WISCONSIN HOSPITAL ASSOCIATION

ADVOCATE. ADVANCE. LEAD.

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February 25, 2025

The Honorable Ron Johnson
United States Senate
Washington, DC 20515

The Honorable Tammy Baldwin
United States Senate
Washington, DC 20515

The Honorable Gwen Moore
U.S. House of Representatives
Washington, DC 20515

The Honorable Mark Pocan
U.S. House of Representatives
Washington, DC 20515

The Honorable Glenn Grothman
U.S. House of Representatives
Washington, DC 20515

The Honorable Bryan Steil
U.S. House of Representatives
Washington, DC 20515

The Honorable Tom Tiffany
U.S. House of Representatives
Washington, DC 20515

The Honorable Scott Fitzgerald
U.S. House of Representatives
Washington, DC 20515

The Honorable Derrick Van Orden
U.S. House of Representatives
Washington, DC 20515

The Honorable Tony Wied
U.S. House of Representatives
Washington, DC 20515

Dear Members of Wisconsin's Congressional Delegation:

Thank you for meeting with WHA and RWHC members two weeks ago to discuss crucial extensions needed for federal health care programs before the end of the year, as well as concerns our health care leaders have about possible items up for debate in a potential reconciliation package. While we understand the current situation is fluid, ***we have significant concerns about the House Budget Resolution's target of $880 billion in savings for the House Energy and Commerce (E&C) Committee which has oversight of important federal health care programs. WHA wanted to make you aware of some of the potential impacts Wisconsin could be exposed to if certain proposals that have been discussed for federal savings are pursued to achieve that number.***

We sincerely appreciate the commitment from President Trump to not do anything with Medicare and Medicaid "unless we can find some abuse or waste." However, WHA remains concerned about the large target number as it is hard to imagine where the $880 billion in savings will come from if not from Medicaid or Medicare cuts. The following is a preliminary analysis from WHA on the potential impact certain Medicaid and Medicare proposals could have on Wisconsin's Medicaid program and the hospitals and health care providers that care for Medicaid and Medicare patients.

Various Proposals to Alter State Medicaid Program Rules

WHA is aware of various proposals to alter the rules for State Medicaid programs being discussed at the federal level. It is important that members of Wisconsin's Congressional delegation understand the unique healthcare

coverage model Wisconsin has. We are the only state which does not have a coverage gap that does not receive enhanced federal funding for the Medicaid expansion population. Wisconsin's Medicaid program covers everyone up to 100% of the federal poverty level (FPL) with a normal 40% state 60% federal (approximate) Medicaid match while transitioning those with incomes above 100% FPL onto the ACA exchange.

WHA greatly appreciated the recognition of this in the 2017 *Graham-Cassidy-Heller-Johnson* "Repeal and Replace" legislation which recognized Wisconsin's coverage model and its partial Medicaid expansion – gradually increasing Wisconsin's federal funding from $2,054 per person (which was on the low end of states) to the same $4,400 per person that all states would eventually receive in the form of a block grant. Obviously, this legislation did not pass, and Wisconsin has continued to be penalized in the form of lower matching federal dollars than other states that took a traditional Medicaid expansion. We urge members of Wisconsin's Congressional delegation to pursue options that would no longer punish states like Wisconsin that did not take the traditional Medicaid expansion.

Considering Wisconsin's unique approach, below are a list of some proposals to alter state Medicaid funding parameters up for discussion at the federal level along with a brief analysis on the impact for Wisconsin.

- **Lowering the FMAP Floor** – This proposal would only impact the 13 states that benefit from a floor that prevents them from receiving less than 50% federal funding for their Medicaid match due to the FMAP formula being based on per-capita incomes and these states having high per-capita incomes. Wisconsin already receives a roughly 60% match and would not be impacted by this.

- **Limit Medicaid Provider Taxes** – Wisconsin currently has a very transparent and conservative hospital assessment that is applied uniformly, in contrast to some states that have more complex pass-throughs and hold-harmless provisions. All Wisconsin hospitals pay into the assessment and those with the highest proportion of Medicaid payments receive the highest proportion of access payments that result from the assessment (to preserve access to services that often lose money due to a high Medicaid mix).

  While Wisconsin's current assessment is under 3%, we are pursuing an increase to help boost Wisconsin's Medicaid rates that are among the lowest in the nation. ***WHA is concerned that limiting provider assessments could unfairly leave behind states like WI that have historically been more conservative in their use of such Medicaid funding arrangements, potentially perpetuating existing disparities in states' share of federal Medicaid dollars.***

- **Equalize Medicaid Payments for Able-Bodied Adults Without Dependents** – As we understand it, this proposal would reduce the enhanced federal match for this population down to the state's normal FMAP for its non-expansion population. Because Wisconsin does not receive an enhanced federal match for this population, we do not believe this would impact Wisconsin.

- **Allowing Medicaid DSH Cap from the ACA to Take Effect** – The ACA instituted a future cap on federal Medicaid DSH payments with the idea being that hospitals would have less uncompensated care as more people gained coverage via Medicaid expansion or subsidized ACA marketplace insurance. However, Congress has repeatedly provided funding to prevent the Medicaid DSH cap from taking effect. Wisconsin has historically been a "low-DSH" state and continues to spend only up to (but not over) the DSH cap. As such, we would not be impacted by Congress allowing the cap to take effect.

Medicaid Work Requirements

One item likely to be in front of the E&C Committee for which there appears to be widespread GOP support is Medicaid work requirements for able bodied adults without dependents. WHA and our members support the goal of getting more people off Medicaid and onto commercial health care coverage. It is a true win-win in terms of lower spending for the federal budget, better reimbursement for health care providers, and more upward social mobility for patients that obtain meaningful work with quality health insurance coverage.

Unfortunately, some of this population would likely lose Medicaid coverage without obtaining commercial health insurance. Due to this dynamic, work requirements are expected to increase hospitals' uncompensated care as more of these patients would likely seek care in emergency departments where hospitals are required by EMTALA to treat them, or by qualifying for hospitals' charity care policies which often forgive medical bills for patients with incomes under 200% FPL and/or provide sliding scale discounts at incomes above that level.

Repealing Hospitals' Not-for-Profit Status

Ninety-six percent of WI hospitals operate as 501(c)(3) nonprofits which have local boards whose "shareholders" are the communities they serve. These boards often choose to direct their hospitals to offer services that operate at a loss (such as OB labor and delivery, inpatient mental health, etc.) because they are important priorities for the community. Any margins these hospitals may be fortunate enough to generate are reinvested into the local hospital and community to support their mission. WI hospitals reported $2.35 billion in community benefits in 2023 – far outweighing the cost of their tax-exempt status. In fact, a 2020 report by Ernest and Young found that hospital community benefits are almost 10 times greater than the value of tax revenue forgone.

In contrast, many for-profit hospitals are run by private equity groups whose sole focus is to generate double-digit profit margins for their shareholders. For these hospitals, the profit margin dictates the service line rather than the community need. A for-profit hospital with this business model is largely responsible for the closure of two long-time WI hospitals (HSHS Sacred Heart in Eau Claire and St. Joseph's in Chippewa Falls) in 2024 by siphoning away many of the profitable services those hospitals depended on to offset their losses for maintaining 24/7 emergency department, ICU, and inpatient psychiatric care – services the for-profit hospital does not provide. The loss of hospitals' nonprofit status would likely result in replays of this scenario across the country – significantly impacting the ability of safety-net nonprofit hospitals to remain financially viable.

Site-Neutral Medicare Payments

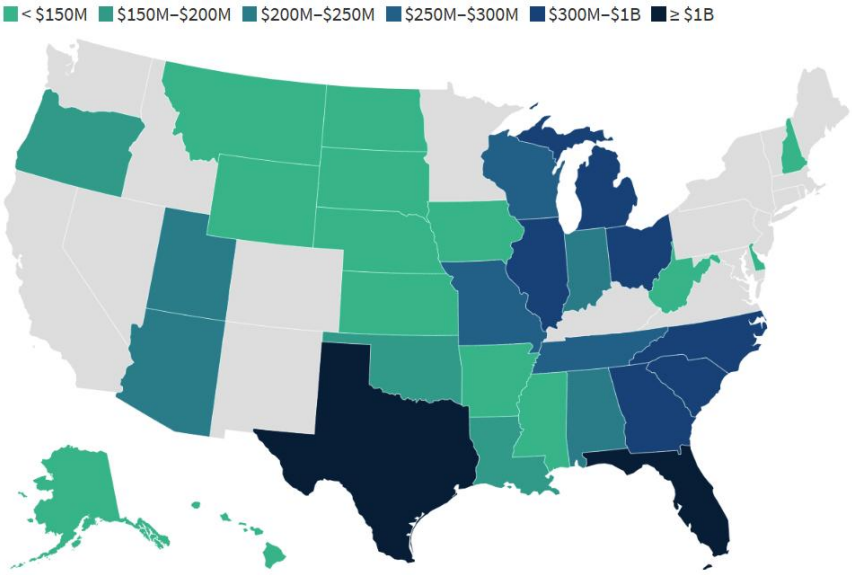
Congressional District	Site-Neutral 10-year Impact
Bryan Steil	-$635 million
Mark Pocan	-$718 million
Derrick Van Orden	-$1.1 billion
Gwen Moore	-$793 million
Scott Fitzgerald	-$385 million
Glenn Grothman	-$520 million
Tom Tiffany	-$273 million
Tony Wied	-$425 million
Statewide	**-$4.78 Billion**

Site neutral payments aim to equalize Medicare payments for health care services regardless of the setting in which they are performed. While they may sound reasonable on their face, they do not take into consideration that hospital outpatient care is an extension of the hospital care continuum and Medicare designed the current policy of higher payments for hospital settings to offset the losses hospitals take from Medicaid and Medicare due to their unique obligation to operate Emergency Departments, Intensive Care

Units, and Inpatient Units 24 hours a day, 7 days a week, 365 days a year.

Hospitals would have no quarrel with Medicare payment policies paying site-neutral rates so long as any losses on the outpatient side were offset by increasing payments for the aforementioned emergency and inpatient safety-net services hospitals provide that they lose money on due to inadequate existing Medicare reimbursement, which pays WI hospitals on average only 74 cents on the dollar. While WHA appreciates that the Cassidy/Hassan site-neutral framework would attempt to offset some of its proposed Medicare reimbursement cuts with additional safety-net hospital "reinvestments," their framework would still lead to an overall cut to WI hospitals that are already losing money on Medicare patients. In fact, an earlier analysis of a similar site-neutral proposal by the American Hospital Associatoin suggested it could cut Medicare payments to WI hospitals by nearly $5 billion over 10 years as shown in the adjoining table.

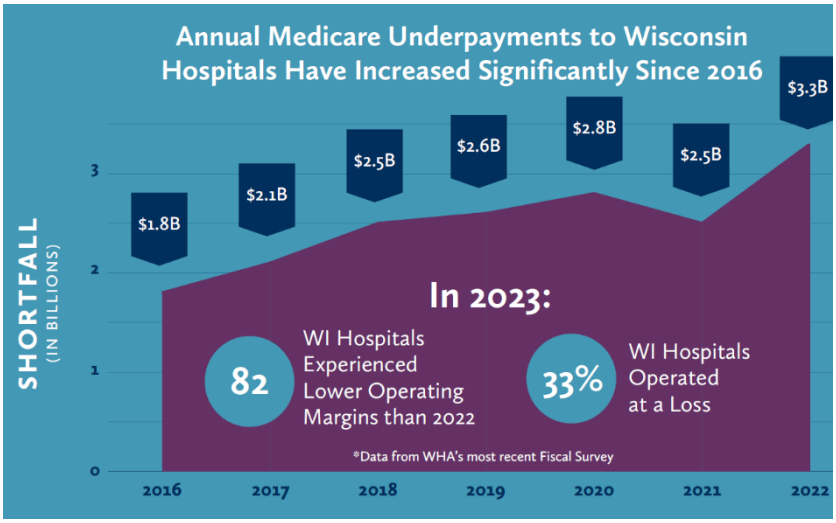
Expiration of Enhanced ACA Marketplace Premium Subsidies



Congress passed enhanced premium subsidies for ACA Marketplace plans during the Biden administration, which greatly lowered the cost of these plans for consumers, including allowing zero-dollar premium plans for incomes up to 150% FPL and lower deductibles and other out-of-pocket cost sharing for higher incomes. As shown in the map to the right provided by the Kaiser Family Foundation, ***Wisconsin is among the states that benefit the most from these enhanced subsidies, which are currently slated to expire at the end of 2025.*** If Congress allows these enhanced subsidies to expire, it will lead to significant cost increases for premiums purchased in the ACA marketplace, which is likely to decrease coverage levels and increase hospitals' uncompensated care.

Current Challenges Facing Hospitals Due to Existing Medicare Underfunding and Aging Demographics

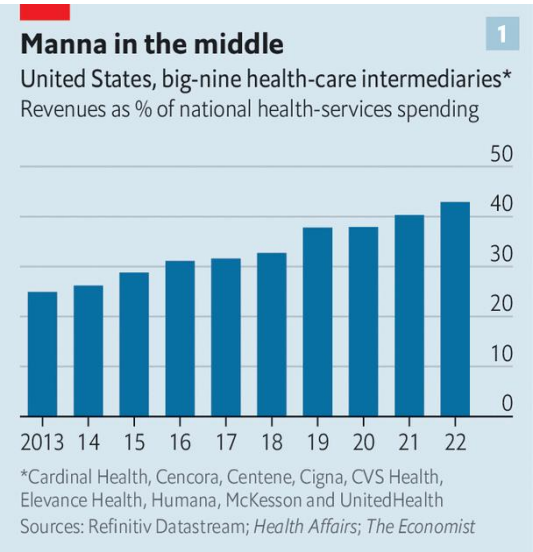
As federal lawmakers evaluate the aforementioned proposals, it's important to understand that hospitals are already facing significant headwinds. According to WHA's most recent fiscal survey, ***one-third of WI hospitals had a negative operating margin in 2023, and about one-half (82) hospitals had a lower operating margin in 2023 compared to 2022, a troubling trend.*** In addition to the two hospital closures previously mentioned, several other hospitals and health systems grappled with difficult decisions to end service lines and close primary care clinics that serve their communities.



Wisconsin's aging demographics mean this challenge is only likely to get worse. In fact, as of 2022, Wisconsin was tied for 11th among states with the highest percentage of their population covered by Medicare, at 21%. This dynamic means that ***Wisconsin hospitals are likely to continue seeing dwindling revenues due to aging demographics and the reality that hospitals lose money as patients transition from commercial market rates to Medicare rates that pay less than it costs hospitals to provide such care.*** This illustrates the need for long-term solutions that allow health care to adapt to these growing challenges.

Congress Should Investigate Waste, Fraud, and Abuse Caused by Health Care Middlemen

WHA urges our Congressional Delegation to protect Wisconsin hospitals from proposals that would further cut Medicaid or Medicare reimbursement. Instead, lawmakers searching for savings in Medicare and Medicaid should look at the increasing bite of the health care dollar being taken by health care "middlemen" that do not provide patient care. A 2023 The Economist article found that the nine biggest health care intermediaries - sitting between patients and their treatments (including health insurers, pharmacy benefit managers, and drug distributors) - increased their combined revenue as a percent of America's health care spending from 25% in 2013 to an astounding 45% just nine years later.



Furthermore, the growth in Medicare Advantage and questionable insurer practices to deny and delay patient care also adds cost and inefficiencies to our health care system, as we can see from the experience of one Wisconsin health system. An article published by HFMA and written by Dr. Alan Kaplan, CEO, and Abigail Abongwa, VP Revenue Cycle at UW Health in 2021 identified that prior authorization processes cost the health system $18.2 million and requires at least 65 FTEs. This burden has likely only gotten worse in the years since it was published.

Nationally, a March 2024 Report by the Medicare Payment Advisory Commission (MEDPAC) estimated that ***Medicare spends 22% more for Medicare Advantage enrollees than it would if those beneficiaries were enrolled in fee-for-service Medicare, a difference that translates into a projected $83 billion in 2024 alone.*** In addition to this, a series of recent articles from the Wall Street Journal have shone a light on questionable upcoding practices by UnitedHealth that have triggered billions of dollars for questionable diagnoses.

As Congress looks into potential waste, fraud, and abuse in the Medicaid and Medicare programs, it should protect hospitals that are already losing money on Medicaid and Medicare patients and instead take a closer look at the federal dollars going to these health care middlemen that do not benefit the patients our safety-net programs are intended to serve.

Sincerely,

Eric Borgerding
President & CEO