Policy Brief

Wisconsin Institute for Law & Liberty

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Seven common sense reforms for healthcare in Wisconsin.

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Introduction

To date, policy debates over healthcare reform have been almost entirely focused on increasing insurance coverage. This was the mission of the Affordable Care Act and the state-level debates about Medicaid expansion. But expanding insurance coverage alone hasn't solved the concerns about increasing costs and the ability to access care. Wisconsin's uninsured rate is one of the lowest in the country — 5.8% without expanding Medicaid — and the state is one of just a handful with no coverage gap. Yet, Wisconsin voters in 2018 ranked healthcare as their top issue.

Policymakers need to earnestly search for ways to lower healthcare costs and increase access to care. Focusing on expanding insurance coverage, alone, isn't enough. Though the Affordable Care Act severely limits the ability of states to innovate and experiment, state lawmakers cannot give up and wait for the federal government to find agreement. In this brief, WILL is proposing healthcare solutions, many with bipartisan support, that aim to lower the cost of healthcare and increase access.

Increase Access to Direct Primary Care

What is direct primary care and how is it different from insurance?

Direct Primary Care, also known as a medical retainer agreement, is when a patient pays a monthly fee to receive unlimited routine services from a doctor. A 2015 survey[1] of DPC providers found the average patient monthly cost to be $93.26 (with a range from $26.67 to $562.50). The idea is that it eliminates the middle man and this is what makes it different from

insurance. Instead of the doctor billing insurance for the care, the routine services would be paid for by the patient directly through their monthly fee. Theoretically, by eliminating the insurance middleman, patients can cut costs by not having to pay the insurance company their "share of the pie." When talking about direct primary care for Medicaid patients, the idea is that if Medicaid can cover this monthly service fee for routine services, this would save taxpayers money. On top of that, many doctors don't accept Medicaid recipients, so if Medicaid was able to cover the monthly direct primary care fee, Medicaid recipients would likely have a larger pool of primary care physicians to choose from.

In Wisconsin

In February 2018, the Wisconsin assembly passed a direct primary care bill (AB 798), but it didn't get through the state senate. The bill would have allowed direct primary care providers to be exempt from state insurance regulations, and it would have allowed the Wisconsin Department of Health Services to investigate issues on a case-by-case basis.

After the bill failed, a joint legislative study committee was formed under the leadership of state Sen. Alberta Darling to consider what direct primary would look like in Wisconsin—i.e. how to regulate the care, what services would be included, what differentiates direct primary care from insurance and overall, whether it would be good for the state.

On Jan. 10, the committee released their findings.[2] Their first recommendation is that direct primary care would be good for Wisconsin. Their second recommendation is that "Group Insurance Board should explore the possibility of integrating an employer-sponsored direct primary care program into the state employee health plan under its current structure."

State Rep. Joe Sanfelippo made a presentation[3] to the U.S. Department of Health and Human Services where he laid out the benefits of direct primary care for Medicaid recipients. His overall argument is that under Direct Primary Care, Medicaid recipients would have better access to good care and there would be fewer barriers to entry for those patients, such as the currently complicated payment procedures that burden the doctors and patients.

To be clear, there are a few direct primary care providers already practicing in Wisconsin such as YourMD in Mequon, which offers urgent and primary care. A family can purchase a membership with YourMD for only $150 per month for the parents and an additional $30 per month for each child. With a membership, each visit is only $25, including urgent care visits.

Reform Retroactive Eligibility for Medicaid

What is retroactive eligibility?

Individuals eligible for Medicaid can request retroactive coverage when they apply, which means that any procedures that took place in the three months prior to their enrollment can be covered

by Medicaid. This causes a whole host of incentive problems. First, individuals are incentivized not to enroll in Medicaid and avoid the monthly premium, because they know that they can always enroll after a procedure. This also creates an incentive for providers to enroll patients after a procedure in order to be sure they receive the payments they're due. While this does reduce uncompensated care for healthcare providers, it increases costs to taxpayers.

In Wisconsin

Several states including Kentucky, Arkansas and Indiana have reformed retroactive eligibility so that Medicaid is only effective in their states after a consumer has enrolled. Wisconsin is not one of these states, and like many, allows retroactive coverage for up to three months prior to enrollment.[4] Reforming this loophole could save the state of Wisconsin a substantial amount of money and would make further Medicaid reforms easier to conduct. For instance, Arkansas plans to move Medicaid recipients onto private insurance, however, retroactive eligibility made that difficult because private insurers don't allow coverage prior to enrollment. Removing this loophole and not allowing patients to receive coverage before they have enrolled in Medicaid causes the program to operate more like private insurance providers, while saving taxpayers some money.

In order for Wisconsin to do away with retroactive coverage, the state will need to apply for a 1115 waiver and have it approved by the Centers for Medicare and Medicaid. The section they would need to waive is 1902(a)(34). States like Kentucky have received this waiver.[5]

Create a Dental Therapy License

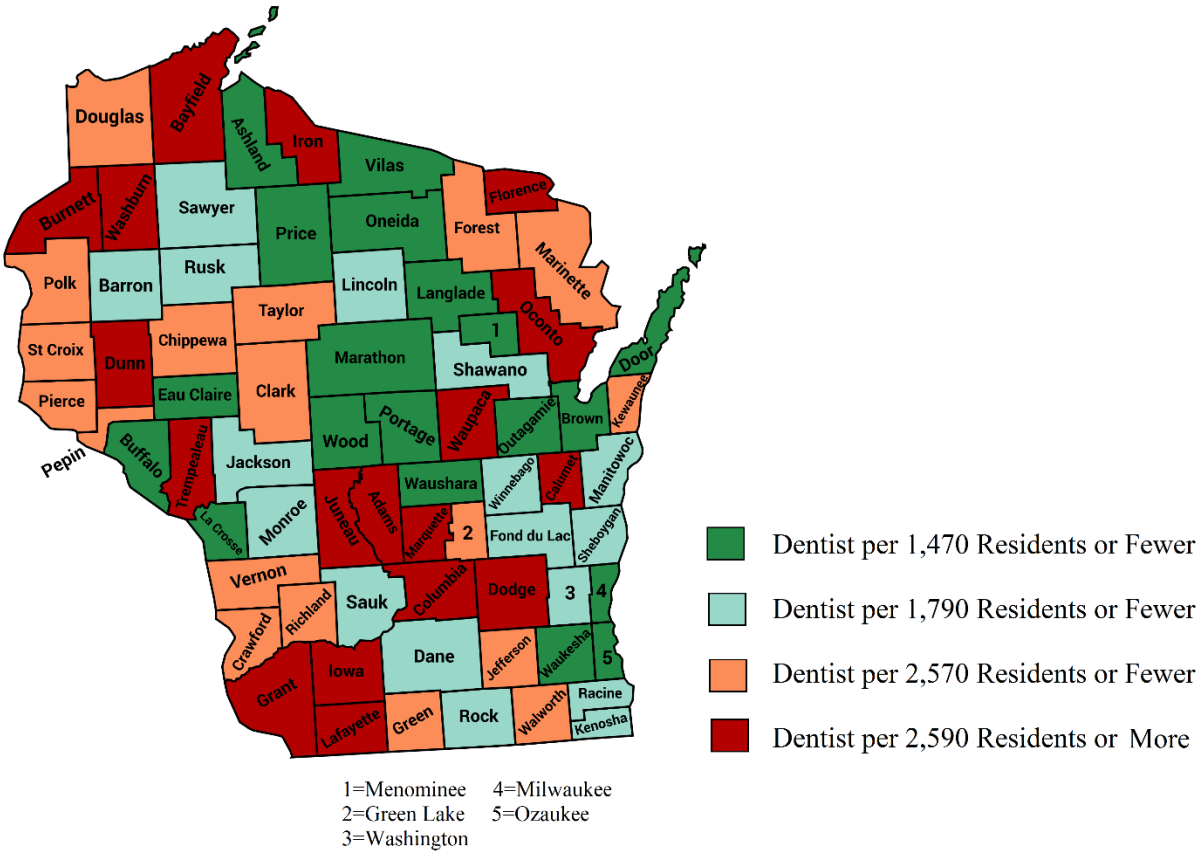
What is a dental therapy license and how is it different than a dental license?

To become a dentist one must receive a doctorate degree in dentistry. Dental therapists are mid-level practitioners who work under a dentist but in the very few states where they are able to practice, can do so after only receiving a bachelors or master's degree in the field. The three states that have created dental therapy licenses—Maine, Vermont, and Minnesota—have increased the availability of basic dental care to their constituents.

In Wisconsin

For many Wisconsinites, dental care remains out of reach. Many companies do not offer dental coverage through their health plans, and the costs of routine procedures can be too much for low- and middle-income families to afford. For instance, Figure 1 on the following page depicts per capita dentists in each Wisconsin county. Particularly in western Wisconsin, there appears to be a lack of dentists, but the problem exists throughout the state. As might be expected, the problems appear to be more acute in rural areas.

Figure 1. Availability of Dentists by County



The Badger Institute[6] and the MacIver Institute[7] have both done important work on this topic in Wisconsin. In addition to the potential lowering costs, a dental therapy license may help increase access to dental care for rural residents. Dental therapists are generally allowed to work outside of the physical presence of the dentist who is the supervisor, which can enable them to travel to isolated communities that lack access to care. They are authorized to conduct routine procedures such as filling cavities and conducting non-surgical extractions of teeth.

The dental therapy license is an idea that has received bi-partisan support in Wisconsin already—having been included by Governor Evers in his budget. In 2018, a bill[8] was proposed in Wisconsin by Senators Craig and Kapenga. This bill would have created the license for Wisconsin. However, the legislation did not make it out of committee.

Take Full Advantage of Short-term Limited Duration Healthcare Plans

What is a short-term limited duration (STLD) healthcare plan?

Short-Term Limited Duration (STLD) healthcare plans[9] were originally designed as a temporary alternative for individuals who experienced life events that left them without insurance—such as

the loss of a job or graduation from college. Because these plans were only designed as a stop-gap measure, they were exempt from most of the more onerous mandates of the ACA.

This means that STLDs can be offered at a significantly lower cost than ACA-compliant plans—meaning that sometimes they are as much as 90% cheaper.[10] Under the Obama Administration, such plans were limited to three months. While this might have reflected the original purpose of the plans, the Trump Administration has seen them as an end-run around the onerous regulations of ObamaCare. They have expanded the duration of such plans to 12 months, and allowed them to be renewed for up to three years.

These new regulations mean that STLD plans can offer a viable insurance alternative, particularly for young and healthy individuals. For those who are using an STLD and get sick, they would have been forced to have no coverage for up to 9 months under the Obama regulatory environment. Now, the sick can be covered for up to for up to three years.

In Wisconsin

Current Wisconsin law does not allow for residents to make full use of STLDs.[11] The term of plans can be up to one year, but the total duration of plans can only be two years. Governor Evers has signed an executive order[12] directing various executive agencies to provide recommendations on "Protect(ing) against attempts to undermine the Affordable Care Act marketplace with short-term plans that do not comply with Affordable Care Act requirements." This suggests that policymakers would face a tough battle in trying to expand coverage under STLDs, but should not be afraid to ask why the governor wants to limit affordable healthcare options for hard-working Wisconsin families. Rather than rolling back such plans, policymakers should consider changing law to conform Wisconsin law to the maximums allowable at the federal level.

Take Full Advantage of ACA Freedom in U.S. Territories

What freedoms from the ACA do U.S. territories experience that states lack?

It is little disputed that the ACA has increased the cost of care. Provisions such as mandating the provision of essential health benefits to those who don't need them, the imposition of a health insurance tax, and the prohibition of fees for preventative care have driven up prices dramatically.[1] While many are eligible for substantial subsidies via the exchanges, these mandates raise the cost of premiums across the board. But one pathway to lower prices that was not available at the time of the ACA's passage now exists: U.S. territories have been freed from most of the ACA's mandates.

Before 2014, insurers in U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and US Virgin Islands) were required to offer insurance coverage to residents

regardless of prior health conditions. However, unlike in the 50 states and the District of Columbia, the ACA did not include the coverage mandate and penalty in the territories. This undermined the system of healthcare in these areas, and made offering insurance very unattractive for insurance companies. In 2014, the Obama administration caved to pressure and ruled that territories were not states under the law,[13] and were not subject to the coverage mandates included within the ACA. Such plans could be offered at significant discounts because they are exempt from ACA mandates, such as guaranteed eligibility, community rating, and the single risk pool, which interstate plans are not.[14]

This represents an important opportunity to free healthcare consumers from the onerous mandates of ObamaCare that does not come with time-frame limitations of the STLDs discussed earlier.

Contrary to conventional wisdom, there are no federal laws prohibiting the interstate sale of insurance. The ACA explicitly permitted states to form interstate compacts to sell insurance subject to the regulations of the state in which the law was written. Currently, Kentucky, Georgia, Oklahoma, Wyoming, and Maine have passed such laws.[15] There is reason to believe that allowing the purchase of territorial insurance would be more successful than plans to allow the interstate purchase of insurance have been. The dramatically lower costs would make them attractive to consumers. This would increase the likelihood of significant enrollment, and thus the likelihood that insurance companies would be interested in undertaking the formation of networks within a particular state.

In Wisconsin

Proposals have been made in the past to allow the purchase of insurance from interstate providers. AB 540[16] by Representative Vukmir from the 2009-10 legislative session would have allowed the purchase of insurance from out-of-state providers and exempted those insurers from many Wisconsin laws. Similar legislation could still be crafted with the simple addition of U.S. territories as a location from which insurance providers could be based.

Allow for Free Speech in Medicine

What is free speech in medicine?

"Off-label" uses for prescription drugs are viable uses for a legal drug that are not the uses for which the Food and Drug Administration (FDA) approved the drug. The FDA does not prohibit off-label uses of approved drugs. However, health professionals are prohibited from discussing such uses. It is the FDA's position that sharing such information constitutes the "promotion" of the drug in question, and that any such promotion in turn constitutes "mislabeling" – a violation of the FTC's labelling rules. Free speech in medicine would help raise awareness among patients of potentially effective treatments, lowering the risk and cost of healthcare.

In Wisconsin

Wisconsin does not currently provide legal protection for the discussion of the off-label use of medicines. Given that this represents a prohibition on the free speech rights of doctors and other healthcare professionals that can have a negative effect on patient outcomes, policymakers should consider following the lead of Arizona and Tennessee by enacting such a statute. To that end, the Wisconsin Institute for Law & Liberty wrote model legislation that we think would behoove the state to enact.

Repeal the Minimum Markup for Prescription Drugs

Minimum markup laws are based on the notion that predatory businesses will enter a market, sell items at below cost, and drive all of their competition out of business. Wisconsin has had a minimum markup law on the books since the 1930s, when the Great Depression increased fears of goods becoming too expensive for the average person to purchase. The law prevents the sale of items below the cost of producing them, including prescription drugs. This means that Wisconsinites are unable to access programs that many companies' now offer in order to provide prescription drugs at significantly-discounted rates. For example, Walmart offers a month's supply of more than forty different common drugs for $4,[17] but many cannot be offered at this rate in Wisconsin.

Concerns that such laws undermine competition are not grounded in the facts. A 2017 WILL study[18] examined the relationship between the presence of a minimum markup law in a state and the number of small businesses in the state. The study found that there was no relationship. Not only does this law raise prices for consumers, but it is ineffective at the goals it is attempting to achieve. At this point, the law largely serves to enrich entrenched pharmacies and other retailers.

In Wisconsin

There appears to be growing support for at least repealing portions of the state's minimum markup law. Governor Evers' budget included a provision to repeal the minimum markup law as it applied to gasoline, but the logic of the repeal—that it raises costs for consumers—also applies to medicine. A number of bills have been proposed in the past to eliminate the minimum markup law, either completely or in part. In the last legislative session, Senate Bill 253[19] would have removed the minimum markup for most products with the exception of gasoline and alcoholic beverages. This bill failed to make it out of committee.

A number of bills have been proposed this session from legislators on both sides of the aisle. This includes a proposal from Senator Carpenter that would repeal the law with respect to prescription drugs only,[20] and one from Senators Stroebel and Craig that would repeal the law

completely.[21] Given the bi-partisan agreement on the repealing this law, and the direct implications for the prices that consumers pay, policymakers should seriously consider these bills.

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