for the "Healthy Indiana Program (HIP) 2.0" section 1115 waiver.[1] The approval allows Indiana 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 existing waivers. The approved project, effectively a health care cut, will worsen or eliminate access to Medicaid for low-income individuals. 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, Hoosiers living below the poverty level or nearly in poverty will be hurt by this 1115 project.[2]

Under the law, HHS is only allowed to approve section 1115 demonstration programs that are experimental and likely to promote the objective of Medicaid — which is to help *furnish* health services to enrollees.[3] HHS's approval raises a number of legal questions involving not only the purported demonstration quality of the project but also whether the harm that the project will cause – reducing access to coverage and care for low-income Hoosiers – reflects Medicaid's objectives.

Among the worst **new** features of the approved Indiana project are:

- **Work requirements**
  - Work requirements like these are not permitted by the Medicaid Act and do not meet the section 1115 standards. Just over one year ago, HHS reviewed the possibility of work requirements and concluded the agency lacks the legal authority to allow states to implement them.[4]
  - These are the facts: The majority of Medicaid enrollees are in a working household. The vast majority of those who are not working have a disabling condition or are retired, in school, or caretakers. Most unemployed Medicaid enrollees who *can* work simply cannot find a job.[5]
  - Work requirements harm all Medicaid enrollees, *including workers*. All enrollees will need to prove they are working or meet one of the exemptions. Enrollees who fail to show that documentation will be suspended and later disenrolled. Many individuals will not even know they have to file paperwork, and many others will not have the needed paperwork.
  - Indiana's own estimates are that this policy will lead to 25,000 Hoosiers losing coverage when fully implemented.[6] Notably, those estimates do not include

thousands more already working or exempt enrollees who will lose coverage due to added red tape to verify their work hours or exemptions.
  - Studies show that mandatory work requirements do not effectively improve long-term secure employment. In Wisconsin's food support program, more than three people lost access to food support for every person that gained employment.[7]
  - Voluntary employment support programs have proven highly effective when properly resourced.[8] In this case, Indiana has added a bundle of red tape mandates but this approval offers no added resources to create new employment opportunities or increase support for job training, education or affordable child care. This is punishment, not progress.
  - There is no evidence that mandatory work programs make people healthier. In contrast, evidence does show that health coverage helps people gain and maintain employment.[9] As a policy to promote work, mandatory work requirements are counterproductive.

- **Additional coverage lock-outs**
  - Indiana already has premium lock-outs (discussed below). Many individuals who fail to file paperwork on time will now also be terminated and prohibited from re-enrolling for 3 months. Many people will be unaware of these requirements or unable to submit paperwork on time because they have moved or are homeless and never receive the forms.
  - Even if individuals correct the paperwork or payment errors, they will *still* be locked out of coverage. This may be true even if individuals are in the middle of cancer treatment or have a regular critical health need, such as kidney dialysis, unless they are able to qualify for an exemption.
  - Indiana's current waiver allows the state to disenroll and lock out some enrollees who miss their premium payments. Based on preliminary evaluations, the access barrier this creates has been substantial (see below). Still, the state sought and received approval for a new punitive lockout.
  - Locking people out of coverage directly contradicts the objective of Medicaid – to furnish coverage.

- **Higher Premiums for smokers**
  - CMS approved Indiana's proposal to now charge 50% higher premiums for individuals who smoke in their second year of coverage. Research shows that raising premiums does not encourage smokers to quit. Rather, individuals who smoke simply drop coverage altogether, reducing their access to smoking cessation treatments.[10] Nearly half (48%) of Indiana Medicaid enrollees smoke.[11]

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 the law, states must promptly enroll everyone who is eligible for Medicaid, and coverage is effective as of the month individuals apply. However, Indiana subjects some applicants living in poverty to a waiting period of up to two months (depending on how fast they pay premiums) before their coverage is effective.
  - Many individuals apply for Medicaid soon after they have a health care crisis and find out they have no insurance. A nearly two month delay in treatment will be a matter of life-or-death for many of these individuals. Of those who do at least manage to get emergency treatments, many will be bankrupted by the medical bills.
  - The most important and entirely predictable result of delaying enrollment for individuals who need health care is worse health outcomes and medical bankruptcies – this is not an innovative experiment.

- **Premiums, terminations, and lockouts**
  - Medicaid law expressly prohibits premiums for individuals under 150% of the federal poverty line.
  - HHS has allowed Indiana to charge premiums to individuals in and near poverty (even those with no income) *and* terminate those near poverty when they fail to pay. The premiums apply to some traditional Medicaid populations, not only individuals who qualify due to Medicaid expansion.
  - Numerous studies consistently show that imposing premiums on low-income individuals reduces coverage. 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.[12] There is nothing experimental about charging premiums, and the known outcome contradicts the objectives of Medicaid.
  - CMS also extended the HIP 2.0 waiver to impose a six month lockout for not paying premiums on time despite evidence of the barrier to coverage this policy has created. In a given month, roughly 37,000 HIP members are in a group subject to disenrollment and lockout.[13] From August 2016 through January 2017, the state disenrolled 9,223 people for nonpayment of premiums, most of whom came from this group.[14] Clearly, lockouts have created a major barrier to keeping Medicaid coverage.

- **Retroactive coverage eliminated**
  - Many individuals apply for Medicaid *after* a fall, accident or serious illness that requires urgent treatment. Federal Medicaid law requires states to provide retroactive coverage so that treatment received prior to application is covered. Even medically frail individuals in the HIP program would not qualify for retroactive coverage.
  - This provision helps protect consumers and medical providers (such as hospitals) from bankruptcies due to expensive, uninsured care.
  - This policy explicitly reduces coverage for enrollees and is the opposite of furnishing medical assistance as per the objectives of Medicaid.

- **Waiver of Non-emergency Medical Transportation.**
  - For some enrollees, the Indiana waiver has 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).[15] 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 Plan Approval Letter and Special Terms and Conditions (Feb. 1, 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-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 Social Security Act §§ 1115 and 1901.

[4] *See* Centers for Medicare and Medicaid Services, AHCCCS 1115 Demonstration Extension 2 (Sept. 30, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/az/Health-Care-Cost-Containment-System/az-hccc-demo-ext-09302016.pdf; Letter from Vikki Wachino, Director, CMS, to Jeffrey A. Meyers, Comm'r, N.H. Dep't of Health & Human Servs. 1-2 (Nov. 1, 2016), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf.

[5] Rachel Garfield, Robin Rudowitz and Anthony Damico, Kaiser Family Foundation, *Understanding the Intersection of Medicaid and Work* at Figures 1 and 6 (Dec. 2017), http://files.kff.org/attachment/Issue-Brief-Understanding-the-Intersection-of-Medicaid-and-Work.

[6] Robert M. Damler et al., Milliman, *1115 Waiver – Healthy Indiana Plan*, 4 (May 24, 2017), attached to HIP 2.0 application.

[7] *FoodShare Employment and Training (FSET) Program Cumulative Data*, Wisc. Dep't of Health Servs. (May 5, 2017), https://www.dhs.wisconsin.gov/initiatives/fset-cumulative.htm.

[8] Howard Bloom et al., MDRC, *Promoting Work in Public Housing: The Effectiveness of Jobs-Plus* (2005), https://www.doleta.gov/research/pdf/jobs_plus_3.pdf; James A. Riccio, MDRC, *Sustained Earnings Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration* (2010), http://files.eric.ed.gov/fulltext/ED514703.pdf.

[9] *See* Ohio Department of Medicaid, *Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly* 46 (Dec. 2016), http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf; Jean P. Hall, Adele Shartzer, Noelle K. Kurth, Kathleen C. Thomas, *Effect of Medicaid Expansion on Workforce Participation for People With Disabilities*, 107 Am. J. Pub. Health 262-264 (Feb. 1, 2017).

[10] Abigail S. Friedman et al. *Evidence Suggests that the ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation*, 35 *Health Aff.* 1176 (2016).

[11] Anne DiGiulio et al. *State Medicaid Expansion Tobacco Cessation Coverage and Number of Adult Smokers Enrolled in Expansion Coverage — United States, 2016*. 65 MMWR 1364 (2016), www.cdc.gov/mmwr/volumes/65/wr/mm6548a2.htm.

[12] Lewin Group, *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*, ii (Mar. 31, 2017).

[13] Ind. Family & Social Servs. Admin. ("FSSA"), *Healthy Indiana Plan Demonstration Quarterly Report, Demonstration Yr 2, Qtr. 3*, 4 (Dec. 30, 2016); FSSA, *Healthy Indiana Plan Demonstration Quarterly Report, Demonstration Yr 2, Qtr. 4*, 5 (Mar. 31, 2017).

[14] *Id.* Due to churn, the total number of individuals enrolled who are subject to lockout over a six month period would be greater than 37,000. The "ever enrolled" figure for this period is not publicly available. Some individuals are disenrolled after their income increases above the poverty level and they then fail to make a premium payment. They are not subject to lockout.

[15] Suzanne Bentler, et al., University of Iowa Public Policy Center, *Non-Emergency Medical Transportation and the Iowa Health and Wellness Plan*, 26 (Mar. 2016), http://ppc.uiowa.edu/sites/default/files/nemt_report.pdf.