December 20, 2022

VIA ELECTRONIC SUBMISSION

Secretary Xavier Becerra
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Wisconsin BadgerCare 1115 Demonstration Extension Request

Dear Secretary Becerra,

The Center on Budget and Policy Priorities and the Georgetown University Center for Children and Families appreciate the opportunity to comment on Wisconsin's application to extend its "BadgerCare" section 1115 demonstration, which is set to expire on December 31, 2023.

The Center on Budget and Policy Priorities (CBPP) is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, CBPP conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. The Georgetown University Center for Children and Families (CCF) is an independent, nonpartisan policy and research center founded in 2005 with a mission to expand and improve high quality, affordable health coverage for America's children and families. As part of the McCourt School of Public Policy, Georgetown CCF conducts research, develops strategies, and offers solutions to improve the health of America's children and families, particularly those with low and moderate incomes.

Wisconsin states that its first objective of the demonstration has been to "ensure every Wisconsin resident has access to affordable health insurance and reduce the state's uninsured rate." We agree with that goal and support the state's request to continuing providing coverage to childless adults with incomes below 100 percent of the federal poverty level (FPL). However, Wisconsin's decision to continue its partial expansion rather than adopting full Medicaid expansion is fiscally foolish and leaves thousands of Wisconsin residents without affordable comprehensive coverage.

Furthermore, most of the other aspects of Wisconsin's extension proposal that we discuss below, like premiums and required health risk assessments, will make it harder for individuals to get and stay enrolled in coverage and access the care they need. These provisions do not promote the objectives of Medicaid and should not be renewed. *We urge you to authorize the continued coverage of hundreds of thousands of individuals in Wisconsin, but to reject the portions of the state's extension application that are not consistent with the objectives of Medicaid because they reduce access to coverage and care.* Doing so would be consistent with Executive Order 14009, Strengthening Medicaid and the Affordable Care Act, which directed the heads of agencies to examine demonstrations that may reduce coverage or otherwise undermine Medicaid as well as policies that may reduce the affordability of coverage.

Wisconsin's expiring approval establishes authority to implement the troubling demonstration features that the state is seeking to renew, however some of these features have never been implemented because of the Medicaid maintenance of effort and continuous coverage protections in effect during the COVID-19 public health emergency. We urge CMS to deny the state's request to

extend features of the demonstration that establish barriers to coverage, and also *to quickly rescind approval of these barriers to coverage that the state has not yet implemented in order to avert coverage losses when the Medicaid protections end.*

Numerous Provisions Do Not Promote the Objectives of Medicaid

Section 1115 of the Social Security Act allows states to implement demonstration projects that promote the objectives of the Medicaid program. The objective of the program, as stated in the Medicaid Act, is to "furnish medical assistance … and rehabilitation and other services." The state's extension request will harm Medicaid beneficiaries by doing the opposite – *reducing* access to medical assistance by restricting coverage to those who can jump the hurdle of premiums and understand and meet all of the requirements, as we describe below. As a result of the COVID-19 public health emergency and the associated Medicaid protections, the most problematic provisions in the current demonstration (premiums, lockouts, and required health risk assessment) have not been implemented so the detrimental effects of these policies have not yet been realized.

While Wisconsin, like other states before it, may invent alternate theories to justify these harmful policies, reviewing courts have been clear that "[t]he text of the statute includes one primary purpose, which is providing health care coverage without any restriction geared to" other considerations, such as helping individuals achieve "financial independence."[1] Circuit courts have repeatedly tied the legislative history and objectives of Medicaid to promoting *coverage*,[2] and there is no serious dispute that the harmful features of the Wisconsin demonstration do nothing to promote coverage and may reduce existing coverage. As such, CMS lacks the authority to approve premiums, lockouts, mandatory assessments, and improper ED copayments, and CMS should discontinue the policies – including rescinding them immediately if necessary. The known harms of these provisions also means that they are not experimental, much less "necessary" to the demonstration.

Premiums, Lockouts, and Required Health Risk Assessments Create Barriers to Care and Will Result in Coverage Loss

Wisconsin's proposed extension seeks to extend authority to require individuals with incomes above 50 percent of the poverty line to pay monthly premiums and complete a health risk assessment as conditions of eligibility. In addition, if individuals do not pay the required $8 per month premium, they would be disenrolled from coverage and *locked out of coverage for up to six months*. Those who fail to complete a health risk assessment at the time of application would not be enrolled in Medicaid and individuals already enrolled would have to complete the assessment at renewal to avoid losing coverage.

As you know, research has shown that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty who are more likely to become uninsured if premiums are charged.[3] It should come as no surprise to the state of Wisconsin that you do not believe that it is an appropriate use of Secretarial 1115 authority to permit states to

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[1] Gresham v. Azar, 950 F.3d 93 (D.C. Cir. 2020) (vacated as moot).

[2] *Id*. at 100.

[3] Madeline Guth, *et al*., "Understanding the Impact of Medicaid Premiums & Cost Sharing: Updated Evidence from the Literature and Section 1115 Waivers," September 9, 2021, https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/.

charge premiums to Medicaid beneficiaries below the federal poverty line, as CMS' concerns about premiums were clearly delineated and supported by ample evidence in Administrator Brooks-LaSure's 2021 rejection of similar requests from Arkansas and Montana.[4]

In Indiana, which requires adults to pay between $1 and $20 in monthly premiums to enroll in a more comprehensive plan, over 35,000 individuals either did not make their initial payment or missed a payment in a single year.[5] These individuals were either never enrolled in coverage, dropped to a lower tier benefit plan with significantly more out-of-pocket costs, or disenrolled from coverage. Once uninsured, people face increased barriers to accessing care, greater unmet health needs, and increased financial burdens. A recent study from Michigan's evaluation of its "Healthy Michigan Plan" found that premiums imposed on Healthy Michigan beneficiaries *above 100 percent of the federal poverty line* increased the likelihood of individuals voluntarily disenrolling from coverage.[6] The effect would likely be greater in Wisconsin where premiums would be imposed on beneficiaries with incomes *below* the poverty line.

The research is clear that premiums decrease participation in Medicaid and increase uninsurance and hardship. We urge you to take similar action on Wisconsin's request as you did in Arkansas and Montana and disapprove the imposition of premiums through the demonstration. As CMS noted in these disapprovals, premiums can exacerbate health disparities among historically under-resourced populations, present a barrier to coverage, and as such, do not promote the objectives of Medicaid.

Wisconsin's proposal would disenroll individuals who do not pay their required premiums from coverage *and* would prohibit them from reenrolling in Medicaid for *up to six months – in effect establishing a forced period of uninsurance*. Forcing people to become uninsured for a period of time serves no purpose and does not align with the objectives of Medicaid. In Montana, where premiums were imposed on beneficiaries with incomes from 50 percent to 100 percent of the poverty level, only 40 percent made their premium payment for the month, and only half of those beneficiaries required to pay with incomes above the poverty line did so.[7]

Wisconsin's lockout policy, which the state is seeking authority to continue, is extremely harsh. Disenrollment for non-payment of premiums would not occur, according to the state's current STCs, until a beneficiary's annual redetermination. At that time, if an individual is found to have any unpaid premiums, they would lose their Medicaid coverage and *be prohibited from reenrolling for six months or until all owed premiums are paid prior to the six-month time period ending* (up to $96 total, which would be 17% of monthly income for a childless adult at 50 percent of the federal poverty line). In Indiana, where the state's lockout policy is limited to individuals above the poverty line,

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[4] CMS approval letter for Arkansas Health and Opportunity for Me section 1115 demonstration project, December 21, 2021, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/ar-arhome-ca.pdf; CMS approval letter for Montana Health and Economic Livelihood Partnership section 1115 demonstration project, December 21, 2021, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf.

[5] Lewin Group, "Healthy Indiana Plan Interim Evaluation Report," pg. 150, December 18, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf - page=250.

[6] Betsy Q. Cliff, *et al.*, "Adverse Selection in Medicaid: Evidence from Discontinuous Program Rules," National Bureau of Economic Research, May 2021, https://www.nber.org/system/files/working_papers/w28762/w28762.pdf.

[7] Niranjana Kowlessar, *et al.,* "Federal Evaluation of Montana Health and Economic Livelihood Partnership (HELP): Summative Evaluation Report," November 30, 2020, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/summative-eval-rpt-montana-2020.pdf.

approximately 1,000 people per year experienced a six-month non-eligibility period for non-payment of premiums.[8] This number would surely be higher in Wisconsin given the lower income threshold of 50 percent of the federal poverty line, and it is a fairly safe assumption that those who are locked out for nonpayment of premiums will remain uninsured for the duration of the lockout.

While lockout periods are generally prohibited in Medicaid, states are allowed to have lockouts for non-payment of premiums in the Children's Health Insurance Program (CHIP), which serves beneficiaries at higher income levels.[9] Despite this, during the COVID-19 pandemic, many states, including Wisconsin, have waived their lockout periods for CHIP,[10] underscoring that states recognize that the policy presents a barrier to necessary coverage. Approving Wisconsin's lockout policy would contribute to periods of uninsurance, exposing low-income adults to medical debt and unmet health needs. In addition, the policy would put people of color, who have greater levels of medical debt, at increased risk of financial instability.[11]

Wisconsin is also seeking authority to continue a requirement that all individuals enrolled through the demonstration have to complete a health risk assessment in order to become enrolled and/or maintain enrollment in Medicaid. As part of the health risk assessment requirement, individuals must answer *all* questions, including questions on substance use; failure to do so results in denial of or disenrollment from coverage. Tying access to necessary medical services to invasive personal questions would likely deter some people from seeking coverage in the first place, limiting access to substance abuse and mental health treatment among other negatives and should have never been approved – especially in light of the nation's ongoing opioid public health emergency.[12] Filling out this form is an administrative barrier for everyone, but it is likely to be an even more difficult undertaking for those with cognitive or certain physical disabilities, limited English proficiency or other barriers.

Ultimately, whatever the alternate aims of this policy are, the policy itself would directly reduce coverage and thus is inconsistent with the objectives of Medicaid. This provision creates unnecessary red tape and barriers for eligible individuals and would likely result in coverage loss and costly churn for those already enrolled in coverage through the demonstration because they would be required to complete the HRA at renewal to remain enrolled.

If the state's goal is to encourage healthy behaviors among beneficiaries, the state should be taking steps to assist individuals in achieving those behaviors, like educating them about health risks and linking them with primary care providers or medical homes, rather than creating barriers to accessing needed care by asking questions that could deter some people from enrolling in the first

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[8] Lewin Group, "Healthy Indiana Plan Interim Evaluation Report," pg. 149, December 18, 2019, https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/in-healthy-indiana-plan-support-20-pa8.pdf - page=249.

[9] The Center for Children and Families has urged that lockouts are eliminated in CHIP. See, Alker, J and Dwyer, A. *"Future of Children's Health Coverage: Next Steps for CHIP"* August 24, 2021 available at https://ccf.georgetown.edu/2021/08/24/future-of-childrens-health-coverage-next-steps-for-chip/

[10] Wisconsin Children's Health Insurance Program State Plan Amendment (WI 20-0005), August 19, 2020, https://www.medicaid.gov/CHIP/Downloads/WI-20-0005.pdf.

[11] Neil Bennett, *et al.,* "Who Had Medical Debt in the United States?," United States Census Bureau, April 7, 2021, https://www.census.gov/library/stories/2021/04/who-had-medical-debt-in-united-states.html.

[12] Health and Human Services Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis, September 29, 2022, https://aspr.hhs.gov/legal/PHE/Pages/Opioids-29Sept22.aspx.

place. Evidence has shown that using sticks to incentivize healthy behaviors is not likely to produce desired results and can be harmful, while incentives such as reward-based programs have a greater chance of success if limited to attempting to change short-term behaviors.[13]

The proposed policies detailed above would result in coverage loss and limit access to health care, and they should not be approved under section 1115 authority. We urge you to deny the state's request to extend these elements of the demonstration.

Emergency Department Copayments Will Deter Needed Care

The extension application also requests the authority to continue charging an $8 copayment for emergency department (ED) use determined not to meet the "prudent layperson standard of a medical emergency." The Medicaid statute allows cost-sharing for non-emergency use of the ED under specific conditions, including finding that the enrollee has an "actual available and accessible" alternative service provider and providing the individual timely notice and a referral to such an alternate provider.[14] The state notes at pps. 1 and 6 of its application that it intends to comply with existing federal regulations regarding copayments at 42 CFR § 447.54(b), however, the state seeks a comparability waiver to apply these emergency copayments only to childless adults.

Research has found that even minimal cost-sharing among individuals with low incomes is associated with a reduction in access and use of care, not to mention that greater out-of-pocket costs increase the financial burden on these individuals.[15] And *according to the state's own evaluation, charging these copayments is not changing individuals' behavior in a meaningful way.*[16] We urge CMS to deny this request.

Harsh Requirements and Penalties Will Be Complex to Administer, Especially After the Continuous Coverage Protection is Lifted

The imposition of numerous requirements for beneficiaries to maintain coverage would add significant complexity to the Medicaid program at a time when it is likely to be under stress for other reasons. Currently, the monthly premium and health risk assessment requirements have not been implemented due to the Families First Coronavirus Response Act (FFCRA)'s maintenance of effort requirement associated with additional federal matching funds. However, once the requirement is lifted, the state could implement these provisions.

This means that in addition to beneficiaries navigating normal redeterminations, in some cases for the first time since they enrolled in coverage, they would also have to figure out whether they owe a

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[13] Hannah Katch and Judith Solomon, "Restrictions to Access to Care Don't Improve Medicaid Beneficiaries' Health," Center on Budget and Policy Priorities, December 11, 2018, https://www.cbpp.org/research/health/restrictions-on-access-to-care-dont-improve-medicaid-beneficiaries-health; Ron Saunders, *et al.*, "Are Carrots Good for Your Health? Current Evidence on Health Behavior Incentives in the Medicaid Program," Duke Margolis Center for Health Policy, June 2018, https://healthpolicy.duke.edu/sites/default/files/2019-11/duke_healthybehaviorincentives_6.1.pdf.

[14] Section 1916A(e) of the Social Security Act.

[15] Guth, *et al.*

[16] University of Wisconsin-Madison Institute for Research on Poverty, "Wisconsin's Medicaid and BadgerCare Plus Health Coverage CMS 1115 Waiver Provisions for 2019-2023," pg. 93, August 2022, https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/wi-badgercare-reform-extension-pa.pdf.

monthly premium, the process for paying that premium (which the state does not specify in its proposal), and complete a health risk assessment as part of their renewal. State agency staff will be under considerable stress to process redeterminations for the state's entire caseload. These challenges for states have recently been highlighted by the National Association of Medicaid Directors.[17]

As a recent report from the Assistant Secretary for Planning and Evaluation (ASPE) outlined, unwinding the continuous coverage protection will likely lead to a high volume of procedural disenrollments – estimating that 6.8 million enrollees will lose coverage despite still being eligible – and the state should not be allowed to implement or continue these onerous requirements, which would worsen potential coverage losses.[18] As we suggested earlier, if it appears that the demonstration extension agreement will not be completed before the pandemic maintenance of effort and continuous coverage protections end, CMS should rescind approvals for the harmful waiver components forthwith, i.e. before they can be put into effect.

Conclusion

Our comments include numerous citations to supporting research, including direct links to the research for HHS' benefit in reviewing our comments. We direct HHS to each of the studies cited and made available to the agency through active hyperlinks, and we request that the full text of each of the studies cited, along with the full text of our comments, be considered part of the administrative record in this matter for purposes of the Administrative Procedure Act.

Thank you for consideration of our comments. If you would like any additional information, please contact Joan Alker (jca25@georgetown.edu) or Allison Orris (aorris@cbpp.org).

[17] Letter from National Association of Medicaid Directors to congressional leadership, November 17, 2022, https://medicaiddirectors.org/wp-content/uploads/2022/11/NAMD-continuous-enrollment-requests.pdf

[18] HHS Assistant Secretary for Planning and Evaluation (ASPE), "Unwinding the Medicaid Continuous Enrollment Provision: Projected Enrollment Effects and Policy Approaches," August 19, 2022, https://aspe.hhs.gov/sites/default/files/documents/60f0ac74ee06eb578d30b0f39ac94323/aspe-end-mcaid-continuous-coverage.pdf.