Harold P. Wimmer
National President and
CEO

February 22, 2018

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

Re: Request to Extend Wisconsin's 1115 BadgerCare Reform Demonstration Project

Dear Secretary Azar:

The American Lung Association appreciates the opportunity to comment on the *Request to Extend Wisconsin's 1115 BadgerCare Reform Demonstration* waiver application.

The American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease, being the voice of the 32.2 million Americans who suffer from lung disease. The Lung Association tracks patient access to treatment for tobacco cessation and asthma guidelines-based care, is on the forefront of analyzing how policies impact patient care and works to ensure lung disease patients have access to the treatment they need.

The first stated goal of the waiver, "ensure that every Wisconsin resident have access to affordable health insurance to reduce the state's uninsured rate" is something the Lung Association fully supports. However, the policies in the proposed amendment would not achieve this goal and would be harmful to lung disease patients.

The Lung Association has signed onto the submitted and attached letter regarding the waiver in its entirety, however the Lung Association is in a unique position to comment in more detail on the healthy behaviors incentive.

Healthy Behaviors Incentive

The waiver proposes to implement a healthy behavior incentive program – which in theory sounds positive, but in practice will be harmful. Enrollees making between 51 and 100 percent of the federal poverty level ($6,191.40 to $12,140 annually) would be charged premiums and subject to the healthy behaviors incentive program.

The state believes this program will encourage healthy behavior and lower health care costs. If members do not engage in certain health risk behaviors, they will have their premium reduced by half. One of the healthy behaviors is abstaining from tobacco use. Charging tobacco users more than non-tobacco users for health coverage is a tobacco surcharge.

While the Lung Association supports efforts to encourage smokers to quit, the tobacco surcharge or healthy behavior incentive has not been proven effective in helping smokers quit and reducing tobacco use. Recent studies from Health Affairs[1] and the Center for Health and Economics Policy at the Institute for Public Health at Washington University[2] have suggested that tobacco surcharges do not increase tobacco cessation. The studies also have data suggesting tobacco users eligible for Marketplace or exchange health plans forgo health insurance rather than paying the surcharge. Tobacco users often have expensive comorbidities. Charging a tobacco surcharge could cause those enrollees to go without coverage and access to preventive care (including tobacco cessation), allowing comorbid health conditions to worsen. This could result in more expensive healthcare being required later on.

Instead, the American Lung Association recommends working to increasing the utilization of tobacco cessation treatment under BadgerCare, which can reduce costs and save lives. BadgerCare has a nearly comprehensive tobacco cessation benefit, and increasing utilization and successful quitting by BadgerCare enrollees would do far more to help smokers quit than the wellness incentive.

The Lung Association encourages CMS to work with the state of Wisconsin to look at the evidence-based policies to further the goals of BadgerCare for all enrollees. Medicaid enrollees are disproportionately impacted by lung disease and need quality and affordable healthcare to manage their diseases. The proposed waiver amendment as written would not allow for that.

Thank you for reviewing our comments. We appreciate the opportunity to provide feedback.

Sincerely,

Harold Wimmer

Harold P. Wimmer
National President and CEO

CC: The Honorable Seema Verma,
Administrator, The Centers for Medicare and Medicaid Services

[1] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests That The ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. doi: 10.1377/hlthaff.2015.1540 accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[2]Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

Attachment 1

February 22, 2018

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

Re: Request to Extend Wisconsin's Section 1115 BadgerCare Reform Demonstration Project

Dear Secretary Azar:

Thank you for the opportunity to submit comments on Wisconsin's request to extend its Section 1115 BadgerCare Reform Demonstration Project.

The undersigned organizations represent millions of individuals facing serious, acute and chronic health conditions across the country. Our organizations have a unique perspective on what individuals need to prevent disease, cure illness and manage serious and chronic health conditions. The diversity of our groups and of those we represent enables us to draw upon a wealth of knowledge and expertise and serve as an invaluable resource regarding any decisions affecting the Medicaid program and the people that it serves. We urge the Department of Health and Human Services (HHS) to make the best use of the recommendations, knowledge and experience our patients and organizations offer here.

Our organizations are committed to ensuring that Medicaid provides adequate, affordable and accessible health care coverage. However, we are concerned that several of the policy proposals included in Wisconsin's application could have harmful implications for individuals with serious, acute, and chronic conditions. We therefore provide HHS with the following comments and recommendations.

<u>Premiums</u>
Wisconsin seeks to charge premiums of eight dollars per month for childless adults with incomes between 51 and 100 percent of the federal poverty level ($6,191.40 to $12,140 annually). These premiums are substantial for individuals with such low incomes, potentially making coverage unaffordable for those who need it most. We urge HHS to reject Wisconsin's request to impose premiums on this vulnerable population.

Numerous studies have shown that charging premiums to the Medicaid population leads to a loss of coverage.[i] Recently, a report prepared for the Indiana Family and Social Services Administration (FSSA) by the Lewin Group found that 29 percent of Indiana's Heathy Indiana Plan (HIP) 2.0 enrollees failed to pay their premiums and were disenrolled in the HIP 2.0 program, resulting in poorer coverage or no coverage depending on income level.[ii] Our organizations are concerned that Wisconsin's proposal could result in a similar loss of coverage.

Wisconsin's proposal would penalize individuals who do not pay these premiums by locking them out of coverage for up to six months, unless they are able to pay their outstanding premiums in the interim. This lockout will harm all eligible enrollees, but could be particularly harmful to individuals who are in the middle of treatment for a life-threatening disease, rely on regular visits with health care providers and take daily medications. These patients cannot afford a sudden gap in their access to care.

Additionally, Wisconsin proposes to reduce premiums by 50 percent for individuals who do not engage in certain health risk behaviors. We are concerned that, instead of incentivizing healthy behaviors, this approach will make coverage unaffordable for individuals in need of care. For example, studies have shown that charging tobacco users higher premiums does not increase tobacco cessation and may instead lead tobacco users to forgo health insurance rather than pay the increased cost.[iii,iv] Ensuring that Medicaid enrollees have access to comprehensive health coverage that includes all of the treatments and services that they need to live healthy lives is likely to be a more effective approach for Wisconsin.

Cost-Sharing

Wisconsin's waiver includes a proposal to charge certain enrollees an eight dollar copayment for emergency department (ED) use. This amount of money is significant for the enrollees making less than the federal poverty level who would be impacted by this policy, and it could deter people from seeking necessary care during an emergency. Delays in care could have harmful impacts on the short- and long-term health of individuals with serious, acute and chronic diseases.

People should not be financially penalized for seeking lifesaving care for a breathing problem, a heart attack, hyperglycemia, complications from a cancer treatment, or any other critical health problem that requires immediate care. When people do experience severe symptoms, they should not try to self-diagnose their condition or worry that they can't afford to seek care. Instead, they must have access to quick diagnosis and treatment in the ED.

Evidence suggests cost-sharing may not result in the intended cost savings.[v] Research demonstrates that low-income individuals served by Medicaid are more price sensitive compared to others, more likely to go without needed care, and more likely to experience long-term adverse outcomes. A study of enrollees in Oregon's Medicaid program demonstrated that implementation of a copay on emergency services resulted in decreased utilization of such services but did not result in cost savings because of subsequent use of more intensive and expensive services.[vi] This provides further evidence that copays may lead to inappropriate delays in needed care. We oppose charging copays for emergency room use and ask HHS to reject this proposal.

Time Limits with a Work Component

Wisconsin requests the authority to institute a 48-month time limit on coverage for certain enrollees. After being enrolled for 48 months, these individuals would be locked out of coverage for a six-month period. This arbitrary time limit simply will not work for the individuals we represent. People with serious and chronic conditions need uninterrupted access to care to manage their illnesses, and loss of

coverage at a critical point during treatment could easily lead to life-threatening consequences and the need for even more expensive health interventions. Furthermore, all individuals, whether they currently face serious and chronic conditions or not, need uninterrupted health care coverage to maintain and improve their health. Our organizations urge HHS to reject Wisconsin's request to impose time limits on coverage.

As part of the time limit proposal, Wisconsin also asks for the authority to institute new requirements for certain adults to work at least 80 hours per month in exchange for not counting that month of coverage against their 48-month time limit. While Wisconsin acknowledges that there are some circumstances that limit or prevent a member from being able to work, the state's application does not provide much detail on who will qualify for exemptions or how they will be identified. Therefore, our organizations are concerned that the current exemption criteria may not capture all individuals with, or at risk of, serious and chronic health conditions that prevent them from meeting these requirements. Regardless, even exempt enrollees will have to provide documentation of their condition, creating opportunities for administrative error that could jeopardize their coverage. No exemption criteria can circumvent this problem and the serious risk to the health of the people we represent.

A major consequence of these employment and training requirements will be to increase the paperwork burden on all patients, as the process of having to document exemptions from or compliance with the new requirements is likely to create substantial administrative barriers to maintaining coverage. Battling administrative red tape in order to keep coverage should not take away from patients' and caregivers' focus on maintaining their or their family's health. Our organizations view these requirements as a significant barrier to coverage and ask HHS to reject Wisconsin's request to include them in this demonstration.

Wisconsin has also requested that the federal government provide matching funds to finance the employment training activities related to this proposal. This would divert limited federal resources from Medicaid's core goal – providing health coverage to those without access to care.

We urge HHS to consider our recommendations and focus on solutions that can promote adequate, affordable and accessible coverage in Wisconsin's Medicaid program. Thank you for reviewing our comments.

Sincerely,

American Diabetes Association
American Heart Association
American Lung Association
Arthritis Foundation
Cystic Fibrosis Foundation
The Leukemia & Lymphoma Society
Lutheran Services in America
National Multiple Sclerosis Society
National Organization for Rare Disorders

CC: The Honorable Seema Verma, Administrator,
The Centers for Medicare and Medicaid Services

[i] Samantha Artiga, Petry Ubri, and Julia Zur. "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Research Findings." June 1, 2017. Accessed at: https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/

[ii] *Healthy Indiana Plan 2.0: POWER Account Contribution Assessment*. Prepared by the Lewin Group, Inc. March 31, 2017. Accessed at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf.

[iii] Friedman, A.S., Schpero, W. L., Busch, S.H. Evidence Suggests that the ACA's Tobacco Surcharges Reduced Insurance Take-Up and Did Not Increase Smoking Cessation. Health Aff 2016; 35:1176-1183. Accessed at: http://content.healthaffairs.org/content/35/7/1176.abstract

[iv] Monti, D., Kusemchak, M., Politi, M., Policy Brief: The Effects of Smoking on Health Insurance Decisions Under the Affordable Care Act. Center for Health and Economics Policy Institute for Public Health at Washington University. July 2016. Accessed at: https://publichealth.wustl.edu/wp-content/uploads/2016/07/The-Effects-of-Smoking-on-Health-Insurance-Decisions-under-the-ACA.pdf

[v] See for example: Chernew M, Gibson TB, Yu-Isenberg K, Sokol MC, Rosen AB, Fendrick AM. Effects of increased patient cost sharing on socioeconomic disparities in health care. J Gen Intern Med. 2008. Aug; 23(8):1131-6. Ku, L and Wachino, V. "The Effect of Increased Cost-Sharing in Medicaid: A Summary of Research Findings." Center on Budget and Policy Priorities (July 2005), available at http://www.cbpp.org/5-31-05health2.htm.

[vi] Wallace NT, McConnell KJ, et al. How Effective Are Copayments in Reducing Expenditures for Low-Income Adult Medicaid Beneficiaries? Experience from the Oregon Health Plan. Health Serv Res. 2008 April; 43(2): 515–530.