WDA
Wisconsin Dental
Association, Inc.

Senate Bill 438
Testimony By Dr. Thomas Hughes
WDA President-Elect
Wednesday, March 8, 2000

Good afternoon, Chairperson Moen and members of the Senate Health Committee. I'm Dr. Tom Hughes, and I'm a practicing dentist in the Southwestern Wisconsin community of Cassville, and, as president-elect of the Wisconsin Dental Association (WDA), I'm here testifying on Senate Bill 438.

The WDA is testifying for information and is requesting one specific amendment to Senate Bill 438. On the one hand, we agree with the HMOs that the state must do an audit on its BadgerCare program to determine what rates are "actuarially sound" and/or sufficient to attract HMOs and independent health care providers into the program. We agree that sufficient providers are needed in order to deliver the care promised to those enrolled in the state's programs. On the other hand, the dental BadgerCare program has been underfunded from the start. Now, a variety of groups outside of dentistry have joined us in our efforts of asking the state to set BadgerCare/Medicaid dental rates that are actuarially sound. Although the program was slightly improved during the previous budget cycle, it is still light-years away from attracting dentists into the program. In fact, dental reimbursement rates under BadgerCare are a far cry from being "sound" in the eyes of any dental office. These same rates apply to the dental Medicaid program that we all know has a severe access problem across the state.

Unfortunately, we've been unable to convince the legislature to truly buckle down and spend the money that needs to be spent in order to improve both the administration and the reimbursement problems of the program. The HMOs have been able to grab the attention of the entire legislature by demanding that they need more money or they will drop their participation in the BadgerCare program.

If you have large corporate HMOs unable to make ends meet with the low reimbursement and the bureaucracy of the BadgerCare program, how in the world do you think the small business dental offices in the state have managed to survive the program's shortcomings? The simple answer is that they haven't – and that is precisely the reason why you see dental offices dropping from a state program that absorbs the most time, labor, energy and money from the dental office staff when compared to other dental benefit programs in the state. The WDA, as an association, is struggling to keep its members involved in the BadgerCare and Medicaid programs. Actions like Senate Bill 438 compound the dental community's disbelief with the ability of the legislative process to truly solve the problems with the DENTAL program. By once again knowing that corporate HMOs have a better chance of getting their voices heard than do the nearly 3,000 licensed and independently practicing dentists who are members of the Wisconsin Dental Association.

Our profession has been blamed by public officials, including some legislators, for the shortcomings of the state's BadgerCare and Medicaid dental programs. We've pointed out time and time again that this issue has to be resolved in a comprehensive fashion

and that it is a state program and the solutions must be solved by both the state AND the dental association. We understand your desire to make sure that BadgerCare and Medicaid recipients have adequate access to care but we are disappointed that you seem primarily concerned with the medical program and are once again forgetting that dentistry is an important part of the overall health care of Wisconsin's citizens.

The American Academy of Pediatrics (physicians, not dentists) and the Milbank Foundation have both researched the issue of access to overall health care for children and found that dental care should make up 20% of the dollars spent for overall health care. Currently, the state's BadgerCare and Medicaid programs spend less than 5% of their dollars on oral health for children. Furthermore, the dental program is less than 1% of the entire BadgerCare\Medicaid program in Wisconsin. In order to truly improve access to dental care under the BadgerCare\Medicaid program, more money must be allocated towards dental health. If you would like the research products I've referenced, please call Mara Graven of the WDA legislative office in Madison and she can provide you with the research from both the AAP and the Milbank Foundation.

Please consider adding the DENTAL fee for service and HMO BadgerCare and Medicaid programs to this bill so that an audit can be done on the rates involved in the dental BadgerCare and Medicaid programs as well as the state's medical programs. Furthermore, please pass on any rate increase that is given to the Medical side of the BadgerCare program to the dental side of the program so that it, too, can survive. Thank you for your time and consideration, I'll be happy to answer any questions you may have.

Dental Hygiene Association of Wisconsin, Inc.

Advancing the Profession of Dental Hygiene Through Education, Community Service and Professional Networking

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Written Testimony RE: Senate Bill 438
March 8, 2000

Dental Hygiene Association of Wisconsin supports the request of the Wisconsin Dental Association for an audit of the Medicaid and BadgerCare programs. Determining what is needed to establish a system that is actuarially sound with reference to dental reimbursement must be done for both HMOs and the equity of reimbursement for the approximately 3400 dentists in the state.

The Wisconsin Dental Association has been requesting reasonable dental reimbursement rates for the Medicaid program. The BadgerCare program increased the burden of inadequate reimbursement for services. As a result, the dental access for these underserved populations continues to be a problem. The WDA has made a concerted effort to increase the number of Medicaid certified dentists and services rendered through their program of "Share the Care", and yet, the difficulty increasing the number continues due to the low reimbursement rate.

In addition, the burdensome paperwork involved with reimbursement for dental services is an issue of great concern. The request of the Wisconsin Dental Association for an administrator separate from the medical administrator is reasonable, and necessary, for helping solve the lack of access to care for Medicaid and BadgerCare populations.

Please vote to call for an audit of the Medicaid and BadgerCare dental system, in addition to the medical system, to determine equity of reimbursement and for hiring a dental administrator separate from the medical administrator.

Respectfully,

Midge Pfeffer

Midge Pfeffer, RDH,BS, Executive Chair
Dental Hygiene Association of Wisconsin

March 8, 2000

TO: Members, Senate Health Committee

FROM: Scott Peterson, Director of Government Relations

SUBJECT: Senate Bill 438

A provision in Senate Bill 438 requires DHFS to reimburse an HMO at the fee-for-service rate for services provided to Badgercare eligibles who are later determined to be ineligible for the Badgercare program. As a matter of equity, WHA supports this provision. Where the HMO owns or employs the provider, the current language will work fine, as the HMO and the provider are essentially one and the same.

However, under the Badgercare program, many services are provided by third-party providers that are not owned or employed by an HMO. In order to fully implement the intent of the bill to pay providers on a fee-for-service basis, the HMO should pass on the enhanced fee-for-service payment to the third-party provider who actually provided the health care services. The provider is the entity directly bearing the service costs. Consequently, it seems unfair that the HMO would fully capture the reimbursed fee-for-service payment

In general, the fee-for-service provision in Senate Bill 438 promotes accountability within the Department for the Badgercare program, and we believe our correction will accomplish what the provision intended. WHA would like to rectify this inadvertent omission in the language and fully close the payment loop from DHFS to HMO to provider in cases of erroneous Badgercare eligibility.

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When the HMO receives fee-for-service compensation under this section for health care services provided by an individual provider who is not employed by the HMO, or by an organization that is not owned by the HMO, the HMO shall reimburse such provider for such services at the same fee-for-service rate that the HMO was reimbursed by the department.

GROUP HEALTH

COOPERATIVE OF EAU CLAIRE

Testimony Presented to
Senate Committee on Health, Utilities, Veterans and Military Affairs
Regarding BadgerCare
Presented by Peter Farrow
General Manager, Group Health Cooperative of Eau Claire
March 8, 2000

Thank you Senator Moen and members of the Committee. My name is Peter Farrow. I am the General Manager of Group Health Cooperative of Eau Claire. I am presenting testimony today to provide background information regarding the BadgerCare program.

Let me begin by reinforcing our support for the BadgerCare program. When Governor Thompson and the Legislature created BadgerCare, they recognized that in helping people transition from welfare back in to the workforce, health care coverage might not be available. With BadgerCare, lower income working families are now able to obtain health care coverage.

Has BadgerCare been successful?

By most measures, it has. BadgerCare has reduced the number of uninsured in Wisconsin. Moving over 50,000 people from the ranks of the uninsured to insured status shrinks the overall uninsured rate by more roughly one full percentage point.

Hospitals and health care providers gain tremendously. Because many of the working poor now have health care coverage, the need for charity care and other write-offs for people who can't pay for a hospitalization decreases dramatically. While it is true that Medicaid level reimbursements are lower than commercial payments, hospitals and other healthcare providers are now collecting a substantial part of the bill, where before they likely would have collected nothing. The result is a more stable payment collection system for health care providers, and less of a need to cost-shift these lost funds to commercial patients.

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BadgerCare is a whole new program, serving a new population. Whenever a new program like BadgerCare is launched, there will be growing pains, and there will be lessons learned in the early going.

To be successful, policymakers knew BadgerCare would have to piggyback on the Wisconsin's Medicaid statewide managed care program. Because little data was available on exactly who would enroll in the program and what sort of costs would be generated, the Department of Health and Family Services was forced to make a number of assumptions about costs and trade-offs in costs between the traditional Medicaid population and the BadgerCare population. In essence, the best anyone could do was make educated guesses.

When the decision was made to reimburse HMOs at the same rate per person as the Medicaid population, many HMOs expressed concerns that costs would run higher for this population. Because BadgerCare was launched in the middle of a contract period with the HMOs in the Medicaid program, providing care to BadgerCare enrollees was a voluntary decision.

This decision to participate in this initial phase of BadgerCare was not an easy one. With most HMOs operating at or below the break-even point, plans could not afford to take substantial risks on an under-funded program. During this initial phase, plans were assured that if costs were significantly higher than predicted, adjustments would be made in the capitation rates to compensate for them. In the end, I believe the ten HMOs that participated in BadgerCare did so because of the positive, working relationship that had been established with the DHFS in the Medicaid managed care program.

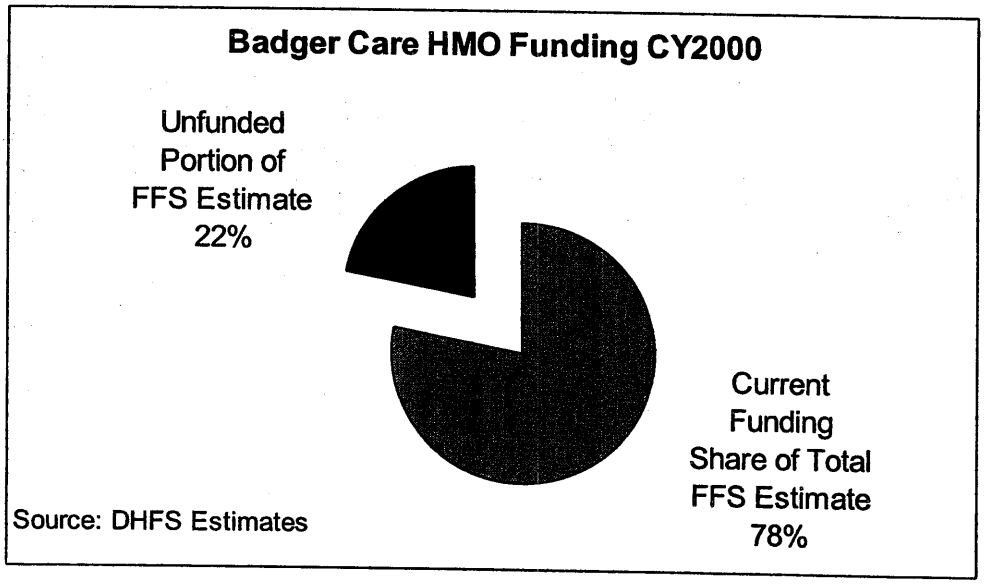
After months of examining enrollment statistics and preliminary claims data, both DHFS and the HMO industry agree: BadgerCare is under-funded. There is even relative agreement on size of the deficit in the funding to participating HMOs. Using the Department's numbers, it is estimated the BadgerCare program will cost about 33% more than the traditional Medicaid population. Said another way, that level of cost would result in the state receiving a 25% discount in funding compared to the costs of the program, if Medicaid AFDC HMO payment levels were used.

What information is this conclusion based on? Both DHFS and the Wisconsin Association of Health Plans, at DHFS' request, used enrollment data in the BadgerCare program to establish an age/sex mix of the population. This analysis concluded that the average age in BadgerCare is 27, compared to 11 for Medicaid. Actuarial analysis consistently shows that the older a population is, the more health care costs it generates.

Typically, health care claims will take anywhere from days to four or five months to be submitted by providers for reimbursement. In other words, we are just now able to tell the actual claims cost of the first few months of BadgerCare. This preliminary data supports the cost estimates stated earlier.

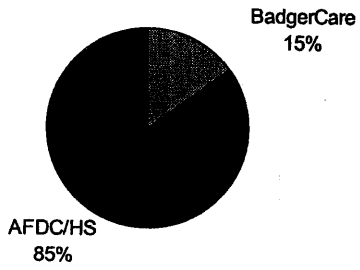
Pharmacy costs are the exception. Because pharmacy claims are transmitted and adjudicated real-time, meaning when the pharmacist processes the prescription, we know the actual costs related to prescription drugs. Statewide, pharmacy costs are running about 90% higher for BadgerCare than the traditional Medicaid population.

DHFS has proposed a capitation rate for BadgerCare that is 5% higher than the Medicaid base rate for calendar year 2000. In addition, the Department has proposed a risk-sharing corridor to cover a portion of the losses that will be incurred by HMOs. However, this payment structure continues to be inadequate for a program that will continue to cost 28% more than traditional Medicaid (the equivalent of a 22% discounted rate).

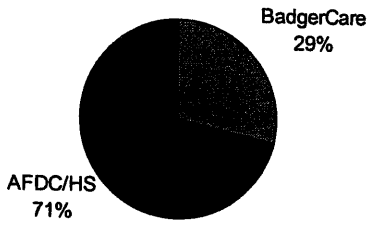


Going forward, the deficit in BadgerCare funding has upset the balance between HMOs. As I have said, when the ten HMOs decided to participate in the early phase of BadgerCare, they did so with the belief that they would be protected if the program experienced significantly higher costs. Because those ten HMOs will have a majority of the BadgerCare population, going forward they will be saddled with a disproportionate share of the losses. The only way to prevent penalizing the HMOs who participated early is to fund BadgerCare with the realistic chance of breaking even.

7 HMOs Entering BadgerCare on 4/1/00
Block Mix AFDC vs. BadgerCare
(Enrollment projection at year end 2000)



10 Original BadgerCare HMOs
Block Mix AFDC vs. BadgerCare
(Enrollment projection at year end 2000)



No HMO in this discussion has demanded a profit on BadgerCare. In insurance, the best you hope for is a rate that offers a realistic chance to net a positive return. In this case, HMOs have requested a rate that offers a realistic chance to only break-even. In any other industry that goal would be unheard of.

Allow me to offer an analogy. If it cost $1.25 to make a pen, not retail, but actual cost to produce, how long do you think the state could buy them for $1.25, with no profit at all for the pen maker? How many pen makers do you think will sell a pen at $1.05, so they lose money on each and every pen they sell?

This is not an issue of markup, or covering a budgeted rate of return. The issue is covering the actual costs of a program at a break-even level.

This bill is being considered today because the Department has done all it can to address BadgerCare costs within the confines of its budget. I want to close by recognizing the long hours and commitment that Secretary Leean and his staff have committed to working on this issue and thank them for it.

Thank you for the opportunity to offer testimony on BadgerCare. I'd be happy to answer any questions the Committee may have.

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

DHFS TESTIMONY ON SB 438

SENATE COMMITTEE ON HEALTH, UTILITIES, VETERANS AND MILITARY AFFAIRS
MARCH 8, 2000

The Department of Health and Family Services appreciates the concern and support for continuing the successful BadgerCare program which the Governor and many legislators have expressed. To the extent that 1999 Senate Bill 438 attempts to address the potential budgetary needs for continued enrollment and the HMO rate adjustments for BadgerCare participants, the Department appreciates the intent of the effort. However, this legislation creates several policy and legal problems for the Department in terms of BadgerCare, Medicaid and Healthy Start and therefore cannot be supported by the DHFS. Some of these problems are listed below.

Separate BadgerCare and Medicaid Contracts

SB 438 appears to require separate contracts for BadgerCare and AFDC-Related/ Healthy Start Medicaid. The contract the Department sent on March 1, 2000 to the HMOs for BadgerCare and Medicaid includes separate rates and risk sharing for BadgerCare. Given that BadgerCare rates are different than Medicaid rates, it's unclear what would be accomplished by having two contracts. Federal managed care regulations apply equally to HMOs serving BadgerCare or Medicaid; therefore, the contract requirements would be identical.

Separating BadgerCare and Medicaid administratively would make administration of BadgerCare and Medicaid managed care more cumbersome for families, HMOs, and the Department. For example, a member of one family eligible for Medicaid could potentially have a choice of several HMOs, while another family member eligible for BadgerCare may have to choose between different HMOs for their family's health care. HMOs who don't serve both populations in that scenario would likely lose enrollment.

In addition, the review and processing of two separate legal documents would be more costly for both the Department and HMOs without any added value to the program.

It could be that the intent of the "separate contracts" requirement is to prohibit the Department from linking the contractual obligations, i.e. from requiring any HMO serving the AFDC/Healthy Start population to also serve the BadgerCare population. The effects of this would be to allow HMOs to only select parts of the Medicaid, Healthy Start and BadgerCare enrollment and would destroy the BadgerCare program as it now exists.

Actuarial Requirements

To meet the federal requirement that HMO rates must be actuarially sound, *the Department already contracts for independent actuarial services* to conduct detailed analyses of projected costs that Medicaid/BadgerCare would incur on a fee-for-service basis in the absence of managed care. The Department Secretary determines the final rates based on this detailed independent analysis and the analysis of Department staff.

In addition, the Department and HMOs agree that BadgerCare recipients, because there are more adults in BadgerCare than children, are likely to cost more than Medicaid recipients where the ratio of adults to children is reversed. What some HMOs don't accept is that when BadgerCare and Medicaid rates are combined with the higher rates and risk sharing added for BadgerCare, they yield a combined discount of 5%. The 5% discount is consistent with other Medicaid managed care programs as well as with discounts widely accepted and in effect in many state Medicaid managed care programs.

Another problem presented in SB 438 is the lack of any definition of "actuarially sound." This term is used in the insurance statutes (also undefined), but there it is used with respect to commercial policies. This provision also contains a direct delegation by the legislature to an unknown private firm of the power to set capitation rates. Under the proposal, if the actuarial firm concluded the current rates were not actuarially sound, it would specify new rates, which "shall apply" to services from 7/1/99 to 12/31/01.

BadgerCare Audit

1. Insurance Principles – The bill directs an audit to see if BadgerCare is operated on sound insurance principles. BadgerCare is not an insurance program and cannot be run like a private insurance company. Federal regulations governing rate setting in managed care programs are very specific and non-negotiable, particularly the Medicaid fee-for-service equivalent calculation that is mandatory and is a "cap" on rates. In addition, Medicaid rules already require that rates be actuarially sound. In practice, this has meant that most states either contract with, or employ, certified actuaries.
2. Ineligible Persons – Persons who are not eligible for BadgerCare are not enrolled in BadgerCare. If after a person is enrolled and is later found to be ineligible, that person is removed from BadgerCare with a ten-day federally -required termination notice. In those situations, ***HMOs are allowed to keep their capitation payments*** when someone is determined retroactively ineligible for either BadgerCare or Medicaid. The Department has a long-standing policy not to take back HMO capitation payments when eligibility is reversed retroactively. However, the Department cannot pay HMOs both a capitation payment *and* pay fee for service claims that have been incurred during the time period of ineligibility, as the bill seems to require. Such payments would be duplicative and a violation of federal and state regulations.

Contract Cancellation

The bill also includes a provision that allows HMOs to cancel a contract with the Department if rates are inadequate with 30 days notice. The current contract requires HMOs to give the Department 90 days notice for unilateral termination. The department needs at least 60 days to reassign the HMO's members to another HMO in an orderly manner. In addition, rates are reviewed annually at which time HMOs can decide not to contract with the Department.

Thank you for your consideration of our concerns.