CLASP
policy solutions that work for low-income people

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Director Michael Heifetz
Division of Medicaid Services
P.O. Box 309
Madison, WI 53707-0309

BadgerCare Reform Demonstration Project -- *Coverage of Adults Without Dependent Children with Incomes at or Below 100% of the Federal Poverty Level*

Comments on the Draft 1115 Demonstration Waiver Amendment Application

Dear Director Heifetz,

I am writing on behalf of the Center for Law and Social Policy (CLASP). CLASP is a national, nonpartisan, anti-poverty nonprofit advancing policy solutions for low-income people. We work at both the federal and state levels, supporting policy and practice that makes a difference in the lives of people living in conditions of poverty. In particular, these comments draw on CLASP's deep experience with Temporary Assistance for Needy Families (TANF) and the Supplemental Nutrition Assistance Program (SNAP), two programs where many of the policies proposed in this waiver have already been implemented – and been shown to be significant barriers to low-income people getting and retaining benefits. These comments also draw on CLASP's experience in working with six states under the Work Support Strategies project, where these states sought to dramatically improve the delivery of key work support benefits to low-income families, including health coverage, nutrition benefits, and child care subsidies, through more effective, streamlined, and integrated approaches. From this work, we learned that reducing unnecessary steps in the application and renewal process both reduced burden on caseworkers and made it easier for families to access and retain the full package of supports that they need to thrive in work and school.

CLASP submits the following comments in response to the 1115 Demonstration Waiver Amendment Application and raises serious concerns about the effects of the waiver, as proposed, on the coverage and health outcomes of low-income Medicaid beneficiaries in Wisconsin. In particular, the policies would have a dramatic and negative impact on access to care for adults without dependent children. This waiver takes a big step backwards in coverage and rolls back important coverage gains. We therefore believe that it is inconsistent with the goals of the Medicaid program.

Wisconsin has not drawn down federal funds to expand its Medicaid program to cover all adults at or below 138% the Federal Poverty Level (FPL), but the state had already expanded coverage prior to the Affordable Care Act through a waiver to provide a limited Medicaid benefit package to certain parents and other adults. Today, all adults are eligible for Medicaid up to 100% FPL.

Medicaid plays a critical role in supporting the health and well-being of low-income adults and children. For many low-income adults there are no other options for affordable health care. Many work in low-wage jobs where employer sponsored health care is not offered, or is prohibitively expensive. Others may have health concerns that threaten employment stability, and without Medicaid, would be denied access to the medical supports they need to hold a job, such as access to critical medications. A key finding from an analysis of Ohio's Medicaid expansion is that providing access to affordable health care actually helps people maintain employment. More than half of Ohio Medicaid expansion enrollees report that their health coverage has made it easier to continue working.[1]

The Medicaid statute is clear that the purpose of the program is to furnish medical assistance to individuals whose incomes are not enough to meet the costs of necessary medical care and to furnish such assistance and services to help these individuals attain or retain the capacity for independence and self-care.[2] States are allowed in limited circumstances to request to "waive" provisions of the rule but the Secretary of Health and Human Services (HHS) may only approve a project which is "likely to assist in promoting the objectives" of the Medicaid Act. A waiver that does not promote the provision of health care would not be permissible. This waiver proposal's attempt to transform Medicaid and reverse its core function will result in many adults losing needed coverage, poor health outcomes, and higher administrative costs. It includes provisions that have not been approved in any other state, and a number of the provisions have never been approved for traditional, non-expansion populations.[3]

Our specific comments follow.

Time Limits on Medicaid Eligibility and Work Requirements

CLASP strongly opposes this unprecedented waiver proposal to arbitrarily limit Medicaid eligibility for childless adults age 19-49 to 48 total months of coverage when they are not working or participating in a work program. This is proposed without any evidence of a problem that this is intended to solve; rather, this proposal is based on a false assumption that people do not wish to work and need to be incentivized to do so. (There is also no basis offered for the arbitrary age limits proposed for this policy.) A recent Kaiser Family Foundation (KFF) study found that the overwhelming majority of non-working Medicaid recipients were ill or disabled, attending school, caring for other, or seeking work.[4] The stated justification that Wisconsin wants to "promot[e] employer-sponsored insurance as the preferred means for health care coverage" misses the mark. Many Medicaid beneficiaries work, but for low-wage workers, employer-sponsored insurance is often either not offered or is prohibitively expensive. Even if unemployed Medicaid recipients obtain jobs, they are highly likely to continue to need health coverage through Medicaid.

These time limits are inconsistent with the goals of Medicaid because they would act as a barrier to access to health insurance, particularly for those with chronic conditions and disabilities, but also for those in areas of high unemployment, or who work the variable and unpredictable hours characteristic of many low-wage jobs. In addition, while the purported goal of this provision is to promote work, the reality is that denying access to health care makes it less likely that people will be healthy enough to work. This provision would also increase administrative costs of the Medicaid program and reduce the use of

preventative and early treatment services, ultimately driving up the costs of care while also leading to worse health outcomes.

Time limits would act as a barrier to coverage

The KFF study found that 35 percent of unemployed adults receiving Medicaid—but who are not receiving Disability/SSI benefits—reported illness or disability as their primary reason for not working.[5] Under this proposal, people with chronic conditions that impact their ability to work but do not qualify them for disability benefits will be at high risk of losing access to care. Chronic conditions are, by definition, not time-limited and often impact individuals for extended period. While the proposal states that the time limit will not apply to beneficiaries who are diagnosed with a mental illness or who are physically or mentally unable to work, the evidence from other programs with similar requirements is that in spite of official exemptions, in practice, individuals with disabilities are often not exempted and are more likely to lose benefits.

The evidence from SNAP is most relevant, as this provision is clearly modeled after the SNAP time limit for so called "able bodied adults without dependents." For example, one study from Franklin County, OH, found that one third of the individuals referred to a SNAP employment program in order to keep their benefits reported a physical or mental limitation, 25% of whom indicated that the condition limited their daily activities. Additionally, nearly 20% of the individuals had applied for SSI or SSDI within the previous 2 years.[6] In Wisconsin, SNAP has seen a dramatic drop off over the last two years in the number of people participating who are subject to the 3-month SNAP time limit. Between July 2015 and December 2016, over 64,000 Wisconsin SNAP recipients lost access to critical food assistance while only 21,000 individuals became employed through the program.[7]

Similarly, repeated studies of TANF programs have found that clients with physical and mental health issues are disproportionately likely to be sanctioned for not completing the work requirements.[8] Such clients may not understand what is required of them, or may find it difficult to complete paperwork or travel to appointments to be assessed for exemptions. Access to employment services on a voluntary basis can certainly be beneficial for some, but work requirements and time limits most often serve as a mechanism to take away crucial support for low-income individuals.

This provision may also affect many people who work, but do not consistently meet the 80 hours of work threshold. Workers in low-wage jobs experience significant fluctuations in number of hours and timing of shifts from week to week.[9] Many workers are assigned to "call-in shifts", providing no guarantee of work, but preventing them from scheduling other work or activities.[10] The two industries with the largest numbers of employees covered through Medicaid are restaurant and food services and construction,[11] both industries well known for their variable and seasonal hours of employment. Individuals with variable hours of employment may also lose coverage if they fail to keep up with the requirement to document their hours of employment.[12]

Access to Medicaid supports work

There is no evidence offered that such time limits would promote work. In fact, because providing access to coverage is an important way to support work, this proposal would likely reduce employment outcomes. A recent report from Ohio found that providing access to affordable health care through Medicaid helps enrollees to seek and maintain employment. More than half of Ohio 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 their health coverage made it easier to seek employment.[13] Without the support of Medicaid, health concerns would threaten employment stability.

Time limits would led to worse health outcomes, higher costs

The proposal implements a 6-month lock-out period for re-enrollment after the 48 months of coverage have expired. This provision essentially serves as a time limit for Medicaid coverage and will have profound implications for the health care outcomes of beneficiaries, and will ultimately lead to increased costs to states. Once terminated from Medicaid coverage, beneficiaries will likely become uninsured. Needed medical services and prescription drugs, including those needed to maintain positive health outcomes, may be deferred or skipped. Because people without health coverage are less likely to have regular care, they are more likely to be hospitalized for avoidable health problems and to experience declines in their overall health.[14] And during the lock-out period, these now-uninsured patients present as uncompensated care to emergency departments, with high levels of need and cost—stretching already overburdened hospitals and clinics.

When the beneficiary re-enrolls in Medicaid after the lock-out period, they will be sicker and have higher health care needs. Studies repeatedly show that the uninsured are less likely than the insured to get preventive care and services for major chronic conditions.[15] Medicaid will end up spending more to bring these beneficiaries back to health.

Even before beneficiaries reach the time limit, this may have adverse effects, as healthy individuals may opt to forgo coverage in order to "bank" their months of eligibility against future need. This means that they are likely to forgo preventative care and screenings. Again this will lead to both worse outcomes and higher costs.

Time limits would add complexity and administrative costs

Tracking these time limits would significantly add complexity and cost to the administration of the Medicaid program. Wisconsin would need to develop a whole new system to track months towards the time limit, send notices to clients, and determine whether a beneficiary qualified for an exemption in that month. One of the key lessons of the Work Support Strategies initiative is that every occasion when a client needs to bring in a verification or report a change adds to the administrative burden on caseworkers and increases the likelihood that clients will lose benefits due to failure to meet one of the requirements. In many cases, clients remain eligible and will reapply, which is costly to families who lose benefits as well as to the agencies that have to process additional applications. The WSS states found that that

reducing administrative redundancies and barriers used workers' time more efficiently and also helped with federal timeliness requirements.[16]

An administrator in Idaho reported that unnecessary reevaluations resulted in wasting caseworkers' time and confusion for families. A Colorado WSS team member reflecting on their former processes noted "it was crazy-making for us… it was a constant workload for all of us."[17] Adding new complicated requirements to Medicaid eligibility, including determining exemptions and tracking the hours of work, which often vary from month to month, would be a major step in the wrong direction.

Substance Abuse Identification and Treatment

CLASP strongly opposes the waiver proposal to condition Medicaid eligibility on a required drug screening assessment and, if indicated, a drug test. CLASP shares the state of Wisconsin's deep concern about the widespread abuse of drugs, particularly opioids, and the devastating effects they have on individuals, families, and communities. However, we strongly reject the suggestion that conditioning Medicaid eligibility on compliance with a regime of mandatory screening and chemical testing is an appropriate way to address this issue. The proposed policy is grounded in stereotype rather than evidence. It would be costly and burdensome for the applicant, for medical providers, and for the state, and ineffective at the goal of connecting individuals in need of substance abuse treatment with appropriate services. Additionally, many of the details in this proposal are not fully specified, which leaves room for discrimination within its implementation

Proposed policy is grounded in stereotype

We strongly oppose the assumption that all adults who need health benefits are likely using drugs and need to be screened and tested. Requiring people to complete drug testing is based on stereotypes about the prevalence of substance abuse among recipients. In a number of cases, the courts have indicated that receiving public assistance is not a basis for suspicion of drug use and the state must have some reason to believe that a particular individual may be using drugs. In 2014, the U.S. Eleventh Circuit Court of Appeals held that Florida's drug testing law violated the Fourth Amendment for its "unreasonable search of applicants without evidence of a more prevalent, unique, or different drug problem among TANF applicants than in the general population." Additionally, the court affirmed that the state failed to meet its burden of establishing a "substantial special need to drug test all TANF applicants without any suspicion". Requiring all beneficiaries to take a screening for Medicaid makes the assumption that drug use is more prevalent in the Medicaid-applicant population—and the state presents no evidence to support that claim.

Former Secretary of Agriculture, Tom Vilsack stated that Congress has "repeatedly rejected the expensive, intrusive practice of suspicion-less drug testing,[18]" and that they have uncovered very little drug use... research indicates that this is true. In 1996, the National Institute of Alcohol Abuse and Alcoholism found that "proportions of welfare recipients using, abusing, or dependent on alcohol or illicit drugs are consistent with proportions of both the adult U.S. population and adults who do not receive welfare." [19] Additionally, in the states that implemented drug testing for TANF cash assistance recipients between 2010-2014, applicants had lower rates of testing positive for drug use than the general

population. The national drug use rate is 9.4 percent. In the aforementioned states, the rate of positive drug tests to total welfare applicants ranges from 0.002 percent to 8.3 percent, but all except one have a rate below 1 percent.

Screening and testing regime would be costly and burdensome to beneficiaries, the state and health care providers

The proposed policy would be deeply stigmatizing and burdensome to applicants for Medicaid. While it is not clear exactly how this provision would be implemented, it appears that it would require questions about drug use to be incorporated into the application process. Many Medicaid applicants currently apply by mail, on phone, or online. It would be hugely burdensome to require all applicants to come in person, but not clear that screening would be effective through other means. Adding a separate screening step would delay the processing of applications. Some individuals might abandon their application for assistance rather than admitting to substance abuse. Beneficiaries who are required to undergo testing will bear a significant time and effort burden, including scheduling, finding transportation, and missing work, school or caregiving responsibilities.

There are also state costs associated with screening, testing, and treatment. The state would have to spend time training staff, and possibly hiring new staff to perform these tasks. New tracking and application processes would need to be implemented. When drug abuse screening and testing has been mandated as a requirement for receiving TANF, very few drug tests came back positive. In some cases, states ended up spending more money on testing regimes than they saved by denying benefits.[20]

Additionally, this policy would put hospitals and health care providers at risk of not being paid if the patient later does not comply with drug testing/treatment regimen. This could lead to discrimination against patients who are perceived as possibly drug users.

Testing does not effectively identify beneficiaries in need of treatment

We are pleased to see that a positive indication on the drug screening and/or test does not result in losing eligibility. In addition, beneficiaries will continue to be eligible for all health care services if substance use treatment is not immediately available, and not be penalized for lack of access to services. This acknowledges the reality of lack of access faced by many in need of treatment for addiction and substance abuse.

However, prioritizing those who test positive on a drug test for treatment risks wasting resources on those who do not really need treatment. Chemical testing for presence of controlled substances is a highly ineffective way to identify those in need of treatment. It may catch the occasional user of marijuana (which remains in the system on an ongoing basis) but miss the abuser of alcohol (which is not on chemical screens) or the opioid abuser who has abstained for long enough that substances do not remain in their system. It also cannot distinguish between a person appropriately using prescription painkillers and one who has become addicted (but has a valid prescription). Health care providers, not government bureaucrats, should be deciding who needs treatment. In addition, individuals who self-report substance abuse or addiction but do not test positive should still have access to treatment.

Details of screening and testing policy remain unknown

This is an unprecedented proposal, and many crucial details have not yet been determined.[21] For example, the proposal does not say what screening tool will be used or how it will be administered and verified. In TANF, states use a range of screening tools that do not produce clinical diagnosis, but can be used to identify individuals for further assessment. However, some states also rely on caseworker perception of substance use, which could lead to biased implementation.[22] It also does not discuss what protections a client who tests positive might have to appeal. Wisconsin should provide these details and have another public comment opportunity before any such policy is implemented.

Monthly Premiums

Medicaid has strong affordability protections to ensure that beneficiaries have access to a comprehensive service package and protects beneficiaries from out-of-pocket costs, particularly those due to an illness.[23] Medicaid generally prohibits premiums for Medicaid for beneficiaries with income below 150% of the Federal Poverty Level (FPL). Nonetheless, HHS has recently approved waivers allowing a few states to test the effects of imposing premiums. These states have been allowed to apply mandatory premiums for individuals with incomes between 100-150% FPL and only voluntary premiums for individuals with incomes below 100% FPL. Furthermore, no Section 1115 waivers have been approved to date for any Medicaid population that include premiums as a condition of eligibility or coverage or coverage lock-outs for non-payment for those under 100% FPL.[24]

CLASP strongly opposes this waiver proposal to require adults with incomes between 20% and 100% of FPL to pay a monthly premium, going much further than HHS has previously permitted. Adults without dependent children with incomes as low as $200 a month would have to pay premiums or risk losing coverage for up to six months. Studies of the Healthy Indiana waiver, which required Medicaid recipients with incomes between 100 and 138% of FPL to pay a premium[25] or face disenrollment or lockout,[26] have found that it deters enrollment. About one-third of individuals who applied and were found eligible were not enrolled because they did not pay the premium.[27]

A large body of research shows that even modest premiums keep people from enrolling in coverage.[28] Individuals, particularly during period of unemployment or other financial hardship, may be unable to afford to make the payments. Low-income consumers have very little disposable income and often must make choices and stretch limited funds across many critical purchases. While Medicaid is designed to protect consumers against costs, this proposal adds another cost to their monthly budget.

Moreover, simply the burden of understanding the premium requirements and submitting payments on a regular basis may be a challenge to people struggling with an overload of demands on their time and executive functioning capacities. In a survey of Indiana enrollees who failed to pay the required premium, more than half reported confusion about either the payment process or the plan as the primary reason, and another 13 percent indicated that they forgot.[29] Finally, states or insurance companies may fail to process payments in a timely fashion, leading to benefit denials even for people who make the required payments.[30]

While the stated goal of this provision is to align coverage with private health insurance, the reality is that very few individuals have to write checks on a monthly basis to purchase coverage. The vast majority of people with private insurance receive it through their employers, and have their share of the premiums automatically withheld from their paychecks, without having to take any positive action. Moreover, one-quarter of households with incomes under $15,000 reported being "unbanked,"[31] which may create additional barriers to making regular payments.

What is more, like in Indiana, this proposal introduces a non-payment lock out period of 6 months. As with the time limit, this will reduce the use of preventive services and interfere with ongoing treatment, harming health outcomes and ultimately increasing medical costs.

We strongly encourage Wisconsin to eliminate its proposal to introduce premiums in Medicaid and to maintain Medicaid's strong affordability protections. At a minimum, before submitting this waiver request to the federal government, the state should specify how consumers will be notified about missed premium payments or termination of benefits. It should also help beneficiaries maintain continuous coverage by defining a sufficiently long grace period to allow repayment of past premiums without benefits being terminated.

Copays for Emergency Room (ER) Use

Medicaid plays an important role in helping beneficiaries have a usual source of care that helps them seek health care in appropriate settings. However, sometimes beneficiaries will experience emergencies and present in the emergency department. We are concerned that this waiver penalizes even appropriate use of the emergency room by requiring a copay for all visits.

The Center for Medicare and Medicaid Services (CMS) lacks the authority to change the rules on ER co-pays under a Section 1115 waiver. Waivers of cost-sharing provisions can only be approved under the separate waiver authority in section 1916(f). Specifically, a state requesting a waiver for cost-sharing 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.

What Wisconsin is requiring goes well beyond what CMS can grant. Indiana did receive a waiver for ER co-pays but exclusively for people who use the emergency room in non-emergency situations, and the results of this waiver have not yet been evaluated. Wisconsin should not replicate—or go further than—Indiana until the results of this implementation have been formally evaluated.

This proposal does not distinguish between visits to the emergency room that are appropriate and not, nor does it define criteria of what an inappropriate use of the emergency room would be. If a co-pay is charged for emergency visits, it should only be applied for uses of emergency services that are

inappropriate based on clearly defined criteria that take into consideration what a reasonable layperson would do, and not simply the ultimate medical diagnosis and determination of whether to admit the patient. The state should also track the geographic patterns in the use of emergency services that are determined to be "inappropriate" and assess whether this data indicates lack of alternative medical services.

Furthermore, the co-pay for even the lowest income beneficiaries is significantly higher than co-pays traditionally allowed under Medicaid. The proposed charges of $8 for the first visit and $25 for subsequent visits are significant amounts of money for very low-income individuals, and could mean that beneficiaries would face unacceptable choices between needed emergency care or having the money needed to pay rent or buy gas to go to work

Thank you for your consideration of these comments.

If you have any questions, please contact Elizabeth Lower-Basch at elowerbasch@clasp.org or (202) 906-8013.

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