May 19, 2017

Michael Heifetz
Director
Division of Medicaid Services
PO Box 309
Madison, WI 53707

Dear Director Heifetz:

On behalf of the nearly 30 million Americans living with diabetes and the 86 million more with prediabetes, the American Diabetes Association provides the following comments on the BadgerCare Reform Demonstration Project waiver amendment application.

According to the Centers for Disease Control and Prevention, almost 375,000 adults in Wisconsin have diabetes and another 1.33 million have prediabetes. Access to affordable, adequate health coverage is critically important for all people with, and at risk for, diabetes. When people are not able to afford the tools and services necessary to manage their diabetes, they scale back or forego the care they need, potentially leading to costly complications and even death.

Adults with diabetes are disproportionately covered by Medicaid.[1] For low income individuals, access to Medicaid coverage is essential to managing their health. As a result of inconsistent access to Medicaid across the nation, these low income populations experience great disparities in access to care and health status, which is reflected in geographic, race and ethnic differences in morbidity and mortality from preventable and treatable conditions.

While the American Diabetes Association shares the state's goal of improving the health outcomes for low-income Wisconsin residents, we have deep concerns regarding some of the provisions of the BadgerCare waiver amendment application, and provide the following comments and recommendations to help ensure the needs of low-income individuals with diabetes and prediabetes in Wisconsin are met by the state's Medicaid program.

Healthy Behavior Incentives Program

In its application, the state notes one goal of the amended waiver is to "more closely align the program for childless adults with private health insurance…." The state also notes "promoting and incentivizing

healthier lifestyles" is a main focus of the demonstration program. However, the state's proposal to assess whether members engage in behaviors or have a body weight the state has deemed as health risks and charge those identified twice as much as other Medicaid enrollees will not achieve either stated goal. First, charging health plan enrollees higher premiums based on health status is prohibited in the private market.[2] While there are exceptions to this prohibition for wellness programs,[3] the program proposed by the state does not meet the requirements for those types of programs.[4] Specifically, a wellness program is defined as a program of "health promotion or disease prevention", and the regulations note they must have a "reasonable chance of improving the health of, or preventing disease in, participating individuals." [5] In contrast, the state's proposal attempts to identify potential enrollees with high health risks, but rather than offering them a program to help improve their health or prevent disease, the state proposes to charge higher premiums to those identified.

The Association supports voluntary wellness programs that encourage individuals to adopt healthy lifestyles and provide support for doing so. However, we have concerns about programs that use premium or other health care cost rewards and penalties tied to achievement of a health status or outcome. Use of such incentives should in no way jeopardize access to health care or be used as a proxy for discrimination on the basis of health status. Currently, there is insufficient peer-reviewed research demonstrating the efficacy of financial incentives in motivating long-term behavior change. In addition, other states' efforts to incentivize healthy behaviors in the Medicaid program have had limited impact and are difficult to administer.[6] It is critical financial rewards intended to motivate behavior change are designed in a way that protects individuals from discrimination based on health status and preserves access to adequate and affordable health coverage. **Implementation of the incentive program as proposed will result in discrimination against Medicaid enrollees and applicants based on their health status and therefore should not be implemented.**

As an alternative to the premium-based health status penalty proposed, the Association strongly recommends Wisconsin explore opportunities to improve the health of Medicaid enrollees with and at risk for developing diabetes by providing coverage for evidence-based programs. In 2012, diagnosed diabetes cost $4.36 billion in Wisconsin.[7] This included $3.28 billion in direct medical costs and $1.09 billion in indirect costs such as absenteeism, unemployment due to disability and premature mortality.[8] Diabetes is the leading cause of new cases of adult blindness, non-traumatic lower-limb amputations and kidney failure in the United States.[9] People with uncontrolled diabetes or with diabetes complications have medical costs as high as eight times that of people with well-controlled or non-advanced diabetes. [10]

Fortunately, we know diabetes complications can be avoided or delayed with adequate management of blood glucose.[11] Diabetes self-management training (DSMT) provides the foundation to help people with diabetes make their daily self-management decisions and perform complex care activities. Access

to DSMT can lead to improved diabetes knowledge and self-care behaviors, lower hemoglobin A1c, lower self-reported weight, improved quality of life, healthy coping and reduced health care costs.[12]

We also know type 2 diabetes can be prevented or delayed through the National Diabetes Prevention Program (National DPP), an evidence-based lifestyle intervention program proven to have long-term impact. Research shows that even after 10 years, people who completed the program were one-third less likely to develop type 2 diabetes, [13] providing Wisconsin a long-lasting impact for their investment. According to the Centers for Disease Control and Prevention, over 1.94 million adults in Wisconsin have prediabetes or are at risk for developing type 2 diabetes.[14] If just 16% of those people participate in the National DPP, almost 60,000 years with diabetes can be averted, saving the state of Wisconsin more than $76 million over 10 years.

Rather than the proposed health behavior incentives program, the Association strongly urges Wisconsin Medicaid cover the National DPP for enrollees with prediabetes and cover DSMT for enrollees with diabetes. These are evidence-based, cost-effective ways to help the state achieve its goal of improving the health of low-income Wisconsin residents.

Cost Sharing

The Association is concerned the premium and cost-sharing requirements proposed in Wisconsin's BadgerCare waiver amendment application could deter individuals from obtaining Medicaid coverage or from obtaining needed medical care. According to a study conducted by staff at the Agency for Healthcare Research and Quality (AHRQ), a premium increase of $10 per month is associated with a decrease in public coverage of children in families with incomes above 150% of the FPL, with a greater decrease in coverage for those below 150% FPL.[15] Wisconsin is proposing to require a beneficiary earning as little as $200 a month to pay monthly premiums, locking them out of Medicaid coverage for up to six months if they are unable to pay.

In addition to the monthly premium requirements proposed, the existing cost-sharing requirements for medical care in the state's state plan amendment would still apply. A Kaiser Family Foundation review of research related to cost-sharing and premiums in state Medicaid and CHIP programs found that "[f]or individuals with low income and significant health care needs, cost-sharing can act as a barrier to accessing care, including effective and essential services, which can lead to adverse health outcomes." [16]

Diabetes is a complex, chronic illness requiring continuous medical care with multifactorial risk reduction strategies beyond glycemic control. Ongoing patient self-management education and support are critical to preventing acute complications and reducing the risk of long-term complications. Studies show intensive diabetes management can delay the onset and progression of diabetic nephropathy, which is the leading cause of end stage renal disease.[17] When people are not able to afford the tools

and care necessary to manage their diabetes, they scale back or forego the care they need. **The Association is opposed to the state's proposal to require Medicaid beneficiaries to pay monthly premiums and co-payments for needed care which will render coverage unaffordable, limiting Medicaid enrollees with diabetes' ability to successfully manage the disease.**

Time Limit on Medicaid Eligibility Linked to Work Requirements

The Association is deeply concerned by the state's proposal to limit certain Medicaid beneficiaries' enrollment to 48 cumulative months. This type of coverage limit undermines the State's goal to continuously improve its Medicaid program while maintaining access to affordable, quality health care coverage for its residents. Further, linking this eligibility time limit to work requirements is contrary to the goal of the Medicaid program: offering health coverage to those without access to care.

Most people on Medicaid who can work, do so. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60% are working themselves. Of those not working, more than one-third reported that illness or disability was the primary reason, 28% reported they were taking care of home or family, and 18% were in school.[18] For people who face major obstacles to employment, harsh Medicaid requirements will not help to overcome them. In addition, research shows work requirements are not likely to have a positive impact on long-term employment.[19] Instead, instituting a work requirement would lead to higher uninsured rates and higher emergency room visits by uninsured Americans who would have been eligible for Medicaid coverage, and increase the administrative burden for the state and its Medicaid managed care plans.[20,21] **Therefore, the Association recommends the state not implement the eligibility time limit or work requirements – either together or separately.**

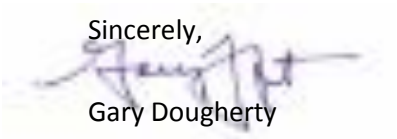
Summary

The Association appreciates the opportunity to provide comments on the BadgerCare Reform Demonstration Project waiver amendment application. Because adults with diabetes are disproportionately covered by Medicaid, we want to ensure the changes made to the Wisconsin Medicaid program do not jeopardize access to care for low-income Wisconsinites with diabetes and prediabetes. Unfortunately, the BadgerCare program changes proposed by the state will result in discrimination against Medicaid enrollees and applicants with perceived health risks; imposes cost-sharing that will deter enrollment in the program and access to needed medical care; increase the state's administrative burden; and jeopardize the state's goal to continuously improve its Medicaid program while maintaining access to affordable, quality health care coverage for its residents

Instead, the Association recommends the state consider implementing strategies to improve access preventive services and needed medical care, specifically by providing coverage of the National DPP and DSMT.

If you have any questions, please contact me at 1-800-676-4065 x4832.

Sincerely,



Gary Dougherty
Director, State Government Affairs and Advocacy
American Diabetes Association.

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[1] Kaiser Commission on Medicaid and the Uninsured, The Role of Medicaid for People with Diabetes, November 2012. Available at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8383_d.pdf.

[2] 42 U.S.C. §1182(b) (prohibits group health plans from requiring an individual to pay a premium greater than similarly situated individual on the basis of any health status-related factor, which includes evidence of insurability). 42 U.S.C §300gg—4(b)(1) (prohibits individual and small group plans from requiring an individual to pay a premium greater than a similarly situated individual on the basis of any health status-related factor, which includes evidence of insurability).

[3] 42 U.S.C. §1182(b)(2)(B) and 42 U.S.C. §300gg-4(b)(2)(B)

[4] 29 C.F.R. §2590.702(f).

[5] 29 C.F.R. §2590.702(f)(3)(iii) and (f)(4)(iii).

[6] Blumenthal KJ, Saulsgiver KA, Norton L, et al., Medicaid Incentive Programs to Encourage Healthy Behavior Show Mixed Results to Date and Should be Studied and Improved, 32 Health Affairs 3, March 2013. See also, Askelson NM, Wright B, Bentler S, et al., Iowa's Medicaid Expansion Promoted Healthy Behaviors But Was Challenging to Implement and Attracted Few Participants, 36 Health Affairs 5, May 2017.

[7] American Diabetes Association, Economic Costs of Diabetes in the U.S. in 2012, Diabetes Care, April 2013. Available at: http://care.diabetesjournals.org/content/36/4/1033.

[8] Economic Costs of Diabetes in the U.S. in 2012.

[9] See National Institute of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Diabetic Kidney Disease, available at: https://www.niddk.nih.gov/health-information/diabetes/overview/preventing-problems/diabetic-kidney-disease; Sahakyan K, Klein BEK, Lee KE, et al., The 25-Year Cumulative Incidence of Lower Extremity Amputations in People with Type 1 Diabetes, 34 Diabetes Care 3, March 2011; National Institute of Health, National Eye Institute, Facts About Diabetic Eye Disease, available at: https://nei.nih.gov/health/diabetic/retinopathy.

[10] Economic Costs of Diabetes in the U.S.

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[12] American Diabetes Association, Standards of Medical Care in Diabetes – 2017, Diabetes Care, Jan. 2017.

[13] Diabetes Prevention Program Research Group, 10-Year Follow-Up of Diabetes Incidence and Weight Loss in the Diabetes Prevention Program Outcomes Study, Lancet, November 2009. Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3135022/.

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[15] Abdus S, Hudson J, Hill SC, Selden TM, Children's Health Insurance Program Premiums Adversely Affect Enrollment, Especially Among Lower-Income Children, 33 Health Affairs 8, August 2014
[16] Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid and the Uninsured, February 2013.
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[21] Katch H, Medicaid Work Requirements Would Limit Health Care Access Without Significantly Boosting Employment, Center on Budget and Policy Priorities, July 2016, available at: http://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly.