Policy Brief

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Healthcare Myth Busters: Fact-Checking the Wisconsin Legislature on Healthcare Policy

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Executive Summary

Since his election, Governor Evers has made clear that expanding access to Medicaid is one of the chief priorities of his administration[1]. Working with legislative Democrats, the Governor pushed the idea that Medicaid Expansion represented free money for the state, all while pushing a number of myths about the state of healthcare in Wisconsin. Much like WILL's regular Education Myth Busters briefs, this brief will endeavor to correct the record on six of the major whoppers that have been told in service of increasing the dependence of Wisconsinites on the federal government for their health insurance.

1. "What does Medicaid Expansion mean to you? It means lowering the cost of healthcare for everyone." –Governor Evers June 1, 2019[2]

Time and again, Democrats have claimed that Medicaid expansion will lower the cost of care for everyone. As we stated in our Medicaid study,[3] this is in fact a myth and instead, Medicaid expansion will cost the average family of four an extra $700 per year. This more than offsets the "free money" that would come from Washington, resulting in a net cost, to the citizens of Wisconsin of approximately $400 million *after taking increased federal dollars into account.*

One reason that Medicaid expansion will not lead to significant savings in Wisconsin because the state does not have a coverage gap. Everyone in the state up to 100% of the federal poverty limit is eligible for Medicaid, and all those low-income individuals above that threshold are eligible for heavily subsidized care via the Affordable Care Act (ACA) exchanges.[4] Expansion would people from this from of insurance to Medicaid, driving up the cost in several ways. First,

healthcare providers would receive smaller reimbursements through Medicaid than they do through private insurance and will be forced to pass that cost onto consumers. It might look like costs have been lowered for the new Medicaid recipients but costs for others will increase. And secondly, studies have found that the utilization of expensive healthcare options like emergency room care actually goes up following expansion, though this may be lessened in Wisconsin due to the lack of a coverage gap.[5]

There are a number of ideas with a greater likelihood of lowering costs that proponents of Medicaid expansion ought to consider if lowering costs is the true goal. Earlier this year, WILL released a policy brief that detailed seven common sense reforms that can be implemented even under the current regulatory environment of the ACA to accomplish that goal.[6] Among the most intriguing of these ideas is Direct Primary Care. This system cuts out the middleman, the insurer, and allows the patient to pay the doctor directly for their services. In the Milwaukee area, there is a direct primary care office that only costs about $125 per month for a family of four.

2. *"This is money that our taxpayers have already paid in federal taxes, and 36 states have decided to expand Medicaid." LaTonya Johnson, June 6, 2019.*[7]

Senator Johnson is correct that Wisconsin is forgoing federal money in the short term by not taking expansion. But the key word here is *in the short term*. The federal welfare state is facing insolvency at an increasingly rapid pace. Social Security is expected to have withdrawals exceed income for the first time in 2020, and Medicare's Hospital Insurance Fund is supposed to be depleted by 2026.[8] There is no guarantee that the federal government will continue to meet its promise first made under Obama to reimburse states for Medicaid expenses at 90%. Even a small reduction in this reimbursement rate could throw Wisconsin's budget into a tailspin under expansion.

In fact, this reduction may come sooner rather than later. Even the Obama Administration, which crafted higher reimbursement rates for Medicaid to induce states to participate, proposed alterations in the reimbursement rates for Medicaid. The proposal for a so-called "blended rate" was designed to bring three formulas for Medicaid together as one for each state. But this rate could have been significantly lower than what was promised by Obama in order to induce states to participate in ObamaCare.[9] Under a blended rate, the "free money" from the feds would cost a lot more, and the state of Wisconsin would be left scrambling to pay for Medicaid coverage for those who are currently covered by private insurance. Given the coming entitlement crisis, there is little reason to expect the federal government to hold to its guarantees in the long-term.

In the end, the old axiom that there is no such thing as a free lunch still holds. Wisconsin already gets more than its fair share of federal money, and should always be wary of taking more.

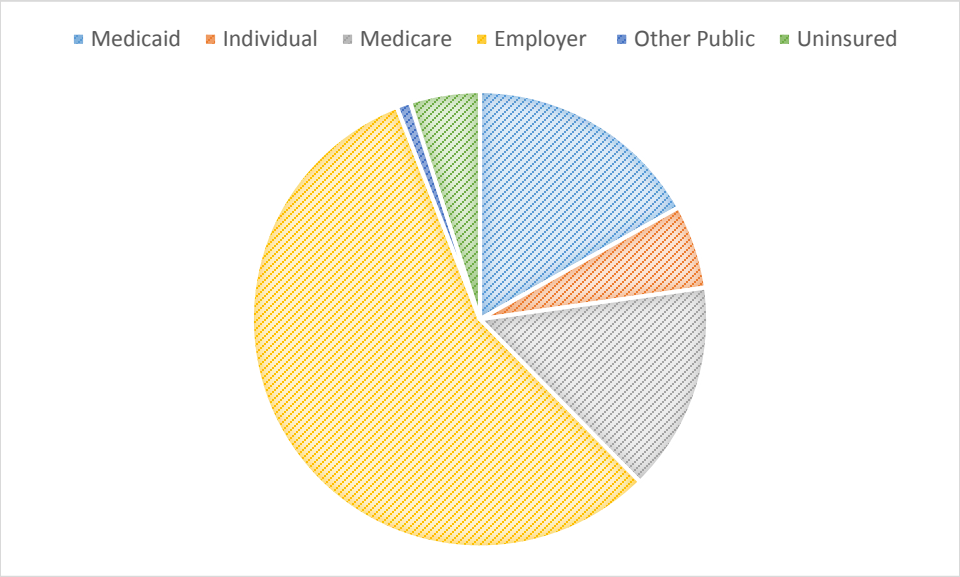
3. *"The Health Affairs study shows that Medicaid Expansion isn't just the right thing to do morally, it's the right financial decision for Wisconsin."-Evan Goyke June 7, 2019*[10]

This is an extreme mischaracterization of the results of a *Health Affairs* study[11] that was extremely limited in scope. The *Health Affairs* study endeavored to examine what would happen to health insurance premiums for the segment of Wisconsinites on the individual market if Medicaid expansion were to be passed. It compared premiums for such individuals in Wisconsin and border counties in other states and found that premiums for those on the individual market would be 13-19% lower. But note that this result is only for the individual market. Most Wisconsinites with private insurance obtain group coverage through their employers. For the individual marketplace, this result may make perfect sense. Those with lower incomes tend, on average, to be less healthy and less likely to seek medical care.[12] When those at the lowest income levels are removed from the marketplace, the overall health of the pool is likely to improve, potentially resulting in lower premiums.

But individuals who get insurance on the individual marketplace represents only about 6% of the entire marketplace for health insurance. The pie chart below uses data from the Kaiser Family Foundation to depict the source of health insurance for the state. About 57% of Wisconsinites get their insurance via employer-sponsored coverage. An additional 17% have Medicaid coverage, followed by 15% who have Medicare. The small orange sliver here represents the only slice of the pie that the *Health Affairs* study has relevance for. Thus it is not surprising that, even if individual market premiums go down, overall costs would go up as we found.

The statement of Representative Goyke is far too broad. Another study by WILL looked at prices across the board rather than just in the individual market, and found that prices for insurance actually would increase for private payers under Medicaid Expansion. Given that our study includes the entire market and not just the individual marketplace, the Health Affairs findings suggest that it *underestimates* the costs for those with employer insurance given the *Health Affairs* findings. We ought not be sacrificing the interests of 57% of Wisconsin families to potentially lead to small premium decreases for a portion.

Figure. Health Insurance Sources, Wisconsin 2017



4. ***"Yesterday, Republicans had the opportunity to approve @GovEvers DHS Budget proposal to increase quality and affordable health care for children, families, and seniors by accepting federal dollars to expand Medicaid and they REJECTED it."-Jennifer Shilling, June 2019[13]***

Senator Shilling appears to suggest that Medicaid Expansion is the only—or at least a good—way to increase access and decrease the cost of health insurance. While some evidence does exist for improved health outcomes in other states, it is important to remember the unique position that Wisconsin is in when it comes to healthcare access. Unlike all other states that have expanded Medicaid, Wisconsin does not have what is known as a coverage gap.

In other non-expansion states, there are individuals who make too little money to get a plan on the individual exchange but too much money to qualify for Medicaid. For such individuals, there are very few viable options for getting insurance short of increasing their income. But this is not the case in Wisconsin. Prior to the ACA, Wisconsin had one of the most generous Medicaid plans in the country, covering people up to 200% of the federal poverty limit. Because the ACA began offering subsidized coverage to those in that range, Governor Walker and the legislature rolled back Medicaid coverage to 100% of the poverty limit.[14] This led to a savings for the state while also insuring that every low-income individual still had access to free or extremely low cost insurance via the exchange.

There is strong evidence that putting people onto the Medicaid rolls will actually have the opposite effect of what Senator Shilling claims. Only 45% of doctors are willing to accept new Medicaid patients according to recent studies, compared to 94% willing to accept private

insurance and 93% willing to accept Medicare.[15] This means that many new enrollees might be left out in the cold with healthcare providers that they had previously used. When patients can't access care, they wait for emergencies which leads to detrimental health outcomes and more expense for the state. A comprehensive study in Oregon[16] took advantage of lottery data to compare health outcomes for those who gained access to Medicaid by winning a lottery for access with those who did not. They found that while Medicaid access increased the likelihood of diagnosis with certain conditions, it had no impact on the health outcomes of individuals. Such a finding would be even more likely in Wisconsin where there is no coverage gap.

> ***5. "Our health care system is broken, and I favor a single payer system to take the profit out of health care while providing healthcare to EVERYONE, including dental and mental health care. In our current system, at the very least there should be a public option available in the ACA Health care exchanges."-Chris Taylor, Undated from Website[17]***

A single-payer system will not lower the cost of care because in order to fund it, the government will need to simultaneously raise taxes and decrease payouts to doctor.[18] Estimates on the cost of Medicare for All vary, but they all come with a very high price tag. An analysis by the Mercatus Institute pegged the cost at $32.6 trillion over its first 10 years.[19] While it is true that a some of this new burden might be compensated for by the removal of the burden of premiums and deductibles, this is no free lunch for taxpayers as it is often presented by the left. When something is free, people demand more of it whether or not the benefits exceed the cost (which, as far as they are concerned, is nothing).

Another flawed argument that single payer defenders like to claim is that money will be saved due to fewer administrative costs with one system. Since when has putting the government in charge of anything meant less bureaucracy and waste? Research from the Heritage Foundation compared private sector administrative costs with those for private sector healthcare providers.[20] They show that talking points on the administrative savings of Medicare fail to account for the number of Medicare enrollees. In reality, the administrative cost-per-enrollee is higher for Medicare patients than for the private sector.

Taylor also claims that single payer would take the profit out of healthcare, suggesting that there wouldn't be private sector insurance if the U.S. was to adopt such a system. While plans like that offered by Presidential candidate Bernie Sanders do ban private health insurance in most cases,[21] the reality in other countries that are often held up as examples of single payer is quite different. Both Sweden and Australia, two common models for single payer on the left, still have private sector health insurance. In Sweden, enrollment in private insurance tops 10% of the population.[22]

In countries like Sweden, people may get their regular insurance through the single payer system, but if they have the money they will purchase additional coverage through the private sector in order to skip lines and receive access to ambulatory care specialists, according to the International Commonwealth Fund.[23] In fact, Australia actually encourages its citizens to enroll in private insurance through tax rebates and goes as far as to penalize people above a certain income threshold for failing to enroll in private health insurance.

In the end, what this creates is a system of healthcare whereby only the wealthiest have access to the sort of high quality care that is already available to a significant share of families in the United States via private insurance. Taylor is right that our current system is broken, but single payer is an extremely costly alternative with a whole set of problems of its own.

Even more fundamentally, incentives generally lower cost. We have not taken "profit" out of essentials like food and yet the cost has been driven down over time. If we want cheaper health care, we ought to rely more on markets and not less.

6. "Our health care system. Well I think the one thing that really came out during the hearing that is not surprising is, if you are interested in protecting pre-existing conditions, if that is a priority for your constituents and for you, the only way to do that is to preserve Obamacare, the Affordable Care Act."-*Minority Leader Gordon Hintz January 21 2019*[24]

The Affordable Care Act is unequivocally not the only way to protect those with preexisting conditions, and it is undoubtedly one of the most expensive for other healthcare users. Under the ACA, insurance companies are mandated to charge those without preexisting conditions the same rates as people with preexisting conditions. For those in the latter camp, the subsidizing of care for more expensive individuals has contributed to skyrocketing premiums. The sickest 10% of Americans account for two-thirds of health spending according to the Kaiser Family Foundation.[25] According to the Department of Health and Human Services, premiums increased from $232 on average for an individual in 2013 to $476 by 2017—a 105% increase.[26] Rather forcing healthy people to pay more for the sick, a number of intriguing alternatives have been proposed.

Perhaps the most promise is in a proposal offered by former Speaker of the House Paul Ryan, who proposed subsidizing new High Risk Pools (HRP) with federal money. HRP were available to those with preexisting conditions who were denied coverage under traditional insurance. This proposal would reestablish the ability of insurance companies to charge those with preexisting conditions higher rates, but only if the state established a HRP which would receive significant federal subsidies. Not all HRPs were well regarded. Many were underfunded, and left some people out in the cold with premiums that were too high. However, Wisconsin had a HRP that was considered "one of the most successful in the country" according to PolitiFact.[27]

Another alternative for many may be found in Direct Primary Care (DPC). DPC removes the insurance middle man between a doctor and a patient. Patients pay a flat monthly fee and can get most of their regular medical needs covered, such as annual physicals and immunizations.[28] While this would not be likely to prove effective for those with the worst conditions, it could be effective for those who have chronic pre-existing conditions such as those with diabetes or heart disease. Because DPCs can cover routine services, conditions such as these that require routine maintenance and tests can potentially receive they care they need under this model[29]

While the relative benefits of these and other alternatives to the ACA could be debated, Representative Hintz is completely off-base in saying that the ACA is the only means of providing coverage. DPC, HRP and other options provide viable alternatives that would have the added benefit of helping to lower the cost of healthcare for Wisconsinites.

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