July 14, 2017

The Honorable Tom Price, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Price:

The undersigned organizations appreciate the opportunity to comment on Wisconsin's Medicaid proposed amendment to its 1115 waiver, the BadgerCare Reform Demonstration Project ("the amendment").

Wisconsin states that its first goal is to "ensure that every Wisconsin resident has access to affordable health insurance to reduce the state's uninsured rate." While we agree with that goal, the policies Wisconsin is proposing would likely increase the state's uninsured rate by blocking eligible individuals from receiving needed care.

In addition to the troubling policy proposals discussed below, the waiver amendment appears to assume the BadgerCare waiver will be renewed beyond December 31, 2018, when it is currently scheduled to expire. The amendment states that implementation will begin at least one year after approval. The state's proposals — particularly the 48-month time limit — cannot be implemented and evaluated during the very limited period between approval and expiration of the waiver. This in and of itself should be grounds to reject the proposal unless and until the state submits a proper extension request.

Premiums and Cost-Sharing Create Barriers to Care

Wisconsin's proposed amendment would require individuals and families with incomes above 50 percent of the poverty line to pay $8 monthly premiums or risk losing coverage for up to six months. Those who fail to pay would be locked out of coverage for six months unless they paid their outstanding premiums before the end of the lock-out period. No state has ever been allowed to bar people with incomes below the poverty line from coverage for failure to pay premiums.

Wisconsin proposes to offer reduced premiums to beneficiaries who complete a health risk assessment and who do not engage in (or attest to controlling) behaviors that increase health risks, such as "alcohol consumption, body weight, illicit drug use, seatbelt use, and tobacco use." The state refers to research finding a 23.5 percent health risk assessment completion rate for health risk assessments.[1] Experience in Iowa and Michigan, which tested behavioral incentives in their Medicaid programs, showed lower participation than the already low rate Wisconsin cites for similar assessments, and surveys in those states showed that few beneficiaries were aware of these programs.[2] A state analysis in Michigan found that only 14.9 percent of beneficiaries enrolled in a

[1] Wisconsin failed to provide a citation to the research with this finding.

[2] Hannah Katch and Judy Solomon, "Are Medicaid Incentives an Effective Way to Improve Health Outcomes?" Center on Budget and Policy Priorities, January 2017, http://www.cbpp.org/research/health/are-medicaid-incentives-an-effective-way-to-improve-health-outcomes.

health plan for at least six months completed the states' health risk assessment.[3] Similarly, Iowa found that 17 percent of beneficiaries with incomes below the poverty line completed a health risk assessment and received a wellness exam. Some 90 percent of beneficiaries surveyed did not know they could get their premiums waived if they met these requirements.[4]

The amendment also states "research demonstrated a 4 percent and a 2 percent reduction in enrollment due to the introduction of premiums for households making full and reduced payments respectively." Research actually shows that the reduction in enrollment is likely to be far higher A recent report from the Kaiser Family Foundation looked at research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income people enrolled in Medicaid and CHIP. The authors concluded that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty. The research shows that while some individuals losing Medicaid or CHIP coverage move to other coverage, others become uninsured. Those with lower incomes are most likely to become uninsured. Once uninsured, people face increased barriers to accessing care, greater unmet health needs and increased financial burdens.[5]

In Oregon, for example, nearly half of adults disenrolled from Medicaid after premiums increased to a maximum of $20. Many former enrollees became uninsured and faced barriers to obtaining care.[6] Similarly, a recent study of the Healthy Indiana Plan, which requires adults to pay between $1 and $100 in monthly premiums to enroll in a more comprehensive plan, found that 55 percent of eligible individuals either did not make their initial payment or missed a payment.[7]

Wisconsin's own experience shows that the premiums it is now proposing would significantly depress participation. In 2012, when enforceable premiums were imposed on adults with incomes above 138 percent of the poverty line, over two-thirds of these adults left the program within six months.[8] Imposing premiums on people with even lower incomes would likely lead to at least the same result or possibly even a greater loss of coverage.

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[3] "Michigan Adult Coverage Demonstration Section 1115 Annual Report," May 17, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-annual-report-DY6.pdf.

[4] Natoshia M. Askelson et al., "Health Behaviors Incentive Program Evaluation Interim Report," March 1, 2016, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-bhvrs-int-rpt-mar-2016.pdf.

[5] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[6] *Op cit.,* Artiga, Ubri, and Zur 2017.

[7] *Ibid.,* see also The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA)," March 2017. Premiums in Healthy Indiana are generally set at 2 percent of household income or $1 a month for people with incomes below 5 percent of the poverty line.

[8] *Ibid.,* Gates and Rubinowitz 2014.

The research is clear that premiums decrease participation in Medicaid and increase uninsurance and hardship. States should no longer be permitted use 1115 waiver demonstrations to test the effect of premiums in Medicaid.

Wisconsin's attempt to justify its proposal on the basis of Medicaid's aggregate cap on premiums and cost-sharing should also be rejected, because the five percent cap does not provide authority to charge premiums and cost-sharing above Medicaid statutory limits. Prior to enactment of the Deficit Reduction Act of 2005 (DRA), states had extremely limited authority to impose premiums and co-pays in Medicaid. The DRA expanded authority for co-pays and premiums and gave states new flexibility to charge premiums and copays for people with incomes above the poverty line. For example, states could charge coinsurance amounts up to 10 percent of the cost of a covered service for people with incomes above poverty and 20 percent for people with incomes above 150 percent of the poverty line. They were also authorized to charge premiums to people with incomes above 150 percent of poverty. Because this new authority could result in excessive cost-sharing, the DRA also included an out-of-pocket cap, limiting aggregate premiums and cost-sharing to a maximum of five percent of household income measured on a quarterly or monthly basis. The five percent limit is an out-of-pocket maximum that should only be reached in rare cases for people with incomes above the poverty line. The DRA is not an authorization to charge *all* beneficiaries — including those with incomes below poverty — up to 5 percent of their income in premiums and cost-sharing charges.

Emergency Department Copayments Will Deter Needed Care

The amendment also requests authority to charge an $8 copayment for emergency department (ED) use by adults not raising children. First and foremost, the Secretary does not have authority under section 1115 to waive the cost-sharing protections specified in section 1916 of the Social Security Act. Waivers of cost-sharing provisions can only be approved under the separate waiver authority in section 1916(f). A state requesting such a waiver must meet the following five criteria:

1. The state's proposal will test a previously untested use of copayments;
2. The waiver period cannot exceed two years;
3. The benefits to the enrollees are reasonably equivalent to the risks;
4. The proposal is based on a reasonable hypothesis to be tested in a methodologically sound manner; and
5. Beneficiary participation in the proposal is voluntary.

Indiana is currently the only state with CMS approval for special cost-sharing waiver authority to implement a copayment for Medicaid beneficiaries, and it is for people who use the ED for non-emergent purposes. Wisconsin's amendment goes beyond what Indiana has been allowed to do, proposing to impose cost-sharing on *all* ED use for these adults, which could deter them from seeking necessary emergency care and have a detrimental effect on their health. Wisconsin's proposal does not meet the criteria for a waiver under section 1916(f). In fact, the state did not even acknowledge the criteria in its proposal. HHS should reject the co-payment proposal, because it is not an appropriate use of 1115 waiver demonstration authority.

Even if the lack of compliance with section 1916(f) is set aside, the proposal should not be approved because of the harm it would cause beneficiaries. The review of the literature on premiums and cost-sharing discussed above found that even small levels of cost sharing, in the range

of $1 to $5, are associated with reduced use of care, including necessary services. The review cites numerous studies that have found that cost sharing has negative effects on individuals' abilities to access needed care and health outcomes, and increases financial burdens for families.[9]

Work Requirements and Time Limits Would Harm People Who Cannot Work

Wisconsin proposes a 48-month time limit on benefits tied to a work requirement. Under the proposed amendment, adults under age 49 without dependent children would lose coverage for six months after 48 months of enrollment, but months in which they are working or participating in job training would not count toward that 48-month time limit.

Work requirements are contrary to the goal of Medicaid to offer health coverage to those without access to care. Most people on Medicaid who can work, do so, and for people who face major obstacles to employment, harsh requirements such as limiting their eligibility for coverage will not help overcome them. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, more than one-third reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home or family, and 18 percent were in school.[10]

By imposing a time limit on Medicaid eligibility with an exception for those who are employed, the amendment would harm individuals who are unable to work. This is clear from the state's own assumption that 58 percent of individuals would fail to meet the work requirement (including an estimated 31 percent eligible for an exemption). While the proposal does exempt some individuals from the work requirement and time limit, it can be difficult and burdensome for people with disabilities, family care responsibilities, or other significant problems or limitations to prove to a state bureaucracy that they are unable to work. State Temporary Assistance for Needy Families (TANF) programs have failed to implement systems that successfully determine which individuals should be exempt from work requirements. Studies show that TANF recipients who are sanctioned for not meeting a work requirement have significantly higher rates of disability than those who are not sanctioned.[11] Moreover, TANF work requirements failed to increase long-term employment or reduce poverty among those subject to the requirement; the same result would be likely in Medicaid.[12]

The amendment would also harm those who *are* working. The complex rules and required monthly tracking would likely lead to errors and coverage terminations for those who are working or participating in a job training program. If a beneficiary does not understand that they have to report

[9] Op cit., Artiga, Ubri, and Zur 2017.

[10] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

[11] LaDonna Pavetti, Michelle Derr, and Emily Sama Martin, "Assisting TANF Recipients Living with Disabilities to Obtain and Maintain Employment: Conducting In-Depth Assessments," Mathematica Policy Research, Inc., February 2008.

[12] LaDonna Pavetti, "Work Requirements Don't Cut Poverty, Evidence Shows," Center on Budget and Policy Priorities, June 2016.

participation or an eligibility worker fails to properly record whether each month counts against a beneficiary's time limit, working individuals may erroneously lose coverage and face additional burdens in proving their eligibility.

If the loss of coverage resulting from a work requirements leads to a deterioration in health for some people, as it well could, a work requirement could make it harder for some of the affected low-income adults to become or remain employed. Many people not working have health conditions that could worsen without access to health coverage, such as opioid addiction. For some of these individuals, access to health services could be the primary pathway to employment; if blocked from Medicaid coverage, they could find it much more difficult to find and hold a job. Ohio's Department of Medicaid found that Medicaid can reduce health barriers to finding or holding a job for beneficiaries who are not working: three-quarters of beneficiaries who received care under the state's Medicaid expansion and who were looking for work reported that Medicaid made it easier to do so. For those who were currently working, more than half said that Medicaid made it easier to keep their jobs.[13]

Moreover, federal law does not permit work requirements in Medicaid. Several states have requested authority to impose work requirements in Medicaid; none have been approved.[14] Federal Medicaid law defines the factors states can consider in defining who is eligible for Medicaid. It does not require an individual to be working or seeking work as a permissible factor in determining Medicaid eligibility.[15]

Drug Testing Would Deter People With Addiction Disorders From Treatment and Isn't Allowable Under Section 1115

As Wisconsin notes in its amendment, expanding treatment for substance use disorders (SUDs) is critical to combating the SUD epidemic in Wisconsin and across the country. Unfortunately, the state's proposed amendment could prevent individuals in need of SUD treatment from receiving it. The amendment would require all adults without dependent children to complete a drug screening questionnaire as a condition of Medicaid eligibility, and those whose answers suggest possible abuse of controlled substances would have to complete drug testing and/or treatment to receive coverage. A recent New York Times op-ed by two professors of government and history at Cornell University aptly described Wisconsin's proposal: "This would tie lifesaving health care benefits to government procedures that force people to submit to degrading invasions of privacy. Of all the ways to help Americans with drug problems, threatening their Medicaid eligibility is among the worst options."[16]

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[13] Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf.

[14] MaryBeth Musumeci, "Medicaid and Work Requirements," Kaiser Family Foundation, March 23, 2017, http://www.kff.org/medicaid/issue-brief/medicaid-and-work-requirements/; *see also:* Department of Health and Human Services, Letter to Mr. Tom Betlach, September 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.

[15] Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program, March 2017.

[16] Jamila Michener and Julilly Kohler-Hausmann, "Why We Shouldn't Drug Test Poor People," The New York Times, June 28, 2017, https://www.nytimes.com/2017/06/28/opinion/drug-test-poor-medicaid-walker-trump.html.

The federal government has never allowed drug testing in Medicaid. Drug testing would likely deter some people from seeking coverage and getting needed health care due to the consequences of a positive test or, more likely, the invasive and burdensome process that can require taking time off from work and finding transportation for a separate trip to the Medicaid office.[17]

The experience in TANF has shown that drug testing is costly and ineffective. In recent years, seven states with drug testing programs have spent over $1 million, only to find that in six of the states, fewer than one percent of beneficiaries tested positive, compared with 10 percent of the general population.[18]

There is no reason to believe that Medicaid beneficiaries are more likely to use illicit drugs than the general population; yet the risk of making Medicaid coverage contingent on drug testing and treatment is significant: individuals eligible for Medicaid may not get the treatment they need not only for opioid addiction but for other illnesses and conditions due to the requirements for screening and drug testing. This is a dangerous public health policy at a time when more Americans are dying of drug overdoses than car accidents. The responsible and evidence-based policy would be to *expand* access to treatment for these individuals and reduce barriers to care.[19]

Moreover, conditioning eligibility on drug screening, testing and treatment is not permitted in Medicaid for at least three reasons. First, it is contrary to the purpose of Medicaid. Medicaid's purpose is to "furnish medical assistance" to those "whose income and resources are insufficient to meet the costs of necessary medical services."[20] Wisconsin's proposal would indefinitely terminate Medicaid eligibility for otherwise eligible people, preventing people from accessing the very care Medicaid was intended to provide. Thus, conditioning eligibility on complying with the drug screening, testing, and treatment would fail to promote the objectives of Medicaid, a requirement of Section 1115.

Second, like the work requirement, Wisconsin's proposal would create new eligibility criteria that are outside what is allowed under federal law. Conditioning eligibility on compliance with the proposed drug assessment, testing, and treatment scheme would add new eligibility criteria that fall outside the criteria in the statute.[21] Congress has acted to permit states to drug test and subsequently sanction TANF beneficiaries,[22] but has chosen not to do so for Medicaid.

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[17] The state appears to have failed to include in its calculation of the amendment's budget neutrality any calculation of the effect of the drug testing proposal on enrollment. It is highly improbable that the proposed policy would have no effect on Medicaid enrollment.

[18] *Ibid.,* see also: Bryce Covert, "What 7 States Discovered After Spending More Than $1 Million Drug Testing Welfare Recipients," *Think Progress*, February 2015.

[19] *Ibid,* Michener and Kohler-Hausmann 2017.

[20] Section 1901 of the Social Security Act.

[21] The four statutory criteria are: (1) US citizenship or "qualified immigrant" status; (2) residence in the state in which the applicant is applying for Medicaid; (3) membership of a covered population (in this case, a childless adult); and (4) income eligibility (in this case, income below 100 percent of the federal poverty level).

[22] 21 USC § 862b

Third, the proposed drug screening, testing and treatment requirements would violate the Americans with Disability Act (ADA), which cannot be waived through Section 1115.[23] Title II of the ADA prohibits public entities, including states, from excluding an individual with a disability who is otherwise qualified for the state's programs because of the individual's disability.[24] While people currently using illegal drugs are largely excluded from protection under the ADA, alcohol use and *prior* illicit drug use are protected disabilities under the ADA.[25] While Wisconsin's proposal does not describe the drug screen questionnaire it intends to use, its questionnaire may identify people who use alcohol or have a history of illegal drug use as needing to undergo additional testing. These individuals, who are protected under the ADA, may then be excluded from Medicaid because of their disabilities, in violation of the ADA. Congress permits states to drug test TANF beneficiaries "notwithstanding any other provision of law," including the ADA, but Congress has chosen not to do so in Medicaid.[26]

Harsh Requirements and Penalties Will Be Complex and Costly to Implement

In addition to the amendment's likely harm to Wisconsin's Medicaid beneficiaries and the state's failure to show that it is implementing a demonstration program that would promote the objectives of Medicaid, the proposal would add significant complexity and costs to the Medicaid program. State experience implementing work requirements in TANF suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.[27] Moreover, recent research shows that state savings from premiums are limited. Studies find that potential increases in revenue from premiums are offset by use of more expensive services, such as emergency room care, costs in other areas, such as resources for uninsured individuals, and administrative expenses.[28] For example, a recent study looking at Arkansas' Independence Accounts found that they were not cost effective to implement. The state collected $426,457 from eligible enrollees, but spent $595,135 in

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[23] The Medicaid statute enumerates what federal requirements may be waived and federal laws like the ADA are not among them. See Section 1115 of the Social Security Act.

[24] 42 U.S.C. § 12132

[25] U.S. Department of Justice, Civil Rights Division, "The Americans with Disabilities Act Title II Technical Assistance Manual," II-3.8000 Illegal use of drugs (1993), available at: https://www.ada.gov/taman2.html. See MX Grp., Inc. v. City of Covington, 293 F.3d 326, 337-42 (6th Cir. 2002) (narcotics addiction qualified as a disability under the ADA in suit against public entity since it can impair major life activity or be regarded as a disability). See also Pac. Shores Properties, LLC v. City of Newport Beach, 730 F.3d 1142, 1157 (9th Cir. 2013) (citing Hernandez v. Hughes Missile Systems Co., 362 F.3d 564, 568 (9th Cir. 2004)) ("[T]he ADA's protections extend to persons recovering from drug or alcohol addiction."); Sullivan v. Neiman Marcus Grp., Inc., 358 F.3d 110, 114 (1st Cir. 2004) (citing Bailey v. Georgia-Pacific Corp., 306 F.3d 1162, 1167 (1st Cir. 2002) (holding alcoholism is an impairment under the ADA).

[26] 21 USC § 862b

[27] Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

[28] *Op cit.,* Artiga, Ubri, and Zur 2017.

co-payment protections.[29] In addition to spending more than it collected, the state spent $9 million to contract with a vendor to manage the accounts.[30] For each of the policies Wisconsin is proposing in its amendment, the state would have to create new programs and hire new staff to track beneficiaries' employment or premiums payments and cut off their health coverage if they fail to meet the new requirements.

Thank you for your willingness to consider our comments. If you need additional information please contact Judy Solomon (Solomon@cbpp.org) or Joan Alker (jca25@georgetown.edu).

American Heart Association/American Stroke Association
Center on Budget and Policy Priorities
Children's Defense Fund
Georgetown University Center for Children and Families
HIV Medicine Association
NAMI Wisconsin
NAMI, the National Alliance on Mental Illness
National Center for Law and Economic Justice
National Health Care for the Homeless Council
National Health Law Program
National Multiple Sclerosis Society
Service Employees International Union
Wisconsin Chapter of the American Academy of Pediatrics

[29] By making monthly contributions to their accounts, enrollees were "protected," or not required to pay co-payments for services rendered in the subsequent. The $595,135 represents state spending to offset the enrollee's co-payment obligation.

[30] Joseph Thompson, et al., "Arkansas Experience with Health Savings Accounts in a Medicaid Expansion Population," Arkanasa Center for Health Improvement, June 27, 2017, https://academyhealth.confex.com/academyhealth/2017arm/meetingapp.cgi/Paper/18272.