State of Wisconsin
Department of Health Services

Scott Walker, Governor
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Statement of Dennis G. Smith
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On "State of Uncertainty: Implementation of PPACA's Exchanges
and Medicaid Expansion"
Subcommittee on Health
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Chairman Pitts, Ranking Member Pallone, and members of the Committee, thank you for the opportunity to participate in today's important hearing, "State of Uncertainty: Implementation of PPACA's Exchanges and Medicaid Expansion." Although additional guidance was released by Secretary Sebelius on Monday, there is indeed still a great deal of uncertainty across the country as we are now less than 10 months away from when health insurance exchanges and eligibility changes to Medicaid systems must be operational. We believe the actual experience of many Americans will be different from the expectations that have been created. Thus, a good deal of irony will follow the uncertainty.

Today's hearing is focused on implementation, not policy. Accordingly, my remarks are intended to focus only on the challenges of implementation. It is not my intent to neither re-open past policy debates nor prolong current ones. However my avoidance of those policy discussions, in which there is great passion on both sides, should not be mistaken for support of the positions taken by the Obama Administration. Let me also be clear that Wisconsin Governor Scott Walker has not yet made a decision on a Medicaid expansion. Of course, taxpayers pay 100 percent of the cost regardless of

whether the funding comes from a state account or a federal account. Moreover, funding is not the only consideration for us and other states. The decision whether to expand Medicaid or not may also depend upon whether the federal government will relinquish some of its program control. We strongly believe that Medicaid for working families should be efficient and effective as well as more equitable. I would respond to those who insist that states cannot be left to act in the best interests of their citizens that more than half of the cost of Medicaid occurs because states that have expanded beyond the federal mandated requirements and also remind them of the success of the state Children's Health Insurance Program.

The Reality of the Current Budget

While today's hearing topic is uncertainty, I would like to share some of our realities. The cost of our current Medicaid program continues to increase while the percentage of the Wisconsin Medicaid programs paid with federal funds continues to decrease. Without budgeting for the implementation of PPACA, we have requested an 8.9 percent increase in general revenues for state fiscal year 2014. This compares to the 3.6 percent request for all state agencies and a 3.8 percent increase in general purpose tax revenues. If our request is approved by the Legislature, my Department will take nearly half of all additional tax revenues coming into the state next fiscal year. Included in our request is an increase of $196 million over the 2013-15 budget to make up for the lower match rate we will receive from the federal government during this period. We face other increased state costs to pay for Medicare obligations and a higher state contribution to fund the Medicare Part D drug benefit because of the federal government's inability to control the cost of Medicare.

In the current negotiations surrounding the "fiscal cliff," states are understandably concerned about potential cost shifts from the federal government to the states. In fact, Governor Walker, along with five other governors met with President Obama last week at the White House and expressed this very bipartisan concern.

In regards to the economy, even though the unemployment rate has declined, we have nearly 200,000 more parents, caretakers, non-disabled childless adults and children on Medicaid than were enrolled in July 2008. With Medicaid enrollment 25 percent higher than pre-recession levels, the best solutions will be found in getting the economy back on its feet again and everyone fully back to work.

Who is Currently Uninsured in Wisconsin?

The Current Population Survey (CPS) and the American Community Survey (ACS) estimate the total number of non-elderly uninsured individuals to be 553,600 (out of 558,400 total uninsured) out of our total population of 5.7 million people. In other words, more than 90 percent of our citizens already have health insurance coverage. If all of the individuals who are currently eligible for Medicaid would enroll today, our coverage would be nearly 93 percent. Accordingly, a primary consideration must be to do no harm to Wisconsin's current system of health insurance.

From the 553,600 non-elderly individuals who are uninsured, 267,200 are below 133 percent of the federal poverty level (FPL). Of these, 41,300 are children and 45,843 are parents/caretaker adults who are already eligible for Medicaid. There are another 26,200 children in families with income between 133 percent and 300 percent FPL who are uninsured but likely eligible for Medicaid. Therefore, approximately 113,000 individuals, or 20 percent of the total number of uninsured individuals are already eligible

for Medicaid. The state would not receive the 100 percent federal match for enrolling any of these individuals.

We estimate there is a total of 178,461 childless adults below 133 percent of FPL who are uninsured for whom the state would receive the temporary 100 percent match rate. Of these individuals, 130,350 childless adults are below 100 percent FPL. For the 48,000 individuals between 100 and 133 percent FPL, The U.S. Department of Health and Human Services (HHS) confirmed earlier this week they will be eligible for the tax subsidies if we do not expand Medicaid eligibility.

There are 21,709 childless adults currently enrolled in Medicaid. Even if HHS determines this group to qualify for the 100 percent federal match rate for these currently enrolled individuals, the additional payment for them clearly will not offset the cost of increasing Medicaid enrollment by 113,000 of the parents and children who are currently eligible. Thus, those who once believed that PPACA would be a windfall to the state budget will be disappointed. It is not reasonable or prudent to make budget decisions on the hope that only certain individuals who have the highest match rate will enroll. It is also important to recall that PPACA expanded Medicaid because it was cheaper for the federal government to have individuals in Medicaid rather than pay out tax subsidies.

Four Areas of Uncertainty

Even with some of the additional limited guidance HHS provided earlier this week, PPACA represents massive disruption to the distribution system of health insurance. To participate, will the health plans be required to hold financial risk as well as medical risk? Simply put, who pays and who collects? At this point, we do not know

how advanceable tax credits will be transferred from the federal Treasury to a health plan. Nor do we know how the low income subsidies for cost sharing will be processed.

Insurers are struggling with great unknowns as to how to price their products. Without utilization data, it is difficult to determine rates that will be actuarially sound and competitive. Everyone simply needs to know what the rules are in order to be compliant.

Getting at the heart of today's hearing, we find uncertainty and unforeseen outcomes in four areas: administration, affordability, cost, and simplification.

Administration

In addition to the 553,600 non-elderly individuals who are uninsured in Wisconsin, there are 180,000 people currently through the individual insurance market who will presumably want to shop the exchange. Another 360,000 individuals receive coverage in the small employer group market and are likely to be interested in at least browsing the exchange. Add in some employees from large employers and families in Medicaid whose income is above 100 percent FPL, and it is easy to envision that 1.5 million people in Wisconsin alone, more than 25 percent of our population will hit the health insurance exchange looking for the lower cost and, better coverage promised by the federal government.

To put this in greater perspective, even if only 20 percent of Americans try out the new exchange tool – one in five Americans, that is more than 62 million people nationwide. Or in other words, approximately the entire state populations of Wisconsin, Florida, and California combined. This is a reasonable assumption as the PPACA forecasts 36 to 40 million covered lives will be churned through the health insurance

market. All of these 36 to 40 million people will go through the new federal data services hub ("the Hub") to verify financial and non-financial eligibility information.

Many of these individuals will not know whether they are eligible for Medicaid, tax subsidies, or not eligible at all. Many of these individuals will not be comfortable using only online information and will want to talk with a live person who can assist them. Our experience in Wisconsin in this regard might be instructive. For the 12-month period of October 2011 through October 2012, the Department and our local government partners received a total of 379,450 applications for assistance. As the table below shows, 38 percent of the applications were handled in person, by telephone or mail.

Method	Volume	Percent
▪ In Person	36,687	10%
▪ Phone	31,117	8%
▪ Mail-In	77,013	20%
▪ On-Line	234,633	62%

Projecting the Wisconsin experience of processing eligibility and enrollment applications on a population of 40 million people yields the following results:

Method	National
▪ In Person	4,000,000
▪ Phone	3,200,000
▪ Mail-In	8,000,000
▪ On-Line	24,800,000

Assuming the federal government will end up processing half of the applications (participating state based exchanges and partnership states the other half); it will need to prepare to handle applications for seven million people who will conclude the internet does not meet their needs. Further, it is likely that a portion of the individuals applying on-line will require assistance from an eligibility worker. In Wisconsin, workers assist individuals on seven percent of those applications on-line. Most importantly, in Wisconsin each and every application submitted online requires review by an eligibility

worker, and while HHS envisions a streamlined process that does not require such review, one has to question how much fraud and abuse will go unchecked or the tax burden that individuals may face when the IRS attempts to reconcile at tax time. There is little to suggest the federal government is prepared to handle this volume or what the contingency plans are to ensure quality service to consumers.

We are very concerned that the lack of federal preparation will mean many of these people will turn to our local and county agencies by default and in frustration. It costs $150 to process each application regardless of whether someone turns out to be eligible. We have estimated that it may cost nearly $50 million over the next biennium in local and county eligibility worker costs to accommodate the increased volume as a result of the exchanges and a possible Medicaid expansion. With additional costs associated with systems changes, we estimate the total administrative cost to reach $65 million over the next biennium ($29 million state share).

Technical specifications related to the federally facilitate exchange (FFE) and federal data services Hub are just now starting to be released and HHS has stated publicly that the specifications are not complete and will be continuously updated. States do not have resources sitting on the bench waiting for HHS to provide complete information, and will be unable to integrate with the FFE on the timeline established. In building systems, especially when dealing with something so complex, sensitive, and critical as eligibility, you build, test, revise, and then implement. States are now in a position where they must accept the fact that work completed to date must be reviewed and significant rework may be required to comply with the ever changing federal guidance. To complicate this even more HHS has placed too many conditions on the enhanced funding

for systems development. Frankly, the most prudent decision for a state may be to forego changing their systems and avoid the Hub.

In short, we are not confident that the federal government has adequately prepared for handling an unprecedented number of applications, verifications, and enrollments. This leaves us uncertain on whether the federal government will be ready to effectively administer this program less than 10 months from now.

Affordability

The federal government insists that health insurance will be more affordable. But what is affordable will be decided by people, not government rulemaking. People do not always live their lives according to the assumptions made by government officials. Some Wisconsin residents will pay more and be required to purchase richer benefits than they choose to purchase today. Even after the application of tax subsidies, 59 percent of Wisconsin's individual market will experience an average premium increase of 31 percent.

40 percent of people currently in Wisconsin's individual market will be required to purchase benefits beyond their current coverage. This will likely lead to unnecessary utilization and increased health care costs which ultimately circles around to increases in premiums and cost sharing.

Since July, we have been applying the PPACA premium rules to adults on Medicaid with income at or above 133 percent FPL. Adults are required to pay the same percentage of their income now as they will be required beginning January 1, 2014. The premiums begin at 3 percent of income at 133 percent FPL and increase to 9.5 percent.

The results on average are consistent with our assumptions about participation rates. Overall, 77 percent are paying the required premiums. But as the premiums increase, participation declines. Individuals do not typically think about payments as a percentage of income, they view prices in absolute dollar terms. Enrollment of individuals with income between 200 and 300 percent FPL with an average monthly premium of $207.00 has dropped by 52 percent.

In Wisconsin, individuals at the lower income levels are more consistently paying their premiums compared to individuals at higher income levels. The results to date suggest that there may be an affordability "donut hole" for individuals that question the value of the health care that they will be required to purchase. If healthy individuals indeed conclude that their premiums are greater and the value of the benefits are less than meets their expectations, the Exchange could become a national high risk pool. If healthy individuals deem health insurance at PPACA prices to be unaffordable and risk paying the small penalty while assured of being able to get coverage later, the number of uninsured individuals will increase, not decrease.

And ultimately, we still do not have final rules on two fundamental issues – who is eligible and how will a health plan get paid – leaving us again uncertain about the affordability of PPACA.

Cost

The federal government assumes that adding 36 to 40 million covered lives to the health insurance market will lead to increased competition and a reduction in (premium) costs. But PPACA also fragments the market by separating the non-disabled, non-elderly

Medicaid population from the rest of the insurance pool, even by separating children from their parents.

We are concerned that the federalization of health insurance will lead to consolidation among health plans, which will ultimately drive costs higher yet. The big insurance companies can afford to become the banker if that is what the payment system demands.

The impact on employer sponsored insurance is perhaps the greatest unknown. We have 180,000 people in the individual market. There are more than three million lives in the large group market. Some health carriers fear its erosion, while others are planning for it and positioning themselves for massive employer disruption over time. It is not difficult to see that the large health plans that can play in all four spaces—large group, small group, individual, and Medicaid—can squeeze out the smaller, regional companies.

We see consolidation throughout the health care sectors—pharmaceuticals, hospitals, and physician practices. Federal officials frequently convey their belief that PPACA will stimulate competition. It is not difficult to foresee the opposite may occur.

Even if a state chooses not to expand Medicaid and enrollment remains as is, the effects of PPACA will still likely increase costs on the state in direct and hidden ways. Here are just two examples. First, the new tax on health plans will hit our Medicaid managed care plans. We have 700,000 people enrolled in managed care plans and those plans are certain to demand an increase in rates in order to pass the tax back to the taxpayers. If a health plan wants the privilege of marketing through the FFE, it will cost the plan another 3.5 percent of premiums. Here is a new twist on intergovernmental

transfers. The Centers for Medicare and Medicaid Services (CMS) will pay the Wisconsin Department of Health Services to make payments to managed care plans which will then pay the money back to the Internal Revenue Service (IRS). Collections by the IRS will increase – courtesy of CMS and the State of Wisconsin.

Additionally, while the federal government will cover the benefit costs of the primary care provider rate increase for Medicaid to match Medicare rates over the next two years, states are still required to pay for a portion of the administrative costs to implement the changes. Coupled with the fact that HHS just released final guidance on the provision only increases the administrative burden on states to develop a retroactive change to re-process claims and adjust them to the new rate. Of course, we are faced with the uncertainty of what happens after the temporary adjustment and federal match rate increase expire. Repeating the federal experience of the Medicare "doc fix" is not an appealing prospect.

Second, health care providers are also employers and will be affected by the mandate to provide health coverage to their own workers or pay a tax penalty. This may particularly affect small and mid-size employers such as personal care agencies or nursing homes that employ lower skilled workers. The Medicaid personal care rate is $16.08 per hour. Let's assume the average full time worker bills 1,500 hours a year and generates $24,000 of Medicaid revenue per year. If the provider chooses the less expensive option and elects to pay the $2,000 per employee penalty (excluding the first 30 employees), that works out to about eight percent of revenue per employee. The employer, of course, will expect an increase in Medicaid rates to offset the new cost.

In addition, Medicaid will have to compete against the new federal subsidies for providers. It is only prudent to anticipate that at some point, the state is certain to be forced to increase provider rates in order to ensure access for the Medicaid population. The amount of those increased rates, of which there is no additional federal match, remains uncertain at this point, adding to our overall uncertainty about the overall costs of PPACA.

Simplification

HHS seeks to create a streamlined process and application so that there is "no wrong door." In reality, HHS will force Wisconsin to make the current process and application more complicated. Wisconsin already has a streamlined, integrated eligibility application for Medicaid/CHIP, FoodShare (SNAP), TANF, and W2 and supports online application submissions. Each federal agency is establishing its own data use rules governing how the data can be used. For example, the IRS has indicated that the information provided by their agency through the new federal data hub can only be used for insurance affordability programs, the data cannot be used for determining eligibility for FoodShare. For Wisconsin this means that we will need to uncouple—not streamline—our integrated process. There is no added value to Wisconsin for integrating with the federal data Hub, only increased administrative cost and rules to follow to do what we already do today.

While federal officials talk simplification, implementation of PPACA seems to be going in the opposite direction. CMS needs to move to simpler solutions instead of more complex ones such as relying on the Hub which does not even exist today. We have yet to be able to match Social Security numbers with the Social Security Administration

(SSA) on a real time basis. Negotiations to do so have taken more than a year to complete, with more than 10 months to develop the integration with SSA at a total cost of $800,000. The insistence that the Hub, with integration to the SSA, IRS, and DHS, is going to be operational in 10 months is highly questionable.

MAGI-based eligibility rules are a set of new household composition and income counting rules established by PPACA. MAGI refers to "Modified Adjusted Gross Income," which is defined by U.S. tax code and will be used as the basis for determining Medicaid and CHIP eligibility for certain populations starting in 2014. There is no additional federal funding for the increase in enrollment due to covering to MAGI. In addition to changing which types of income and expenses are counted, MAGI introduces tax filing status and tax relationships as new factors in determining how households are tested for eligibility. The new rules are highly complex and will require massive systems and operational changes by state Medicaid agencies between now and January 2014.

MAGI, by virtue of basing eligibility on tax filing status and tax relationships, creates significant inequities in eligibility results for families that are nearly identical in make-up. It is expected that these complex rules will cause mass confusion for Wisconsin residents. Furthermore, it seems unreasonable to expect families to understand that how they file their taxes at the end of the year will impact the health insurance options available to them. Additionally, it is unclear how states are going to successfully implement these rules and explain them to customers without requiring local and county eligibility workers to become tax experts.

A few examples of the inequities and complexities of migrating to MAGI are attached as Appendix A.

The FFE will begin using MAGI to assess/determine eligibility for state Medicaid/CHIP programs in October 2013, even though it does not take effect until January 1, 2014. The FFE will verify income through the federal data Hub using IRS data. This method of verifying income will lack accuracy for many of those at lower income levels that are not required to file income taxes or whose records are not current. Medicaid agencies in most cases will need to confirm current income and may have to maintain dual systems to accommodate these referrals from the FFE to test eligibility under current determination rules as well as MAGI.

The FFE may tell consumers it looks like they are eligible for Medicaid based on the individual attesting to their income and then refer them to the Medicaid agency, but Medicaid may tell them they are not eligible because the FFE is not verifying attestations, or because they are not eligible based on current determination rules. This is hardly going to be a customer-friendly situation. Further, families that apply to the FFE may be sent in two different directions. Families with incomes between 133 percent and 300 percent FPL will be split with parents and caretakers enrolling in qualified health plans through the exchange and children being referred to states for enrollment in Medicaid. Again, we are uncertain that the federal government's attempt at simplification will actually benefit consumers and states.

Conclusion

Finally, in a previous governmental role, I served at the Centers for Medicare and Medicaid Services (CMS) during implementation of the Medicare Modernization Act of 2003 (MMA). The history of MMA holds some useful lessons for the topic at hand. In implementing a major new program, money is always important but timing is just as

critical to success. MMA was signed into law in December 2003, and the final rule was promulgated 13 months later in January 2005, giving everyone almost a full year to understand the rules before the benefits were to begin. Insurers were able to begin marketing plans in October 2005 and enrollment into the new Part D benefit began on November 15, 2005 for January 1, 2006 coverage.

Bear in mind that PPACA is far more complex than MMA. In MMA, we knew exactly the universe of people we were going to serve. We knew a great deal about their utilization of health care. We had a well-functioning enrollment system called the Social Security Administration that seniors knew and trusted. The average premium turned out to be about $5 less than original estimates. We had solid partnerships with all 50 states and the District of Columbia that filled some critical roles at critical times. There were multiple partners at multiple levels. Redundancy provided us with some flexibility to make last minute adjustments when things did not go exactly to plan. For example, our state partnerships allowed us to auto-enroll several million dual eligible into drug plans. Despite all of our preparation, there were plenty of problems to be patched after the program began. States continued to serve duals for several months well into 2006.

These were tremendous advantages compared to what CMS faces today in implementing PPACA. To increase the chance for success, the federal government needs more partners, not fewer. It needs to offer greater flexibility to solve problems, not less. But the hard line taken by the federal government, as further evidenced in the guidance this week, in response to state requests likely will mean federal officials and the American people will have to adjust their expectations for 2014.

Thank you for the opportunity to participate in today's hearing. I look forward to any questions you may have about Wisconsin's experience.

Appendix A

All examples below assume Medicaid eligibility levels of 138% of the FPL for parents and caretakers and 200% of the FPL for children.

MAGI and Tax Filing Examples

Mary and Brad are not married. They have a daughter in common, Jessica (age 10), and Brad has a son, Kris (age 15) from a previous marriage. Mary has $3,690/month in income from her job, and Brad has $2,100/month in income from his job.

Scenario 1

Both Mary and Brad are filing taxes. Brad is claiming Jessica and Kris as his tax dependents.
Mary's group includes herself. For a household of 1 with income of $3,690/month, Mary is at 396% FPL and is ineligible for Medicaid.
Brad's group includes himself, Jessica and Kris. For a household of 3 with income of $2,100/month, Brad is at 132% FPL and is eligible for Medicaid.
Jessica's group includes herself, Brad, Mary and Kris. For a household of 4 with income of $5,790/month, Jessica is at 301% FPL and is ineligible for Medicaid.
Kris' group includes himself, Brad, and Jessica. For a household of 3 with income of $2,100/month, Kris is at 132% FPL and is eligible for Medicaid.

Scenario 2

Both Mary and Brad are filing taxes. Mary is claiming Jessica as her tax dependent and Brad is claiming Kris as his tax dependent.

Mary's group includes herself and Jessica. For a household of 2 with income of $3,690/month, Mary is at 292% FPL and is ineligible for Medicaid
Brad's group includes himself and Kris. For a household of 2 with income of $2,100/month, Brad is at 166% FPL and is ineligible for Medicaid.
Jessica's group includes herself, Brad, Mary and Kris. For a household of 4 with income of $5,790/month, Jessica is at 301% FPL and is ineligible for Medicaid.
Kris' group includes himself and Brad. For a household of 2 with income of $2,100/month, Kris is at 166% FPL and is eligible for Medicaid.

There are a number of other inequities that are created as a result of basing Medicaid eligibility on tax rules.

The "Marriage Penalty"

Jack and Diane are married and will file their taxes jointly. They have two children, ages 5 and 8, whom they will claim as tax dependents. Diane earns $2,000/month at her job, while Jack receives $690/month in unearned income. Under MAGI, Jack and Diane and their children will be considered as part of the same household, and their income will be counted together. As a household of 4 with $2,690/month in income, the entire group is at 140% FPL. Under this scenario, the parents are ineligible for Medicaid and the children are eligible.

Rob and Anna are not married. They have two children, ages 5 and 8, whom Anna will claim as tax dependents. Anna earns $2,000/month at her job, while Rob receives $690/month in unearned income. Under MAGI, Anna's group will include her two children. The children's group will include both children and both parents. Rob's group includes just Rob. With a household of 3 with $2,000/month in income, Anna is at 126% FPL and is eligible for Medicaid. With a household of 4 with $2,690/month in income, the children are at 140% FPL and are eligible for Medicaid. With a household of 1 with $690/month in income, Rob is at 74% FPL and eligible for Medicaid.

In this scenario, Jack and Diane are both above 133% FPL and ineligible for Medicaid but Rob and Anna are both below 133% FPL and eligible for Medicaid – only because Jack and Diane are married and Rob and Anna are not.

Child Support Disregard

Lyle and Kate are married and have two daughters, ages 7 and 9. Kate has a son, age 13, from a previous marriage. Kate's son receives $300/month in child support, which is disregarded under MAGI rules. Kate and Lyle are filing jointly and claiming all three children as tax dependents. Lyle earns $1,600/month from his job, while Kate earns $1300/month from hers. As a household of 5 with $2,900/month in income, they are at 129% FPL under MAGI rules and are eligible for Medicaid.

Mike and Liz have two daughters, ages 7 and 9. Liz has a son, age 13, from a previous marriage. Mike and Liz are filing jointly and claiming all three children as tax dependents. Mike earns $1,600/month from his job, while Liz earns $1,300/month from one part-time job and $300/month from a second part-time job. As a household of 5 with $3,200/month in income, they are at 142% FPL.

Under this scenario, total income for both families is $3,200/month. Lyle and Kate are eligible for Medicaid because the $300 of child support income is disregarded under MAGI. Mike and Liz, whose income is also $3,200/month, are ineligible for Medicaid because all of their income is earned income, and therefore counted towards their eligibility.