WISCONSIN HOSPITAL ASSOCIATION, INC.

Assembly Committee on Federalism and Interstate Relations

Comments by
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Chairman Vorpagel, members of the Committee, thank you for holding this hearing today and for the opportunity to speak on behalf of Wisconsin's hospitals and health systems. In every corner of the state, our members are the foundation of the health care safety net, each day caring for thousands of low-income and uninsured people. Because of this, hospitals are in a unique position to identify both the positive and negative aspects of our current Medicaid program and the Affordable Care Act, and will bear the implications, positive or negative, of health care reforms.

Today more than ever, health care, and particularly Medicaid, is an issue and a debate that should not and cannot only happen in Washington, nor its outcome rest solely in the hands of Congress and the President.

No other issue intertwines state and federal policy like health care, and I believe no other issue for which decision are made in Washington has as much impact on this building and the work you all do inside it. It is very appropriate that these issues are before this committee, because the Affordable Care Act, and whatever may come next, is not solely a "federal issue". It is a debate, the result of which will land squarely in your laps, for better or worse. Hopefully, we will all work together to assure the former, because we have a great deal at stake in what comes next, and we must have voices directed toward Washington for Wisconsin.

This is why, as events in Washington have unfolded these past five months, WHA has been heavily engaged in the debate. The outcome will have significant implications for hospitals and patients throughout Wisconsin, and for state public policy, including the state budget.

When it comes to the ACA, Wisconsin is not like other states. We took a "hybrid" approach to implementing the law and expanding coverage. Our approach, frequently touted as the "Wisconsin Model", relies on two key programs to substantially expand coverage – Medicaid and subsidized premiums on the Obamacare insurance exchange.

Regarding Medicaid, many states chose the full Medicaid expansion, receiving a massive boost in federal dollars for providing Medicaid coverage to those with income at 138% ($20,480) of poverty and below. Other states chose not to expand at all. Wisconsin chose its own unique model.

Wisconsin did not take the federal Medicaid expansion dollars (which to date would have totaled $1.75 billion in federal dollars and expenditure of $680 million less in GPR), but did expand Medicaid to cover all with income below 100% of the federal poverty level, adding some 130,000 people who are "in poverty" to Medicaid. This is important to note and understand. Wisconsin Medicaid now, by and large, covers only those below the federal poverty level, those who are "in poverty", those making less than $11,800 per year. That reduction in eligibility, that focus on those "in poverty", in and of itself, is a significant Medicaid reform that we should not lose sight of.

Indeed, Wisconsin, despite rejecting Medicaid "expansion" has added more people to Medicaid than five of the states that accepted Medicaid expansion. Further, WI has a lower uninsured rate than 25 of the 31 states that adopted full Medicaid expansion. By any normal measure or definition, we expanded coverage and expanded Medicaid. But, the ACA, and its replacement the AHCA, use a different dictionary, one that relies on the Washington definition of expansion.

Here's why I say that - the Obama Administration defined "expansion" as making people with incomes up to 138 percent of the federal poverty level (FPL) eligible for Medicaid, regardless of how many people a state might actually add to Medicaid. In other words, expand their way and the Feds would cover up to 90 percent of the cost of doing so … expand a different way, receive no enhanced funding. This makes no sense for a state like Wisconsin, and we believe Congress and the President should now redefine Medicaid "expansion," including recognizing how it has been and, as importantly, how it can be achieved.

Here's why they must - after rigorous debate, Wisconsin rejected Obamacare-defined "expansion" but instead, and as I previously noted, added 130,000 people below 100 percent FPL, those "in poverty," to Medicaid. But according to Washington, this was not "expansion", and thus not eligible for enhanced federal funding. It is a consummate example of Washington's "our way or the highway" mentality that has created a state patchwork of Medicaid haves and have nots that is proving one of the biggest snags in the effort to repeal the ACA.

Our rough estimate puts the added cost to Wisconsin for not "expanding" Medicaid the Washington way, (despite adding 130,000 impoverished people to our Medicaid program) at about $280 million per year. In other words, 31 states receive nearly 100 percent federal funding for the exact same population that Wisconsin now spends hundreds of millions to cover. Since 2014 we have been essentially penalized upwards of one billion dollars GPR for expanding coverage to 130,000 of our most vulnerable, impoverished citizens. Ironically, this could also mean Wisconsin will receive fewer federal Medicaid dollars under new funding formulas and spending caps now being considered in the Obamacare replacement.

This is more than a math exercise. These are dollars Wisconsin could use expand our diminishing health care workforce, train more primary care doctors and nurses, improve access in underserved rural and urban areas, boost reimbursement and reduce Medicaid cost shifting to employers and families, or even creating our own low income insurance pool should Congress eliminate the income-based premium subsidies that have been so important to the Wisconsin Model of coverage expansion..

For Wisconsin, this is an issue that should transcend the partisanship of the ACA or expansion debate. It is about fundamental fairness that our state and federal elected official should coalesce around in demanding a change.

For example, we agree with, and support, the proposal forwarded last month by the Republican Governors of four Medicaid expansion states (Ohio, Michigan, Nevada and Arkansas) that would give states like Wisconsin the same level of federal funding as the so-called expansion states (see page two in our March 20 letter to Governor Walker).

We agree with the co-chairs of the Joint Finance Committee, Rep. Nygren and Sen. Darling, when they said, in a February 24 letter to the Wisconsin Congressional Delegation "We are asking that you once again stand up for Wisconsin and insist that we are treated fairly by receiving the same level of Medicaid funding that other expansion states receive going forward."

And, we agree, again, with Rep. Nygren and Health Committee Chair Rep. Sanfelippo, who said in a March 10 statement "We are calling on Wisconsin's Congressional delegation to amend the American Health Care Act (AHCA) …This legislation needs to be improved by placing Wisconsin's Medicaid program on equal footing with states that took the federal Medicaid expansion."

When it comes to Medicaid, the ACA, and its proposed replacement the AHCA, both pick winners and losers based on an arbitrary multiple of the federal poverty level, *not on how many people are actually covered.* That is unfair to Wisconsin, especially when one remembers that the goal here is to expand and sustain, not penalize, coverage. It is a fixable flaw that our elected leaders in Washington and Madison should insist be remedied in whatever replaces the ACA.

However, equity in Medicaid funding is only one aspect of the effort to repeal the ACA that must be taken into account for Wisconsin. A second and equally important component of the Wisconsin Model for coverage is a well-functioning private market that allows tax subsidies based on income so that low-income individuals and families can afford coverage. The tax credits proposed in the AHCA did not go far enough and could leave thousands in here who have benefited from the Wisconsin Model, without an affordable option.

While rejecting one element of Obamacare (Medicaid expansion), the Wisconsin Model very purposefully, and very heavily, has relied on another element of Obamacare, its income-based insurance premium subsidies, to expand coverage. Over 190,000 people have used the Obamacare subsidies to purchase coverage in Wisconsin, most heavily in our rural areas. It is also the Obamacare exchange, and those subsidies, that Wisconsin very purposefully relied on when we both rejected Medicaid expansion and rolled back eligibility to 100% FPL. In 2014, about 60,000 people with income between 100% and 200% of the federal poverty level were moved off of Medicaid because subsidies were available to help them purchase private coverage.

The fact is, we cannot tout the Wisconsin Model and the 38% reduction in the uninsured it has achieved, nor can anyone point to how we have expanded coverage while rejecting Obamacare Medicaid expansion, without also acknowledging, at the very same time, how instrumental the Obamacare premium subsidies have been in achieving these accomplishments.

Just as important as the level of the tax subsidies, is the overall stability of the insurance market. We are seeing reports of insurers exiting the ACA's insurance exchanges across the country. We are fortunate in Wisconsin that in nearly every county, there are two or more insurers participating in the exchange. Wisconsin has one of the most competitive markets in the country, which is something we should be proud of and continue to support. However, to the extent problems in the insurance exchange are not addressed, this market could be in jeopardy.

If the subsidies are not sufficient or the market overall fails, so does the Wisconsin Model of coverage. And if that happens, then a key element in Wisconsin's decision to reject full Medicaid expansion also disappears.

Wisconsin has a proud tradition of high quality, high value, and high access health care. This success is well documented and does not come by chance. It is the result of the commitment of hospitals and health systems across the state and the dedicated and compassionate staff who serve their patients. And it is enabled by good public policy – something we work very hard with you and the Governor to try and achieve. We are proud to represent hospitals and health systems that, together, have helped to build this reputation which is envied across the nation. Our strong interest is in working with you to support and sustain access to this high quality care.

Thank you for holding this important hearing today, and thank you for the invitation to speak. I am happy to answer any questions.