FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

July 15, 2017

The Honorable Tom Price, Secretary

Department of Health and Human Services
200 Independence Ave., SW
Washington, DC 20201

Submitted online via *Medicaid.gov*

Re: Comments on BadgerCare Reform 1115 Waiver Amendment

Dear Secretary Price:

Families USA is grateful for the opportunity to comment on the state of Wisconsin's BadgerCare Reform 1115 amendment request to modify and elements of its existing BadgerCare adult coverage waiver. We are a national healthcare advocacy organization with the mission of supporting policy changes that will expand access to affordable healthcare for all Americans.

We support Wisconsin's decision to extend Medicaid coverage to low income adults and hope to work in concert with HHS to ensure all state Medicaid programs work efficiently and effectively for the low-income healthcare consumers they serve.

However, we believe that the program components in the BadgerCare Reform amendment would detract from rather than promote the objectives of the Medicaid program. We share the Secretary's and the state's goals of improving access to affordable health for low income people but based on the best available evidence, the believe the amendment as proposed would have the opposite effect: It would increase the rate of the uninsured and make health care harder to access for current and future enrollees.[1]

Our concerns and suggestions for improvements that might better align the waiver with federal law as well as state and federal goals are discussed in greater detail below. We believe many of these concerns can, and should, be addressed during the waiver amendment approval process. Other concerns relate to requests that we believe do not comport with federal law and should be denied.

[1] Letter to Governors from Department of Health and Human Services Secretary Tom Price outlining federal goals for Section 1115 waivers, March 2017 https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf (last accessed July, 15 2017)

Summary of Comments

Our principal concerns are summarized below. These, as well as some additional concerns and suggestions for improvement, are discussed in the "comments" section following.

- CMS should provide for a second state comment period for two reasons. First, the waiver proposal lacks critical detail in several areas, making meaningful comment difficult. Second, there have been concerns raised by Wisconsin stakeholders regarding efforts to chill participation during the state comment period and these impediments run contrary to federal regulatory requirements for a meaningful comment period.

- The waiver will create increased administrative complexity and cost that must be monitored and reported on by the state. The current waiver fails to incorporate adequate cost reporting provisions.

- The imposition of premiums enforced by a six-month lock-out for non-payment is overly punitive and should not be approved as requested.

- The request for $8 emergency room copays should be denied for lack of proper Section 1916(f) waiver authority.

- The Health Risk Assessment program as proposed lacks detail, would likely not be effective, raises beneficiary privacy concerns, and should not be approved without significant revision.

- CMS cannot legally approve a time limit on Medicaid coverage tied to a work requirement under Section 1115 authority. It would not promote the objectives of the Medicaid program or serve a demonstration purpose and must be denied.

- CMS cannot legally approve drug screening and mandatory treatment participation under Section 1115 authority. Such a policy would not promote the objectives of the Medicaid program or serve a demonstration purpose and must be denied.

Overarching Comments

I. Process and Procedure

a. <u>The state comment process failed to meet the requirements of 42 CFR § 431.408; the waiver lacks critical detail which makes meaningful comment difficult or impossible and the comment process failed to meet federal requirements.</u>

The waiver submitted to CMS lacks critical detail required for meaningful comment; to name just one example, exemptions to the work requirement and health risk assessment are opaque. This opacity means that enrollees could lose coverage contrary to CMS intent, or based on discrimination in its implementation. This issue was raised by several commenters who offered suggestions to flesh out the exemptions.[2]

Although the state adjusted several aspects of the waiver after the comment period and before submission in response to comments, as well as offering clarification in several areas, the VAST majority of substantive concerns raised by commenters were either ignored and minor adjustments made by the state did little address underlying legal and policy concerns.

There was inadequate opportunity for public input. Reports from Wisconsin indicate that there were no public hearings held in Madison, hearings were at inconvenient times- for example, during business hours- and commenters were only given two minutes to voice their concerns.

Comments submitted did not receive adequate review and consideration. Comments from the Primary Care Association, NAMI Wisconsin, Wisconsin Faith Voices for Justice and over one thousand other stakeholders were not publicly posted and not adequately addressed in the federal waiver submission.[3] It was only upon FOIA request that press were able to obtain these comments, and even then the names of commenters were redacted.[4]

We strongly agree with the Secretary's commitment to transparency in the 1115 waiver process and hope the Department will hold the states to a high standard of public accountability. We recommend the waiver amendment be sent back to the state for a second state notice and comment period, and HHS should require added detail before certifying the waiver as complete.

b. Administrative Complexity

This waiver breaks new ground in its complexity of administration and burdensome requirements on state systems and BadgerCare members. Drug testing, health risk assessments, collection of premiums with penalties for non-payment and work requirements all require intensive tracking and monitoring on behalf of the state and frequent submission of information from members. There is no provision in the waiver for increased DHS staff members or comparable resources to ensure consumers understand the requirements of the program and there is no mechanism to ensure that the waiver amendment is operationalized in

[2] In particular, we would refer you to the comments from the Wisconsin Primary Care Association for concrete suggestions to clarify the scope of exceptions.

[3] We recognize that publicizing state comments is not a requirement of an 1115 amendment. Nevertheless, it has become a common practice for states to post comments as a good faith effort to engage stakeholders, address concerns and engage in public discourse that is open and fair.

[4] Scott Bauer, "Records Show Scant Support for Walkers Plan" US News and World Reports, (June, 2017) https://www.usnews.com/news/best-states/wisconsin/articles/2017-06-20/ap-exclusive-records-show-scant-support-for-walkers-plan

a way that does not foist the burden of this complexity on to enrollees.

The state claims in its budget neutrality calculations that premiums, co-pays, and the 48 month time limit will save money through decreased enrollment and co-pays/premiums collected. Aside from this assertion the state does not, however, detail the administrative costs of running these programs, an important variable when considering costs to the federal government.

Our recommendation is that HHS require detailed reporting on administrative costs on a quarterly and annual basis, particularly as it relates to expense and budget neutrality and enrollee access to coverage and care. Such reporting is critical to any serious and meaningful assessment of the state and federal cost/benefits of the waiver provisions, essential to determine the success or failure of this program.

II. Premiums and Cost Sharing

a. Charging premiums to individuals below poverty does not promote the objectives of the Medicaid program or serve any demonstration purpose

The state seeks to charge premiums of $8 per household per month for people between 50 and 100 percent of the federal poverty level (FPL). As such, a single individual at 50 percent FPL would pay approximately 1.5 percent of monthly income on premiums. Enrollees may be dis-enrolled for non-payment and subject to a six month lock out period unless back due premiums are paid. Wisconsin's stated purpose for charging premiums to enrollees below poverty is to support and encourage members' transition to private health coverage.

Charging premiums as a condition of eligibility has been shown time and again to decrease access to coverage and care for low-income populations and therefore there is no legitimate demonstration purpose to Wisconsin's proposal.[5] There is an abundance of recent evidence from Section 1115 Medicaid expansion waiver programs showing premiums stifle enrollment and retention of coverage, including from Indiana, Montana, Iowa, Arkansas and Michigan.[6] For example, in the first year of Indiana's HIP 2.0 Medicaid expansion waiver 2,677 individuals above the poverty line were dis-enrolled for failure to pay premiums. Another 21,445 people below the poverty level were enrolled in a lesser benefit package for failure to make monthly premium payments.[7] Michigan's demonstration requires premiums for enrollees above

[5] David Machledt and Jane Perkins, "Medicaid Premiums and Cost Sharing" The National Health Law Program, (March, 2014) http://www.healthlaw.org/publications/browse-all-publications/Medicaid-Premiums-Cost-Sharing#.WVQFSITyu00

[6] Andrea Callow, "Charging Medicaid Premiums Hurts Patients and States" Families USA (April, 2016) http://familiesusa.org/product/charging-medicaid-premiums-hurts-patients-and-state-budgets

[7] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," (July, 2016), 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

poverty, although there is no disenrollment penalty. Collection rates are generally below 50 percent, attesting to the difficulty even higher income enrollees have meeting premium payments.[8] Evidence from Indiana and Michigan supplements the voluminous body of evidence compiled over the last twenty years showing the deleterious effect of premiums in Medicaid and CHIP, particularly for people below poverty.[9]

Wisconsin's own experience reflects the damaging effect of premiums on coverage. In July 2012, Wisconsin added or increased premiums for some adults enrolled in BadgerCare. Enrollees with incomes between 133 and 150 percent of poverty who had previously had no premium costs were required to pay three percent of their income in premiums. Preliminary analysis showed that premium payments had a negative effect on the ability of these low-income enrollees to maintain coverage. From July through September 2012, there was a 24 percent enrollment reduction due to nonpayment of premiums for those in the 133 to 150 percent of poverty income group. The enrollees that would be affected by the BadgerCare reform amendment have even lower incomes than those who suffered disenrollment under BadgerCare in 2012. Evidence shows that people living below the poverty line feel the adverse effects of premiums most acutely.[10] Indeed, the state's own enrollment projections contained in the amendment application show a *decrease* in enrollment from 2017 to 2018.

The rationale that charging monthly premiums to enrollees as a condition of eligibility will better align BadgerCare with private coverage doesn't withstand scrutiny. The majority of people with private coverage have employer based insurance and have their premiums withheld from their paycheck without having to take any positive action. Moreover, one-quarter of households with incomes under $15,000 in annual income reported being "unbanked," which may create additional barriers to making regular payments. [11]

Finally, in addition to creating barriers to coverage, imposing premiums on low income people and the barriers to coverage and care that flow from premiums has been shown to result in

[8] Michigan Department of Health and Human Services, "July 2016 Program Evaluation Report on Healthy Michigan," https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mi/Healthy-Michigan/mi-healthy-michigan-qtrly-rpt-jan-mar-2016.pdf

[9] Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low Income Populations: Updated Review of Research Findings" The 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/

[10] *Id.*

[11] Federal Deposit Insurance Corporation, "2015 National Survey of Unbanked and Underbanked Households," https://www.economicinclusion.gov/surveys/2015household/banking-status-findings/

higher ED usage[12] and higher hospital uncompensated care. [13]

b. The state's request to charge emergency room (ER) copays of $8 is incomplete and fails the necessary requirements of Section 1916(f) for the Social Security Act

In order to charge ER copays for both emergent and non-emergent ER visits, the state must request a waiver of 1916(f) as waiver of cost sharing authority is outside the scope of Section 1115. Although the waiver chart appears to request a waiver of Section 1916(f), the Secretary has no legal authority to waive these cost sharing requirements unless the state meets each condition of that provision. Wisconsin's proposal fails to meet the requirements of 1916(f) and to do so would create significant additional requirements for the state.[14]

In order to comply with Section 1916f and impose increased cost-sharing under a waiver, must meet several criteria. The increased cost sharing must (1) test a unique and previously un-tested use of co-payments, (2) be limited to two years, (3) provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients, (4) be based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area, and (5) be voluntary. The state fails on all five requirements of Section 1916(f).

Increased cost-sharing for use of the ER is far from unique, as it is already being tested in Indiana. The waiver request is for five years, not the required two. The state provides no indication that benefits will be equal to the risk to recipients. There is real risk to low- income Medicaid enrollees with an emergency but who deter necessary care because of cost sharing requirements. This issue is not addressed in the state's waiver. Furthermore, the co-pays are not structured as a hypothesis with the use of control groups, nor is participation in the account deductions voluntary. The requirements that must be met for the Secretary to grant cost-sharing changes under the applicable section of the Social Security Act are clearly not met.

We note that the state, in response to public comment, appropriately changed its initial requirement from $25 to $8 for *all* ED visits. Unfortunately, the state ignored voluminous

[12]Federico SG and Steiner JF et al "Disruptions in insurance coverage: patterns and relationship to health care access, unmet need, and utilization before enrollment in the State Children's Health Insurance Program" *Pediatrics* (October, 2007) https://www.ncbi.nlm.nih.gov/pubmed/17908722

[13] John Holahan, Matt Butgens and Stan Dorn "The Cost of Not Expanding Medicaid" The Kaiser Family Foundation (July, 2013) https://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf

[14] 42 USC 1396o(f), p.45 of the submitted waiver

comment that the co-pay be only for *non-emergent* use of the emergency department as allowed without waiver under Medicaid law. To charge enrollees living below the poverty line what amounts to a very high copay for appropriate use of the emergency room will discourage ill enrollees who may be advised by their doctor to go to the ER (someone with COPD, a heart condition or recovering from surgery, for example) from seeking necessary and appropriate care.[15]

c. Suggestions for improvement in premiums and cost sharing

If HHS approves premiums for enrollees with incomes below poverty, there are ways to mitigate the predictable negative impact on individuals' ability to afford or retain coverage. We urge HHS to modify Wisconsin's waiver application to incorporate these strategies.

- **Clarify that there is a 90 day grace period for non-payment of premiums before disenrollment**. The waiver application refers to a grace period, but does not specify its length. A 90 day period tracks the grace period offered through the Marketplace and consistent with approved adult Medicaid expansion waivers.

- **Use alternatives to disenrollment with lock-out for non-payment of premiums**. For example, in Indiana's HIP 2.0 program non-payment of premiums for people below poverty results in moving to a less generous benefit tier with cost-sharing instead of premiums and lock-out period.

- **Allow eligible individuals who have been dis-enrolled for failure to pay premiums to re-enroll without paying back premiums**. Instead, turn back-due premiums into a debt to the state and forgive these premiums on a rolling quarterly basis like Montana in its HELP 1115 program.[16]

- **Allow for fast track premium payments.** Similar to Indiana's HIP 2.0 program, the state should allow enrollees to pay for multiple monthly payments, up to one year, up front, ensuring continuous coverage for up to a year.[17] 20 percent of all Indiana HIP 2.0

[15] While non-emergent copays would be more in line with the purposes of the Medicaid program, we also note that evidence suggests even these are ineffective as a means to reduce ED utilization in Medicaid. Karoline Mortenson, Health Affairs 1643 (2012); David J. Becker et al., Copays and Use of the Emergency Department Services in the Children's Health Insurance Program, 70 Med. Care. Rev. 514 (2013).

[16] Montana HELP Section 1115 Waiver Demonstration Approval (December, 2016) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/mt/mt-HELP-program-ca.pdf

[17] Continuous coverage is a stated goal of the Secretary's April 2017 letter to states on Sec. 1115 waivers, *See* Note 1 *supra*.

enrollees used fast track payments for a year of coverage paid up front at enrollment.[18]

- **Clarify that enrollees will be able to receive coverage even if they are unable to make their first payment**. In its response to state comments, Wisconsin indicated enrollees would still be able to obtain coverage even if they could not make a first payment. Given the current structure of disenrollment and the lack of detail on grace period times, it is unclear how this policy will be operationalized. CMS should ensure any final waiver clearly allows enrollment absent an initial payment and indicate how that enrollment will work.

III. Health Risk Assessments and Health Behavior Incentives

The state proposes to charge members who do not engage in behaviors that increase health risk lower premiums than those who engage in specified "risky" behaviors. For members who engage in a risky behavior, but attest to actively managing their behavior "and/or have a condition beyond their control" the lower premium may also apply. Those who refuse an Health Risk Assessment to determine risky behavioral status will be subject to the higher premium. Risk behaviors include alcohol consumption, body weight, illicit drug use, seatbelt use and tobacco use. The state will identify risky behavior within the five broad categories using BRFSS and NHIS data. The state asserts collecting this information will allow for "more efficient management and understanding of the demonstration population."

We have considerable concerns with respect to the healthy behavior incentive program as proposed. For those who are in poor health and are more likely to report an unhealthy behavior are also those more likely to need insurance and care. To them, answering forthrightly and not being able to afford their premiums puts them in an impossible position: lie to the state or be unable to afford the care they need.

Evidence suggests that healthy behavior programs both in Medicaid and the private market are poorly understood and of limited success. 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.[19]

[18] The Lewin Group, "Indiana Healthy Indiana Plan 2.0: Interim Evaluation Report," (July, 2016), 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

[19] 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. A state analysis in Michigan found that only

The proposal includes a troubling lack of detail on how risk behaviors will be assessed initially, who may receive an exemption or how re-evaluation for risk behaviors will be undertaken. Simply stating that Wisconsin will rely on NHIS and BRFSS data is not provide the specificity necessary for CMS to determine whether the provision promotes the objectives of the Medicaid program or subjects certain enrollees to discrimination.

The state of Wisconsin should not be the party performing HRAs and behavioral interventions. This should be left to physicians. We strongly support your position "… in favor of making certain that Medicaid is a system that responds to patients, not the government."[20] The purpose of an HRA should be to develop a care plan for health improvement, not a state exercise in collecting protected health information and intrusive monitoring. Thus, a person's physician, not a government bureaucrat, is the best party to be performing these assessments.[21] Second to a physician, a managed care plan's care coordinator should be performing the assessment, and the waiver specifically invokes managed care plan HRA practices in its justification for performing risk assessments. An individual is more likely to be frank with his or her treating provider or care manager, rather than the state, about health risk behaviors, particularly those that may be illegal.

Finally, the state collecting and maintaining a database of protected health information for an indeterminate period of time raises significant privacy concerns. How long will the data be maintained? What rights do enrollees have to challenge errors in their records? Will records be shared with other state agencies? The answers to these questions are critical, and have legal consequences under state and federal privacy laws.

a. Suggestions for improvement

If the state and CMS decide to move forward with a wellness program, we suggest the following

- **Build on what exists and enlist MCOs, Community Health Centers and other community based providers to perform health assessments.** The goal of any wellness program should be to improve enrollee health, not punish low income people for "bad

14.9 percent of beneficiaries enrolled in a health plan for at least six months completed the states' health risk assessment. 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.

[20] Senate Finance Committee Hearing Transcript; Hon. Tom Price, Secretary of HHS (January, 2017) http://www.thisweekinimmigration.com/uploads/6/9/2/2/69228175/hearingtranscript_senatefinancepriceconfirmationhearing_2017-01-24.pdf

[21] As American Association of Physicians and Surgeons have noted, patients and their doctors, not government bureaucrats are the best suited to be making their medical decisions. *Doctors Eager to Empower Patients Not Bureaucrats*, APPS.org (last accessed July 15, 2017) http://aapsonline.org/doctors-eager-to-empower-patients-not-bureaucrats/

behavior" or collect and maintain information on the Medicaid population's habits. Community Health Centers and other community based providers have extensive experience performing HRAs and developing care plans. Providers, and not the state, are best equipped to empower patients and help them to achieve their health goals.

- **Wellness programs that offer rewards rather than penalties are more effective and more closely track how wellness programs in the private, employer based market are structured.** If the state seeks to create greater alignment between Medicaid and the private market with the goal of transitioning individuals to private coverage, offering a wellness plan that provides positive incentives like grocery store gift cards, exercise class passes, smoking cessation aide and coupons would not only offer greater private market alignment but would also be more effective.[22]

- **Ensure very strong provider and enrollee education programs.** Data from Michigan and Iowa's wellness programs showed very low provider and enrollee knowledge of the program. A wellness cannot be effective if program requirements and incentives are unknown. No enrollee should be penalized for a healthy behavior for a lack of information.

- **The state should add much needed clarification to the HRA exemption provided for enrollees with a "condition beyond their control" to ensure these individuals are charged $4 premiums.** For example, individuals with a serious mental illness, HIV-AIDS, and dozens of other chronic conditions should be given an automatic exemption. For all other enrollees, self-attestation should be wholly sufficient to receive an exemption (and thus be subject to lower premiums).

IV. Work Requirement and Time Limit on Eligibility

The waiver amendment proposes a 48 month non-consecutive time limit for BadgerCare eligibility for childless adults under age 49, at which time they will be locked out of coverage for six months. The clock is stopped while an individual satisfies a work requirement.

a. Work requirements and time limits on coverage are contrary to the objectives of the Medicaid program and a violation of federal law

The state and HHS both hold the best way for low-income people to be healthy and

[22] Lydia Mitts and Sascha Murillo, "Key Differences between Wellness Reward/Penalty Programs and Value-Based Insurance Design," Families USA, (2013) http://familiesusa.org/sites/default/files/product_documents/VBID-Wellness-Programs.pdf

independent is through work.[23] Even if that is the case, the mere connection of an activity, in this case employment, and health does not create a sufficient nexus to promote the objectives of the Medicaid program—which is to provide medical assistance to low income Americans.

Starting down the path of linking eligibility for the Medicaid program to activities or conditions unrelated to Medicaid's purpose sets a dangerous precedent that could undermine the program's effectiveness in meeting its objective of providing medical assistance to low income people.

Moreover, federal case law confirms the illegality of work requirements enforced through a time limit. Federal Medicaid law defines the factors states can consider when defining who is eligible for Medicaid. It does not require an individual to be working, seeking work or engaging in community services as a permissible factor determining Medicaid eligibility.[24] Furthermore, any time limit on program eligibility would fundamentally change the entitlement nature of the Medicaid program. Approving such a fundamental program change is outside the Secretary's authority under Section 1115 of the Social Security Act and must instead be undertaken through an Act of Congress.

b. Work requirements seek to solve a problem that doesn't exist

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 – indeed they are likely to have the opposite effect. Eight in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Two thirds of Medicaid enrollees that work do so forty hours per week or longer. 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.[25]

From a practical standpoint, work requirements applied to health coverage get it exactly backwards and this policy will work against the goal of ensuring Medicaid enrollees are fully

[23] According to the state, the goals embodied in the work requirement and time limit are (1) keep health care costs at a sustainable level ensuring continued assistance is available to those most in need and (2) promote employer sponsored insurance.

[24] Jane Perkins, "Medicaid Work Requirements: Legally Suspect," National Health Law Program (March, 2017) http://www.healthlaw.org/about/staff/jane-perkins/all-publications/medicaid-work-requirements-legally-suspect#.WWpSyMaZMkg

[25] 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/

employed. Data from Ohio's Medicaid expansion found that providing access to Medicaid help people maintain employment and seek employment. More than half of Medicaid expansion enrollees report that their health coverage has made it easier to continue working, and three quarters of unemployed Medicaid expansion enrollees looking for work reported that health coverage has made it easier to seek employment.[26] The majority of adult Medicaid expansion enrollees are employed, and an individual needs to be healthy in order to obtain and maintain employment. A work requirement can prevent an individual from getting the health care they need to be able to work.

c. To the extent enrollees are not employed, often it is through no fault of their own and tying Medicaid coverage to work's sole aim will be punitive

State's proffered reason to impose work requirements, namely to encourage work and "promote employer sponsored insurance as the preferred means of health coverage" does not take into account that most Medicaid enrollees work in industries- like retail, home health care and food service—that do not offer employer sponsored insurance (or if they do, it is unaffordable). Just 12 percent of workers earning the lowest 10 percent of wages had employer-provided health insurance in 2016.[27]

Furthermore, this requirement will punish people who cannot find jobs because they live in an economically depressed area, particularly those in struggling rural economies or areas with high rates of unemployment.[28]

d. Requiring individuals to provide community service in order to meet their requirement and receive health care coverage is bad policy and may violate federal labor laws.

In most cases, Medicaid pays health care providers for services provided to Medicaid enrollees or purchases insurance coverage for enrollees, enrollees do not receive any payments from the program.[29] Enrollees may go many months without receiving any direct benefit from Medicaid (i.e., people do not use health services all the time, the need is often unpredictable, hence the rationale for insurance to protect one from unpredictable costs). Given the way Medicaid operates, the state's proposed work/community service requirement which amounts to requiring those without paying jobs to engage in unpaid work in exchange for health coverage. That is not only bad public policy—essentially requiring work in exchange for a non-monetary benefit—there is also the potential for labor market

[26] The Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the General Assembly" http://medicaid.ohio.gov/portals/0/resources/reports/annual/group-viii-assessment.pdf

[27] The Center for Law and Social Policy, "Work Supports" (last accessed July 15, 2017) http://www.clasp.org/issues/work-supports

[29] Medicaid may pay enrollees directly for some long-term services and supports.

disruption. In communities with weak labor markets, "free labor" provided through community service work could displace paying jobs and have the effect of increasing the ranks of the unemployed and the poor. Additionally, it may be that laws not related to the Medicaid program would be violated by this proposed scheme. While Families USA is not an expert in this area, we urge CMS to solicit input from the Department of Labor regarding this aspect of Kentucky's proposal. In addition to being contrary to Medicaid law, the community service requirement in the request may be in violation of the Fair Labor Standards Act.

e. Wisconsin state and national data show work requirements aren't effective at helping people get and keep jobs

From 2015-2017 when the FoodShare Employment Training program instituted a similar work requirement, for every one enrollee who got a job another three lost their access to benefits. A work requirement in the Medicaid program will likely have similar rates of coverage loss. In the waiver amendment application, Wisconsin estimates that one in four BadgerCare enrollees the state estimates will not meet the work requirement or qualify for an exemption.

For those who do find employment, odds that their job will include employer based health insurance are slim. Medicaid-eligible individuals work in industries- like retail, home health care and food service—that do not offer employer sponsored insurance (or if they do, it is unaffordable). Just 12 percent of workers earning the lowest 10 percent of wages had employer-provided health insurance in 2016.[30]

f. Suggestions for improvement

We appreciate that Wisconsin is concerned about the employment opportunities available to low-income people. We fully support states' efforts to create *independent* (from Medicaid) and *voluntary* employment supports for people living below the poverty line. Works support programs which include child care support, the earned income tax credit and SNAP eligibility have been shown to be more effective as a way of connecting low income people with work. For example, universal kindergarten programs have been shown to raise low income parents' workforce participation in Colorado.[31]

V. Drug Screening, testing and mandatory treatment

[30] *Id.*

[31] Arloc Sherman, Danilo Trisi and Sharon Parrot, "Various Supports for Low-Income Families Reduce Poverty and Have Long-Term Positive Effects on Families and Children" The Center on Budget and Policy Priorities (July, 2013) http://www.cbpp.org/research/various-supports-for-low-income-families-reduce-poverty-and-have-long-term-positive-effects

Under the amendment proposal, all applicants must undergo a drug screening. If indicated from the results of the screening, applicants must undergo a drug test. An applicant remains ineligible for benefits until test is complete. If test registers positive, the applicant must fully complete treatment program to be eligible for benefits.

Wisconsin notes in its amendment, expanding treatment for substance use disorders (SUDs) is critical to combatting the opioid epidemic in the state. We share the state's and HHS' deep concern about the widespread abuse of drugs, particularly opioids. However, we strongly opposes the state's screening, testing and mandatory treatment scheme as a way to address these concerns.

Rather than connect individuals with treatment, drug testing will prevent individuals from even seeking out Medicaid and please a state barrier between a patient seeking can and a medical provider.[32] This deterrent effect will have both individual and public health ramifications, particularly with respect to diseases like HIV-AIDS and Hepatitis C which are prevalent among intravenous drug users.[33]

a. Screening and testing regime does not promote the objectives of the Medicaid program

Section 1115 waivers must promote the objectives of the Medicaid program. The objectives of the Medicaid program are to "to furnish medical assistance… [to individuals] whose incomes and resources are insufficient to meet the costs of necessary medical services…" Premising Medicaid coverage on the results of a drug test and willingness to seek treatment will bar many low-income people who cannot afford necessary medical services, potentially indefinitely (for those who have an active substance use disorder but will not submit to state mandated treatment).

The federal government has never allowed drug testing in Medicaid. In addition to failing to meet the requirements to waive Section 1115, drug testing runs afoul of the 4th Amendment

[32] We hope that Sec. Price will recall his commitment to restore the doctor patient relationship and clamp down on government overreach when reviewing the terms of Wisconsin's waiver. *See* Robert Pear, "Trump's Health Secretary Pick Leaves Nationa's Doctors Divided" The New York Times, (December, 2016) https://www.nytimes.com/2016/12/26/us/tom-price-hhs-donald-trump-cabinet.html and *supra* at note 21

[33] Lexy Gross, "What Did Indiana's HIV Outbreak Look Like?" The Indy Star, (July, 2016) https://www.indystar.com/story/news/local/indiana/2016/07/28/what-did-indianas-hiv-outbreak-look-like/87655500/

and the Americans with Disabilities Act (ADA).[34] Drug testing will mire the state in law suits much like drug testing in the state FoodShare program has.[35]

b. Drug screening and testing will be burdensome to both the state and BadgerCare enrollees

The evidence on drug testing in public benefits finds the cost far outweighing any perceived benefit.[36] In its May 2015 budget summary, the Wisconsin legislative fiscal bureau reviewed the cost of drug testing in the BadgerCare program for childless adults. It found that drug testing would cost approximately $33 per test.[37] If enrollment in BadgerCare adult waiver is 146,407 in 2018 as the waiver projects, and ten percent[38] are tested, that is nearly half a million dollars in taxpayer dollars the state spends on testing. All of this isn't taking into account the increased cost of scaling up a testing infrastructure. These are funds that could be going towards medical care and targeted interventions for enrollees with a substance use disorder.

Conclusion

We support the state's decision to cover the adult population up to 100 percent FPL and share its goals of improving health outcomes, engaging consumers and expanding treatment for opioid abuse. However, these goals must be undertaken within the confines of federal law and based on objective evidence. As proposed, Wisconsin's waiver amendment works against the purposes of the Act by tying Medicaid coverage to a work requirement and time limit, high premiums and copays for very low-income people, mandatory drug screening and a dubious health risk assessment program. The amendment as submitted would place current Wisconsin Medicaid enrollees in a worse position than they are now, making it more difficult for them to access and afford care, achieve and maintain continuous insurance enrollment. Additionally, the request lacks the detail in many areas needed for complete comments, and the planning

[34] The ADA explicitly requires that "an individual shall not be denied health services, or services provided in connection with drug rehabilitation, on the basis of the current illegal use of drugs if the individual is otherwise entitled to such services." Medicaid's very purpose is to provide "medical assistance" and "medical services" to those who cannot afford them. 42 § USC 12210(c). Conditioning Medicaid eligibility on drug screening, drug tests and drug treatment would impermissibly deny health services to people because of their illegal drug use. 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. 21 § USC 862b

[35] Arthur Delaney, "Court Tosses Scott Walker's Food Stamp Drug Testing Lawsuit" The Huffington Post, (October, 2016) http://www.huffingtonpost.com/entry/scott-walker-drug-testing_us_57f65f53e4b05f39c51e7aad

[36] Josh Israel, "States Spend Millions to Drug Test the Poor, Turn Up Few Positive Results, ThinkProgress.org, (April 2017) https://thinkprogress.org/states-spend-millions-to-drug-test-the-poor-turn-up-few-positive-results-81f826a4afb7

[37] The Wisconsin Legislative Fiscal Bureau Report to the Joint Committee on Finance, "Drug Screening and Testing for Adults without Dependent Children Enrolled in BadgerCare Plus (May 19, 2015) https://docs.legis.wisconsin.gov/misc/lfb/budget/2015_17_biennial_budget/102_budget_papers/355_health_services_drug_screening_and_testing_for_adults_without_dependent_children_enrolled_in_badgercare_plus.pdf

[38] The national average drug use rate is 9.4%, although experience shows the rate of drug use of public benefit recipients is significantly lower than the national average

and evaluation necessary for full public engagement. We request HHS return the application to the state for additional detail and a second state comment period.

Thank you for the opportunity to comment on this important program. Should you have any questions, please don't hesitate to contact Dee Mahan, Director of Medicaid Initiatives at dmahan@familiesusa.org or Andrea Callow, Associate Director of Medicaid Initiatives at acallow@familiesusa.org .

Respectfully,

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Cc: Ms. Seema Verma, Administrator, Centers for Medicare and Medicaid Services
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