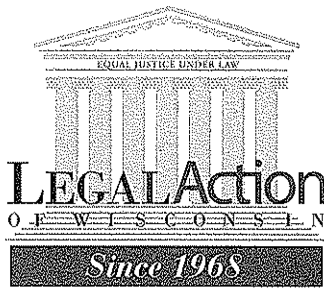

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May 19, 2017

Linda Seemeyer, Secretary
Department of Health Services
1 West Wilson Street Room 651
Madison, WI 53702

RE: Draft 1115 Demonstration Waiver Amendment Application

Dear Secretary Seemeyer:

Legal Action of Wisconsin is the state's largest provider of free, high-quality civil legal aid. We represent low-income individuals and families, the elderly, persons with disabilities, veterans, and survivors of violence in 39 of Wisconsin's 72 counties. We represent clients in a variety of matters, including Social Security, Medicare, Medicaid, BadgerCare, Food Share, W-2, Child Care, and housing, consumer and family matters. These comments, on behalf of the individuals and families we represent, are submitted in response to the Department of Health Services (DHS) draft waiver request seeking amendments to the BadgerCare waiver program as it affects childless adults. We are concerned that the waiver request will weaken and undermine a currently effective program, and will have negative consequences for our clients and our client population statewide.

Wisconsin first began to cover childless adults in 2009 with the initiation of the BadgerCare Core program. At that time and until 2014 the income limit for the program was set at 200% of the poverty level. However, because of limited funding and higher than expected demand, enrollment in the Core program was frozen shortly after it began and a waiting list was established. Effective January 2014 the BadgerCare income limit was reduced to 100% of poverty for new applicants. The reduction for ongoing recipients was effective April 1, 2014. The waiting list for childless adults seeking to enroll in the BadgerCare program was eliminated when the qualifying income limit for the program was reduced.

Wisconsin's BadgerCare Program operates as a Medicaid waiver program. The waiver currently in effect provides that non-disabled, non-pregnant adults are eligible for BadgerCare if their income does not exceed 100% of the poverty level. Parents and caretakers of dependent children can continue to receive BadgerCare for 12 months if

their income exceeds this amount. Premiums during this period or "extension" are required after six months if the parent/caretaker's income is at or less than 133% of poverty; for those with income above 133% of poverty premiums are required when the extension of coverage begins. Childless adults are not eligible for this 12 month extended coverage; their eligibility ends when their income exceeds 100% of the poverty level.

Project Objectives

The draft waiver amendment identifies a number of project objectives. Included among the objectives are the following:

- to ensure that every Wisconsin resident has access to affordable health insurance to reduce the state's uninsured rate;
- to create a medical assistance program that is sustainable so a health care safety net is available to those who need it most;
- to help more Wisconsin citizens become independent so as to rely less on government-sponsored health insurance; and
- to empower members to become active consumers of health care services to help improve their health outcomes.

The current program already satisfies these objectives. The expansion of the BadgerCare program to childless adults allowed many individuals to receive regular and ongoing health care, some for the first time in years, others for the first time in their lives. Our clients' stories illustrate the success of the current BadgerCare program for childless adults:

- One of our clients, Mary, who is in her late 50s, has worked her entire life as a CNA or certified nursing assistant. Despite being employed she lacked health insurance for most of her life and only visited a doctor when she could afford it. About 10 years ago she developed glaucoma and was prescribed medication to halt the effects of the disease and prevent the loss of her sight. Mary could not always afford the medication and as a result is now blind in one eye. Since enrolling in BadgerCare and receiving regular preventive care her doctors are hopeful that the eyesight in her other eye can be saved.
- Another of our clients, Tim, was employed with health insurance until 2009 when he lost his construction job due to the recession. After that he could no longer afford to regularly treat his diabetes which he had suffered from for most of his life. As a result, his condition became uncontrollable, he was hospitalized on numerous occasions for infections and ultimately lost one of his legs below the knee. With BadgerCare he has been able to receive ongoing medical care and is now in a re-training program and hopes to return to work.
- A third example, also illustrative of many of the clients we serve, is Anita. She is also in her late 50s. Until the recession she worked at a bank and had health benefits through her employment. After losing her employment, she was diagnosed

with thyroid cancer. Because she was without insurance Anita was forced to exhaust her retirement savings to pay for her health care. Since losing her job at the bank she has only been able to secure two part time jobs with combined earnings below the poverty level. BadgerCare has afforded her the ability to receive the ongoing medical care she needs, including the thyroid replacement medication she must now take, to maintain her health and keep working. And it has allowed her to continue to pay her mortgage and save the home she has worked so hard to maintain.

The stories of Mary, Tim and Anita demonstrate that the BadgerCare program operates as intended. The program only serves the most needy: those with income at or below the poverty level (currently $1005 a month). It insures that these low-income childless adults receive the health care they need to not only maintain their health but to stay employed and be productive contributing members of our state, and it has allowed them to manage and take control of their health care needs. Without the care they have been able to receive as a result of the BadgerCare program all three would be in a constant state of health crisis, relying on emergency care, unable to work and forced to apply for disability. In fact research shows that after Wisconsin created the Core program in 2009 inpatient hospitalizations declined by 59% and preventable hospitalizations declined by 48% among the covered population of childless adults. Thomas DeLeire, Laura Dague, Lindsey Leininger, Kristen Voskuil and Donna Friedsam, *Wisconsin Experience* Indicates *That Expanding Public Insurance To Low-Income Childless Adults Has Health Care Impacts*, Health Affairs 32, no. 6 (2013).[1]

In addition, the physicians and other health providers who testified at the recent public hearings testified that the department's other objectives are also being met. The program has allowed individuals to receive coordinated health care that both identifies and helps manage their health risks. The result is "improved health care value" and "integrated care." For homeless individuals, many of whom suffer from mental health problems, this is especially true. It has allowed our client Loretta to receive both mental health care and management of her diabetes and other physical health needs. Loretta receives her treatment through one of Milwaukee's federally qualified health centers that provides integrated care with access to social workers and case-managers who have helped Loretta secure transitional housing, continue to take the medication she needs and enroll in a Goodwill training program.

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[1] These findings are consistent with studies showing that MA coverage for adults is associated with improved access to primary care, better medication adherence, increased screening for and detection of diabetes, more regular treatment of chronic conditions, and improved self-reported health. Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller and Ashley Wong, *"The Effect of the Patient Protection and Affordable Care Act Medicaid Expansion on Financial Well-Being*, Washington, DC: National Bureau of Economic Research, April 2016; *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*, Kaiser Family Foundation (February 2017).

The proposed amendments serve to defeat the very objectives they purport to advance. Premiums, time limits and the other proposals offered as "improvements" for persons like Mary, Tim, Anita and Loretta will only interfere with and limit their access to health care, force them to rely on emergency care and very likely result in greater, not less, dependence on assistance programs.

Monthly premiums

The waiver amendment proposes to require premium payments for childless adults with income above 20% of the federal poverty level (income ranging from $211 to $1005 a month). Premiums will range from $1 to $10 a month. Failure to pay premiums may result in ineligibility for up to six months.

A number of studies, as well as Wisconsin's own experience, demonstrate that cost-sharing, including premiums, leads to loss of heath care coverage with the result of increased emergency department use, hospitalizations that could have been avoided, negative health care outcomes, and increased program costs over time.

In 2012 Wisconsin began to require monthly premiums from adults receiving BadgerCare, including parents enrolled in the transitional BadgerCare program, with income above 133% of poverty. Thereafter, the data shows that enrollment of adults with income between 133% and 150% of poverty dropped significantly, especially among parents eligible for transitional coverage.[2] During the first six months after the imposition of premiums 24% of adults with income between 133% and 150% of poverty were disenrolled from the program for the failure to pay premiums; for adults receiving transitional coverage the figure was 26%. Overall, fewer than a third of adults with income between 133% and 150% of poverty who were enrolled when the premium requirement took effect, were still enrolled 6 months later. Only 14% of adults in the transitional program were still enrolled.

These findings from our state's own experience are consistent with numerous other national studies that show, without question, that premiums and other cost-sharing requirements serve as a barrier to accessing, obtaining, and maintaining health care coverage and result in an increase in the number of uninsured individuals. See, e.g., Samantha Artiga and Molly O'Malley, Kaiser Commission, *Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences* (May 2005), and

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[2] See *Wisconsin Medicaid Premium Reforms: Preliminary Price Impact Findings*, at https://www.dhs.wisconsin.gov/publications/p0/p00447.pdf. These findings were confirmed in a subsequent DHS report that is no longer available on line. It is also noteworthy that as a result of a lawsuit, *Charles v Wisconsin Department of Health Services*, 12-CV-00463 (E. D. Wis. 2012), initiated by this office it was discovered that many childless adults on the waiting list for the BadgerCare Core program in 2012 were previously enrolled in the program and lost coverage when they could not afford to pay the $60 annual enrollment fee that was a condition of eligibility at the time.

Premiums and Cost-Sharing in Medicaid: A Review of Research Findings, Kaiser Commission on Medicaid on the Uninsured (February 2013). Studies of Medicaid waivers in other states have found that charging enrollment fees, premiums or co-pays to persons at income levels of 200% FPL or less reduced enrollment, reduced the use of preventive and primary care, and increased the use of emergency care (including for non-emergency care).[3] Further research has shown that cost-sharing causes low-income individuals to use fewer effective, essential health services and/or prescription drugs, leading to more adverse medical events and emergency room visits.[4] Premiums as low as two percent of household income have been shown to reduce enrollment by over 40%.[5] And in Oregon, increased cost-sharing resulted in a large reduction in Medicaid enrollment. This led to reduced use of primary care and increased emergency room use by those who left the program due to the increased cost-sharing.[6]

The waiver amendment seeks to impose premiums on individuals living at or below the poverty level, some with incomes as low as $211 a month. Premiums, no matter how small, will pose an insurmountable burden to persons barely getting by. Our own experience with the imposition of premiums on individuals with income at or above 133% of poverty tells us that the likely result will be to increase the number of uninsured individuals and serve to defeat the very objective the state is attempting to achieve.

Barring individuals from receiving BadgerCare for up to six months for non-payment of premiums will also interfere with the goal of encouraging individuals to manage their health risks. Individuals will simply forgo care with the result that chronic health conditions such as diabetes and heart disease will worsen leading to increased and more expensive costs at a later time and/or costly emergency care. In addition, premiums, instead of encouraging individuals to work, will result in an increased burden on the working poor and sends a message that work will be penalized, not encouraged.

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[3] See, e.g., John McConnell and Neal Wallace, *Impact of Premium Changes in the Oregon Health Plan*, Office for Oregon Health Policy and Research, February 2014; *Office of Health Care Statistics, Utah Primary Care Network Disnerollment Report*, July – August 2003," Utah Department of Public Health, August 2004; *The Lewin Group, Indiana Healthy Plan 2.0*: Interim Evaluation Report (July 6, 2016); *State of Wisconsin BadgerCare Plus Demonstration Project Waiver, Coverage of Adults Without Dependent Children with Income At or Below 100% of the Federal Poverty Level and Requiring Monthly Premiums for Adult Parents and Caretaker Relatives for Transitional Medical Assistance (TMA)*, 1115 Demonstration Project Application (August 9, 2013), at page 30.

[4] Leighton Ku, *Charging the Poor More for Health Care: Cos-Sharing in Medicaid* (May 2003), available at: http://cbpp.org/archiveSite/5-7-03health.pdf.

[5] Id. (Figure 4).

[6] Bill J. Wright, Matthew J. Carlson, Tina Edlund, Jennifer DeVoe, Charles Gallia and Jeanene Smith, *The Impact of Increased Cost Sharing On Medicaid Enrollees,* Health Affairs 24, no. 4 (2005).

For many individuals the very act of paying the premium will be an impossible task. Our clients' experiences has shown us that BadgerCare recipients often lack access to bank accounts or debit and credit cards, making monthly payments difficult. For many, the cost of a money order will exceed the cost of the premium and the only option will be to make cash payments. For some, especially those in rural areas without access to transportation, the physical act of delivering the premium payment to the agency may be a burden that cannot be overcome.

As a final matter the imposition of premiums will result in increased administrative costs, costs that will likely outweigh the benefits, if any, the state is trying to achieve. Reporting requirements, notices of decision and other changes will need to be made. Because many individuals enrolled in the program, due to temporary or seasonal employment or jobs with varying hours, have fluctuating income, premiums will have to be continually adjusted and re-adjusted. All this will lead to a significant and increased burden on the county agencies that administer the program.

Time Limit on Medicaid Eligibility and Work Requirements

The draft amendments limit the receipt of BadgerCare to 48 months for individuals under 50. Once an individual has received BadgerCare for 48 months he or she will be ineligible for 6 months. Exemptions include persons who are working or enrolled and participating in an employment and training program for at least 80 hours a month, persons suffering from mental illness, receiving SSDI, unable to work, participating in an AODA treatment program, receiving UC or enrolled in certain school programs.

These measures will limit access to health care, especially for adults with mental and physical health issues and low-wage workers. There is no indication that time limiting access to health care and imposing work requirements will increase employment or wages, and we believe the opposite will in fact occur - periods of ineligibility will result in negative health outcomes such as a needless increase in avoidable hospitalizations and increased emergency department use. In addition, the proposed changes are simply not needed.

Studies show that a majority of adult Medicaid enrollees are already working. In 2015, over 60% of non-elderly, non-disabled adults enrolled in Medicaid in Wisconsin were working. An even higher proportion - over 80% - of adult enrollees had at least one family member who was employed. Rachel Garfield, Robin Rudowitz, and Anthony Damico, *"Understanding the Intersection of Medicaid and Work,"* Kaiser Family Foundation (February 2017).[7] Of those adults enrolled in Medicaid and not working, 33% have an illness or disability that prevents or limits work. ibid.

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[7] See, http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/.

In addition, most mandatory work programs have not been shown to have any lasting results. They have not led to improved and sustained employment opportunities or increased income for participants.[8] Moreover, the proposal to model the BadgerCare employment and training program on Wisconsin's current FSET program offers little promise. The Food Share work requirement for childless adults has resulted in a significant reduction in participation without any appreciable gains in employment or wages for participants. Our clients who have participated in FSET have not received access to needed education, work supports, job or skills training. FSET'S focus on job search has done nothing to address the lack of permanent full-time work that offers a living wage or the lack of affordable health insurance. At best it has resulted in reduced caseloads and a waste of resources. And the largest FSET provider in Wisconsin has faced criticism from the Food and Nutrition Service for failing to provide adequate programming and supports for participants.

In contrast to FSET, well-designed voluntary work programs that engage participants and offer employment and training services and support – like the Jobs-Plus public housing demonstration program – result in lasting employment for those participants who were not employed and better-paying jobs for participants who were already employed. James A. Riccio, *Sustained Earning Gains for Residents in a Public Housing Jobs Program: Seven-Year Findings from the Jobs-Plus Demonstration*, Manpower Demonstration Research Corporation, January 2010.[9] Focusing limited resources on programs that improve the educational levels and job skills of BadgerCare eligible populations would be a far more effective strategy than a punitive approach that is likely only to disconnect needy individuals from preventive and needed health care. Our clients with chronic medical conditions need, and want, supportive employment services to address barriers to employment such as criminal records and lack of access to reliable transportation.[10]

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[8] See e.g., *Jonathan F. Pingle, What if Welfare Had No Work Requirements? The Age of Youngest Child Exemption and the Rise in Employment of Single Mothers*, Federal Reserve Board, August 2003; Elizabeth Lower-Basch and Mark Greenberg, *Single Mothers in the Era of Welfare Reform*, (*The Gloves–off Economy: Workplace Standards at the Bottom of America's Labor Market*); and Alana Samuels, *The Near Impossibility of Moving Up After Welfare*, The Atlantic *(July 2016).*

[9] See, http.//www.mdrc.org/publication/sustained-earnings-gains-residents-public-housing-jobs-program.

[10] It should also be noted that many recipients who are underemployed and who may not satisfy the 80 hour a month work requirement face unstable and unpredictable work schedules and "call-in" shifts that prevent them from complying with work search and other job program requirements. Elizabeth Lower-Basch, *Adding Stumbling Blocks in the Path to Health Care*," Center for Law and Social Policy (March 2017). Unless and until these concerns are also addressed, work requirements will not be effective.

As discussed above, the BadgerCare program as currently designed allows recipients to stay healthy and obtain and maintain employment. Research has found that the recent expansion of Medicaid has promoted work by allowing recipients to do just that - remain in good health and stay employed. Larisa Antonisse, Rachel Garfield, Robin Rudowitz, and Samantha Artiga, *The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review*," Kaiser Family Foundation (February 2017).[11]

The examples of just a few of our clients, Mary, Tim, Anita and Loretta, demonstrate that often individuals are not working or are forced to stop working because they are in poor health and do not have access to regular health care and, when they do have health care, they are better able to work. Two of our other clients, Thomas and Maurice, both are in their 40s and have worked all their lives. Recently they have only been able to secure jobs with fluctuating hours, both are earning less than the poverty level. Both have chronic health conditions, diabetes and heart problems, and without BadgerCare would not be healthy enough to keep working. Two additional clients, Leslie and Eric, both in their 20s, took responsibility for their health care by enrolling in the Marketplace. Because their income was below the poverty level at the time their applications were sent to the state and they were enrolled in BadgerCare. They have both moved onto better employment and left the program.

Studies and the above examples from our clients' experiences show that BadgerCare recipients do not need any further incentive to work. They already work when they are physically and mentally capable of working and when employment is available to them. Time limits and yet another poorly conceived and improperly executed work program are not needed and do not address the real issues facing the BadgerCare population.

Substance Abuse Screening and Testing

As a condition of eligibility, the draft amendments require BadgerCare applicants and recipients to complete a drug screening assessment. If the screening identifies a substance abuse disorder the individual must submit to a drug test. If an individual tests positive for illicit drug use, he or she will be referred to treatment. Individuals who fail to complete the drug screening and, if referred, the drug testing and treatment will be ineligible for BadgerCare, unless treatment is not available.

Implementing and administering a system of drug screening and testing will be costly. And there is simply no need for it. There is no evidence that BadgerCare recipients have a higher rate of substance abuse than the general population. In fact a 2015 review of the seven states that implemented drug testing in their TANF programs found that the states were "spending hundreds of thousands of dollars to ferret out very few

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[11] See, http://kff.org/medicaid/issue-brief/the-effects-of-medicaid-expansion-under-the-aca-findings-from-a-literature-review/.

drug users." Bryce Covert and Josh Israel, *What 7 States Discovered After Spending More than $1 Million Drug Testing Welfare Recipients,* Think Progress, February 2015.[12]

The data reviewed by the authors showed that applicants for public assistance had lower rates of positive drug tests, ranging from 0.0002 percent to 8.3 percent, when compared to the national drug use rate of 9.4 percent. They found further that the seven states reviewed spent nearly $1 million dollars to identify insignificant number of drug users. For example, in Missouri 446 persons out of 38,970 applicants were tested, just 48 tested positive at a cost of $336,297 in one year. In Utah 29 applicants out of 9552 tested positive at a cost of more than $64,000; and in Kansas 11 out of 2,783 applicants in a six month period tested positive at a cost of $40,000. In the case of *Lebron v. Secretary of the Florida Department of Children and Families*, the Eleventh Circuit in striking down that state's drug testing policy as unconstitutional found that "the State has not demonstrated a more prevalent, unique, or different drug problem among TANF applicants than in the general population." [13]

The presumed purpose of the waiver amendment is to help identify BadgerCare applicants who are in need of treatment and require them to get that treatment, As such, it is likely to be ineffective. The physicians, substance abuse treatment providers and other experts who testified at the public hearings noted that it is the individual's medical providers who are in the best position to identify whether an individual is in need of treatment. These experts also agreed that an individual cannot be forced into treatment, but must be ready and willing.

In reality, requiring drug testing will likely drive those most in need from the program. Those who have substance abuse problems are more likely to simply not enroll in the program or fail to comply with the screening and testing and, as a result, be barred from the very care that is likely to identify the abuse and offer treatment options. In addition, the state will be attaching an unwarranted and unneeded stigma to the program causing others to forgo assistance, even though they are in need and do not have substance abuse problems. Either way the result will be to drive up the state's uninsured rate.

The real problem, as the medical and treatment providers testified, is the lack of treatment options in many communities and the long waiting lists for treatment in others. A coordinated and well-funded state effort to tackle the lack of treatment options for those who receive Medicaid-funded health care and who are requesting substance abuse help would be a far more effective solution than broadly applied wasteful and

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[12] See also Bryce Covert and Josh Israel, *Drug Testing Welfare Recipients Is A Popular New Policy That COST States Millions. Here Are The Results,* Think Progress, February 2016.

[13] See *Lebron v Secretary of the Florida Department of Children and Families*, 772 F.3d 1352,1355 (11th Cir. 2014).

ineffective screening and testing measures.

Finally, like the waiver proposals as a whole, screening and testing will add to the burden of the local agencies administering the BadgerCare program. The waiver fails to offer any details regarding the administration of the screening and testing - how it will be conducted, how confidentially will be maintained, how often an individual will be able to undergo testing and/or start treatment and what will happen if an individual tests positive but is determined by a medical professional not to need treatment. These are complicated and important questions that are not addressed by the waiver request

Healthy Behavior Incentives and Health Risk Assessment

The draft waiver amendment requires BadgerCare recipients to complete an annual Health Risk Assessment which asks them to identify whether they are engaging in "healthy" vs "risky" behaviors. It reduces premiums by 50% for individuals that demonstrate "healthy behaviors." Individuals who report "risky behaviors" (alcohol consumption, body weight, illicit drug use, seatbelt use and tobacco use) will also be afforded premium reductions if they attest to actively managing their risky behavior.

Studies regarding the use of incentives in Medicaid programs show mixed results. While limited, the evidence that is available shows that rewards are most effective for one-time or short term activities, such as showing up for an annual exam. Amanda Van Vleet and Robin Rudowitz, *An Overview of Medicaid Incentives for the Prevention of Chronic Disease Grants*, Kaiser Family Foundation, September 2014; and Jessica Greene, *Medicaid Efforts To Incentivize Healthy Behaviors*, Center of Health Care Strategies, July 2007. There is no evidence that they are effective when coupled with reductions in premium payments. In addition, they tend to be more effective when coupled with programs that help individuals manage their behaviors, like smoking cessation and weight loss programs and gym memberships.There is no indication that the state will increase the availability of these types of treatment options.

Physicians and other health professionals testifying at the recent public hearings uniformly agreed that the identification and management of health risks are matters best left to health care providers. The proposal, assumes, without any evidence or study, that BadgerCare recipients do not receive routine preventive care and that medical professionals fail to identify "risky behaviors" and/or help their patients manage such behaviors. An approach that would better serve our clients would focus on increasing supports available to the medical community, supports such as transportation to medical appointments and case management services, instead of needless complications to the BadgerCare application process.

Finally, administering the proposed assessment and incentives will lead to increased costs and an increased burden on local agency staff who are already stretched thin. Most BadgeCare applications and renewals are completed on-line or over the phone. It is not clear how the assessment will be administered, whether local agency staff, who

are not trained in such matters, will have the responsibility of assisting applicants and recipients and how they will find the time to do so. The content of the assessment is not described, nor is it clear how sensitive confidential health matters will be protected.

Co-pays for Emergency Department Use

The proposed waiver amendment requires BadgerCare recipients who use the emergency department to pay an $8 co-pay for the first visit and $25 for each subsequent visit in a 12 month period.

The proposal makes no distinction between emergency department use that is appropriate and use that is not. It appears to penalize all emergency department use regardless of the circumstances. And while studies show that Medicaid recipients use the emergency department more than persons with other insurance, studies also show that they are in poorer health and that most visits are appropriate. Anna Sommers, Ellyn Boukus and Emily Carrier, *Dispelling Myths About Emergency Department Use: Majority of Medicaid Visits are for Urgent or More Serious Symptoms,* Center for Studying Health System Change, HSC Research Brief, no. 23,

Co-payments, like premiums and other cost-sharing mechanisms, only serve to discourage individuals from receiving care. Focusing efforts on access to preventive health care, improved care coordination, integration of health and social services, and addressing medical transportation issues would lead to improved health outcomes and be far more useful for our clients, rather than measures that serve only to penalize emergency department use.

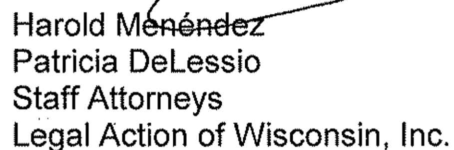
Conclusion

The BadgerCare program for childless adults operates as intended - it has reduced Wisconsin's uninsured rate, provides cost-effective managed health care to those most in need, and allows those who work to maintain their health and keep working. The proposed waiver amendments assume that recipients are not taking responsibility for their health care, abuse drugs more than the rest of the population, and need to be pushed to work. Nothing could be further from the truth. The proposed waiver amendment perpetuates unwarranted and unfounded stereotypes about recipients and needlessly increases the stigma associated with receiving public assistance.

The waiver amendment if implemented will be also be costly, wasting limited state resources, and impose a significant administrative burden on local county agencies. It will increase Wisconsin's uninsured rate, emergency department use and health care costs in general. It will neither benefit BadgerCare applicants and recipients, nor the

state as a whole. Our clients with chronic health conditions, who are struggling to both manage those health issues and work and support their families, will not be well-served by this waiver request, and will instead face numerous new obstacles to their health and well-being.

Very truly yours,



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