February 8, 2022

Testimony of the American Lung Association
Opposing Assembly Bills 934 and 936
Assembly Committee on Public Benefit Reform

Dear Chair Krug and members of the committee,

The American Lung Association represents thousands of patients and families with lung disease in Wisconsin and are committed to ensuring that BadgerCare provides adequate, affordable, and accessible health care coverage. The COVID-19 pandemic and its economic impact have highlighted the importance of the Medicaid program and its robust healthcare coverage for low-income children, adults, seniors, and people with disabilities. However, Assembly Bills 934 and 936 set policies that would jeopardize coverage for patients who remain eligible for Medicaid. The Lung Association urges Wisconsin lawmakers to oppose these bills.

Assembly Bill 934 would prohibit state agencies from automatically renewing people's Medicaid benefits, require eligibility to be verified every six months (instead of annually), and would require that people lose their coverage for six months if they fail to report any change that may impact their eligibility. This bill will lead to administrative chaos and massive disenrollment, including of enrollees who are eligible but lose coverage due to administrative red tape. Low-income individuals who qualify for Medicaid may move frequently and not receive notices about their eligibility, therefore not realizing they have lost their Medicaid coverage until they show up at a hospital, physician's office, or pharmacy. This loss of coverage would likely lead to delays in accessing needed care.

The evidence is clear that policies that increase administrative red tape for patients lead to coverage losses for individuals with serious and chronic health conditions, including lung disease. For example, when Washington state changed its renewal process from every twelve months to every six months and instituted new documentation requirements in 2003, approximately 35,000 fewer children were enrolled in the program by the end of 2004.[i] Additionally, a recent report found that 1.6 million individuals lost their Medicaid coverage in 2018, including 744,000 children, with the largest coverage losses in states that had burdensome redetermination processes.[ii] Battling administrative red tape in order to keep coverage should not take away from patients' or caregivers' focus on maintaining their or their family's health.

AB 934 would also require Medicaid enrollees' to timely report change of employment or wages or be locked out of coverage for six months. Low-income individuals' wages and housing situations often fluctuate due to the nature of hourly wages and income insecurity. The Medicaid agency should be reviewing this information at the 12-month redetermination check. Doing so more frequently will result in more churn in the Medicaid program, more gaps in coverage, worse health outcomes and ultimately higher healthcare costs.

The American Lung Association strongly opposes proposals to increase the administrative burden on individuals in the Medicaid program and lock patients out of coverage, which will decrease the number of individuals with quality, affordable healthcare. Adding this burden is especially dangerous at this time as Wisconsin will already need to devote resources to

processing hundreds of thousands of eligibility redeterminations at the end of the COVID-19 public health emergency. This is not a responsible use of tax dollars because it will mean increased costs for the administration, higher medical bills for those who are forced to go without coverage, and more red tape for patients who should be focused on their health.

Assembly Bill 936 would prohibit adults aged 18-64 without dependent children from not accepting an offer of employment or an increase in their hours or wages for the purpose of maintaining their Medicaid eligibility. If the state finds that individuals have failed to accept a job they were offered, they will be locked out of coverage for six months. These lock outs would negatively impact the patients we represent, whether disenrollment results in no longer having access to maintenance medication resulting in a condition worsening, or not getting a preventive screening resulting in a diagnosis at a later, less treatable phase of a disease or cancer.

The American Lung Association is also 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 working. Regardless, even exempt enrollees may have to report their exemption, 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.

Ultimately, these requirements do not further the goals of the Medicaid program or help low-income individuals find work. Most people on Medicaid who can work already do so.[iii] A study published in *JAMA Internal Medicine* looked at the employment status and characteristics of Michigan's Medicaid enrollees.[iv] The study found only about a quarter were unemployed (27.6%). Of this 27.6% of enrollees, two thirds reported having a chronic physical condition and a quarter reported having a mental or physical condition that interfered with their ability to work. Additionally, studies in *The New England Journal of Medicine* and *Health Affairs* have found that Arkansas's work requirement was associated with a significant loss of Medicaid coverage, but no corresponding increase in employment.[v,vi]

The U.S. Court of Appeals for the District of Columbia has reaffirmed that the purpose of the Medicaid program is to provide healthcare coverage and that Arkansas' restrictive Medicaid waiver, including a work requirement policy, did not meet that objective. Additionally, considering coverage losses and the ongoing impact of the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) has withdrawn work and community engagement guidance as well as approvals of work and community engagement requirements.

If Wisconsin lawmakers want to strengthen the health of the workforce, they could agree to expand Medicaid which would mean people could earn more while maintaining their health care coverage. It would also qualify our state for more than $1 billion in savings which could be used to bolster work supports. There are, in fact, many alternative policies that Wisconsin could pursue to ensure patients who remain eligible for Medicaid coverage maintain their access to care and we would be very happy to serve as a resource to develop ideas to strengthen this program. The American Lung Association urges Wisconsin lawmakers to reject these proposals and instead focus on policies that promote affordable, accessible, and adequate health care coverage in Wisconsin.

[i] Tricia Brooks, "Data Reporting to Assess Enrollment and Retention in Medicaid and SCHIP," Georgetown University Health Policy Institute Center for Children and Families, January 2009.
[ii] https://familiesusa.org/sites/default/files/product_documents/Return_of_Churn_Analysis.pdf

[iii] Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017. Available at: http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.
[iv] Renuka Tipirneni, Susan D. Goold, John Z. Ayanian. Employment Status and Health Characteristics of Adults With Expanded Medicaid Coverage in Michigan. *JAMA Intern Med.* Published online December 11, 2017. doi:10.1001/jamainternmed.2017.7055
[v] Benjamin D. Sommers, MD, et al. "Medicaid Work Requirements—Results from the First Year in Arkansas," *New England Journal of Medicine*. Published online June 18, 2019, https://cdf.nejm.org/register/reg_multistep.aspx?promo=ONFGMM02&cpc=FMAAALLV0818B
[vi] Sommers, B., Chen, L., R. Blendon, E. Orav, and A. Epstein. 2020. Medicaid work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care, Health Affairs 39(9): 1522-1530. Accessed at: https://www.healthaffairs.org/doi/10.1377/hlthaff.2020.00538