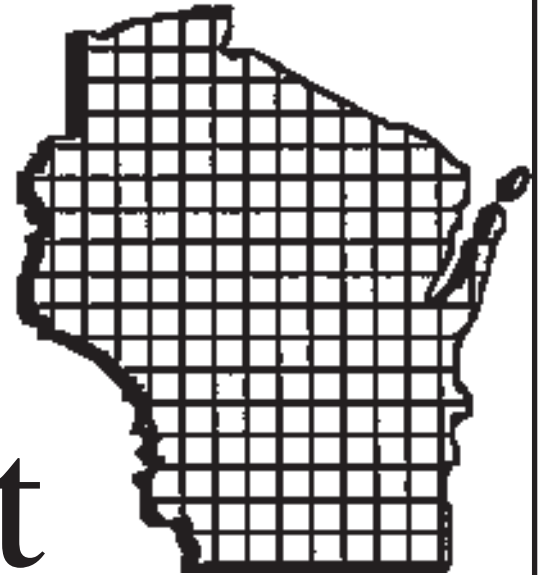


Wisconsin

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Research
Institute

Report



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**Will Healthy
Wisconsin Bust
The State
Budget?**

REPORT FROM THE PRESIDENT:

The one issue that hovers over Wisconsin like a darkening storm cloud is Healthy Wisconsin. The Democrats have accelerated their push to make Wisconsin the first state where the government would run health care.

We believed it was time for us to take another serious look at this health care plan and to examine two major parts. The first is the claim by the Democrats that this is not a government-run plan and secondly the serious impact this could have on Wisconsin's budget. This research project was headed by our Executive Vice President, George Lightbourn, who is a former Secretary of Administration for the State of Wisconsin. He was assisted by one of our fellows with health care experience, Christian Schneider.

One of the claims that has continued to be made by the Democrats is that this is a private sector program. This report totally refutes that idea. There is no way that anyone can view Healthy Wisconsin as a private sector initiative because it will be up to the Legislature and the Governor of the state of Wisconsin to decide whether or not it becomes law. More to the point, they will also determine how much is spent and, ultimately, how it is spent. Under Healthy Wisconsin, government will control the dollars.

That is where the second part of this project becomes so important. When we discuss Healthy Wisconsin we are describing the largest tax increase in Wisconsin history. It will call for more money per year than we now have in our annual budget. The numbers that are being tossed around by liberals are just that — numbers that are being tossed around. There is no way to know exactly what this program will cost, and there are reasons to believe that \$15 billion per year is definitely on the low side. If this program were to be passed, the impact on Wisconsin's budget could be simply astonishing. The potential impact would be a serious problem not only for the state, but would also change the way businesses do business in Wisconsin. If Healthy Wisconsin were a financial failure our economic structure would be fractured for years, if not decades, to come. It has the potential to exacerbate Wisconsin's ongoing problem of being one of the highest taxed states in the country.

There is little doubt that some kind of health care reform is coming. This study points out that Healthy Wisconsin is not so much a solution to the problem as it is the creator of even bigger problems that will dwarf the current crisis we have in health care.

James H. Miller

WISCONSIN POLICY

RESEARCH INSTITUTE, INC.

*P.O. Box 487 • Thiensville, WI 53092
(262) 242-6409 • Fax: (262) 242-6459*

E-mail: wpri@wpri.org • Internet: www.wpri.org

**Will Healthy
Wisconsin Bust The
State Budget?**

GEORGE LIGHTBOURN
CHRISTIAN SCHNEIDER

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EXECUTIVE SUMMARY

Wisconsin is home to the broadest health care reform proposed anywhere in America. The initiative — dubbed Healthy Wisconsin — was introduced two times by Democratic leadership in the Wisconsin State Senate during the current legislative session. While unsuccessful to date, they have vowed to bring it back in 2009, when there is a real possibility that Democrats could control both houses of the Legislature. Wisconsin Democrats have explicitly made Healthy Wisconsin the key campaign issue in their attempt to gain full control of the Wisconsin Legislature.

We are told by the plan's advocates that Healthy Wisconsin is simply insurance reform. "We didn't want it where it was a government-run type of system," said Senator Erpenbach, the chief sponsor. "We wanted to keep it in the private sector."

However, as this report details, Healthy Wisconsin would turn every aspect of the health care system over to state government. Government involvement in health care would not only be likely, it would be required. As with every other aspect of the state budget, the Legislature will have to set the level of payroll tax that supports the plan and establish a global budget for the plan. Further, given that the tax will be by far the largest levied by state government, and that spending on Healthy Wisconsin will exceed the entirety of the state's general fund budget, it is inevitable that health care finance and spending will be prominent political and campaign issues.

While proponents suggest that government's involvement will cease the day the program is enacted, that simply cannot be the case. State government has shown no predisposition to keep its hands off of "independent" programs. It is likely that the Healthy Wisconsin program would have no more independence than the University of Wisconsin system. When legislation creating the UW system was passed in 1974 the responsibility to manage the system was assigned to the Board of Regents, including responsibility for setting tuition. Over time, state government has withdrawn much of the UW's independence, now dictating tuition levels, the ground rules for the transfer of credits, and even the start date for the fall semester. Similarly, when the Healthy Wisconsin legislation is signed, state government will exercise its legislative oversight prerogative.

What would be the likely focus of the oversight? In a phrase, cost containment. Such is the case in England, France, Canada and every other country with a single-payer health care system. Government faces a constant struggle to contain health care spending; to contain taxes. These countries have controlled spending by limiting capital expansion, rationing the use of high-cost new technology and containing the salaries of health care workers. This is the reality of a government-sponsored health care system, which the Senate leadership wants to import into Wisconsin.

It is inevitable that the Legislature would, soon after passage of Healthy Wisconsin, be faced with an increase in the payroll tax that supports the initiative. It turns out that Healthy Wisconsin is founded on a fragile set of actuarial assumptions that suggest that the growth in health care costs can be brought closer to the rate of growth in wages. If that cannot be accomplished, the program will face a shortfall of between \$4.79 billion and \$10 billion by 2017. The promises of Healthy Wisconsin will be tested early and often in the halls of the State Capitol. Will they lower provider and hospital reimbursement rates, moderate capital projects and delay approval of expensive new drugs and medical technology, expand patient wait times or limit access to expensive specialists? These are the decisions that will rest in the hands of the Governor and the Legislature because, at its heart, Healthy Wisconsin will be created and funded by government and will be ultimately subject to oversight by government.

The report also outlines how the creation of a Healthy Wisconsin Trust Fund would impact the state budget. While no one is discussing it, it is likely that whenever the state budget is short of general fund revenues, the Legislature could shift individuals from Medicaid to Healthy Wisconsin, thus saving state general tax dollars. The Legislature has a history of moving people off of Medicaid and BadgerCare as a way to manage the state budget. This type of budget management would be more likely in the future since Healthy Wisconsin would provide a safety net.

Finally, the report highlights a disturbing recent trend in Wisconsin budgeting. The Governor and the Legislature have increasingly shown a willingness to transfer funds from segregated and trust funds in order to balance the general fund budget. In recent years, they have transferred \$1.45 billion from the Transportation Fund and \$200 million from the Injured Patients and Families Compensation Fund. The \$15.2 billion Healthy Wisconsin Fund would have several hundred million dollar reserves that would certainly be available to accommodate future shortfalls in Wisconsin's general fund.

SECTION 1 — INTRODUCTION

Health care is on the mind of America. It is the one public policy issue that directly touches every American and holds the potential to make our lives immeasurably better or worse. It is the issue that has saddled the federal budget with an almost unfathomable deficit while it gobbles up an ever-increasing share of the nation's economy.

For decades, state governments for the most part have been on the sidelines, watching as the federal government and businesses wrestled with health care. No more. State budgets are infected with maddeningly inaccurate health care estimates that have become particularly burdensome as state economies sag and revenues soften. Having been lured by irresistible federal matching funds, state governments have willingly participated in Medicaid spending and have even begged the federal government to go along with large Medicaid expansions. Wisconsin has leveraged the federal matching funds to create BadgerCare and SeniorCare, two programs that are putting serious pressure on the budget. In addition, state governments have historically provided generous benefits to their employees and are generally either the largest, or among the largest, consumers of health care in the state. This too has exacerbated the budget strain. It is as though state governments have awakened to find health care gobbling up an ever-increasing share of dwindling revenues.

While Medicaid and Medicare are two behemoth government programs, U.S. health care is largely provided via the private marketplace. It is a market that has produced a highly sophisticated, very expensive system. It is a system that requires an increasing share of our wealth, as it grows in cost one third faster than the growth of the economy.¹ It is a system in which most people have insurance but some do not. It is a system where some individuals pay little or nothing for comprehensive coverage while others are dealing with increasing co-pays and deductibles. While most Americans have access to reliable health insurance, some small employers and individuals face the precariousness of high cost and the uncertainty of insurance from year to year. As with any marketplace, the U.S. system of health care is dotted with imperfections that have led to undesirable frictional effects. It is these imperfections that have garnered the attention of policymakers.

No longer have state governments been willing to sit on the sidelines. Elected officials have seen health care costs eating holes in state budgets and have read poll after poll that has identified health care as a top issue troubling their citizens. As costs have risen and the political winds have shifted, in statehouses throughout America rhetoric has turned into legislative action. Maine, Massachusetts and Vermont all have enacted comprehensive health care legislation in recent years. The Massachusetts program is the most aggressive, requiring coverage for all of the citizens. In addition, fifteen other states have introduced serious legislation aimed at attacking affordability, access or both.²

However, no state has introduced legislation as sweeping as what has been proposed and passed by the Wisconsin Senate. Named *Healthy Wisconsin*, this legislation would extend health care coverage to all citizens of the state, funding the initiative through a payroll tax that would be shared between employer and employees. No one would be uninsured and no one would be able to completely opt out of Healthy Wisconsin. From cradle to grave, every citizen would have access to the same health care. Modeled loosely on the health care systems found in other countries, its proponents tout it as providing coverage for everyone while reining in costs. And, they add, it accomplishes this by leveraging market concepts and by avoiding the entanglements that come with government programs.

Healthy Wisconsin sounds almost too good to be true. Of course, there are a number of questions that need answering. This report will address one of the underlying tenets of the program: that it is not a government program. Proponents of Healthy Wisconsin maintain that it is a private sector program using: private insurance companies, private providers and private hospitals. But what is the reality and, what will the answer to this question mean to the taxpayers?

We cannot help but reflect on the innocent, well-intentioned beginnings of Medicare and Medicaid. When those programs were created in 1965, it was not envisioned that they would eventually cost nearly \$600 billion and represent 37% of the nation's health care spending.³ Currently consuming 5% of U.S. GDP, Medicare and Medicaid, fueled by demographics and health care inflation, are projected to grow to the point they will consume 13% of GDP and cost each household \$14,000 in federal taxes. Not Truman, not LBJ or anyone else could have envisioned a system that so dominates the health care market and threatens to bankrupt the treasury.

Could Healthy Wisconsin be setting Wisconsin on a similar path? That is the central question this report will explore. In Section 2 we will outline the Healthy Wisconsin program as introduced by the Wisconsin State Senate. In Section 3 we will pull back and provide perspective to this analysis by examining some of the health care models

that exist in other countries. This discussion will provide the underpinning for our understanding of how governments interact with a central health care system. Section 4 will lay out the way that Healthy Wisconsin is linked to state government and its impact on the state budget and the Wisconsin taxpayers.

SECTION 2 — DESCRIPTION OF HEALTHY WISCONSIN

The Healthy Wisconsin initiative was introduced into the state budget by the Wisconsin State Senate in the summer of 2007. The plan is ambitious and complex. Its ambition owes to the fact that it would require a radical departure from the status quo for 68% of the Wisconsin health care market — those who are currently covered by private insurance.⁴ Its complexity is largely due to the complexity of the health care and health insurance industries. The sponsors of the initiative seemingly wanted to change the economics of Wisconsin's health care marketplace without changing the basic manner in which health care is delivered.

As would be expected from such a comprehensive, sweeping change, Healthy Wisconsin has been a policy lightning rod. Proponents note that the initiative would ensure health care for all Wisconsin residents, provide improved health care, and lower costs. Opponents note the plan would require state government to levy a \$15.2 billion tax, jeopardize the quality of health care, and would not lower costs.

Below is a brief description of Healthy Wisconsin. This description is intended to give the reader an overview of the plan's key policy points. Many of the finer elements of the plan are not presented here. The information included in this summary is taken from a combination of information presented by proponents of the plan or from the summary of the plan prepared by the Legislative Fiscal Bureau.⁵

People Covered

Healthy Wisconsin would replace the privately-secured health insurance for most citizens. Those on Medicare, Medicaid and BadgerCare would not be covered by Healthy Wisconsin (without a waiver from the federal government). It should be noted that, under Healthy Wisconsin, an individual's health care provider might not change. Whether an individual or a family must change providers would largely depend on the results of bids solicited by the Healthy Wisconsin Board. It will also depend on the willingness of the individual or family to pay more to stay with a provider that is not included in the low bid in their area.

Healthy Wisconsin Board

At the center of the plan is a public board charged with establishing, funding and administering a health care system for Wisconsin. The board is patterned after the Group Insurance Board, which purchases health care for state employees. The board would either purchase health care from insurance carriers that represent specific provider networks or directly from hospitals and providers. The board is obligated to provide health care benefits that are the same as those provided to state employees and to ensure the capability of each provider or health care network. Any entity bidding must agree to enroll all people who choose their services.

Process of Pricing Health Care

The board would solicit bids for a stated benefit package. An individual or family enrolling in the health care network that submits the low bid in their area would pay no supplemental charge for health care. Those choosing coverage from a network other than the low bidder would pay the full difference between the low bid and the chosen network. The board would also establish payments to providers who charge a fee for services. Annual increases could not exceed the national rate of medical inflation. As with the bids from health care networks, if the fee for service option is a higher cost than the lowest cost network (which is almost certain to be the case), the participant would pay the difference.

In addition, participants would be required to pay a deductible of \$300 for each participant over 18 years old. No deductible would be charged for those under 18 years. Also, participants (those over 18) would be charged a co-

pay of \$20 for medical and hospital visits and \$5 to \$15 for drugs approved by the board and \$40 for drugs not approved by the board. The maximum out-of-pocket for co-pays and deductibles would be \$2,000 for individuals and \$3,000 for families.

Taxes and Other Assessments

The vast majority of the public cost of Healthy Wisconsin would be paid from payroll taxes collected by the Department of Revenue. The board would set the tax rate somewhere between 9% and 12% of wages. In addition, each worker would be assessed a payroll tax between 2% and 4% of wages (the rate could be less for people with extremely low wages). The analysis presented by proponents estimated that the tax on employers would be 10.5% of wages and individuals would be assessed the maximum of 4% of wages. For self-employed people, the tax rate would be set between 9% and 10% of wages. People with no wages subject to Social Security taxation would pay a flat 10% of adjusted gross income.

Source of Savings

Proponents maintain that Healthy Wisconsin will reduce the overall cost of health care for participants. Among the factors noted that will yield lower costs are:

- Competitive bidding of services from health care networks;
- An 8% cap on administrative and overhead costs paid to health care networks;
- The use of co-pays and deductibles to discourage nonessential usage;
- Centralized purchasing of pharmaceuticals;
- There will be no cost shifting since all people will be required to participate in the plan;
- An emphasis on prevention will avoid larger future health care expenditures; and
- Financial incentives are provided to ensure cooperation among fee-for-service providers.

SECTION 3 — HEALTH CARE IN OTHER COUNTRIES

With an issue as complex as health care, there is a tendency to oversimplify the description of its various elements. When discussing health care systems in different countries, we similarly tend to generalize. Yet every country has its own unique approach to health care. Each has its own system for financing health care, its own system for delivering care, its own method for rationing care and its own manner for managing access.

Health care is a window into the national psyche and value system of each country. Many countries have fairness as the central tenet around which they developed a health care system. People in these countries are more comfortable with elevated tax support and longer waiting periods for treatment, as long as everyone is covered and everyone is treated the same. For example, the United Kingdom publishes a wait time for diagnostic tests to be eighteen weeks.⁶

People in many developed countries would find the number of uninsured in the U.S. to be unacceptable. Similarly, they would blanch at the use of co-pays and deductibles as a way to ration care and would find salaries paid to physicians in the U.S. to be excessive. People in other nations have grown accustomed to a health care system oriented around mandates and regulations, the kind of centralization Americans would find stifling. Americans have become comfortable with a system that ostensibly leaves medical decisions in the hands of the medical industry. We chafe at the rules imposed by the health insurance industry, the closest thing many of us covered under private health insurance come to centralized government control of health care.

What follows is an overview of health care finance and delivery system in the U.S and three other countries often cited as alternatives to our system. This discussion is not meant to suggest one system over another, but rather to highlight the differences in the way the systems are financed and the manner in which health care is delivered. This will provide a broader context within which to analyze Healthy Wisconsin.

United States

The U.S. health care system is a diverse blend of a private, market-based system and a central, government-funded system. For decades leading into the Great Depression the nation wrestled with the shortcomings of the health care system: it was too expensive and not enough people had access.⁷ Further, hospitals and physicians saw their revenues threatened by high unemployment and low wages. The American Hospital Association (AHA) began offering prepaid hospital insurance and Blue Cross was created. Soon thereafter, the American Medical Association (AMA), seeing the wisdom of the hospital move, began offering a similar product to cover physician services under the rubric of Blue Shield.

State governments chose not to treat the Blues as regular insurance companies, instead according the new entities a light regulatory touch and favorable tax treatment, two factors that led to their substantial growth in the ensuing decades. For purposes of the discussion here, the significance was that Americans quickly became accustomed to paying a flat fee that would cover health expenses and were willing to allow their relationship with providers and hospitals to be managed by a third party.

Insurers soon realized the advantages of employer-based policies. Employer-based insurance was an early way of limiting risk since those that were insured were at least healthy enough to work. Further, insurers were able to experience-rate the employers, thus making their costs more predictable. The relationship between health care and employers was cemented in 1942 when the federal Stabilization Act allowed employers to provide health insurance to employees tax free. This was codified later in 1954 in the Internal Revenue Code. So, the U.S. health care system was largely funded via prepaid insurance contributions made through employers.

It wasn't until 1965 that President Truman's hope for national health insurance would be realized. Medicare, the program to pay the health costs of the population over 65 and Medicaid, the needs-tested program, allowed the federal government to jump into health care with both feet — although no one expected the growth either of those programs experienced. After all, Medicare didn't cover anyone under 65 and, at the time of enactment, the life expectancy was 66 for the average male and 71 for females. In 1967, the House Ways and Means Committee predicted that in 1990 Medicare would cost \$12 billion. The actual cost turned out to be \$110 billion.

By the 1960s, the basic structure of the U.S. health care system was established. The intervening years have produced enormous changes in technology and nearly every aspect of the practice of medicine, yet the structure created in the 1960s remains in place. It is a system with the following characteristics:

- A mixture of public and private health insurance. For Medicare and Medicaid, the government determines the budget and how the covered population is to receive treatment. Those who are covered by private insurance have no such explicit budget limitations but rather have the funding and care managed by insurers.
- The preponderance of private insurance is purchased through employers. The percentage of people under 65 who have employer-provided health insurance stands at 63%.⁸
- Private health insurance entails payment through a third party insurance company. This injects complexity into the health care system, a complexity that some people maintain increases administrative cost. It is also a reality that insurance companies, by experience rating groups of people, have caused the health care purchasers to become Balkanized, effectively competing with one another for lower rates.
- A number of reimbursement innovations have been implemented in an attempt to lower cost increases and improve care — HMOs, PPOs and managed competition are the three most prominent examples. However, overall costs continue to spiral upward, currently consuming 16% of the U.S. GDP.⁹
- A large portion of the population currently covered by health insurance is satisfied with their health care plan.¹⁰ It is likely that any change that would threaten existing coverage would be viewed skeptically by most people.

United Kingdom

The health care system in the United Kingdom is an extreme example of a single-payer system.¹¹ The central government collects revenue to support the system through general taxes (value added, payroll and income taxes) and the care is provided in government hospitals by government employees. A very small amount of user fees supports the system (mostly for long-term care, dental care and eye care). In addition, there is a small, but growing private

health care market; some people are willing to pay extra to cut wait times and to ensure access to specialists.

The government has placed significant emphasis on controlling costs and has been somewhat successful in that regard. Whereas 16% of the U.S. GDP is spent on health care, in the United Kingdom it is only 7.5%. In recent years, British spending increases have approximated the growth in the GDP. However, in 2006 the system was carrying a \$1.4 billion deficit.

What is instructive about the United Kingdom's system is the impact of cost containment. The country has explicitly determined to manage health care within a fixed, global budget and the users of the system have come to expect a certain level of rationing of care. For example: While there is good access to general practice doctors, follow-up care presents patients with long wait times. As many as 750,000 patients are waiting for treatment. Wait times include time spent waiting to see a specialist (2.5 months) and time spent waiting for elective surgery (3 months). Further, the access to specialists is pinched, not just by elongated waiting times, but also restrictions on access to particular specialists. By one account, 40% of cancer patients never have access to an oncology specialist. Finally, the United Kingdom's focus on cost containment seems to have restricted the purchase of medical technology. The country has one-fifth of the CT scanners and MRIs per capita as the U.S.

France

France is often held up as an example of a quality health care system. It is ranked as the best in the world by the World Health Organization (which ranks the U.S. system as 37th best) and provides access to all of its legal population. Even some conservative observers in the U.S. acknowledge that the French system has some positive features from which the U.S. could learn.

Health care in France is primarily provided by private physicians and hospitals are both public and private. Patients have full access to choose any general practice physician, any specialist and any hospital. And to date, waiting lists have not been a prominent feature of the French system.

As in the U.S., care is financed through health insurance. However in France, most insurance is publicly funded. Every French citizen is required to participate in a sickness fund (health insurance) and no one is allowed to opt out. Much of the cost of care is paid upfront by the patient and is quickly reimbursed by the sickness fund. For the two-thirds of providers that have agreed to abide by the national fee schedule, the reimbursement covers most, if not all, of the cost.

However, one third of providers have not agreed to the national fee schedule and can charge market rate prices. To cover the residual out-of-pocket costs, many French are purchasing supplemental insurance (most of which is employer provided). By allowing providers to opt out of the national fee schedule and allowing individuals to pay the higher cost, the French system is much more market-driven than the United Kingdom's system. Fully 86% of the French now are covered by supplemental insurance to accommodate the growing market-based sector of the health care system.

Of course at the heart of the French system lies the government, which sets the global health care budget, sets the reimbursement rate for two-thirds of the practitioners and imposes the taxes that fund the system. The system is funded primarily through general taxes (income taxes, payroll taxes and taxes on pharmaceuticals and tobacco). As might be expected, the French health care system has been plagued by escalating costs and budget deficits. French health care consumes 11% of GDP (third highest) and is contributing \$16 billion to the French national deficit.

There are a couple of findings that point out the value differences between France and the U.S. First, French physicians are paid much less than their U.S. counterparts: the average French physician's salary is \$55,000 compared to \$146,000 for primary care physicians and \$271,000 for specialists in the U.S. Second, a national survey reveals that overwhelmingly the French believe the quality of care they receive is less important than ensuring that everyone has equal access to care. It is doubtful that the American public would respond the same way.

Canada

Perhaps due to its proximity to the U.S., the Canadian health care system is often held up as an example of a better way to provide national care. It is a system with government at its core, but is quite different than either the United Kingdom or France.

Canadian health care is a constitutional responsibility of the provinces or territories, which means they are responsible for funding and delivering health care. The national government plays the role of regulator and exacts compliance with national standards through the threat of withholding transfer payments to the provinces. Canada's decentralized system is not entirely dissimilar from our Medicaid program where the national government sets the basic terms of health care and uses financial incentives to elicit the cooperation of the states.

Basic insurance is provided to all residents (three-month residency) by the provinces and territories. In addition, 73% of Canadians are covered by supplementary insurance to cover drugs, dental/vision, hospital room upgrades and non-standard care (e.g., chiropractic care). While the Canadian system is partially funded through user fees, there are no user fees charged for services the national government deems to be medically necessary.

Most physicians are private, while the preponderance of hospitals are public. Physicians are paid on a fee-for-service basis through rates negotiated with the government. Capital expenditures, in order to be reimbursed, must be approved by the government. Many physicians complain about the condition of hospitals and the lack of diagnostic facilities. By way of comparison, the U.S. has five times as many MRIs per capita as Canada.

The Canadian system is primarily financed from general taxes levied by municipal and provincial governments. The national government funds its transfer payments to the provinces from general fund tax revenues. In addition, 30% of Canadian health care costs are paid either out-of-pocket by consumers or by private insurance.

As is evident, each of these countries has developed their own approach to providing health care to their citizens. They have different delivery systems and different ways of financing the systems. However, at the heart of each system is government — more explicitly involved in the actual provision of service in the United Kingdom than in either France or Canada. However, in all three countries, health care is dependent on the taxes raised by government. As each country grapples with the two-headed hydra of containing health care costs and restraining taxes, the central government has become the key player in shaping the nation's health care system.

SECTION 4 — HEALTHY WISCONSIN AND THE STATE BUDGET

The Healthy Wisconsin plan is nothing like the United Kingdom, France or Canada according to the plan's proponents. They have gone to great lengths to portray the initiative as non-governmental. They have done so in the public presentations promoting the initiative, as well as in designing the legal framework for the program. However, the fact is that the proposed legislation creating Healthy Wisconsin creates a government program that would share many of the traits of the health care systems in those other countries. In fact, Healthy Wisconsin would operate almost exactly like every other program in state government.

The vigor with which proponents have protested connections to government is somewhat curious given that many of those who favor single-payer health care reform are quite comfortable with a government-run system. Yet the program's sponsors have seemingly been on a mission to distance it from government. So Healthy Wisconsin is never referred to as "government-run." Rather, the plan is described as "universal care."

Perhaps proponents have shied away from the linkage to government since government doesn't fare especially well in the eyes of the public. In a recent Wisconsin Policy Research Institute poll, a miniscule 2% of respondents said they trust government to do what is right almost all of the time. In the same poll, only 12% of the respondents said they believe voters have the ability to determine what their government spends, while 82% think lobbying groups have more control over state spending.¹²

Much of this distrust of government is likely due to a number of high profile problems government in Wisconsin has recently suffered. In 2007, legislative wrangling caused the state budget to be finalized nearly four months late. In recent years, Wisconsin also suffered from several highly publicized court cases that resulted in the conviction and imprisonment of top legislative leaders.

Of course there is one other reason for avoiding being linked too closely with government. Many people favor leaving health care decisions in the hands of a health care professional rather than a government administrator.

What the Proponents Say

Let's review how the program's proponents have attempted to distance it from government. The Healthy Wisconsin web site poses the question, "Is this a government takeover of our health care system, or socialized medicine?" The answer given is an emphatic, "No, Healthy Wisconsin does not change our first rate health care system." And further, "It will be run by a non-profit board that is publicly accountable. . . . Most of the major decisions made under Healthy Wisconsin are *not* made by government." One might be left with the impression that the operation of Healthy Wisconsin will be akin to any other free-market system.

One of the chief proponents of Healthy Wisconsin is the Wisconsin chapter of the AFL-CIO which maintains, "Healthy Wisconsin does not change our first rate health care system. You will still receive care from the same network of private doctors, clinics, and hospitals. The plan changes the way we pay for access to the health care system, substantially reducing cost, while guaranteeing access and choice. It will be run by an independent public/private partnership, and everyone can choose between a public or private health plan, and will be covered."¹³

Joe Lekan, former Secretary of the Wisconsin Department of Health and Family and Healthy Wisconsin advocate was asked if the plan was a government-run program. He was emphatic that such a claim was, "not true," and that the plan, "is governed by a board of trustees made up of representatives of large and small businesses, labor, education and agriculture with an advisory group from the health care provider community."¹⁴

But the clearest explanation of how Healthy Wisconsin is non-governmental was provided by Senator Jon Erpenbach, the chief sponsor of the legislation. Senator Erpenbach, in a statewide broadcast said, "When we put the package together, we did not want to re-invent things." "We didn't want it where it was a government-run type of system. We wanted to keep it in the private sector."¹⁵

What the Proponents Do Not Say: The Reality

The plain fact is that Healthy Wisconsin is a government program. It cannot be anything other than a government program. It would have to be created in state statute and would entail the levying of a tax. State government in Wisconsin cannot collect a tax from its citizens and turn the proceeds over to a private entity. Tax proceeds cannot be turned over to an independent body without the Legislature and the Governor either tacitly or explicitly approving how the money is spent. They would have the ultimate control over the funding of Healthy Wisconsin. In this section we will detail why Healthy Wisconsin cannot be described as anything other than a government program.

Government Oversight

Let's start with the most obvious observation; Healthy Wisconsin will be created by state law, passed by the state Legislature and signed by the Governor. Its very existence will be dependent on proactive government action. As such, the details of the plan will also be controlled by the Legislature and the Governor.

If the legislation is approved, the authority to implement Healthy Wisconsin would be assigned to a 16-member Board of Trustees — the independent board supporters cite when making the case for the plan's independence. The members of the board will be nominated by the Governor and appointed with the advice and consent of the Senate. As a result, the very makeup of the plan's governance is inextricably linked to government. While it would undoubtedly be desirable for appointments to such a board to be devoid of politics, such has not consistently been the case with other independent boards such as the Board of Regents and the Natural Resources Board — nominees to these boards tend to be politically palatable to the sitting governor. Further, in recent history, confirmation of gubernatorial appointments has been withheld by the State Senate for months and even years. In cases in which confirmation has been withheld, it is usually due to thinly veiled political considerations rather than merit. Therefore, the fact that the board is government-appointed will entangle the board in Wisconsin politics.

Under the Healthy Wisconsin legislation, board members will have a number of government-like responsibilities, including:

- Enrolling every eligible Wisconsin resident;

- Creating a program for consumer protection and a process to resolve disputes with providers;
- Establishing an independent and binding appeals process for resolving disputes over eligibility and other determinations made by the Board, and entitle individuals adversely affected by any such determination to judicial review of the determination;
- Submitting an annual report on the Board's activities to the Governor and each house of the Legislature;
- Contracting for the annual, independent program evaluations and financial audits that measure the extent to which the plan is achieving its statutorily defined goals;
- Accepting bids from health care networks, or make payments to fee-for-service providers, upon consulting with the Department of Employee Trust Funds to determine the most effective and efficient way to purchase health care benefits;
- Auditing health care networks and providers to determine if their services meet the plan's statutory objectives and criteria.

As can plainly be seen, the requirements of the board closely resemble government involvement. The annual report is submitted to the Governor and Legislature because those entities actually have final oversight of the program. An annual audit by the Legislative Audit Bureau (LAB) is mandated; yet state statutes mandate audits of *state* programs, or at least programs with substantial state involvement (such as the Southeast Wisconsin Stadium District). The state can't send the LAB in to audit private insurance companies, for instance. The plan's authors have drafted the Healthy Wisconsin legislation as a governmental program.

Government's Continuing Involvement

The Healthy Wisconsin legislation embodies the micromanagement of the health care system. It mandates a number of operating requirements all of which impinge on the free market nature of the program. For instance, the legislation requires that, in order to qualify, a health network must:

- Spend at least 92% of the revenue it receives under the plan on health care benefits specified under the plan. In other words, no more than 8% of the network's revenue can be spent on administration;
- Ensure that participants living in an area that a health network serves would not be required to drive more than 30 minutes, or in a metropolitan area served by mass transit, spend more than 60 minutes using mass transit facilities, in order to reach the offices of at least two primary care providers;
- Ensure that physicians, assistants, nurses, clinics, hospitals, and other providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment are conveniently available (as defined by the Board) to participants living in every part of the area the network serves;
- Ensure that participants have 24-hour access, seven days a week, to a toll-free hotline and help desk that is staffed by persons who live in the area and who have been fully trained to communicate the benefits provided under the plan;
- Emphasize and promote "healthy lifestyles" and preventative care in its policies, among other requirements.¹⁶

Each of these mandates on private health networks would be set in state law. It is likely that over time, as the program evolves, other mandates would be adopted by the Legislature.

Wisconsin state government has a history of statutorily restricting management independence of government entities. Therefore, we would expect that this list of mandates would grow over time, just as it has for other "independent" programs.

The sponsors of Healthy Wisconsin legislation maintain that, once enacted, the program will be divorced from government and beyond the reach of government. That cannot be the case. The program, if enacted, would be a creature of state statutes and the statutes are a living document. Change should be expected.

Let's examine the statutory interplay between the statutes and another ostensibly independent agency, the University of Wisconsin system. The UW system was created in 1974 when two separate public higher education systems were merged. A new section in Wisconsin statutes was created to spell out the various requirements and responsibilities for the new system. However, a review of the 1974 statutes and the current statutes show some significant changes.

- In 1974 the Board of Regents had broad latitude in setting tuition. Current statutes prohibit the board from setting tuition that would generate an amount beyond what is approved in the statutes. Tuition setting is now done in the state budget, not by the Board of Regents.
- In 1974 there were no restrictions on the regents' ability to set the academic calendar. Current statutes prohibit commencing the fall semester before September 1.
- In 1974 the Board of Regents had full authority over student transfers between UW campuses and transfers from non-UW universities. Current statutes provide guidance in how transfers are to be handled. It is likely that the statutes would be more prescriptive had the Board of Regents not made changes to accommodate legislative desires on credit transfers.

This is not to say that legislative intervention into the operation of the UW system is inappropriate. People might disagree as to whether the University of Wisconsin should be statutorily directed to begin classes after September 1, but few would argue that this policy matter is beyond the purview of legislative review. Whether appropriate or not, in a dynamic country public policy evolves. Technology advances, popular preferences change and elections bring fresh ideas and new perspectives to state government. It is expected that every aspect of government will periodically be subject to scrutiny and change. We should expect nothing different if Healthy Wisconsin is enacted into Wisconsin state statutes.

Government Sets the Health Care Global Budget

Regardless of what proponents say or what they have attempted to do in crafting the legislation, state government will be responsible for establishing a global budget for health care. It would have no choice. This would be the case in spite of the rather creative provision that would seemingly minimize legislative involvement in setting the health care budget. In the draft of Senate Bill 562, the language provides that a sum sufficient will be available to the Healthy Wisconsin Board to carry out the health care plan. Further, the legislation would prohibit the display of the amount spent on Healthy Wisconsin in the schedule listing all state spending.

While these provisions were intended to give the appearance of minimal legislative involvement in setting the global budget, the reality is that the Legislature would be directly involved. Legislative involvement would occur in two ways. First, the Legislature and the Governor would have to establish the tax rate and would have to adjust the rate upward if necessary. It is almost certain that the tax rate would go up since actuarial estimates place the payroll tax for workers at 4%, which is the maximum rate allowable under the proposed legislation. Also, since health care costs have risen faster than payroll in recent decades, it is likely that the employer payroll tax would also be bumping up against the 12% maximum within a short time.

Second, each biennium the Legislature and the Governor would have the opportunity to approve the appropriation of funding for Healthy Wisconsin. Crafting the appropriation for Healthy Wisconsin as a sum sufficient does not negate the possibility for approval by both the Legislature and the Governor. Every two years they would have the opportunity to approve the Healthy Wisconsin budget. Given that the payroll tax, which would support Healthy Wisconsin, is larger than the entire state budget, it is likely that state government would go well beyond a cursory review of Healthy Wisconsin. The Healthy Wisconsin budget might not receive the detailed level of oversight as other agency budgets, but it would be naïve to assume there would be no oversight over the expenditure of such a significant use of tax revenue. Undoubtedly, health care would be a key election issue given the state role in levying the payroll tax.

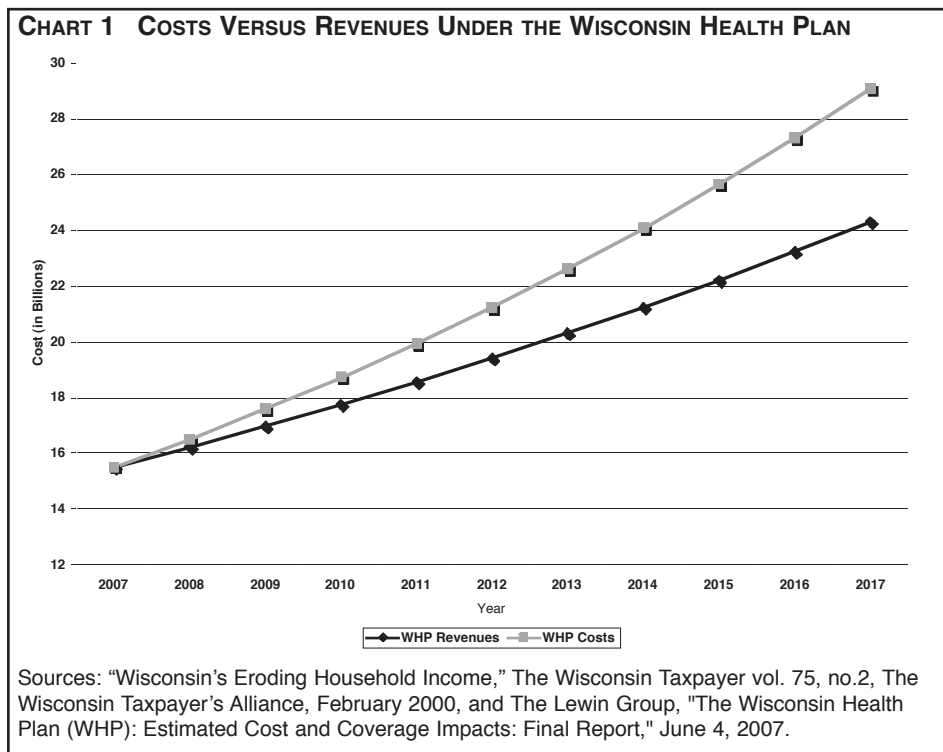
Thus, Wisconsin's elected officials would assume the role that central governments in most countries assume; setting the overall health care budget for the citizens. Further, unlike the current health care finance system with all of its complexities, under Healthy Wisconsin, health care financing would be handily located in one place: the State Capitol. As such, Healthy Wisconsin would be subject to the same public input as other state programs. Taxpayers and businesses would likely push to minimize the payroll tax, while health care providers and hospitals would want to ensure adequate funding is provided. Health insurers would likely push to increase the allowable administrative expenses.

Regardless, there are tax caps in the legislation that would likely need adjusting soon after enactment. For example, the payroll tax on workers would be set at between 2% and 4% of wages. The actuarial estimate released by the proponents of the legislation¹⁷ placed the necessary tax on individuals at the cap of 4%. Soon after enactment, the Legislature would have to consider raising the tax rate.

While the sponsors of Healthy Wisconsin suggest that the competitive factors built into the program would mitigate cost increases, it is questionable whether that would actually occur. The track record of government in estimat-

ing health care costs is not good. The federal government has historically underestimated Medicare and Medicaid costs.¹⁸ There are a number of factors that could drive costs higher including costs related to utilization, enrollment, technology, and pharmaceuticals to name a few. To project that Wisconsin's health care cost increases would not exceed increases in wages one would have to assume health care costs increases in Wisconsin would be substantially below those experienced in the rest of the country. It is likely that within a short time after enactment, the Legislature and Governor would have to address whether to increase the payroll tax on employers and workers.

Chart 1 demonstrates the growing gap between anticipated revenue and spending under the Wisconsin Health Plan (WHP), which was a precursor to the Healthy Wisconsin program. According to the Lewin Group, both revenues and expenditures for the WHP were expected to be \$15.5 billion for 2007. As can be seen in the chart, given



the assumptions put forth by the plan's supporters themselves, the gap between revenues and expenditures grows to over \$4.79 billion by 2017. It is also important to note that in its assessment of the WHP, Lewin warned that tax rates would have to increase in the next decade to fully fund the program. In Figure 34 of their analysis, which is entitled "Tax Rates Required to Fully-Fund the WHP in 2007 through 2017," they note the tax rate on businesses will have to increase to 13.51% and on employees to 4.62% by 2017 to keep the system solvent — perhaps to fill the gap demonstrated above.

Healthy Wisconsin Sets Up a One-Stop Shop for Health Care Policy

What of health care policy matters other than taxes? There are a number of health care issues that are currently left to the private marketplace that, given the comprehensive nature of Healthy Wisconsin, now would be raised in the public sector. In essence Healthy Wisconsin would create a one-stop shop for health care policy. The list of issues that would likely arise might include: physician salaries, incorporation of new technology, approved pharmaceuticals, waiting times, new buildings and dozens of other issues that appear daily in the print and electronic media. Even the advocates envision that Healthy Wisconsin would provide a forum for many troublesome issues. Few discussions of Healthy Wisconsin have occurred without the advocates mentioning the cost impact of new medical facilities, implying that fewer such facilities should be approved. With the enactment of Healthy Wisconsin these issues would quickly arise in state government.

This discussion of the link between Healthy Wisconsin and state government should not be overstated. It is unlikely that the legislation would result in an explicitly government-run health care system like the one that exists in the United Kingdom. More likely is the prospect of a relationship between government and health care akin to what exists in France and Canada. In those countries the government plays a role in setting the global budget. From that broad responsibility, government derives control over the way health care is provided. As with any funding issue, there is a tradeoff between the level of funding and access and the quality of service. In Canada this has led to a more limited implementation of technology than exists in America. In France, government involvement has resulted in a significantly different pay scale for physicians than that to which we have become accustomed. These are but two examples of the type of influence government financing might exert over health care.

Finally, we should consider the interplay that might occur if the Healthy Wisconsin board were to take an unpopular action; say to disqualify a health care network that services a large number of people. The legislation vests the Healthy Wisconsin Board with broad power to “implement cost containment strategies that will retain and assure affordable coverage for all Wisconsin residents.” Under this authority, the Board would have broad powers to create waiting lists, limit access to care, limit access to new technologies, and resurrect a certificate of need requirement, among other “cost containment” actions. All of these actions are common cost containment strategies in other countries.

Yet, any cost containment strategy implemented by the Healthy Wisconsin board could be overridden by the State Legislature. Most of the mandated procedures in current law are there because of strong constituencies dependent on those procedures — and Healthy Wisconsin would likely be no different. If waiting lists ever became a realistic possibility, it’s likely that the Legislature would step in and force some kind of change to the plan to ameliorate the problem.

Healthy Wisconsin: A Back Door Funding Source for Medicaid

Overlooked to date in the analysis of Healthy Wisconsin is the impact it will have on the state budget. In the previous section we showed how state government would become involved in setting the global budget for Healthy Wisconsin. Yet the impact on the state budget will go well beyond that. Recent history suggests that there would be a rather interesting interplay between Healthy Wisconsin and the remainder of the state budget. A significant element of the interplay is related to the Medicaid budget, so let’s begin there.

Since its inception in 1965, Medicaid has been a partnership between the federal government and the states to provide health care to low income and disadvantaged people. The program is administered by the state under rules set down by the federal government. The federal government applies a unique reimbursement rate to the cost for each state based on per capita income. Wisconsin is reimbursed for 58% of its Medicaid cost.¹⁹

In Fiscal Years 2008 and 2009, the state has budgeted \$1.7 billion in state general purpose revenue for the Medicaid program. This state funding is matched by \$2.8 billion and \$3 billion, respectively, in federal funds.²⁰ According to the Lewin Group, Healthy Wisconsin is expected to cost the state’s taxpayers \$15.2 billion per year, which makes it nine times as large as the state’s current program for low-income uninsured.

Expecting that the two programs would act independent from one another seems unlikely. Given the different funding sources and different populations within each program, it is entirely possible that funds and individuals could be shuttled between Healthy Wisconsin and Medicaid to suit the state’s needs at the time.

For instance, suppose the economy was to take a sharp downturn, as many experts are expecting in 2008. When the economy recedes, more people become reliant on Medicaid for health insurance — yet at the same time, the state has less money to fund the MA program. It is entirely possible that, if the Healthy Wisconsin program were in effect, the state would have a strong incentive to move people off traditional Medicaid and into the Healthy Wisconsin program. This could be achieved by lowering income limits for the Medicaid program (within federal guidelines), thereby shrinking the number of individuals eligible for coverage. Fewer people on Medicaid would translate into a savings for the state’s general fund.

In Fiscal Year 2000, Wisconsin spent \$2.8 billion on its Medicaid and BadgerCare program from all funding sources. By Fiscal Year 2009, that number had increased 78.1%, to \$5.1 billion. In comparison, state General Purpose Revenues (GPR) only increased 24.5% in that same time period. In fact, even in years when state revenue suffered dramatically, spending for MA related programs increased substantially.

Table 1 demonstrates the increase in state funding for MA-related programs (MA, BadgerCare) between 2000 and 2009.

Chart 2 demonstrates the above table graphically. As can be seen, the increase in MA-related funding exceeds the increase in GPR in every year except 2002 and 2006.

The fact that MA spending is increasing at a faster rate than general revenues has strained Wisconsin’s budget. To address budget realities, steps could be taken to restrict access to citizens in the future. Such a move would be especially tempting if there was a universal government-run program on which to fall back.

Yet even without the “safety net” of universal health care, state governments have begun to save money in their Medicaid programs by tightening eligibility requirements for adults. In 2004, Arizona repealed eligibility of parents under their KidsCare program. Kansas moved to cut adult Medicaid benefits for anyone receiving benefits more than 24 months. Texas dropped the eligibility level of pregnant women from 185% of the federal poverty level (FPL) to

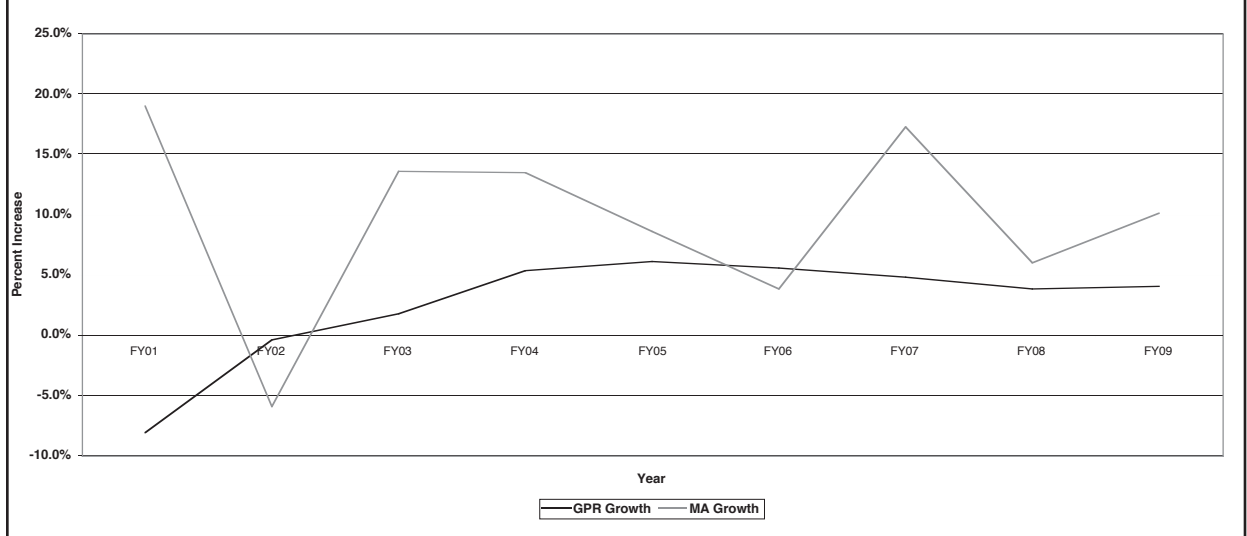
158% and eliminated a program they called the Medically Needy Spend Down, which covered an average of 10,000 individuals.²¹

Like any government program, Medicaid is not static. While the federal government routinely changes features of the program, the most dramatic changes are initiated by state government. Wisconsin has obtained approval for two significant expansions in recent years: BadgerCare and SeniorCare. SeniorCare is a program implemented in

TABLE 1 MEDICAID-RELATED (MA) FUNDING VERSUS GENERAL PURPOSE REVENUE (GPR), 2000-2009 (IN MILLIONS)

Year	GPR	Change	MA	Change
FY00	\$10,946.0	N/A	\$2,872.3	N/A
FY01	\$10,063.4	-8.1%	\$3,649.4	27.1%
FY02	\$10,020.2	-0.4%	\$3,447.4	-5.5%
FY03	\$10,199.7	1.8%	\$3,852.7	11.8%
FY04	\$10,739.3	5.3%	\$4,169.2	8.2%
FY05	\$11,396.7	6.1%	\$4,270.9	2.4%
FY06	\$12,030.1	5.6%	\$4,194.6	-1.8%
FY07	\$12,613.7	4.9%	\$4,716.8	12.4%
FY08	\$13,101.1	3.9%	\$4,819.9	2.2%
FY09	\$13,627.2	4.0%	\$5,114.2	6.1%
Total:		24.5%		78.1%

CHART 2 MA AND BADGERCARE FUNDING VS. GENERAL PURPOSE REVENUE



2001 to assist the elderly purchase prescription drugs. BadgerCare was enacted in 1997 to expand health care coverage beyond the very poor to the working poor. A review of the short history of BadgerCare will show how the Legislature has been willing to change elements of the program to manage the cost of the program.

Since its inception, BadgerCare has proven to be a difficult program for which to accurately estimate costs and has now grown into a much more costly program than originally envisioned. Enacted in 1997, BadgerCare was intended to provide health insurance for individuals below 185% of the federal poverty level (FPL), but above the 133% cutoff for MA eligibility. The thinking was that people in the gap between 133% and 185% would pay a premium for health care, while those under the 133% level would continue to receive cost-free benefits. Once in the program, people could stay in the program until their income reached above 200% of the FPL.

The first drafts of BadgerCare legislation had enrollees paying 7% of their income in premiums to participate in the program. Charging premiums for this group was thought to “encourage personal responsibility and move individuals from government support toward self sufficiency.”²²

However, an analysis by the Lewin Group—the same actuary used by proponents of Healthy Wisconsin—detailed the effect of cost sharing on a similar program in Washington State. Lewin argued for lower premiums, using nearly the exact rationale for the Healthy Wisconsin program: the cheaper health care is made for participants, the more preventative care they will receive, which will save money in the long run. Lewin said:

In practice, “necessary” care deterred by cost sharing may cause an increased utilization of health services at later states of an illness, resulting in higher health expenditures and lower health status in the long term. These deterrent effects are especially profound when considering the effects of cost sharing on poor and near-poor populations.²³

In the end, the Legislature responded to the Lewin analysis and reduced the premium to 3% of an eligible family’s income. Additionally, families with incomes up to 143% of the FPL were eligible for free care; up from the initial 133%. The program was funded through a mixture of general purpose revenue, expected premiums paid by enrollees, and federal matching funds. The LFB estimated that at the 3% premium level, the program would serve 19,600 children and 22,800 adults, for a total of 42,400 enrollees.²⁴

When the program went into effect in 2000, the results were somewhat of a surprise, given the expectation that cost sharing made people “self sufficient” and low premiums saved money in the long-term. In the first quarter of enrollment, the program welcomed 23,151 new enrollees (6,298 children and 16,853 adults). By the end of 2003, that number had grown to 114,237 enrollees (37,839 children and 76,383 adults).

The cost of BadgerCare increased commensurately. In Fiscal Year 2001, the first full year of the program’s operation, the Legislature spent \$129 million in all-funds revenue on BadgerCare. By Fiscal Year 2004, merely three years later, that number had nearly doubled to \$205.6 million.

The introduction of a new, high cost program like BadgerCare couldn’t have come at a more stressful time for the Governor and the Legislature. In 2003 they were dealing with the aftereffects of the 2001 recession and, as was the case in nearly every state, tax revenue plummeted leaving the state budget with a \$3.2 billion budget shortfall. Every program, including BadgerCare was put under the microscope in search of savings.

In response to both the fiscal challenges and policy concerns, the Legislature began to make changes that trimmed the BadgerCare program. In the 2003-05 budget, new requirements were added that:

- Increased premiums for enrollees over 150% FPL from 3% to 5% of family income;
- Required each member of a family who is employed to verify his or her earnings;
- Required enrollees to provide documentation as to whether their employer provides family health coverage; and
- Required participants to provide documentation as to how much their employer pays towards their health care premiums.

It was clear to the Legislature that BadgerCare costs were unsustainable given the fiscal condition of the state. The action taken by the Legislature worked. Enrollment in BadgerCare began to fall in 2004. The program had

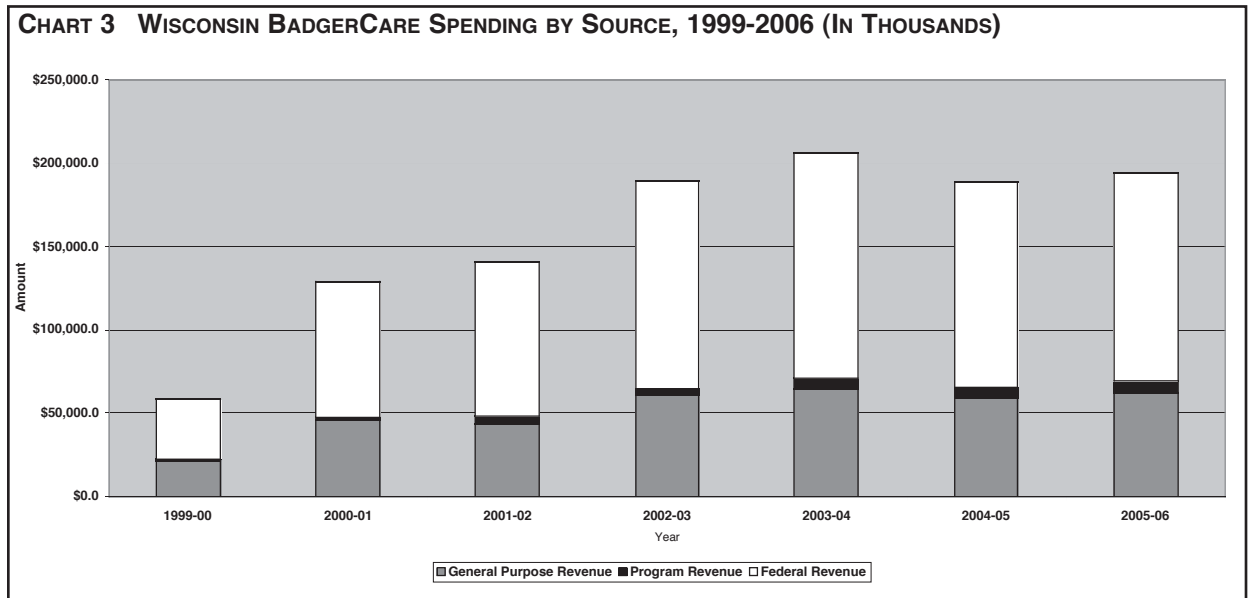
reached a high water mark of 114,237 enrollees in March 2004; by September 2006, that number had dropped to 94,034. Accordingly, the cost of the program also fell. As noted, in Fiscal Year 2004, \$205.6 million was appropriated for BadgerCare. The next year, appropriations for the program fell to \$188.6 million, before climbing to \$194.4 million in fiscal year 2006 – likely due to the rapidly rising cost of health care.

Table 2 details total BadgerCare year-end enrollment between 1999 and 2006.

TABLE 2 BADGERCARE ENROLLMENT BY YEAR-END, 1999-2006

Year Ending	Children	Adults	Total
1999	12,851	32,003	44,854
2000	22,636	51,885	74,521
2001	27,753	61,832	89,585
2002	34,445	68,988	103,433
2003	37,839	76,383	114,222
2004	30,302	62,728	93,030
2005	29,489	61,767	91,256
2006	28,688	65,346	94,034

Chart 3 details total spending for the BadgerCare program between 1999 and 2006.



Recounting of the history of BadgerCare demonstrates how program changes have been made to affect enrollment and program cost. More to the point, it shows the willingness of state government to make program changes in the interest of balancing the state budget. However, in the past, when changes have been made to reduce enrollments, it has been assumed that the affected families have obtained insurance either on a stand-alone basis or through an employer — or that the families have simply done without health insurance. The enactment of Healthy Wisconsin would change that.

Any change to BadgerCare, or any component of the Medicaid program that would impact eligibility, would now simply move the displaced population onto Healthy Wisconsin. So policymakers would not be faced with a choice between whether or not to include people in a government health care program, but rather, the choice would be which program to use. As such, Healthy Wisconsin would be the ultimate safety net, a point with which proponents would not disagree. In some respects, the decision to reduce the BadgerCare population would be easier knowing that a safety net exists.

Clearly there would be fungibility between Medicaid and Healthy Wisconsin. When general fund revenues are tight, it might be tempting for the Governor and Legislature to move more of the Medicaid population onto Healthy Wisconsin. After all, state general fund taxes are picking up 42% of the cost of Medicaid whereas general fund taxes would pick up 0% of the cost of Healthy Wisconsin. Further, a change in Medicaid, which would save the general fund, say, between \$40 and \$50 million, would have a minute impact on the \$15 billion Healthy Wisconsin program.

It should be noted that the proposed Healthy Wisconsin legislation would have the state request that federal approval be sought allowing the Medicaid and BadgerCare populations to be merged into Healthy Wisconsin. If this were to occur, the fungibility would be explicit; the Healthy Wisconsin Board would manage health care for the entire population. But even without federal approval, there would be a degree of fungibility between the two programs.

However, we should note that the fungibility could actually work in the opposite direction. Were the payroll tax to become contentious — a distinct possibility — it would probably be argued that more costs should be moved onto Medicaid and BadgerCare where 58% of the cost will be borne by the federal government.

The point is that Healthy Wisconsin will be inextricably linked to the state budget.

Healthy Wisconsin as a Revenue Source to Balance the State Budget

This is not only relevant with respect to Medicaid, but also with respect to the general management of the state budget. It is entirely conceivable that Healthy Wisconsin could be looked to as a source from which to balance the

budget. It should be noted that the Healthy Wisconsin legislation would have placed the revenues that support the program in a separate trust fund. It would ostensibly be off limits for purposes other than to fund Healthy Wisconsin.

However, in recent Wisconsin budgets the Legislature and Governor have increasingly used revenues from segregated funds — which were thought to be off limits — to make up deficiencies in the state’s general fund. Since 2003, \$1.25 billion has been transferred from the segregated transportation fund (the impact of which was partially offset with increased bonding authority). In addition, the most recent biennial budget included a \$200 million transfer from the Injured Patients and Families Compensation Fund (which was established in 1975 to provide excess malpractice coverage for physicians, not to help balance the state budget). In fact, a budget stalemate was broken largely due to this \$200 million transfer of revenues assessed to health care providers. The Wisconsin Medical Society filed suit contesting the transfer, but a decision has yet to be rendered.

Would the Healthy Wisconsin Trust Fund be subject to a similar transfer? In all likelihood, the answer is “yes.” Since the Healthy Wisconsin program would perform many of the functions of a health insurer, it would be prudent for the agency to maintain reserves. Since every 1% held in reserve on the \$15 billion program would be \$150 million, it would run counter to historical precedent for state government not to use this source to avoid future spending cuts or tax increases.

Healthy Wisconsin: The Budget Busting Gamble

Without question, the proposed Healthy Wisconsin program would have a major impact on the state budget. This would also be the case in any state that implemented a single-payer health care program. The tax revenue needed to support the plan would put the initiative front and center in the state budget. This is not a theoretical budget impact but rather a budget impact that is inevitable.

Setting aside the issues that are generally the focus of discussion: the impact on health care spending, the impact on the economy and jobs, the value of extending coverage to the currently uninsured population or the effect a Healthy Wisconsin-type single-payer program would have on health care spending, we will focus here on what Healthy Wisconsin would mean for the Wisconsin state budget. By virtue of its size, Healthy Wisconsin will dwarf the rest of the state budget. The \$15.2 billion cost of the program would be collected from employers and workers and would be accommodated in the state budget. Not only would the \$15.2 billion for Healthy Wisconsin be the largest expenditure of state-collected tax revenues, it would eclipse the size of the Wisconsin’s general fund budget. The 2007-08 state budget appropriates \$13.8 billion for all state programs and transfer payments.

And, if adopted, it would be impossible to reverse the change and return to the current health care system. Healthy Wisconsin would change the way the public interacts with the health care system. Businesses would dismantle the infrastructure built up to purchase and manage employee health care. The insurance industry would make significant changes engendered by a single-payer system. The currently uninsured would now have insurance. Providers and hospitals would adapt to the realities of operating under a single, global budget. There is simply no going back, no returning to the health care system as it currently exists.

Healthy Wisconsin would alter the focus of budget and tax policy. Its significance would be more substantial than the merger that created the University of Wisconsin system, reform of the welfare system, school choice, and every other policy issue dealt with by government in the entire history of Wisconsin. The payroll tax — up to 12% on the employer and up to 4% from the worker — would be the largest state tax levied on most Wisconsin households. Not only would the Legislature and Governor assume responsibility for overseeing an industry that accounts for approximately 15% of the state gross domestic product, they would be overseeing an industry that affects every citizen. Healthy Wisconsin would be huge, complex and pervasive; traits that would attract more, not less, government oversight.

In addition, the design of the Healthy Wisconsin program is remarkably fragile. The funding of the plan is based on an actuarial analysis that makes a number of assumptions that health care cost increases will be mitigated by various elements of Healthy Wisconsin.²⁵ The Lewin study, while noting that Healthy Wisconsin will require \$800 million to cover costs of the currently uninsured and \$800 million in administrative expenses, estimates that these increases will be more than offset by theoretical savings related to practicing more aggressive preventive medicine, lower administrative costs and the reduction in employer health care costs, most of which accrues to government employers. (It should be noted that detailed data supporting the actuarial data have yet to be released.)

Much is riding on those actuarial assumptions. Can Wisconsin turn the tide and better control health care costs? While that is the hope upon which Healthy Wisconsin has been forwarded, there is no assurance that the arc of health care costs would be lessened. Government's track record in reducing health care costs is disappointing. For decades the federal government has attempted to modify cost increases. In recent years, several states have also attempted to use the power of government to reduce cost increases. To date, none have proven to provide long-term cost containment. Will Wisconsin be the first? That is the gamble Healthy Wisconsin asks taxpayers to take.

But what if the effort were to prove unsuccessful? One Health Care expert has calculated the impact if the Lewin assumptions prove wrong. According to Michael Tanner of the CATO institute, the Legislature and Governor would have to address whether to increase the payroll tax that supports Healthy Wisconsin very shortly after the program is enacted. Tanner estimated that if health care costs increase at a rate of 6.5% per year (as estimated by the Lewin Group) and income growth increases at 4.6% per year, by 2017 Healthy Wisconsin will face a \$10 billion deficit.²⁶ In Chart 1 above, we have demonstrated a funding gap of \$4.79 billion with the Wisconsin Health Plan. Thus, it is reasonable to assume a deficit within the range of \$4.79 billion and \$10 billion with any future plan of this type. If this occurs, it will take legislative action to remedy the shortfall, in the same way the Legislature has dealt with shortfalls in other government-sponsored health care programs that have recently seen large cost increases.

Further, a legal analysis shows it likely that the waiting period included in the Healthy Wisconsin legislation is invalid.²⁷ Rather than requiring a twelve-month residency in Wisconsin to qualify for coverage, it is likely that anyone would be eligible for coverage under Healthy Wisconsin the moment they establish residency. Also likely is that this would attract to Wisconsin people who have significant health issues and who have been unable to secure adequate health insurance in their home state. This adverse selection is likely to have a significant impact on the cost of Healthy Wisconsin — well beyond what was included in the Lewin analysis.

In the end, Healthy Wisconsin is constructed assuming that the growth in health care costs can be brought closer to the rate of growth in wages. If that cannot be accomplished, Wisconsin's elected officials will be dealing with the same issues that plague governments in other countries that are home to single-payer health care systems. The promises of Healthy Wisconsin will be tested early and often. The most significant test will occur at the point when state government must either raise the payroll tax rate or control the global health care budget. The health care industry will undoubtedly face lower provider and hospital reimbursement rates, moderated capital projects and slower incorporation of expensive drugs and medical technology. Patients are likely to face longer wait times and the availability of fewer specialists. These decisions will rest in the hands of the Governor and the Legislature because, at its heart, Healthy Wisconsin will be created and funded by government and will be ultimately subject to oversight by government.

NOTES

1. The Brookings Institution and the Heritage Foundation joint report, *Taking Back Our Fiscal Future*, April 2008.
2. National Conference of State Legislatures, 2007-2008 Health Reform Bills.
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5. Legislative Fiscal Bureau, *Healthy Wisconsin Plan, Summary of Senate Changes to Joint Committee on Finance*, June 28, 2007.
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ABOUT THE INSTITUTE

The **Wisconsin Policy Research Institute** is a not-for-profit institute established to study public-policy issues affecting the state of Wisconsin.

Under the new federalism, government policy increasingly is made at the state and local levels. These public-policy decisions affect the life of every citizen in the state. Our goal is to provide nonpartisan research on key issues affecting Wisconsinites, so that their elected representatives can make informed decisions to improve the quality of life and future of the state.

Our major priority is to increase the accountability of Wisconsin's government. State and local governments must be responsive to the citizenry, both in terms of the programs they devise and the tax money they spend. Accountability should apply in every area to which the state devotes the public's funds.

The Institute's agenda encompasses the following issues: education, welfare and social services, criminal justice, taxes and spending, and economic development.

We believe that the views of the citizens of Wisconsin should guide the decisions of government officials. To help accomplish this, we also conduct regular public-opinion polls that are designed to inform public officials about how the citizenry views major statewide issues. These polls are disseminated through the media and are made available to the general public and the legislative and executive branches of state government. It is essential that elected officials remember that all of the programs they create and all of the money they spend comes from the citizens of Wisconsin and is made available through their taxes. Public policy should reflect the real needs and concerns of all of the citizens of the state and not those of specific special-interest groups.