State of Wisconsin
Department of Health Services

Scott Walker, Governor
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Statement of Dennis G. Smith

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Committee on the Budget Hearing on

The Fiscal Consequences of the Health Care Law

U.S. House of Representatives

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Thank you, Chairman Ryan, for convening this important hearing, "The Fiscal Consequences of the Health Care Law." Ranking Member Van Hollen and members of the Committee, I appreciate the opportunity to join you today to examine the fiscal consequences of the Patient Protection and Affordable Care Act (PPACA). The impact of the PPACA on state budgets, families, individuals, employers, the health insurance industry, health care providers, and our national economy is still slowly rising above the horizon and has yet to come into full view.

Wisconsin has an important and impressive story to tell that may be useful in the ongoing national debate over this controversial new law. Wisconsin has been a leader and innovator in health care reform for more than two decades. In Wisconsin, a higher percentage of our citizens already have health care coverage than has been forecast for national peak coverage. According to the Centers for Medicare and Medicaid Services (CMS), the percentage of our citizens with health insurance coverage will reach nearly 94 percent at its peak. However, the University of Wisconsin Population Health Institute estimates that nearly 95 percent of Wisconsin citizens already have access to health insurance. Wisconsin has achieved this high level of coverage without an individual mandate and without guaranteed issue, while maintaining a robust and competitive insurance market.

The Wisconsin Department of Health Services (DHS) has retained expert actuarial consultants to analyze the impact of PPACA on individuals, employers, and the various insurance markets. While our work still continues and we understand that the federal government must resolve a number of substantial issues before we will know the full fiscal impact of PPACA, there are some preliminary findings that we hope will be helpful. Further, the state is developing a sophisticated mock-up of a web-based intake system that might be

considered a first generation of how parts of an exchange might work in terms of eligibility and selection of health plans. We hope the experience of Wisconsin will be helpful as Congress and the Administration make critical decisions that must be made over the next 18 months, well before the major parts of PPACA go into effect.

The prospect of adding another 16-20 million individuals nationally to Medicaid is clearly a concern for the states both in terms of financing and in providing access for the Medicaid population. Wisconsin currently faces a Medicaid shortfall of about $214 million in the current fiscal year that must be closed by the end of June. For state fiscal year 2012 and state fiscal year 2013, the combined Medicaid shortfall is about $1.8 billion. We know that we are not alone as most states are also struggling with increasing caseloads in a weak economy.

The best solution to ease the tremendous pressures on state budgets is to get people back to work. Between February 2008 and December 2008, our monthly enrollment of children increased by 15,691. Our monthly enrollment of adults with children during this same period grew by 12,500 (February is used for comparable available data among groups; pregnant women and childless adults are not included as program changes were implemented that affected enrollment). Between December 2008 and December 2009, our monthly enrollment of children increased by 55,802 and the monthly enrollment of adults with children grew by 46,837. In other words, enrollment between December 2008 and December 2009 grew three times faster than between February 2008 and December 2008.

In December 2010, our monthly enrollment of children had increased by another 15,357 from the previous year and adults with children increased by 28,621. So in December 2010, our monthly enrollment of children and adults with children was nearly 174,000 higher (32 percent) than in February 2008. Our total Medicaid enrollment surpassed 1 million individuals for the

first time in June 2009 and in December 2010, enrollment reached 1,159,153 individuals out of a statewide population of roughly 5.5 million people. According to Census Bureau estimates, there are 1.4 million children in Wisconsin, of which 374,615 are below 150 percent of the Federal Poverty Level. So current enrollment represents 109 percent of the Census Bureau's estimates of the number of children below 150 percent FPL in 2008/2009 and about 30 percent of all children in Wisconsin.

Getting everyone fully back to work would have a significant impact on the state budget. By way of comparison, if enrollment were to return to the February 2008 levels, the combined federal and state savings would be more than $1 billion.

Some of the most important reasons and assurances originally given for the enactment of the new law appear to be fading. Individuals indeed will lose their current coverage. The cost of health care continues to go up, not down. And most important of all, the promised level of savings for American families will not materialize. We estimate that PPACA will cost the taxpayers of Wisconsin $560 million per year. And, this figure assumes relatively little loss of employer sponsored health insurance. Since Wisconsin has already achieved much of what is envisioned under PPACA in terms of coverage and without the most controversial provisions of the new law, the people of Wisconsin will want to clearly understand what, then, is the gain to be realized?

We estimate that the additional state cost associated with the Medicaid expansion provisions of PPACA from 2014 to 2019 will total $1.12 billion. These costs will occur due to the addition of approximately 85,000 childless adults, the woodwork effect and take-up rates of individuals currently eligible but not enrolled, and additional months of coverage that will be added by reducing the "churning effect."

These costs will be partially offset by the reduction in enrollment of approximately 122,000 children, parents/caretakers, and pregnant women with income above 133 percent FPL who are already currently enrolled. The movement out of Medicaid to the new federal tax credits will save the state approximately $579.4 million between 2014 and 2019. This will reduce the state cost of PPACA to $543 million.

PPACA includes enhanced matches for the State Children's Health Insurance Program (SCHIP) that we estimate will reduce the cost to the state by another $109 million, leaving the net cost of PPACA to the state of $433 million.

However, this net number will be impacted by the pending federal policy decision about the definition of maintenance-of-effort (MOE), who is a newly eligible individual, and whose income is counted in determining eligibility. If, depending on these definitions, the federal government "buys out" our childless adult population, we estimate that cost to the federal budget will be nearly $1 billion, which then would become additional savings to the state to offset our costs. It is unclear whether the Congressional Budget Office (CBO) or the Office of the Actuary at the Centers for Medicare and Medicaid Services (CMS) have assumed the federal government would buy out all of the states' childless adult programs in its fiscal analysis of PPACA.

But simply switching from state dollars to federal dollars does not buy additional coverage. At the end of the day, it matters little to taxpayers whether they are paying for the cost of PPACA through their federal income tax to finance new entitlement spending or higher debt, their state income tax, their local property tax, or higher premiums. There is no doubt PPACA will move hundreds of billions of dollars around in additional benefits and additional costs. It appears that the net impact per family will likely break around 350 percent of FPL. That is, if your income is below 350 percent FPL, the additional benefits of PPACA will be greater than the

additional costs to you. But if you are above 350 percent FPL, the additional costs will likely be greater than the additional benefits. Median family income in Wisconsin for a family of four is equal to about 400 percent FPL. In other words, the additional costs of PPACA will exceed the additional benefits for a majority of individuals and families in Wisconsin.

One of the major promises of health care reform was that individuals would keep their current coverage. This clearly will not be the case. At least 457,000 people in Wisconsin will likely be displaced from their current coverage. This includes 160,000 individuals from the individual market, 175,000 individuals from employer-sponsored coverage and 122,000 individuals, including children, who are currently in our public programs. Analysis of the impact on small group coverage is ongoing, but it is likely that there will be disruption in that market as well. Moreover, the level of losses in employer-sponsored health insurance is widely debated.

Insurance generally involves the assessment, management, and mitigation of risk. PPACA seems to invite risk. It is fair to conclude that no one really knows, for example, how employers will behave, especially in these times of economic uncertainty. Actual experience in Wisconsin also shows how difficult it is to predict total costs because of the variance in the estimates of the numbers of uninsured and the uncertainty about take-up rates. For example, in comparing actual enrollment numbers to the estimates of uninsured children according to the U.S. Census Current Population Survey (CPS), the take-up rate for children with family income below 150 percent of the Federal Poverty Level (FPL) thought to be uninsured was 107 percent and the take-up rate for children with family income between 150 percent and 200 percent FPL thought to be uninsured was 140 percent.

Our actuaries estimate that 46 percent of individuals who will move into public subsidies either through Medicaid or the new tax credit entitlement already have private coverage. When

you add in the federal "buy out" of existing state coverage, a substantial amount of the new federal spending will simply replace federal dollars for existing private sector or state dollars without insuring a single new individual.

Our actuaries' analysis clearly shows that PPACA creates winners and losers. Looking back on the debate over PPACA, important details were missing or blurred as data was aggregated and averages masked significant swings among age groups. For example, according to the preliminary actuarial analysis conducted for the state, overall premiums for the individual market will increase 6.6 percent. However, when we look at member distribution, the variation across groups is significant. 75 percent of those in the individual market will receive an increase in premiums with an average impact of nearly 25 percent. The other 25 percent will receive an average decrease in premium of nearly 20 percent. Moreover, 30 percent in the individual market will face premium increases between 25 and 50 percent and 8.5 percent will face increases of more than 50 percent. Clearly, it will be cheaper for many individuals to simply pay the new federal tax to remain uninsured, knowing they will be able gain entry to the market at a later time. Such dramatic swings will not stabilize the market, they will disrupt it.

Policymakers should look closely at those who face these premium increases. Those who receive a decrease in premium have an average age of 48 while those who will receive an increase in premium have an average age of 31. In other words, the younger, working age population that generally have lower earnings and face the greatest costs associated with raising children will face substantially greater premium increases than those older individuals who are reaching their peak earning power and face lower costs associated with raising children.

Of the individuals our actuaries estimate will enroll in coverage through the health exchange, two-thirds already have coverage through employer-sponsored health insurance or the non-group market.

We are also concerned that greater federal regulation could lead to fewer health plans available to the people of Wisconsin. An individual in the Madison zip code area can choose from 12 health insurance companies offering a total of 324 plans. There are more than 30 companies offering a health insurance product in the individual and small group market throughout Wisconsin. The largest company in terms of premiums has just 12 percent of the individual market. That is a healthy competitive environment that the federal government should not interfere with. But PPACA requirements on benefits and rating practices will significantly disrupt the current individual and small group markets.

Wisconsin can also provide a glimpse into the changes ahead in the insurance distribution system itself as consumers gain access to health exchanges. Our online application tool, ACCESS has recently been highlighted by the Kaiser Commission on Medicaid and the Uninsured in its brief, *Optimizing Medicaid Enrollment: Spotlight on Technology*. ACCESS was developed, implemented, and enhanced over a period of 7 years and allows individuals and families to apply for medical assistance, childcare, and food stamps. While technology can improve productivity, it costs about $287 to process an application at the county level.

While ACCESS is an important tool, our experience demonstrates that reliance solely on a technology will not work for many individuals. The University of Wisconsin Population Health Institute recently concluded an evaluation on the utilization of ACCESS and found that the choice of application methods and the accuracy of enrollment systems vary significantly. ACCESS applicants were the *least* likely to be determined eligible for coverage compared to

phone applications, walk-in, and mail-in applications. Only 69 percent of ACCESS applicants turned out to be eligible, suggesting an exchange will handle a high volume of individuals who will not be eligible for Medicaid or the new tax subsidies. Our own exit survey on the health insurance prototype shows that one-third of individuals responded that the tool did not provide enough information to make a decision on finding and purchasing health insurance. Finally, our experience with auto-enrolling childless adults shows substantial churning among individuals. There are clearly limitations and risks associated with reliance on sharing information across various government databases.

ACCESS and our prototype are exciting and impressive tools. We are already well ahead of most states in building these on-line tools. But what we have built is still the easier parts. We estimate it will still take us another 2.5 years to implement the core functionality of an Exchange. That assumes the federal government will release all necessary guidance in a timely manner and that we will be able to leverage only the systems we currently have. While we are and should be optimistic, we also need to be realistic.

To put this in context, consider that the planning and development of a new Medicaid Management Information System (MMIS) is a 9 to 12 month process. Procurement itself takes another 12 months. It took the state 46 months to implement our new MMIS and another 6 months to obtain CMS certification for a total of 76 months. Is it realistic that this timeframe can be cut in half across the nation? If all of the various federal agencies involved in the implementation of exchanges cannot complete their work this year it is difficult to imagine how 50 states and the District of Columbia will be able to meet the readiness assessment required by law in 2013.

Mr. Chairman, implementation of PPACA as the law currently stands will cause a significant disruption across the nation. There is still a great deal of uncertainty as to the impact of PPACA on state and family budgets, on workers, and employers. Wisconsin already has achieved the coverage rates aspired to under PPACA. We have a strong, competitive health insurance market, which we want to preserve and protect. All of the gains Wisconsin has made should not be put at risk.