

WISCONSIN HOSPITAL ASSOCIATION, INC.



February 11, 2010

TO: Senate Committee on Health, Health Insurance, Privacy, Property Tax Relief, and Revenue

FROM: Eric Borgerding, Executive Vice President

SUBJECT: Requested Changes to SB 484 – BadgerCare Basic

Wisconsin has a laudable record of providing health insurance coverage for its citizens. Through a combination of employer-sponsored coverage, the privatized HIRSP program and government safety-net programs, Wisconsin has the second highest percentage of insured residents in the country and, according to DHS, 98% of Wisconsin residents have access to coverage.

Wisconsin's hospitals have played a key role in helping achieve this status. It was funding from the Disproportionate Share Hospital program that started BadgerCare Core (Core) and funding from the hospital assessment that allowed expansion of Core beyond Milwaukee to the rest of the state. Enacted with bipartisan support, Core was intended to address a fraying strand in the health care safety net – providing coverage to low-income, chronically uninsured adults with no children. Hospital charity care programs and updated billing and collection guidelines have also been instrumental in helping those who fall through the cracks.

At the same time, Wisconsin's hospitals and hospital systems continue providing some of the highest quality care in the country. In 2009, the federal Agency for Healthcare Research and Quality (AHRQ) ranked Wisconsin #1 in health care quality. In 2008, AHRQ ranked Wisconsin second best in the country, down from #1 in 2007.

Amid this relatively good news, Wisconsin has experienced a steady decline in the number of employers offering coverage, particularly small businesses that cannot afford to "self-insure." The number of people who obtain their coverage through government programs, principally variations of Medicaid via BadgerCare and its expanding forms is also increasing. This trend was emerging prior to the recent economic downturn and has become more acute as the economy continues to struggle.

For various reasons, Core enrollment rapidly outpaced projections. When DHS began enrolling people in Core just over one year ago, the first year average monthly enrollment was estimated at 29,400. Today, enrollment is maxed out at 63,544 people – a nearly 160% increase in just 12 months and already 24,000 more than enrollment projected for FY11.

Clearly, Core has become much larger than originally predicted or intended. This is good news for those who would otherwise have no coverage or those who truly have no other options. Nevertheless, Core's rapid growth should serve as a caution as the state moves quickly to create BadgerCare Basic (Basic), which already has in excess of 21,000 potential enrollees, a number that is sure to grow.

We commend the Governor for continuing to seek innovative means of extending health coverage to the uninsured, especially to those who would otherwise have no (or no better) options. WHA supports a balanced public/private approach to expanding coverage. **We believe Basic can complement this approach, but it must**

be designed and implemented as a temporary safety net for those who genuinely have no alternatives. This can only be accomplished if the program is tightly managed and designed. However, SB 484 lacks key details and leaves too many important decisions outside the purview of the Legislature.

We have met on multiple occasions with DHS staff to learn more about Basic and share our thoughts, concerns and suggestions. Some of those are summarized below.

Key Program Details Not in Legislation and No Administrative Rules

Materials distributed by DHS outline the intended design and implementation of Basic, including eligibility, covered benefits, premiums and provider payment. However, these and other important pieces of Basic are addressed inadequately, or not at all, in the enabling legislation. Unlike Core, there are no federal regulatory or waiver requirements for Basic. Crucial aspects of its implementation, including increases in premiums and co-pays, expansion or reduction of covered services, reductions in provider payment (the bill does cap provider payment for service Medicaid rates), are delegated to DHS.

Typically, legislation of this nature is accompanied by administrative rules that flesh-out key details and are informed through public input. SB 484 expressly relieves the state from having to develop administrative rules for Basic, including for important elements such as benefit design, cost sharing and program administration. A change by DHS, now or in the future, to any of these elements could trigger significant adjustments to the other parts program, including enrollee premiums and provider payments. These are decisions that should be made with public and legislative input.

Requested Action: *Amend SB 484 to require key aspects of Basic be included in statute and/or clarified through administrative rule.*

Eligibility and Enrollment

According to program materials, eligibility for Basic is limited to those deemed eligible for Core. However, SB 484 does not require the state to verify that Basic enrollees qualify for Core. Core eligibility will not be verified until a slot opens in the Core program, however long that takes. Until then, eligibility is self-verified; meaning just about anyone can enroll and remain in Basic for as long as it takes a spot to open in Core. The impact this could have on the number of people enrolled in Basic and the “crowd out” of employer-sponsored health insurance and cost shifting is potentially enormous.

Requested Action: *Amend SB 484 to require eligibility verification at the time a person applies for Basic and at regular intervals while enrolled in Basic.*

Preserving the Safety Net for Those in Greatest Need

As stated above, access to both Core and Basic should be tightly defined, monitored and reserved for those who truly have no affordable options. However, affordable options with better benefits do exist for many of those who would otherwise be eligible for Basic.

For example, nearly half of those on the Core waiting list (and thus eligible for Basic) are 30 years old or younger.

Many affordable (roughly \$130/mo.) options with better benefits than Basic are available to people in this age group, including those with pre-existing health conditions.

A few of the alternatives include:

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- Affordable coverage in the individual market
- Coverage under a parent's insurance (WI law now requires family coverage to include children up to age 27)
- Subsidized COBRA coverage
- Subsidized HIRSP coverage for those with chronic illnesses/pre-existing conditions

Other health care programs, such as HIRSP, require applicants to attempt to obtain coverage through other means before being accepted. Implementing similar criteria for Basic could reduce the number of people on the Core waiting list, preserve slots in the (now capped) Core program for those who truly have no alternatives, and give a potentially large segment of the Basic-eligible population a superior package of covered services for their premium dollar.

Requested Action: *Amend SB 484 to require applicants to pursue other coverage options before being accepted into Basic.*

Alternatively, the state could bid out coverage for this population, but on a level playing field. SB 484 exempts Basic from numerous insurance regulations, including mandated benefits and consumer protections. Even with these regulations, we know that affordable options exist in the commercial market for segments of the Core waiting list. If commercial insurers were granted the same exemptions from these regulations as Basic, even more affordable alternatives may emerge.

Requested Action: *Amend SB 484 to require DHS to seek bids from commercial insurers to either cover or provide options for those on the Core waiting list. Also, amend state insurance laws so that commercial insurers could offer the same scaled-down package of benefits in their bids for the Basic plan only.*

Provider Payment and Access

SB 484 specifies that Basic will pay providers *no more* than Medicaid rates. This means payments at levels now well below cost, and that already deter provider participation in Medicaid, will be the ceiling for Basic. In the likely event that program costs exceed the \$130/mo. premium, the most likely cost saving measure will be cutting provider payments.

Coverage does not equal access. Reducing payment rates with no notice to or input from providers will deter many providers from participating in Basic and leave many enrollees with "insurance" coverage but limited access to care.

Requested Action: *Amend SB 484 to require provider payment rates to be set in administrative rule.*