WISCONSIN COUNTIES ASSOCIATION

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MEMORANDUM

TO: Honorable Members of the Senate Committee on Economic and Workforce Development

FROM: Sarah Diedrick-Kasdorf, Director of Outreach & Member Engagement
Chelsea Fibert, Government Affairs Associate

DATE: February 9, 2022

SUBJECT: Opposition to Senate Bill 902, Senate Bill 905, and Senate Bill 912

The Legislature's *Stronger Workforce* initiative includes three bills that will have a significant impact on the state's county-operated income maintenance consortia.

Senate Bill 902: Requires the Department of Health Services (DHS) to enforce work requirements on able-bodied adults without dependents; the FSET requirement on able-bodied adults; and the drug screening, testing, and treatment requirements.

Senate Bill 905: Prohibits DHS from automatically renewing the eligibility of a recipient for Medical Assistance (MA) program benefits. DHS must determine an individual's eligibility every six months under the bill. Additionally, any recipient of Medical Assistance benefits that fails to timely report to DHS or its designee any change that may affect eligibility is ineligible for benefits for six months. The bill also requires DHS to promptly remove from eligibility for the Medical Assistance program any individual who has been determined to be ineligible for the program. The bill also requires quarterly reports on eligibility status if the bill's implementation affects enhanced federal financial participation.

Senate Bill 912: Adds to prohibited conduct for MA eligibility knowingly failing to accept an offer of legal, paid employment and knowingly failing to accept an increase in paid work hours or wages to maintain eligibility for MA benefits.

With the exception of cases in Milwaukee County, all of the eligibility work required in this set of bills will be conducted by our 10 county-operated income maintenance consortia. The workload increases associated with these bills is significant. For example, Senate Bill 905 requires MA eligibility to be determined every six months, as opposed to

every 12 months under current law. That provision alone doubles the eligibility work associated with the MA program. If quarterly reports must be submitted to DHS that workload could actually quadruple. Counties raised concerns about the increased costs associated with FSET work requirements and drug testing when those provisions were first proposed.

These three bills fail to recognize the workload increases on income maintenance consortia and in so doing, fail to provide the resources income maintenance consortia will need to implement the program changes contained in Senate Bills 902, 905, and 912.

The state provides the 10 income maintenance consortia with funding to perform eligibility determinations for Wisconsin's economic support programs through the income maintenance administration allocation (IMAA). Historically, IMAA funding levels have not kept pace with the work involved in processing and managing FoodShare and Medical Assistance cases. In fact, county levy invested in economic support programs is greater than the state's GPR investment – in 2017, the state invested $17.7 million GPR while county levy investment was over $30 million. The 2021-23 state biennial budget proposed by the Governor contained increased funding for the IM consortia to cover projected workload increases due to significantly increasing caseloads. Unfortunately, the Legislature rejected the Governor's increase, causing IM consortia to bear an even greater percentage of costs. Counties simply do not have the levy capacity to fund the increased costs associated with these three bills.

Therefore, due to the failure to fund the increased workload for IM consortia, the Wisconsin Counties Association respectfully requests your opposition to Senate Bill 902, Senate Bill 905, and Senate Bill 912.

Thank you for considering our comments.

WISCONSIN CATHOLIC CONFERENCE

TO: Members, Senate Committee on Economic and Workforce Development

FROM: Barbara Sella, Associate Director for Respect Life and Social Concerns

DATE: February 9, 2022

RE: Senate Bills 902, 905, & 912, FoodShare and Medicaid Continuing Eligibility

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On behalf of the Catholic bishops of Wisconsin, we respectfully urge you to oppose Senate Bills 902, 905, and 912, which limit access to programs that allow vulnerable persons to receive medical care and food assistance. Now, more than ever, we must ensure that people have the resources necessary to recover from the ongoing pandemic.

The WCC has opposed efforts to condition food or health care supports upon a person's productivity. Public assistance programs exist to aid vulnerable individuals and families whose situation prevents them from being able to meet basic needs. Frequently, those who most need FoodShare and Medicaid benefits are facing a myriad of challenges, some of which may be lifelong. Addiction, trauma, illness, accidents, and the loss of family, housing, or employment can all stymie efforts to build stability. The goal of these programs is to accompany vulnerable individuals so they can move out of poverty.

Today, we all have experienced the universal challenge of a pandemic and many continue to face heightened uncertainty. Employees do not know how or when their work will be interrupted by infections in their home or workplace. Many are experiencing the long-term effects of COVID-19 and families are dealing with the loss of loved ones. Finally, all are experiencing heightened food, heating, and other costs associated with widespread inflation.

Senate Bill 902. In response to the pandemic, the State of Wisconsin suspended efforts to enforce FoodShare work requirements and did not seek further implementation of drug testing and FoodShare Employment and Training (FSET) requirements. The pandemic is still with us, so it is appropriate that these suspensions continue. It is also worth noting that our Catholic food pantries, Society of St. Vincent de Paul Conferences, and other charities across the state assist families in need, regardless of health condition, drug addiction, or employment status. These charitable agencies have learned that underlying and untreated mental health issues often prevent individuals from seeking and maintaining work and lead them to self-medicate with drugs and alcohol. Senate Bill 902 would require that these individuals, struggling to return to normalcy, dedicate further time, transportation, and resources towards compliance with drug testing, treatment, and FSET requirements.

Before the pandemic, effective trauma-informed drug treatment programs were too few, but current access to treatment, especially in-person treatment, has been further limited by the

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pandemic. Times of stress can foster relapses, making successful participation in FSET more difficult. In a time of rising food costs and uncertainty, we must remove, not increase, these impediments to alleviating hunger.

Senate Bills 905 and 912. In a similar way, Senate Bills 905 and 912 make it more difficult to retain health care coverage during the pandemic. Senate Bill 905 would require that the Wisconsin Department of Health Services (DHS) determine an individual's eligibility every six months. Currently, most Medicaid recipients must complete a program renewal at least once a year to determine ongoing program eligibility.

Health care is a basic human right and access to health care for all has been a policy goal of the U.S. bishops since 1919. It is important to remember that those who currently receive Medicaid are individuals who are elderly, blind, disabled, pregnant, with chronic conditions or diseases, children and their parents, or individuals living in poverty. By definition they are in need of services and do not have access to the resources necessary to receive treatment and medications without Medicaid. These are individuals and families who are likely struggling to meet home and transportation expenses, as well as meeting the basic needs of their loved ones. They frequently must transition from one home to another, as well as from one employment situation to another, changing addresses, phone numbers, and earnings along the way.

Without the follow-up and case management needed to help Medicaid recipients better assess how to exit poverty and manage the demands of daily life, repeated six-month eligibility reviews become administratively burdensome to both the State and Medicaid participants. The requirement will lead to missed deadlines, appointments, treatments, and medications, rather than a meaningful path towards self-improvement. Many will not even realize that their coverage has lapsed until care is needed.

Senate Bill 912 would punish able-bodied, adult Medicaid participants up to age 65 who do not accept an offer of legal, paid employment or an offer of increased work hours or wages. There is no accounting for when those hours are scheduled, the benefits that may accompany the offer, or whether it is a position that offers any kind of long-term advancement. There is no exception for those who may have retired spouses living at home who do not meet the definition of being "dependent," but may still require greater attention and care. Senate Bill 912 does not acknowledge those who might not be able to hazard the added anxiety or responsibility that comes with increased hours and wages. Still others may be coping with life-limiting conditions or progressive illnesses and may wish to opt for less than a 40-hour workweek.

Under both SB 905 and SB 912, a failure to disclose information in a timely manner can result in a six-month suspension from the Medicaid program. In effect, these bills will force individuals to place immediate employment considerations above family and health commitments and long-term employment strategies. These bills place productivity above individual health and family responsibility and force vulnerable people to take the best short-term offer placed in front of them, regardless of other considerations.

Finally, it is important to note the impact all three bills will have on private charitable actors. Depriving the poorest among us of needed food and health care will only shift the burden to the

hundreds of private charities, Catholic and other, which are already overwhelmed. While as Catholics we stand ready to serve the common good, we cannot be expected to serve more with less.

In conclusion, reforming public assistance programs so as to reduce poverty and dependency requires the involvement of government and the private sector working cooperatively. Reforms must ensure that people in poverty do not become targets, but rather that they receive the supports and services appropriate to their needs. Self-sufficiency and self-determination require that those in poverty be listened to and respectfully engaged. Overly bureaucratic and punitive measures to reduce fraud and encourage responsibility all too often have the opposite effect of deepening hopelessness and further impoverishing the most vulnerable. The problem of poverty requires a holistic approach, something that our Catholic Charities agencies and Society of St. Vincent de Paul councils are adept at doing. Everyone has an interest in reducing drug dependency, improving health, and encouraging labor force participation. We urge you not to tie the hands of our state's most vulnerable individuals by enacting laws that limit their recovery, but instead work together to improve the lives of all of Wisconsin's residents.

Thank you.

LEUKEMIA & LYMPHOMA SOCIETY®

February 8, 2022

The Honorable Dan Feyen
Chair, Senate Committee on Economic and Workforce Development
PO Box 7882
Madison, WI 53708

Written testimony in opposition to SB 905 and SB 912

Dear Chairman Feyen and members of the Committee:

Thank you for the opportunity to submit written testimony in opposition to SB 905 and SB 912.

The mission of The Leukemia & Lymphoma Society (LLS) is to cure leukemia, lymphoma, Hodgkin's disease, and myeloma and improve the quality of life for the more than 1.3 million Americans living with blood cancer, and their families. To ensure they receive appropriate and timely care, LLS works to guarantee that blood cancer patients have access to meaningful health insurance coverage.

Medicaid is one of these coverage sources. Its mission is to provide comprehensive coverage to low-income people so they can obtain the health care services they need.[1] In service of that mission, the ACA streamlined Medicaid enrollment and renewal processes across all states.[2] The intent was to reduce the number of uninsured and keep individuals covered over time by reducing the burden of paperwork.

Unfortunately, neither of these bills serves that purpose. Both proposals will erect new barriers and impose excessively burdensome requirements that are contrary to the goal and intent of the Medicaid program, which will result in coverage losses and an expensive administrative burden to the state.

With regard to SB 912, this proposal would set an unreasonable and even impossible standard for enrollees to meet, potentially requiring individuals to choose between their health coverage or their ability to determine the cadence of their own lives simply because an employer mandated a schedule change. Imagine, for instance, that an employer asked an enrollee to switch from daytime to overnight shifts, or vice versa: if that scheduled resulted in even minimal increases in hours, this bill would force the individual to accept the change or lose their health coverage. There would be no accommodation for any other factor that allowed the individual to determine a schedule that best suits their needs.

[1] 42 U.S.C. 1396

[2] Kaiser Family Foundation, "Implication of Emerging Waivers on Streamlined Medicaid Enrollment and Renewal Processes," February 2018, https://www.kff.org/medicaid/fact-sheet/implications-of-emerging-waivers-on-streamlined-medicaid-enrollment-and-renewal-processes/

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The fact is loss of coverage is a grave prospect for anyone, in particular a patient living with a serious disease or condition. People in the midst of cancer treatment, for example, rely on regular visits with healthcare providers, and many of those patients must adhere to frequent, if not daily, medication protocols.

SB 905 would similarly impose an unnecessary and counterproductive burden on beneficiaries that will likely result in improper coverage terminations. A recent issue brief by the office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy at the Department of Health and Human Services found that Medicaid-eligible populations experience significant disruptions to their coverage, and consequently to their care and treatments, when forced to endure excessive and frequent redeterminations such as those proposed in this legislation.[3] That study also found that consumers who enrolled in and maintained Medicaid coverage for 12 months resulted in lower and more stable state administrative spending, and less overall spending per beneficiary, than those subjected to more frequent redeterminations.

LLS is seriously concerned that these bills may cause patients to go without necessary care, perhaps for an extended period. LLS is equally concerned about Medicaid enrollees who do not currently live with a cancer diagnosis; if during a lock-out period an individual develops blood cancer, it's likely the disease won't be diagnosed early enough to ensure the best possible health outcomes.

Rather than pay more for less and sacrifice the health of many Wisconsinites by implementing these policies, the state should instead fully expand Medicaid. Not only would this reduce churn in the Medicaid program and ensure that state dollars are spent most efficiently, it would also ensure that Wisconsin residents are afforded the same opportunity as the taxpayers in 38 other states to see an available portion of their federal tax expenditure returned to them in the form of increased investment in the health and economic well-being of the people of this state.

Thank you for your consideration of LLS's comments on this important matter. If we can address any questions or provide further information, please contact me at dana.bacon@lls.org or 612.308.0479.

Sincerely,

Dana Bacon
Regional Director, Government Affairs
The Leukemia & Lymphoma Society

[3] Sugar S, Peters C, De Lew N, Sommers B.D., "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic." ASPE Office of Health Policy, Department of Health and Human Services, April 2021, https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf

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BEATING CANCER IS IN OUR BLOOD.

February 9, 2022

American Lung Association.
Wisconsin

Testimony of the American Lung Association
Opposing Senate Bills 905 and 912
Senate Committee on Economic and Workforce Development

Dear Chair Feyen 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, Senate Bills 905 and 912 set policies that would jeopardize coverage for patients who remain eligible for Medicaid. The Lung Association urges Wisconsin lawmakers to oppose these bills.

Senate Bill 905 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.

SB 905 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.

Senate Bill 912 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

February 9, 2022

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[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
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[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

Testimony in Support of Senate Bills 905 and 912

Wisconsin State Senate
Committee on Economic and Workforce Development

February 9, 2022

Chase Martin
Visiting Fellow
Opportunity Solutions Project

Chairman Feyen, vice-chair Testin, and members of the committee,

My name is Chase Martin, and I am a visiting fellow at Opportunity Solutions Project (OSP). OSP is a non-profit, non-partisan advocacy organization dedicated to advancing policies that reduce barriers to work and protect state benefits for the truly needy.

Thank you for hearing this legislation before your committee. I am submitting this testimony in support of two Senate bills, S.B. 905 and S.B. 912, related to Wisconsin's Medical Assistance, or Medicaid, program.

Wisconsin's Medicaid program has changed dramatically in recent years. The program, which historically was reserved for the truly needy, the elderly, disabled, and low-income families, has grown dramatically, with more able-bodied adults on the program than there ever before. In 2000, Wisconsin's Medicaid program served just over a half-a-million people. That number has ballooned to more than 1.3 million today, a staggering increase of 166 percent.[1] And the Medicaid program is eating the state budget alive as well. In 2000, Medicaid represented just 11 percent of the budget. Now, it is more than 20 percent and growing steadily.[2]

Swelling Medicaid rolls consume resources meant for the truly needy, roads, schools, and public safety, and perhaps worst of all, people are being driven from the workforce. It is no coincidence that as Medicaid enrollment has exploded, workforce participation has declined. As you know from seeing the hiring signs up in so many businesses across the state, Wisconsin's workforce shortage is a major crisis. In 2000, Wisconsin's workforce participation rate was over 73 percent. Today, it is just 65 percent. This direct correlation between the increase in Medicaid enrollments and the decrease in workforce participation cannot be ignored.

That is why we support S.B. 912, and S.B. 905. Both deal with issues in the Medicaid program in different ways.

First, **S.B. 912** would make sure that able-bodied adults on the program are going to work when work is available to them. This is a commonsense measure to protect benefits for those that truly need them, and to get able-bodied adults back into the workforce. It may be unlikely that the current federal administration would approve a waiver to this effect, but we do know that it is good policy. Research has shown that when work requirements are in place in welfare programs for able-bodied adults, they more quickly move from welfare to work, and incomes quickly double among those leaving the program.[3]

S.B. 912 is not a work requirement but would have a similar impact by ensuring individuals don't turn down opportunities to work. With more than 200,000 open jobs in Wisconsin,[4] now is the right time to make bold moves to help able-bodied adults move from a life of dependency on welfare to one of independence and self-sufficiency that comes through a job and upward mobility.

S.B. 905 also makes key changes to the program to protect resources for the truly needy. The bill takes important steps to make sure those on the program are actually eligible and provides protection against fraud and abuse in the program. It does this by requiring the state to lock out from the program individuals who commit fraud, having redeterminations conducted twice a year

instead of once a year, and ending the practice of filling out forms for individuals and prepopulating them using outdated information.

The bill also adds several basic, quarterly cross-checks. Ideally, these cross-checks would be weekly, but requiring quarterly cross-checks is a good first step toward improved program integrity. One important feature of the bill is that it requires the state to assess how many ineligible people are on the program right now. Because of the Families First Coronavirus Response Act (FFCRA) and because the state took increased federal payments for Medicaid, the state cannot currently remove anyone from Medicaid, even those who are ineligible for the program. This bill will require that the state at least accounts for how many people enrolled are currently ineligible, that way the state can get a better sense for whether the increased funding is costing the state more in the long run, and can be prepared to remove the ineligible once the requirement to maintain them on the program ends. S.B. 905 offers a good first step forward for the state on program integrity.

Together, S.B. 912 and S.B. 905 show that Wisconsinrecognizes that the growth in Medicaid is unsustainable, especially when it comes to able-bodied adults who can and should be working or those who should not be on the program because they are ineligible. We support this effort to help clean up the rolls and get people back to work.

Thank you for your time.

Chase Martin
Visiting Fellow
Opportunity Solutions Project (OSP)

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[1] Jonathan Bain, "The X factor: How skyrocketing Medicaid enrollment is driving down the labor force," Foundation for Government Accountability (2022), https://thefga.org/paper/x-factor-medicaid-enrollment-driving-down-labor-force/.
[2] Nicholas Horton, "The Medicaid Pac-man: How Medicaid is consuming state budgets," Foundation for Government Accountability (2019), https://thefga.org/wp-content/uploads/2019/10/Medicaid-Pac-Man-Paper-2.pdf.
[3] Ingram, et al, "Food stamp work requirements worked for Missourians," Foundation for Government Accountability (2020), https://thefga.org/wp-content/uploads/2020/10/missouri-food-stamp-work-requirements.pdf.
[4] U.S. Bureau of Labor Statistics – Jobs opening data by state, Nov 2021. https://www.bls.gov/news.release/jltst.t01.htm.

ROB STAFSHOLT

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DATE: **February 9, 2022**
RE: **Testimony on Senate Bill 905**
TO: **Members of the Committee on Economic and Workforce Development**
FROM: **Senator Rob Stafsholt**

Thank you Chairman Feyen and members of the Assembly Committee on Economic and Workforce Development for hearing Senate Bill 905 relating to disenrollment of ineligible individuals from and redeterminations of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility.

Recently, the federal government adopted enhanced reimbursements for each state's Medical Assistance program. States were prohibited from removing existing participants in their Medical Assistance program in return for these additional resources. This has led to countless ineligible individuals remaining on the Medical Assistance program and an abundance of fraud, waste and abuse of this program's dollars.

This bill requires that the Department of Health Services, as soon as allowable, to remove all ineligible participants from the Medical Assistance program. It also increases the eligibility determination from annually to bi-annually and improves eligibility crosschecks between agencies. Due to current federal law, eligibility checks can only be done once every 12 months. This bill as amended requires DHS to request a federal waiver to allow the bi-annual determination.

This is a simple, common sense bill to ensure program integrity for our most vulnerable populations that really need this resource by eliminating the free ride for those that are ineligible.

Again, thank you for allowing me to submit testimony on Senate Bill 905. I would appreciate your support on this piece of legislation.

WILLIAM PENTERMAN

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February 9, 2022
Senate Committee on Economic and Workforce Development
Testimony from Rep. William Penterman in favor of SB 905

Chairman Feyen and members of the Senate Committee on Economic and Workforce Development:

According to the Centers for Medicare and Medicaid Services, improper payments under the Medicaid (MA) program are estimated at $85 billion annually. This issue has only gotten worse as enrollment has expanded due to the effects of COVID-19.

During the recent pandemic, the federal government adopted enhanced reimbursements for each state's MA program. States were prohibited from removing existing participants in their MA program in return for these additional resources. This has led to countless ineligible individuals remaining on the MA program.

With this in mind, SB 905 would make needed changes to our MA program to help protect valuable taxpayer resources. The bill would require eligibility to be re-determined every six months and information to be cross referenced between state agencies that collect financial data. DHS would be required to promptly remove all ineligible individuals unless prohibited by the federal government.

In addition, individuals that fail to update financial data that would make them ineligible would be removed from the program for six months.

This common sense bill is intended to protect the average person. I encourage the members of the committee to support this bill.

Thank you.

William Penterman
State Representative
37th Assembly District

LEGAL ACTION OF WISCONSIN

Providing free legal services to low-income Wisconsin clients since 1968 • Proporcionando servicios legales gratuitos a clientes de bajos ingresos en Wisconsin desde 1968

TO:	**Senate Committee on Economic and Workforce Development**
FROM:	**Abby Bar-Lev Wiley, Legislative Director, Legal Action of Wisconsin**
RE:	**Impact of SB 905/AB 934 on Legal Action's Clients**
DATE:	**February 9, 2022**

Thank you for the opportunity to provide comments on AB 934/SB 905. Legal Action of Wisconsin (LAW) is the largest non-profit law firm providing high-quality, free civil legal aid to low-income people in 39 of Wisconsin's southern counties. Our broad reach and expertise mean that we see what poverty looks like over a wide swath of the state, from urban and rural areas, from farmworkers to construction workers. One of our priority areas focuses on helping clients secure and maintain the government benefits necessary to meet their most basic needs including food, shelter, health, and income. Legal Action has serious concerns about how AB 934/SB 905 would impact our low-income clients.

AB 934/SB 905 Would Wreak Havoc on the Health of Low-Income Wisconsinites

AB 934/SB 905 would require DHS to determine an individual's eligibility for Medical Assistance every six months, and would kick low-income Wisconsinites off the program for six months if they are determined to have failed to report any change that may impact their eligibility. This bill would create a massive administrative burden that would lead to loss of coverage and delays of critical care for Wisconsin's most vulnerable residents, including for the elderly and people with disabilities whose situations do not typically change throughout the year.

People with low-incomes move frequently and face greater health problems, meaning that they may not discover they were kicked off Medical Assistance until they are at the hospital. Our clients who are able to work, as is true for low-income working people generally, tend hourly or several part-time jobs. Their hours and wages fluctuate based on the employer's determination. Their work often does not include paid time off, and they might lose their jobs or face reduction in hours because they lost childcare or a Covid exposure at school requires their young child to quarantine. Lack of stable income means that our clients move frequently, whether because they can no longer afford rent, are facing eviction or foreclosure, or any other unforeseen crisis that struggling families face. The Covid-19 pandemic has deepened the housing crisis and has exacerbated the disparities in access to health care. For example, people with low-incomes tend to face a number of chronic health problems, ranging from depression to asthma, diabetes and heart disease, at significantly greater levels than the rest of the population.[1] Underlying medical conditions are more likely to result in serious illness from Covid-19, putting many low-income families in the hospital or in the grave during the pandemic. Because people with low incomes move frequently, many might not receive notices from DHS regarding their eligibility.

[1] Alyssa Davis, *With Poverty Comes Depression, More Than Other Illnesses*, Gallup, Oct. 30, 2012, https://news.gallup.com/poll/158417/poverty-comes-depression-illness.aspx?utm_source=alert&utm_medium=email&utm_campaign=syndication&utm_content=morelink&utm_term=All%20Gallup%20Headlines.

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Tragically, they might not discover they have lost their health care coverage until they show up at the hospital or the doctor's office in need of care. This heart-sinking moment would require them to decide: do they get the care they need, or do they pay the rent, the bills, or buy groceries for their children?

AB 934/SB 905 Adds Unnecessary Administrative Burdens on Local Agencies

AB 934/SB 905 would prohibit automatic renewals for reenrollment in Medical Assistance. This prohibition is unnecessary and unduly burdensome to local agencies, which would create delays in coverage for Legal Action's clients. Automatic renewals only occur in instances when the agency can obtain the information to determine eligibility data exchanges, in which relevant information is readily available to the agency. The purpose of automatic renewals is to lessen the administrative burden on local agencies, who would need significant funding increases to manage enrollment if they were no longer able to engage in automatic renewals where appropriate. Automatic renewals have been happening for years without any evidence that the process results in more improper certifications of Medical Assistance than non-automatic renewals.

Under the bill, county agencies, or income consortium agencies, would bear the burden of trying to manage the extreme increase in workload the bill proposes. By requiring eligibility checks every six months instead of every year, AB 934/SB 905 would essentially double county agencies' workload, and then add the prohibition on automatic renewals on top of that. They would need more funding and staffing to send out all the additional notices, process the influx of documents necessary to check eligibility, and more. However, the bill makes no attempt to help agencies manage the additional work. As a result, Legal Action's clients would almost certainly suffer delays and gaps in coverage through no fault of their own.

Medicaid Churn Leads to Greater Costs and Likely to Lead to Increased Reliance on Benefits

The massive administrative burden that AB 934/SB 905 places on DHS would also lead to delays in coverage and worse health outcomes and would be costly. DHS is already reviewing every individual's eligibility every 12 months. This is an appropriate time frame that is easy for our clients to anticipate and reduces unnecessary gaps in coverage. Studies have found that states with more Medicaid "churn"—people moving in and out of Medicaid eligibility—see higher administrative costs, less predictable state expenditures, and higher monthly health care costs. For example, "one study found adults with 12 full months of Medicaid coverage in 2012 had lower average costs ($371/month in 2021 after adjusting for inflation) than those with six months of coverage ($583/month) or only three months of coverage ($799/month)."[2] People who experience coverage disruptions are "more likely to delay care, receive less preventive

[2] Sarah Sugar, et. al, Health & Human Services, Asst. Secretary for Planning & Evaluation, Issue Brief, *Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic* (Apr. 12, 2021), *available at* https://aspe.hhs.gov/sites/default/files/private/pdf/265366/medicaid-churning-ib.pdf.

care, refill prescriptions less often, and have more emergency department visits."[3]

The bill is going the opposite direction that many states have taken. Rather than looking for ways to create higher disenrollment and churn, many states have been looking to create more continuity in enrollment given the high costs, administrative burdens, and worse health outcomes associated with Medicaid churn. Prior to the pandemic, 35 states had adopted policies and processes to reduce churn, including such common sense measures as implementing processes to improve communication with enrollees to help prevent them from losing coverage because they do not receive or respond to notices from the state.[4] Unfortunately, AB 934/AB 905 would have the opposite impact, making it harder for low-income Wisconsinites to understand the status of their health coverage and resulting in massive disenrollment.

When people are sick and are not receiving medical care they need, or when they are unable to access preventive services, it is harder for them to get work and more likely for them to lose their jobs. As a result, AB 934/SB 905 will not only result in making low-income Wisconsinites sicker, it is also more likely to lead to a greater dependence on state benefits and higher unemployment. This bill does nothing to help Legal Action's clients; it does not help them obtain family-sustaining jobs that may include health benefits, it simply makes it harder for them to maintain the benefits they need to be able to work and stay well.

Thank you for your consideration.

[3] *Id.*

[4] Bradley Corallo et. al, *Medicaid Enrollment Churn and Implications for Continuous Coverage Policies*, Kaiser Family Foundation, Dec. 14, 2021, https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/.

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Wisconsin BPDD
WISCONSIN BOARD FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES

February 9, 2022

Senate Committee Economic and Workforce Development
Senator Feyen
State Capitol, Rm 306 S
Madison, WI 53707

Dear Senator Feyen and committee members:

The Wisconsin Board for People with Developmental Disabilities' (BPDD) analysis of SB 905 finds this proposal will negatively and disproportionately impact people with disabilities and their families.

Wisconsin has more than 20 Medicaid programs, all of which include participants who have disabilities. This proposal would needlessly double the administrative burden, make it more difficult to complete required forms, and would penalize administrative and reporting mistakes with the loss of health care and long-term care coverage.

BPDD is especially concerned about the consequences for participants in the Family Care, IRIS, PACE/Partnership, Children's Long Term Care Services (CLTS) long term care programs; Katie Beckett which serves disabled children; and the Medical Assistance Purchase Plan (MAPP), the Medicaid-buy in work incentive program for people with disabilities. BPDD also notes BadgerCare covers some people with Intellectual and Developmental Disabilities (I/DD) who do not meet the criteria for long term care programs, people waiting for a disability determinacy, and people with undiagnosed I/DD.

More than 70,000 frail elders, people with physical disabilities, and people with I/DD get health care and supports to help them live and work in Wisconsin communities through Family Care and IRIS. These long-term care programs are designed to help people stay in their own homes and stay out of Medicaid-funded institutions, like nursing homes.

Family Care and IRIS participants must meet the criteria for nursing home level of care, and already undergo an annual functional screen administered by ADRCs to functional status, health, and need for assistance as part of the eligibility requirements for both programs. In addition, participants must be in poverty--100% of the Federal Poverty Level or less, and less than $2000 in assets to qualify.

People who meet nursing home level of care generally continue to do so because the need for supports and functional limitations are the result of a permanent lifelong disabilities—like cerebral palsy, autism, Down Syndrome--or age-related declines. People in Family Care and IRIS may be in fragile health, and often rely on Direct Support workers to get out of bed, use the bathroom, shower, perform complex medical procedures, and other daily tasks and supports to keep them safe at home. Disenrollment can literally mean life or death.

Requiring reapplication for Medicaid eligibility every 6 months instead of annually doubles the administrative cost and burden for ADRCs conducting functional screens, as well as participants and families who would now be required to complete the same paperwork twice or risk losing all care. It is unlikely the functionality of the individual will improve to the degree they would not be eligible for long term care. It is likely this proposal will result in Family Care and IRIS participants being disenrolled

Wisconsin BPDD
Wisconsin Board for People With Developmental Disabilities

because they accidentally miss an administrative deadline or are unable to complete the screening process in time. Further, it appears any administrative mistake that might affect eligibility could risk losing Medicaid health coverage and/or long-term care supports for six months.

This proposal increases the already high mental and emotional burden of family caregivers who consistently describe navigating Medicaid program administrative requirements and paperwork as difficult, mentally taxing, and burdensome. Adding yet another high stakes task to complete on an even more frequent basis makes lives which are already hard much harder. Families are already scrambling to coordinate care and fill in gaps when there are no workers to hire and are providing many natural supports Family Care and IRIS rely upon to fulfill care plan requirements. Many family caregivers describe living in a state of constant crisis. They do not need more stress.

Not all Family Care and IRIS participants have families to help them navigate the already complex Medicaid system. These populations are more likely to be non-drivers, have little or no access to internet connection, and have conditions which may interfere with cognition, reading comprehension, and following complex instructions or tasks.

This bill requires people without families or other support systems living with significant health conditions that limit mobility and cognitive ability to figure out complex administrative requirements on their own or lose the health care and supports that help them live independently. Many will be unable to do so successfully, with disastrous results.

Likewise, the same concerns impact the 32,000 people with disabilities in the MAPP program, almost 15,000 children with disabilities in the CLTS program and the 7,500 children with disabilities in the Katie Beckett program.

BPDD is charged under the federal Developmental Disabilities Assistance and Bill of Rights Act with advocacy, capacity building, and systems change to improve self-determination, independence, productivity, and integration and inclusion in all facets of community life for people with developmental disabilities[1].

Thank you for your consideration,

Beth Swedeen

Beth Swedeen, Executive Director,
Wisconsin Board for People with Developmental Disabilities

[1] More about BPDD https://wi-bpdd.org/wp-content/uploads/2018/08/Legislative_Overview_BPDD.pdf .

State of Wisconsin
Department of Health Services
Tony Evers, Governor
Karen E. Timberlake, Secretary-Designee

TO: Members of the Senate Committee on Economic and Workforce Development

FROM: HJ Waukau, Legislative Director

DATE: February 9, 2022

RE: Senate Bill 905, relating to: disenrollment of eligibility for the Medical Assistance program and database confirmation for public assistance program eligibility

The Wisconsin Department of Health Services (DHS) would like to thank the Committee for the opportunity to submit written testimony for information only on Senate Bill 905 (SB 905), regarding changes to how DHS would process eligibility and reenrollments of Medicaid members. Under the provisions of SB 905 Medicaid members would be required to renew benefits every six months and DHS would be prohibited from automatically renewing a member's eligibility or utilizing pre-populated renewal forms. SB 905 would also impose a six-month disenrollment penalty on Medicaid members who fail to report changes that could affect eligibility in a timely way. Additionally, SB 905 would require DHS to enter into data sharing agreements with any agency that maintains a database of financial or personal information of Wisconsin residents while requiring DHS to terminate a member's enrollment upon receipt of information that they are ineligible for Medicaid benefits. Further, DHS would be required to submit quarterly reports to the legislature on the number of individuals who are ineligible for Medicaid but are receiving benefits.

Under § 42 CFR 435.916(a)(1) states are required to renew Medicaid eligibility at least every 12 months and not more than every 12 months. States are also required under the same regulations to complete administrative renewals whenever possible. And if they are not possible, or if the state can't make a renewal determination on its own, states are required to send a pre-printed renewal form to the member under 42 CFR 435.916(a)(2). States are also prohibited under § 42 CFR 435.952 (d) from terminating eligibility on the basis of information received directly from data exchanges.

Coinciding with the aforementioned federal rules, regulations from the Centers for Medicare and Medicaid Services (CMS) do not permit the state to add disenrollment penalties as an extra eligibility requirement under its existing state plan for Medicaid. DHS could seek a waiver from CMS to allow for the creation of such disenrollment penalties, however it is unknown at this time if CMS would approve such as waiver. Further, per Wis. Stat. § 20.940(2) DHS is not permitted to seek a waiver or a renewal, modification, withdrawal, suspension, or termination of a waiver of federal law or rules unless legislation has been enacted specifically directing the submission of the request. SB 905 as currently drafted does not provide DHS with the authority to seek such a waiver.

Were DHS to seek and receive CMS's approval for a waiver major systems changes would be required and would have significant costs for DHS. The proposed changes would also result in a substantial increase in income maintenance workload. It would more than double the number of renewals that need to be completed each year, and renewals would be much more time intensive without the use of pre-printed renewal forms. DHS estimates that costs of the increased workload would at a minimum be $46.2 million GPR annually and require 138.5 additional full-time equivalent positions. SB 905 does not provide any funding for DHS for these purposes and DHS would be unable to absorb these costs under its existing budget.

DHS thanks the Committee for the opportunity to provide written testimony for information only and offers itself as a resource for any questions or follow up the Committee may have.

Providing quality coverage to nearly 3 million Medicaid and private sector enrollees in Wisconsin.

To:	Chairperson Dan Feyen Members, Senate Committee on Economic and Workforce Development
From:	R.J. Pirlot, Executive Director Caty McDermott, Lobbyist (MA Policy)
Date:	February 9, 2022
Re:	For information only – Senate Bill 905

The Alliance of Health Insurers (AHI) is a nonprofit state advocacy organization created to preserve and improve upon consumer access to affordable health insurance in Wisconsin, both via the private sector and public programs. As of December 2021, AHI health plans provide managed care to 66 percent of the participants in Wisconsin's Medical Assistance program (BadgerCare and SSI program participants).

Under Wisconsin's managed care model, the Department of Health Services (DHS) makes preset, actuarily sound, per member/per month capitation payments to the managed care HMOs and in exchange, the HMOs are at financial risk for the Medicaid services specified in their contracts. Because DHS presets the capitation payments, if a member utilizes costlier services, the HMO assumes the additional expense. Studies have demonstrated that Medicaid managed care health plans provide savings of up to 20 percent compared to fee-for-service programs.[i] This saves taxpayers money and leads to better patient outcomes and better quality of care for program participants.

SB 905 prohibits DHS from automatically renewing an individual's Medicaid eligibility and requires DHS to determine eligibility every six months – instead of the current 12-month timeline. The bill provides that if an individual fails to "timely report" a change that may impact their Medicaid eligibility, they will remain ineligible for Medicaid for the following six months after the department discovers the failure to report. SB 905 also prevents DHS from using any prepopulated form with information from the recipient, except their name and address. In addition, the bill requires DHS to enter into broad data sharing agreements with other state agencies providing public benefits to confirm Medicaid eligibility.

AHI appreciates the legislature's interest in ensuring individuals that are on the Medicaid program are indeed eligible. AHI shares that interest. Currently, managed care HMOs work collaboratively with the state to ensure members are well-informed of redetermination requirements and timelines. To help better understand the full implications of SB 905, AHI requests the committee to consider the following items:

1. **Federal Law and "Unwinding" Impacts -** Federal law (42 CFR § 435.916) provides a recipients' Medicaid benefits "must be renewed once every 12 months, and no more frequently than once every 12 months." AHI cautions the committee to consider the federal law requirements prior to advancing this legislation.

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R.J. Pirlot, Executive Director, pirlot@hamilton-consulting.com
www.allianceofhealthinsurers.com

The 12-month redetermination period is especially critical for the state coming out of the current Covid-19 federal Public Health Emergency (PHE). Since March 2020, states have been operating under the PHE, and have received an additional 6.2 percent point increase in federal Medicaid matching funds. In exchange for the additional federal match, states must meet certain conditions, including continuous eligibility through the end of the month in which the public health emergency ends.

For the last 8 months, Wisconsin has been gearing up for this "unwinding" period[ii] in which Medicaid eligibility will need to be redetermined for Medicaid recipients. This effort will require coordinated outreach to ensure that Medicaid members that continue to meet eligibility requirements can remain on Medicaid and individuals that are no longer eligible can transition to another form of health care coverage (e.g., employer sponsored or via a plan purchased on the exchange). The federal government has provided states with a 12-month timeline to "unwind" the Medicaid program from the PHE requirements. AHI strongly supports this timeline to limit program churn, transition Medicaid ineligible individuals to the exchange, and appropriately manage administrative costs for the significant renewal process.

2. **Capitation Payments Safe Harbor -** As noted earlier, the bill provides that if an individual fails to "timely report" a change that may impact their Medicaid eligibility, they will remain ineligible for Medicaid for the following six months after the department discovers the failure to report. While it could be assumed that there is no retroactive recoupment of Medicaid benefits until DHS "discovers the failure," AHI requests the bill be amended to explicitly clarify that any capitation payments made during the time that a member is in violation should not be recoupable if the managed care HMO is not aware of the action of the member. Any effects of the legislation be prospective and not penalize retrospectively a managed care HMO which has been providing – and paying for – benefits to an individual later deemed to be ineligible.

3. **Autorenewals -** SB 905 restricts DHS' use of prepopulated eligibility forms (except for name and address) which could impede state efforts to streamline the Medicaid renewal process. Under the Affordable Care Act, "states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data."[iii] To streamline this process, Wisconsin and 46 other states have moved towards "real-time" Medicaid eligibility determinations. Technology and improved third-party data sources have been assets in not only allowing for administrative renewals, but to verify member income and work status, which helps identify individuals who are not providing accurate employment records to the Income Maintenance agencies. In general, Medicaid managed care HMOs support efforts to use these technologies to avoid redundant data entry, manage the workload and budgets for the Income Maintenance consortia.

4. **Data Sharing Limitations –** The bill requires DHS to enter into data sharing agreements with other state agencies that maintain databases of Wisconsin resident's personal and financial information. Development of a system like this could be a significant cost for the state, as there are limitations for the various IT systems to be cross referenced. Also, there may be privacy implications – both for Protected Health Information and other

information, which could require additional state resources to appropriately manage. AHI urges the committee to quantify the fiscal impact of this policy.

AHI appreciates the committee's considerations of these items. AHI is dedicated to delivering affordable, high-value care to the state's Medicaid population and welcome the opportunity to work together with the legislature on these issues.

Thank you for your consideration.

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[i] The Lewin Group, "Medicaid Managed Care Cost Savings – A Synthesis of 24 Studies" March 2009
[ii] Wisconsin Department of Health Services, COVID-19 Emergency "Unwinding" Partner Toolkit, January 2022
[iii] KFF, Medicaid Eligibility Determinations, Applications, and Online Accounts, January 2020

KIDS FORWARD

Every Kid. Every Family. Every Community.

DATE: February 7, 2021

TO: Senate Committee on Economic and Workforce Development

FR: William Parke-Sutherland, Health Policy Analyst

RE: Opposition to SB 905 – prohibiting automatic renewals and increasing redeterminations

Chairperson Feyen and committee members

Thank you for the opportunity to submit testimony on Senate Bill 905, which we strongly oppose because it will create administrative barriers to Medicaid participation, thereby reducing access to health care among Medicaid-eligible low-wage workers. It would undermine an important work support and exacerbate racial inequities in access to care and coverage. Reducing access to health care is definitely not something policymakers should do during a pandemic.

Kids Forward aspires to make Wisconsin a place where every child thrives by advocating for effective, long-lasting solutions that break down barriers to success for children and families, notably children and families of color and those furthest from opportunity. Using research and a community-informed approach, Kids Forward works to help every kid, every family, and every community thrive.

SB 905 would prohibit DHS from automatically renewing people's Medicaid benefits, require eligibility to be verified every six months (instead of annually), and disallow the use of prepopulated forms. It would also require that people lose their coverage for six months if they fail to report (in a timely manner) any change that may impact their eligibility, and would require data sharing agreements and force DHS to disenroll people who are automatically found ineligible.

Automatic renewals are one of the best ways that states can ensure those who are eligible for coverage remain covered without adding administrative burdens and red tape like verification and renewal forms. Forms can get lost in the mail, processed incorrectly, sent to the wrong address, not returned in a timely manner, and be misunderstood by beneficiaries. All of these can lead to people losing their coverage and can result in increased health costs and worse health outcomes for people who need health care.

Federal Medicaid rules require that states attempt to renew members' coverage using other available data sources[1] because this is one of the most efficient and cost-effective ways to keep people covered. States are required to use data sources the state determines useful. By requiring data checks for ineligibility and creating six-month sanctions, the bill is trying to have it both ways. If the data is good enough to prove someone is ineligible, then it is good enough to confirm that

[1] 435.916(a)(2) Renewal on basis of information available to agency. The agency must make a redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency under §§ 435.948, 435.949 and 435.956.

person's eligibility. For these reasons, it is likely that the proposed prohibition is inconsistent with federal law.

Renewals are important to make sure that people who are enrolled are Medicaid eligible, but they are also the way people are most likely to lose their coverage, even if they are eligible. SB 905, which would make state staff process twice as many renewals as they currently do, will mean more people fall through the cracks and lose the coverage they are eligible for. Further, it is unclear how many people would be required to renew coverage semi-annually. Federal regulations state that renewals for individuals whose Medicaid eligibility is based on modified adjusted gross income (MAGI) methods may not be done more frequently than every 12 months[2]. This section of the bill would not apply for the vast majority of children, parents, adults without dependent children and pregnant people covered either by Medicaid or the Children's Health Insurance Program.

According to an October 2021 report by the Medicaid and CHIP Payment and Access Commission (MACPAC), Wisconsin already has some of the highest rates of churn in the country. More than 12 percent of enrollees are disenrolled and then re-enroll within 12 months. According to that same report, Black enrollees are more likely to be impacted by churn and needlessly lose coverage than their white counterparts, so increasing the administrative burden could have an inequitable impact on Black Wisconsinites. Language accessibility barriers when using websites, reading communications, and interacting with income maintenance workers could also make it more likely that people who speak a language other than English would be impacted by increased renewals and needlessly lose coverage.

Doubling the number of renewals would also mean tremendous increases in administrative costs and staffing needs, which this bill doesn't acknowledge or allocate funding for. An April 2021 HHS study estimated the cost of processing a single instance of disenrollment and re-enrollment at between $400 and $600.[3]

Tracking and reporting on the income status of everyone who must remain enrolled as a condition of federal maintenance of effort (MOE) requirements and reporting that data multiple times per year to the legislature is a waste of state agency time and staff resources – particularly since the MOE requirements are being phased out. This is not a responsible use of tax dollars because it will balloon state administrative costs, result in higher medical bills for those who are forced to go without coverage, and add more red tape that people will get caught up in.

This bill would greatly increase administrative burdens, which would likely worsen inequality and health disparities. A 2021 report from the Office of Management Budget found that barriers making it harder for people to access public benefits worsen inequity. This bill would require someone on BadgerCare to fill out more paperwork, answer more notices and phone calls, submit more verification and documentation, and have more interactions with income maintenance workers. All of that would fall hardest on those who have the least amount of time and resources. Because of long-term systemic employment and economic discrimination, Black, Indigenous, and People of Color are more likely to be in lower-paying jobs, have less access to insurance, and more likely to face barriers such as lack of access to transportation, connectivity, and financial instability. For example, the report notes that during the *great recession Black and Hispanic workers were less likely to receive unemployment insurance benefits than White workers.* Increasing administrative

[2] § 435.916 Periodic renewal of Medicaid eligibility.

[3] https://aspe.hhs.gov/sites/default/files/migrated_legacy_files/199881/medicaid-churning-ib.pdf

burdens by implementing this proposal would likely disproportionately harm Black, Indigenous, and People of Color in Wisconsin. Senate Bill 905 would perpetuate and exacerbate racial inequity.

Please oppose this bill because it would prohibit one of the best ways of keeping eligible Wisconsinites covered, increase rates of churn where people are needlessly going without care and coverage, exacerbate health inequities, create countless administrative burdens, and balloon administrative costs.

Please feel free to contact me at wparkesutherland@kidsforward.org with questions, follow up, or requests for more information. Thank you.