



COMMUNITY ADVOCATES
Where Meeting Basic Needs Inspires Hope

Public Policy Institute

Contact: David R. Riemer (414.270.2943)

**Statement of David R. Riemer, Director,
Community Advocates Public Policy Institute
to the
Wisconsin Joint Committee on Finance
Wednesday, November 9, 2011**

As you consider at tomorrow's hearing the proposals by the Wisconsin Department of Health services (DHS) to reduce the cost of Medicaid, I wanted to share with you my views on how best to achieve that goal.

I begin from the premise that any plan to cut costs must not impair Medicaid eligibility, diminish Medicaid benefits, or reduce the affordability of Medicaid in Wisconsin. Medicaid is crucial to the health and productivity of hundreds of thousands of working families in every county in the state. Any reduction in access to the low-cost, high-quality health insurance Medicaid provides will have a real effect on real people: children will die and parents will get sick as the number of uninsured rises and people who urgently need health care put off treatment.

Reducing eligibility and benefits is also a false economy. Eligibility and benefit cuts don't save money; they just shift costs. Many BadgerCare enrollees who lose coverage will still have serious illnesses or accidents, eventually ending up in local hospitals but unable to pay their bills. Their health care costs will simply be shifted to local employers—in effect imposing a tax increase, in the form of higher premiums, on private businesses. As a result, jobs that Wisconsin urgently needs will not be created.

Yet we must clearly find new and creative ways to increase BadgerCare's efficiency, reduce its cost and, in the words of DHS Secretary Dennis Smith, "use the dollars more wisely." I am confident that Wisconsin can find savings in a way that does not put an end to health insurance coverage for vulnerable families in our state.

To start, what we do in 2011 to revise Medicaid, improve its efficiency and lower its cost must take place in the context of the federal *Affordable Care Act* (ACA). We are moving rapidly towards the 2014 implementation of the ACA. To some, 2014 seems a long way off. But the reality is that many crucial decisions about how Wisconsin will implement the law—in particular, how we will structure the future relationship between Medicaid and the health insurance exchange, the new health insurance marketplace established by the ACA—are just around the corner.

No later than Labor Day of 2012, less than a year away, Wisconsin must submit to the federal government our proposal for the state's exchange. Our proposal must be built on fundamental decisions about how Medicaid in the future will interact with the "new kids on the block," the individual exchange and the SHOP exchange for businesses, which are jointly referred to simply as "the" exchange. We must have a federally approved plan in place by January 2013. That's not much more than a year down the road.

It is therefore essential that Wisconsin act quickly to develop a broad consensus on exchange legislation—including how Medicaid will work with the exchange—and then create a fully vetted proposal for the exchange’s rules, staffing, standards and system of operation.

During the very brief interim (which we’re already well into) that precedes the start-up of the ACA, Medicaid must not be damaged in ways that hurt enrollees, complicate its operation or mar its capacity to fit together with the exchange.

Above all else, during this transition period, we must not abandon people who rely on BadgerCare for their health insurance and have no other realistic alternative. Some of the most vulnerable children and parents in our state—most whom are working and struggling to get by—depend on BadgerCare for their medical care. It’s essential that no one be removed from BadgerCare or denied benefits unless they truly have another place to go to get affordable health insurance with comparable benefits. The mere possibility of coverage is not enough.

I commend the Department of Health Services on the many proposals it has made to try to avoid Medicaid cuts by increasing inefficiencies in the way the program is delivered in our state, particularly the use of Medical Homes and reforming service delivery. Rather than cut either eligibility or benefits to achieve further savings, however, DHS should pursue the following alternatives:

- In Milwaukee and many regions of the state, DHS should enter into long-term (e.g., five-year) contracts with Federally Qualified Health Centers (FQHCs) to serve the region’s entire BadgerCare population at 90% (or a smaller percentage if possible) of the lowest capitation rate currently negotiated with HMOs from the region. The state should adjust its payment after Year 1 only for the CPI.

In Milwaukee, this would involve contracting with the 16th Street Community Health Center to serve the entire BadgerCare population on the City’s south side and in all southern suburbs. The contract would be with Milwaukee Health Services and other FQHCs for the northern part of the city and the northern suburbs. The FQHCs would be required to provide—creating, if need be—multiple clinics, conveniently distributed throughout their service areas, to offer BadgerCare enrollees a wide choice of primary care providers. The FQHCs should also be required to guarantee high minimum percentages of pre-natal visits, well-baby visits, immunizations and SBIRT procedures, as well as dental check-ups, including application of coatings and sealants. The ACA contains a massive infrastructure investment that our FQHCs should take advantage of to upgrade and expand.

Possibly, enrollees could be permitted to choose instead one of the current HMOs *if* the HMO agreed to charge the same risk-adjusted per-person rate as the FQHC. But it may make more sense simply to cancel the HMO contracts.

Outside of Milwaukee, the state should look to put together the same deal with non-Milwaukee FQHCs or other integrated delivery systems. In Madison, for example, DHS might contract with the Group Health Cooperative of South Central Wisconsin, a staff model HMO that functions much like an FQHC. In north central Wisconsin, DHS might contract with the Marshfield Clinic.

- To the extent DHS continues to rely on HMOs, the department should require BadgerCare enrollees to pay the difference between the lowest capitation rate bid by HMOs and the capitation rate of any more costly HMOs they choose, up to a capped amount. This assumes that, in a region with multiple HMOs, DHS pays different rates. If that’s not true, DHS should allow for different rates in the future but require enrollees to pay the difference up to a capped dollar amount. The purpose is to create incentives for the HMOs to lower their premium bids.

- As soon as the ACA takes effect, DHS should coordinate with the Department of Corrections (DOC) and the exchange to require that, once DOC knows an inmate will be released from prison, the inmate's eligibility for BadgerCare or a qualified health plan offered through the exchange is determined well in advance of release, a health care plan and primary care physician are chosen, medical treatment information is shared, and the inmate starts getting necessary care immediately upon release. This will improve continuity of care—especially for the treatment of addiction and mental illness—as well as lower health care costs and reduce recidivism.

Above all else, Wisconsin must move quickly to create a Wisconsin health insurance exchange that is effective in controlling health insurance premiums and improving health care quality. A well-designed exchange is our only hope for bending the cost curve. As you know, the work involved in creating a workable exchange is enormous and Wisconsin has no time to spare. Wisconsin can use the work already done by the National Association of Insurance Commissioners (NAIC), which has prepared a model act; and the National Academy of Social Insurance (NASI) Study Panel on State Health Exchanges, which has outlined alternatives to the NAIC model to fashion a simple, market-oriented exchange, get its board appointed quickly, get its executive director and staff in place, and get it up and running quickly.

Once the Wisconsin exchange is established, then we can begin moving into it all BadgerCare enrollees who are above 133% of the federal poverty line. This will not only save GPR (not in this biennium, but in the future); it will also, by increasing the number of participants in the exchange, increase the exchange's capacity to lower costs for all its enrollees. Yet the risk that these former BadgerCare enrollees will lose coverage or experience a big drop in benefits—a risk DHS' current plan creates—is far less likely to occur, because of the ACA's substantial sliding-scale subsidies for people between 133-400% of the poverty line and the reasonably generous "essential health benefits" that they will receive (along with everyone else getting coverage in the individual and small group markets).

Also, starting in 2017 we should fully integrate into the SHOP exchange's purchasing pool all government employees. The pool should include all state, county, municipal and public school employees, and we should also consider adding the employees of charter schools, choice schools or other organizations that get virtually all of their money from the state. We should require that the employer contribution be limited to more-or-less the lowest premium bid, within whichever benefit "tier" (Bronze, Silver, Gold or Platinum) has been negotiated with or chosen by the employer. By including in the SHOP exchange pool this additional group of participants, the SHOP exchange pool will get close to the percentage of the state's population needed to drive the market—through the pressure of choice, competition and incentives—to lower health care costs and improve quality.

The state would see immediate GPR savings in the State Employee Health Plan and in the cost of the two-thirds school aid formula (since two-thirds of a lower cost for teachers' health care is less than two-thirds of a higher cost for teachers' health care). It is also possible to cut payments to local governments by the amount of their health care savings, thus saving additional GPR while holding local governments harmless.

With the right decisions, Wisconsin will remain a national leader in providing high-quality health care to our citizens. By making the right decisions about Medicaid and the exchange, Wisconsin can ensure that everyone in the Badger State truly has health insurance that provides good benefits and is affordable, utilizing market forces to bend the health cost curve and create more jobs.

Our state's increased health means increased prosperity for all.

Thank you.