1997-98 SESSION COMMITTEE HEARING RECORDS

Committee Name:

Senate Committee on Health, Human Services, Aging, Corrections, Veterans and Military Affairs (SC-HHSACVMA)

Sample:

Record of Comm. Proceedings … RCP
- 05hrAC-EdR_RCP_pt01a
- 05hrAC-EdR_RCP_pt01b
- 05hrAC-EdR_RCP_pt02

- Appointments … Appt
- **97hrSC_HHSACVMA_Appt_Pt04**

- Clearinghouse Rules … CRule
- **

- Committee Hearings … CH
- **

- Committee Reports … CR
- **

- Executive Sessions … ES
- **

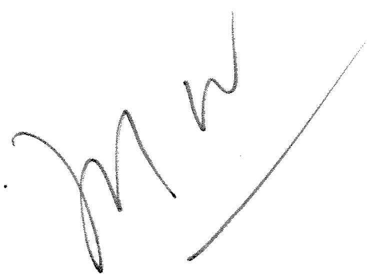
- Hearing Records … HR
- **

- Miscellaneous … Misc
- **

- Record of Comm. Proceedings … RCP
- **

February 27, 1997

MAR 04 1997

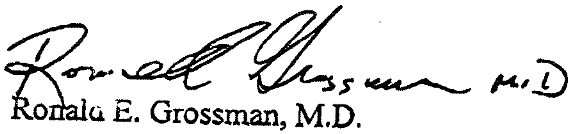


Dear Senator:

I appeared before the Committee on Health and Human Services on Wednesday, February 26th in regard to my reappointment to the Medical Examining Board. I have served on the board since 1994, completing the last two years of a four year term of a physician who resigned at that time. I hope that you will be able to support my reappointment to what would be my first four-year term on the Medical Board, so that I may continue my activities on this committee.

I have included my Curriculum Vitae for your review. I would be happy to communicate with you and am at your disposal if you desire to discuss this reappointment.

Respectfully yours,



Ronald E. Grossman, M.D.

Curriculum Vitae

Name:	**Ronald E. Grossman, M.D.**
Address:	9037 North Range Line Road River Hills, Wisconsin 53217
Telephone:	(414) 352-6516
B.S.	University of Wisconsin
M.D.	Marquette School of Medicine (Medical College of Wisconsin)
Internship:	Mount Sinai Hospital
Residency:	Milwaukee County General Hospital Milwaukee, Wisconsin
Teaching Affiliation:	Clinical Professor of Radiology Medical College of Wisconsin Consulting Staff Veteran's Hospital, Wood, Wisconsin
Certification:	American Board of Radiology, 1966
Positions:	State of Wisconsin, Medical Board of Regulation and Licensing July 1994 to Present Director, Imaging Section of the Breast Health Center Sinai Samaritan Medical Center Milwaukee, Wisconsin Director, Coleman-Soref Breast Diagnostic Clinic 1988 to Present Director, Department of Radiology Sinai Samaritan Medical Center Milwaukee, Wisconsin 1988 to 1990

Positions (Cont.):

Director, Department of Radiology
Good Samaritan Medical Center
Milwaukee, Wisconsin
1981 to 1988

Chief Radiologist, Department of Radiology
Deaconess Hospital
Milwaukee, Wisconsin
1978 to 1980

Organizations:

American Medical Association
Wisconsin State Medical Society
Milwaukee County Medical Society
Milwaukee Roentgen Ray Society
Wisconsin Radiological Society
American College of Radiology

Civic Activities:

Elected Trustee, Village of River Hills, WI, April 1992.
Reelected, April 1995 for a second three-year term.

Publications:

"Histopathology of Parkinsonism"
Marquette Medical Review, 1961

"Renal Artery Aneurysms in Children"
Journal of Urology, February 1965

"Bone Lesions in Primary Amyloloidosis"
American Journal of Roentgenology, Therapy and Nuclear Medicine, December 1967

"Fibrous Histiocytoma or Xanthoma of the Lung with Bronchial Involvement"
Journal of Thoracic and Cardiovascular Surgery, April 1973

"The Lennis Test for Normal Scapular Rest Position: A Reliability and Validity Study"
Accepted for publication, *Physical Therapy*, 1994

Fellowship:	Magnetic Resonance Imaging Fellowship Medical College of Wisconsin, June to August 1989	
	Mammography Tutorial Medical College of Wisconsin, June 1991	
Personal History:	Born:	October 2, 1934 Milwaukee, Wisconsin
	Marital Status:	Married - 32 years Wife - Marisa
	Children:	Seven

Mikki Patterson
1321 St. James Court
Madison, WI 53715

MAR 1 1 1997

Dear Senator;

I am writing this letter to inform you of my interest in serving through completion my second four-year appointment to the State Medical Examining Board. I am now eight months into my term and feel as though I have a lot to offer as a public board member. After serving my first four-year term, I believe that I've learned a great deal about the workings of the Medical Examining Board and a bit about the profession it regulates.

Since I represent the consumers' perspective it is necessary for my insights and perspectives to differ from that of the professional members of the board. I believe my work experiences have helped me to become well aware of the role of consumer advocacy. During a period of time beginning in January, 1987 until September, 1996; I worked as a Counselor Advocate for battered women and their children at Dane County Advocates For Battered Women [now known as; Domestic Abuse Intervention Services} in Madison, Wisconsin. In this position, I learned how to advocate for battered women and their fami lies within the legal system, courts, child protective system, medical services, housing systems and in general most systems offering services to this group. I also helped our agency to remain consumer focused.

In October, 1997 I started working for Employment and Training Association, Inc. As a Resource and Training Developer. Within this position I create and implement Job and Skills training in order to help people transition from welfare to work. Again this places a strong focus on consumer advocacy.

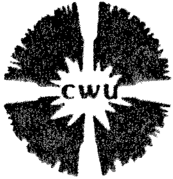
I feel that I know the business of the Medical Examining Board and of course am very familiar with the duties of the board member. I believe that I am an effective spokesperson for the protection of the rights of the consumers of medical services in the state of Wisconsin. While I am respectful of the knowledge and skills of the Doctors on the board, I am not in awe of them and am not afraid to question the decisions made on cases. I am a skillful presenter and know when and how to compromise, however I believe as a Public Board Member I have an important trust placed upon me, that of representing the interests of the People of the state of Wisconsin.

Thank you for your time and consideration of this matter.

Sincerely;

Mikki M. Patterson

Mikki M. Patterson



church women united
in wisconsin

I am Cordelia Mayberry, a board member of Church Women United in Wisconsin, serving as Ecumenical Chair.

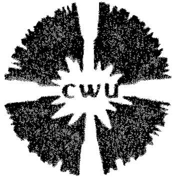
Since 1990 CWU have given health care reform the highest priority. We have conducted hundreds of Health Care Reform Workshops throughout the state during these years. This has been a nation wide effort. We have also been members of the Coalition for Wisconsin Health since it was organized.

We are very glad to appear before you today and that you are considering this important step in health care reform in our state. Tho, this is an important step, we do want to state in the onset that we believe controling health care costs one step at a time does result in cost shifting.

First we have some documentation that appeared in the New England Journal of Medicine dated March 13. This compares hospital adminstration costs of for-profit, non-for-profit and public hospitals. The study was done nation wide and shows that Wisconsin for-profit-hospitals have the highest administrative costs in the country, 42.7%. Our non-for- profits are 22%, about average, but we would not think a good average. Our public hospital's rate is the lowest in the nation, 17%. Thank goodness we only have five for-profit hospitals. However, with very few exceptions they have for-profit long-term care facilities.

This brings us to the second documentation we have. It is raw data, but can easily be analyzed by your staff. It gives a real indication of costs in these facilities.

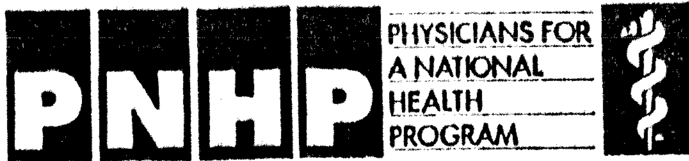
Last year we worked with Assembly Member Rebecca Young hoping she could introduce legislation to increase the coverage of the Wiscon Care Program. At that time got some documentation



church women united
in wisconsin

from the Office of Health Care Information on Uncompensated Health Care. This data has figures that can be used to better understand hospital costs throughout the state.

Because we do believe attempting to control health care costs one step at a time does result in cost shifting we have included a statement that approaches this problem from a more comprehensive perspective. We hope it will also be helpful and can be considered.



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FOR IMMEDIATE RELEASE
March 12, 1997

Press contact:
Dr. Lauren Bern, M.D. - 608-255-0704
Patrick Woodall - 202-543-0706
David U. Himmelstein, M.D. - 617-498-1032

FOR-PROFIT HOSPITALS COSTLIER AND LESS EFFICIENT; PHYSICIANS FOR A NATIONAL HEALTH PROGRAM STUDY SHOWS BUREAUCRACY TAKES 26% OF HOSPITAL BUDGETS NATIONWIDE

A special article in the March 13 New England Journal of Medicine finds that for-profit hospitals are costlier and less efficient than public or non-profit hospitals, and that hospital paperwork costs are rising.

Dr. Lauren Bern, M.D., Medical Director of the Madison Community Health Center and local spokesperson for Physicians for a National Health Program commented, "The information is interesting in light of the recent privatization of the University Hospital which was done under the premise of increasing efficiency and decreasing costs. It's hard to see where there is any assurance that a change in status from public to private is going to decrease administration costs. My concern would be that if there are savings, it would come from cutbacks in the workforce or in services."

"This study shows that administrative costs in for-profit hospitals are soaring. In 1990, the average for-profit spent 31.8% of its budget on administration. By 1994, that figure had jumped to 34%. In medicine, market pressures are breeding inefficiency,' said Dr. Steffie Woolhandler, co-author of the study and Associate Professor of Medicine at Harvard.

In Wisconsin administration consumed 22.5% of total hospital spending, less than the national average of 26%. According to the studies authors', Wisconsin's for-profit hospitals spent 42.7% of their budgets on administration, compared to 22% at not-for-profit and 17.7% at public institutions.

The data, covering 6227 U.S. hospitals, including five in Wisconsin, were obtained from the U.S. Health Care Financing Administration through a Freedom on Information Act request.

According to the national study, a day in the hospital cost 35% to 57% more at for-profit general hospitals than at comparable non-profit or public facilities. Paperwork costs per general hospital stay averaged $2,289 at for-profits, versus $1,809 at non-profit and $1,432 at public hospitals, and all of these figures exclude hospital profits, which average $123 per patient day at Columbia/HCA's hospitals.

The study also found that administration costs rose from 24.8% of total hospital costs in 1990 to 26.0% in 1994 - $61.8 billion. In contrast, Canadian hospitals spend only 10.4% on paperwork. Administration consumed 34.0% of the budget at for-profit hospitals, 24.5% at non-profits, and 22.9% at public facilities. States with more HMOs and for-profit hospitals had higher administrative costs.

'Bureaucracy costs jumped sharply when non-profit and public hospitals were purchased by for-profits. If all U.S. hospitals became for-profit, hospital paperwork cost would rise by $14.8 billion annually,' noted Woolhandler. She continued: 'Its a myth that for-profit hospitals are efficient. They save money by laying off nurses, then hire consultants and bureaucrats to figure out how to avoid unprofitable patients and maximize revenues. For-profits increase costs, decrease care, and generate windfall profits like the $359.5 million pocketed by Rick Scott of Columbia/HCA. They're fat and mean.'

Study co-author Dr. David Himmelstein noted that 'non-profit national health insurance like Canada's could save the U.S. $157 billion each year on bureaucracy and profits, more than enough to cover the uninsured and to upgrade coverage for the rest of us.'

-Physicians for a National Health Program is an organization with 7,000 members nationwide that advocates for Canadian-style national health insurance in the U.S.
-In Wisconsin, Drs. Gene and Linda Farley co-chair the Coalition for Wisconsin Health, which advocates for universal-style health care reform.

Appendix 1 -- Continued

Nebraska	NA	21.2%	20.6%
Nevada	32.0%	25.6%	23.5%
New Hampshire	26.6%	24.5%	NA
New Jersey	44.1%	23.0%	21.1%
New Mexico	36.6%	27.1%	27.5%
New York	28.4%	22.8%	22.8%
North Carolina	36.9%	21.1%	19.6%
North Dakota	NA	20.1%	NA
Ohio	38.6%	24.0%	23.3%
Oklahoma	33.6%	26.9%	24.5%
Oregon	29.6%	26.6%	23.5%
Pennsylvania	35.8%	23.5%	NA
Puerto Rico	27.6%	23.6%	NA
Rhode Island	None	22.5%	None
South Carolina	32.4%	23.0%	19.1%
South Dakota	NA	21.2%	27.0%
Tennessee	33.4%	28.8%	24.7%
Texas	34.2%	24.3%	21.0%
Utah	31.8%	24.4%	27.2%
Vermont	None	23.4%	NA
Virginia	35.5%	23.8%	23.3%
Washington	37.6%	24.5%	24.6%
West Virginia	33.4%	25.7%	30.1%
Wisconsin	42.7%	22.0%	17.7%
Wyoming	31.1%	25.3%	23.8%
Total	34.0%	24.5%	22.9%

Appendix 1 -- All Hospitals[1]

Hospital Administration as a Percent of Total Hospital Spending, by State -- 1994

State	Administration as % of For-Profit Hospital Spending	Administration as % of Private Not-for-Profit Hospital Spending	Administration as % of Public Hospital Spending
Alabama	29.3%	24.3%	20.4%
Alaska	38.0%	29.8%	28.5%
Arizona	36.4%	26.8%	32.5%
Arkansas	34.7%	23.3%	21.1%
California	34.9%	26.6%	26.2%
Colorado	39.1%	24.1%	25.9%
Connecticut	NA	24.2%	30.5%
Delaware	NA	22.0%	NA
D.C.	37.8%	23.9%	NA
Florida	33.5%	27.5%	27.1%
Georgia	30.9%	24.4%	21.6%
Hawaii	NA	30.2%	31.5%
Idaho	33.4%	24.3%	21.3%
Illinois	37.9%	26.7%	23.6%
Indiana	43.8%	24.9%	23.2%
Iowa	24.4%	22.4%	22.7%
Kansas	37.4%	24.6%	22.5%
Kentucky	32.1%	23.9%	22.1%
Louisiana	33.5%	21.0%	20.3%
Maine	NA	26.3%	28.4%
Maryland	32.7%	25.4%	19.0%
Massachusetts	34.4%	26.2%	27.1%
Michigan	34.8%	26.0%	23.2%
Minnesota	NA	21.6%	20.3%
Mississippi	30.6%	22.7%	18.7%
Missouri	34.9%	26.7%	25.3%
Montana	NA	22.3%	22.0%

[1] Total hospitals include: short term general, long term general, cancer, psychiatric, rehabilitation, and other. This is additional unpublished data from "Costs of Care and of Administration at For-Profit and Other U.S. Hospitals," by Steffie Woolhandler, M.D., M.P.H. and David U. Himmelstein, M.D., embargoed by the New England Journal of Medicine until 5:00 P.M. Eastern Time March 12, 1997.

LONG TERM CARE

MEDICAID AND LONG TERM CARE

More than half of all Medicaid expenditures are for low income elderly and persons with disabilities.

- o 28.4% of Medicaid expenditures are for the elderly.
- o 38.8% are for the blind and disabled.

More than 1 in 4 Medicaid beneficiaries are either elderly or younger persons with severe disabilities.

- o 3.7 million Medicaid beneficiaries (11.5%) are elderly.
- o Five million beneficiaries (15.5%) are younger persons with disabilities.

Medicaid is the single largest payor of long term care, particularly nursing home care.

- o 36% of all Medicaid expenditures ($35.8 billion) are for long term care.
- o 2/3rd of Medicaid spending for the elderly is for long term care.
- o Medicaid pays for long term care for about two million persons.

84% of Medicaid long term care dollars are spent on institutional care.

- o Medicaid pays half of the nation's $74.9 billion nursing home bill.
- o Medicaid pays some or all of the nursing home bill for 1.5 million persons, the majority of whom are elderly.
- o Medicaid payments for nursing facilities account for 21.1% of total Medicaid expenditures.
- o Medicaid spends $7.8 billion to care for persons with mental retardation in intermediate care facilities.

• Long Term Care Campaign, P.O. Box 27394, Washington, D.C. 20038 • (202)434-3744 • f(202)434-6403 •

Only 16% of Medicaid long term care dollars are spent on home and community based care.

- Medicaid spends $6 billion on home and community-based care (home health care, personal care, and home and community based waiver services).

- Of the $6 billion, $1.7 billion is for waiver programs designed to keep people out of nursing homes. (This is 6.3% of Medicaid long term care expenditures and 0.3% of total Medicaid expenditures).

- About one-third of home and community care waiver expenditures are for the elderly. Two-thirds are for younger persons with disabilities.

Medicaid provides essential home and community based services for persons with mental retardation and developmental disabilities who cannot live independently. Without these services, these people would be in institutions (ICF/MR's).

- 135,000 persons with mental retardation and developmental disabilities receive home and community based waiver services, at an average annual cost of $26,000. The cost of care in an ICF/MR is double that amount.

- Medicaid provides case management services (needs assessment, treatment planning and monitoring) to nearly 350,000 persons with developmental disabilities.

Medicaid is an indispensable source of assistance for people with severe disabilities who do not have enough money to pay for long term care.

- 60% of people with severe disabilities have incomes under 200% of the federal poverty level (annual income below $14,720 for an individual, $19,680 for a couple).

- 75% have incomes under 300% of the federal poverty level (annual income below $22,080 for an individual, $29,520 for a couple).

Persons with severe disabilities are all ages, although the majority are elderly.

- 71% are elderly.

- 10% have mental retardation or developmental disabilities.

- 13% are adults with physical or mental disabilities.

- 6% are children.

Produced in cooperation with the Alzheimer's Association

SOURCES:

Kaiser Commission on the Future of Medicaid, Medicaid Expenditures and Beneficiary Trends 1988-1993 (September 1994)
Kaiser Commission on the Future of Medicaid, Medicaid Long-Term Care: Current Status and Future Prospects (December 1994)

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Why the U.S. Needs a Single Payer Health System

David U. Himmelstein, M.D. & Steffie Woolhandler, M.D.

1. Our pluralistic health care system is giving way to a system run by corporate oligopolies. A single payer reform provides the only realistic alternative.

A few giant firms own or control a growing share of medical practice. The winners in the new medical marketplace are determined by financial clout, not medical quality. The result: three or four hospital chains and managed care plans will soon corner the market, leaving physicians and patients with few options. Doctors who don't fit in with corporate needs will be shut out, regardless of patient needs.

A single firm - Columbia/HCA - now owns one-quarter of all Florida hospitals, and has announced plans to move into Massachusetts. In the past year alone the firm has purchased more than a dozen hospitals in Denver and Chicago, closing unprofitable ones and shutting out unprofitable physicians and patients.

In Minnesota, the most mature managed care market, only three or four plans and three or four hospital chains are left. In many rural areas a single plan dominates the market, presenting patients and physicians with a take-it or leave-it choice.

Managed care plans in California, Texas and Washington, DC have "delisted" thousands of physicians - both primary care doctors and specialists - based solely on economic criteria. One Texas physician was featured in Aetna's newsletter as "Primary Care Physician of the Month", and thrown out of the plan shortly thereafter when he accumulated high cost patients in his practice.

In Massachusetts, BayState HMO "delisted" hundreds of psychiatrists, instructing their patients to call an 800 number to be assigned a new mental health provider. The for-profit firm running Medicaid's managed mental health care plan has just informed psychiatrists that many of them will be barred from the plan as a cost cutting measure.

HMOs are racing to take over Medicare, despite evidence that HMOs have actually increased Medicare costs. The managed care plans sign up mainly the healthy elderly, often illegally inquiring about their health history. The physician contracts offered by plans such as Secure Horizons/Tufts virtually exclude small practices as well as academic physicians who practice less than full time. Financial incentives that penalize the primary care physician for every specialty referral, diagnostic test, and hospital visit pit patients against doctors, and specialists against primary care physicians.

HMOs/insurers that can raise massive amounts of capital by selling stock have a decisive advantage. Their deep pockets allow them to mount massive ad campaigns, market nationally to large employers, and set premiums below costs until competitors are driven out. Once they've cornered the market they can drive hard bargains with hospitals and doctors. As a result not-for-profit plans across the country are going for-profit (even Blue Cross), and small plans are being taken over. Even the largest physician-owned plans cannot compete with U.S. Healthcare, Prudential and similar firms with multi-billion dollar war chests.

Large drug firms are preparing to directly take over much of specialty care. Merck, Lilly and others are developing "Disease Management" subsidiaries to sub-contract with HMOs to care for patients with expensive chronic diseases such as depression, diabetes, asthma and cancer.

2. A single payer system would save on bureaucracy and investor profits, making more funds available for care.

Private insurers take, on average, 13% of premium dollars for overhead and profit. Overhead/profits are even higher, about 30%, in big managed care plans like U.S. Healthcare[1]. In contrast, overhead consumes less than 2% of funds in the fee-for-service Medicare program, and less than 1% in Canada's program[2].

Blue Cross in Massachusetts employs more people to administer coverage for about 2.5 million New Englanders than are employed in all of Canada to administer single payer coverage for 27 million Canadians.

In Massachusetts, hospitals spend 25.5% of their revenues on billing and administration[3]. The average Canadian hospital spends less than half as much, because the single payer system obviates the need to determine patient eligibility for services, obtain prior approval, attribute costs and charges to individual patients, and battle with insurers over care and payment.

Physicians in the U.S. face massive bureaucratic costs. The average office-based American doctor employs 1.5 clerical and managerial staff, spends

44% of gross income on overhead, and devotes 134 hours of his/her own time annually to billing[2]. Canadian physicians employ 0.7 clerical/administrative staff, spend 34% of their gross income for overhead, and trivial amounts of time on billing[2] (there's a single half page form for all patients, or a simple electronic system).

According to U.S. Congress' General Accounting Office, administrative savings from a single payer reform would total about 10% of overall health spending[4]. These administrative savings, about $100 billion annually, are enough to cover all of the uninsured, and virtually eliminate co-payments, deductibles and exclusions for those who now have inadequate plans - without any increase in total health spending.

3. The current market-driven system is increasingly compromising quality and access to care.

The number of uninsured has risen rapidly, to 39.7 million nationally[5]. The proportion of people with coverage paid by an employer is dropping, and those with employer-paid coverage face rising out-of-pocket costs. Only massive Medicaid expansions - 10.5 million nationally since 1989 - have averted a much larger increase in the uninsured. Proposals for welfare reform and Medicaid managed care programs would shrink Medicaid enrollment (increasing the number of uninsured) and threaten the quality of care for those left on Medicaid.

U.S. Healthcare and other investor-owned managed care plans are inserting "gag" clauses in physicians' contracts. Our own U.S. Healthcare contracts forbid physicians to "take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in U.S. Healthcare or the quality of U.S. Healthcare coverage" and forbids any disclosure of the terms of the contract[6]. Meanwhile, Leonard Abramson, U.S. Healthcare's CEO, took home $20 million in a single year, and holds company stock valued at $782 million.

Insurers are gutting mental health benefits, denying needed care, cutting payment rates, and insisting on the cheapest - and often not the best - form of therapy.

HMOs have sought to profit from Medicare and Medicaid contracts by providing substandard care, and even perpetrating massive fraud. The largest Medicare HMO, IMC in Florida, induced thousands of the elderly to sign over their Medicare eligibility and then absconded with $200 million in federal funds[7]. Nationwide, Medicare HMOs provide strikingly substandard homecare and rehabilitation to the disabled elderly[8]. Tennessee Medicaid HMOs have failed to pay doctors and hospitals for care.

After 360,000 women and children were enrolled (and $650 million was spent annually), Florida suspended enrollment in its Medicaid HMO program because of flagrant abuses. Administrative costs consumed more than 50% of Medicaid spending in at least 4 Florida HMOs. In one plan that enrolled 48,000 Medicaid recipients, 19% of total Medicaid dollars went for the three owners' salaries. Thousands of patients were denied vital care; sales reps often illegally pressured healthy people into joining HMOs, while discouraging those who were ill; patient complaints, and inspectors' findings of substandard care were repeatedly ignored. Overall, a cursory state audit found serious problems at 21 of the 29 HMOs participating in the program. A more extensive evaluation is just beginning.[9] These Florida scandals are a virtual replay of California's earlier Medicaid HMO experience.

HMO payment incentives increasingly pressure primary care physicians to avoid specialty consultations and diagnostic tests. In this coercive climate, errors of judgment will inevitably occur, denying patients needed specialty care, while specialists are idle. In some areas of the nation (eg. New York City and California) market imperatives have led to growing unemployment of physicians, while huge numbers of patients don't get adequate care.

Surveys show that patients greatly prefer care in the small-scale, non-institutional practices[10] that are being wiped out in the current system.

4. A single payer system is better for patients and better for doctors. Canada spends $1000 less per capita on health care than the U.S., but delivers more care and greater choice for patients. Combining the single payer efficiency of Canada's system with the much higher funding of ours would yield better care than Canada's or ours at present.

Canadians patients have an unrestricted choice of doctors and hospitals, and Canadian doctors have a wider choice of practice options than U.S. physicians.

Canadians get more doctor visits and procedures[11], more hospital days[12], and even more bone marrow, liver and lung transplants than Americans[13].

While there are waits for a handful of expensive procedures, there is little or no wait for most kinds of care in Canada. An oft-cited survey that

alleged huge waiting lists counted every patient with a future appointment as "in a queue."[14] (The fringe group that conducted the survey also advocates the abolition of the licensing of physicians to open up free competition among "healers"). More legitimate research shows that the average waiting time for knee replacement in Ontario is 8 weeks, as compared to 3 weeks in the U.S.[15] But patient satisfaction levels with the procedure and care are identical. The time from first suspicion to definitive therapy for breast cancer is actually shorter in British Columbia than in Washington State[16]. There are virtually no waits for emergent coronary artery surgery in Canada, though elective cases face delays, particularly with the surgeons held in highest regard[17]. Interestingly, though Canadian MI patients receive substantially fewer invasive diagnostic and therapeutic procedures, death and reinfarction rates are comparable in the two nations[18]. Finally, under a single payer system we would face much less restraint on care than Canada because we spend (and would certainly continue to spend) much more, and have many more specialists and high tech facilities. Hence even the modest limitations on care seen in Canada are unlikely here.

Surgical outcomes for the elderly (all of whom are insured in the U.S.) are, on average, slightly better in Canada[19].

Surveys show that Canadian doctors are far happier with their system than we are with ours. According to a 1992 poll, 85% prefer their system to ours; 83% rate the care in Canada as very good or excellent, and most physicians would urge their children to enter the profession[20]. Fewer than 300 out of Canada's 50,000 physicians emigrate to the U.S. each year, and a survey of doctors who have practiced in both nations shows a clear preference for the Canadian system[21]. Medicine has remained an extremely desirable profession; medical school admission is even more competitive in Canada than here[22].

Surveys show very high patient satisfaction in Canada. 96% prefer their system to ours, and 89% rate care good or excellent (up from 71% 4 years ago)[23].

Canadian physicians' income are comparable, in most specialties, to those in the U.S.[24], and have kept pace with inflation for the past 25 years.

It is perhaps comforting to know that Canada's highly regarded and efficiently managed health system is run by a government no more competent nor popular than our own. Their postal service and public railroad system generally receive lower marks than ours; their government's record on fiscal management is not better than ours; and polls show that Canadians distrust their government even more than we do.

Many of us have negative feelings toward government, and examples of government inefficiency and incompetence abound. Yet the record of private insurers is far worse. Their overhead is, on average, 600% above that of public programs, and no private insurer's overhead is as low as Medicare's. Dozens of financial scandals have wracked insurers and HMOs in the past year alone (our personal favorite is the $500,000 travel budget consumed by the head of one Blue Cross plan, including a $7000 junket to Africa to lecture on insurance fraud). Moreover, Medicare treats doctors and patients more respectfully than most private insurers, funds virtually all residency training, and pays Massachusetts hospitals higher rates than do most HMOs. Finally, when a public program misbehaves we have channels to seek redress; we know where Congress meets, and can vote them out. For-profit firms must answer only to their stockholders.

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5. Data from U.S. Census Bureau, Current Population Survey March Supplement.
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7. Modern Healthcare 5/1/95:60
8. Health Care Financing Review 1994;16:187
9. Fort Lauderdale Sun Sentinel. Florida's Medicaid HMOs: Profits from Paiin. 12/11-12/15, 1994 and State Health Watch April, 1995.
10. JAMA 1993;270:835
11. NEJM 1990;323:884
12. NEJM 1993;328:772
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14. Waiting Your Turn. Fraser Institute, 1994
15. NEJM 1994;331:1068
16. Medical Care 1993;34:264
17. Health Affairs 1991;10(3):110
18. NEJM 1993;328:779
19. Health Affairs, Summer 1992:61
20. Toronto Globe and Mail, 10/23/92
21. American J Public Health 1993;83:1544
22. Medical school application statistics from JAMA medical education issue, multiple years.
23. Toronto Star 9/13/93
24. NEJM 1990;322:562

Douglas Knight
2019 Hatch Street
Eau Claire, Wisconsin 54701

March 31, 1998

APR 03 1998

Senator Rodney Moen, Chairman
Committee on Health, Human Services, Aging
Corrections and Veterans and Military Affairs
P.O. Box 7882
Madison, Wisconsin 53707-7882

MW

Dear Senator Moen:

Thank you for allowing scheduling of my appearance before your committee after your March meeting. Vacationing with my family and oldest grandson (11 months) in Oregon has been a treat I would not have wanted to miss.

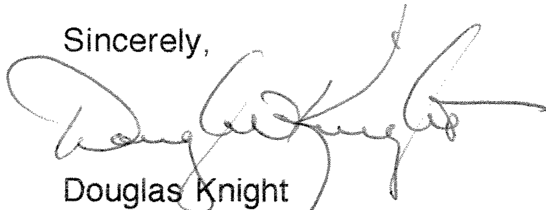
As you are aware, my reappointment to the Examining Board of Social Workers, Marriange and Family Therapists and Professional Counselors is my second full term -- and will be my final term of eligibility. You have played a big part in my confirmation from the very first appointment. Thank you for your support and confidence.

Should you wish materials in addition to items already forwarded by the governor's staff, please advise.

I look forward to appearing before your committee in the relatively near future. Your affirmation of my reappointment would be appreciated.

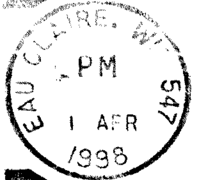
Thanks again, Rod.

Sincerely,



Douglas Knight

D Knight
2019 Haxoh St.
Eau Claire, Wi 54701



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Senator Rodney Moen
P. O. Box 7882
Madison, Wi 53707-7882

53707+7882 82

REINHART | BOERNER | VAN DEUREN
NORRIS & RIESELBACH, S.C.

ATTORNEYS AT LAW

APR 28 1997

April 24, 1997

Senator Rodney C. Moen
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Moen:

I have recently been nominated by the Governor to serve on the Board of Trustees of the Medical College of Wisconsin. I understand that my nomination has been referred to the Senate Committee on Health, Human Services, Aging, Corrections, Veterans and Military Affairs.

I look forward to the opportunity of serving on the Board of Trustees and stand ready to meet with you prior to the confirmation hearing if you so desire. You may contact me either at my office (414) 298-8141 or at home (414) 962-5983. For your convenience, I enclose a brief description of my professional background.

Thank you for your consideration.

Yours very truly,

Richard W. Graber

MW2\11969RWG:CB

Enc.

1000 North Water Street P.O. Box 92900 Milwaukee, Wisconsin 53202-0900
Telephone (414) 298-1000 Facsimile (414) 298-8097 Internet http://www.rbvdnr.com

Denver, CO (303) 831-0909 | Madison, WI (608) 829-3434 | Milwaukee, WI (800) 553-6215 | Washington, D.C. (202) 833-7366

RICHARD W. GRABER
2726 East Shorewood Boulevard
Shorewood, WI 53211

Richard W. Graber is an attorney in the Milwaukee office of Reinhart, Boerner, Van Deuren, Norris & Rieselbach, s.c. He joined the firm in 1981 and has been a shareholder of the firm since 1989. Mr. Graber's practice concentrates in the areas of mergers and acquisitions, general corporate, bank holding company acquisitions, mergers and sales, corporate financing and government relations. He has served on the firm's Board of Directors since April, 1996.

From 1988 until 1997, Mr. Graber was a member of the Board of Governors of the Wisconsin Patient Compensation Fund. He is currently Chairman of the Board of Appeals in the Village of Shorewood. Mr. Graber served as president of the North Shore Rotary Club in 1989.

Mr. Graber graduated from Duke University in 1978 and from Boston University Law School in 1981. He lives with his wife Alex an their two sons, Scott and Erik, in Shorewood.

Vote Record

Senate Committee on Health, Human Services, Aging, Corrections, Veterans and Military Affairs

Date: 4/30/97 ☒ Executive Session ☐ Public Hearing

Bill Number: [illegible]

Moved by: Fitzgerald Seconded by: Breske

Motion: All appt.s except Natalie Kohler Black

Committee Member	Aye	No	Absent	*Present*	*Absent*
Sen. Rodney Moen, Chair	☒	☐	☐	☐	☐
Sen. Roger Breske	☒	☐	☐	☐	☐
Sen. Gwendolynne Moore	☒	☐	☐	☐	☐
Sen. Robert Wirch	☒	☐	☐	☐	☐
Sen. Carol Roessler	☐	☐	☒	☐	☐
Sen. Peggy Rosenzweig	☒	☐	☐	☐	☐
Sen. Scott Fitzgerald	☒	☐	☐	☐	☐
Totals:	6		1		

☒ Motion Carried ☐ Motion Failed

Vote Record

Senate Committee on Health, Human Services, Aging, Corrections, Veterans and Military Affairs

Date: 4/30/97 [X] Executive Session [ ] Public Hearing

Bill Number: ______

Moved by: Fitzgerald Seconded by: Breske

Motion: Natalie Black Kohler Appt

Committee Member	Aye	No	Absent	*Present*	*Absent*
Sen. Rodney Moen, Chair	[X]	[ ]	[ ]	[ ]	[ ]
Sen. Roger Breske	[X]	[ ]	[ ]	[ ]	[ ]
Sen. Gwendolynne Moore	[X]	[ ]	[ ]	[ ]	[ ]
Sen. Robert Wirch	[X]	[ ]	[ ]	[ ]	[ ]
Sen. Carol Roessler	[ ]	[ ]	[X]	[ ]	[ ]
Sen. Peggy Rosenzweig	[X]	[ ]	[ ]	[ ]	[ ]
Sen. Scott Fitzgerald	[X]	[ ]	[ ]	[ ]	[ ]
Totals:	6		1		

[X] Motion Carried [ ] Motion Failed

CORRESPONDENCE\MEMORANDUM **OFFICE OF THE GOVERNOR**

Date: **May 1, 1997**

To: **Members of the Senate Committee on Health, Human Services, Aging, Corrections and Veterans and Military Affairs**

From: **Delora Newton, Director of Appointments**

Re: **Board of Trustees of the Medical College of Wisconsin**

At yesterday's Senate confirmation hearing for the appointment of Natalie Black Kohler, some committee members expressed concern that too many attorneys serve on the Board of Trustees of the Medical College of Wisconsin. This memo clarifies who has appointing authority for the Board of Trustees and how many of the governor's appointees hold law degrees.

The Board of Trustees has 35 members. Per the board's By-laws, the governor appoints 11 members; the Milwaukee County Executive appoints 2 members; the Board of Directors of Froedtert Memorial Lutheran Hospital appoints 2 members; the President of the Medical College serves as a member; and the remaining members are elected by a majority vote of all trustees.

Of the 11 members appointed by Governor Thompson, four have law degrees. Natalie Black Kohler currently serves as Corporation Counsel to the Kohler Company. William Randall is retired, but practiced law for a time with the firm of Shea, Hoyt, Greene, Randall and Meissner. Richard A. Weiss is the Managing Partner for Foley & Lardner. Richard W. Graber is an attorney with the firm of Reinhart, Boerner, Van Deuren, Norris & Rieselbach. Of these four, only Ms. Kohler was formerly employed by Quarles and Brady.

Attached is a list of the 11 current Board of Trustees members who were appointed by Governor Thompson. Please feel free to call me at 266-7887 if you have any questions.

BOARD OF TRUSTEES OF THE MEDICAL COLLEGE OF WISCONSIN

(Effective May 1, 1997)

Charles McNeer
1111 N. Edison Street
Milwaukee, WI 53202
(term expires 05/01/99)

Jon McGlocklin
13555 Bishops Court, Suite 205
Brookfield, WI 53005
(term expires 05/01/98)

Linda Mellowes
9560 North Lake Drive
Milwaukee, WI 53217
(term expires 05/01/03)

Sidney Shindell
929 N. Astor St., Suite 2505-7
Milwaukee, WI 53202-3490
(term expires 05/01/02)

William Randall
6122 N. Berkeley Blvd.
Whitefish Bay, WI 53217
(term expires 05/01/01)

Joseph Gorman
10237 W. Vienna Avenue
Wauwatosa, WI 53222
(term expires 05/01/00)

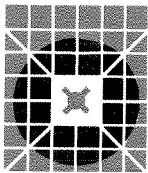
Natalie Black Kohler
Kohler Co.
444 Highland Drive
Kohler, WI 53044
(term expires 05/01/03)

Richard A. Weiss
Foley & Lardner
777 E. Wisconsin Ave.
Milwaukee, WI 53202-5367
(term expires 05/01/02)

Dr. Timothy Thomas Flaherty
547 E. Wisconsin Avenue
Neenah, WI 54956
(term expires 05/01/03)

Richard W. Graber
2726 East Shorewood Blvd.
Shorewood, WI 53211
(term expires 05/01/02)

Charles D. Jacobus
The Jacobus Company
P.O. Box 13009
Milwaukee, WI 53213
(term expires 05/01/01)



Neviaser Investments, Inc. *Commercial Real Estate & Hotels*

25 West Main Street, Suite 465 • Madison, Wisconsin 53703
Telephone (608) 257-3777 FAX (608) 257-4013

MAY 20 1997

May 19, 1997

Senator Rodney E. Moen
Chairman, Committee on Health Services, Aging,
Corrections and Veterans and Military Affairs
State Capitol Building
P.O. Box 7882
Madison, Wisconsin 53707-7882

MW

Dear Senator Moen:

Governor Tommy Thompson has recently appointed me to serve as a Public Member on the Wisconsin Psychology Board. My term will run from April 23, 1997 until the year 2000.

I sincerely want to serve the people of Wisconsin and Governor Thompson in this responsible position and to help ensure the high professional standard that has been set for the licensed Wisconsin Psychologists.

A copy of my current resume is enclosed. In January of 1997 I completed 8½ years on the Wisconsin Medical Examining Board, the last year serving as the elected Chairman of the MEB. Should you have questions of me before my Senate confirmation date, do not hesitate to call me at (608) 257-3777.

Sincerely,

B. Ann Neviaser

B. Ann Neviaser
Vice President

BAN:nla

B. ANN NEVIASER

7221 Colony Drive
Madison, Wisconsin 53717
H-(608) 833-4463, W-257-3777
Fax 257-4013
E-mail: COCLARE@aol.com

EDUCATION

1985 — University of Wisconsin-Madison
MASTER OF SCIENCE DEGREE, CONSUMER SCIENCE

Course work in: Consumer Legislation, Personal & Family Finance and Financial Counseling

1980 — Edgewood College - Madison
Magna Cum Laude, **BACHELOR OF SCIENCE DEGREE IN ECONOMICS** and MINOR IN BUSINESS

1975 — Wisconsin School of Real Estate
Wisconsin Real Estate Brokers License

BUSINESS EXPERIENCE

1976 - 1/97 — **NEVIASER INVESTMENTS, INC.**, Madison, Wisconsin
Vice President, Real Estate Broker, Owner/Manager Commercial Real Estate

GOVERNMENT EXPERIENCE

7/88 - 1/97 — **WISCONSIN MEDICAL EXAMINING BOARD**, Appointed by Governor Thompson - Licensing & Discipline of Medical Doctors - Vice Chair 1993 & 1994. **CHAIRMAN OF THE BOARD 1996.**

8/80 - 8/87 — **WISCONSIN SAVINGS & LOAN REVIEW BOARD**, Appointed by Governor Dreyfus & reappointed by Governor Earl - Regulation of Wisconsin Savings & Loans - Elected Secretary

4/84 - 4/92 — **ELECTED** for 4th Term to **DANE COUNTY BOARD OF SUPERVISORS**, District 21, Far Westside of Madison about 14,000 constituents; attend regular meetings on budgets, taxation, ordinances, contracts

Member **FINANCE COMMITTEE** 4/86-4/92: **CHAIRMAN** Finance Committee 4/88-4/90 FIRST WOMAN IN DANE COUNTY HISTORY TO CHAIR FINANCE, Adopted 1991 Budget $181 Million, - Review contracts and all requests for money, Audit county bills, Authorize price of tax deed lands, Let bids for three (3) year banking contract, - Expansion of Dane County Airport, Dane County Detox Center, Jail and Huber Work-Release Facilities occurred during my tenure.

GOVERNMENT EXPERIENCE (CONT.)

Member **BUDGET COMMITTEE** 4/88-4/90 Coordination of Annual Dane County Budget
DANE COUNTY AIRPORT COMMISSION 6/88-4/90
REAL ESTATE & SPACE NEEDS COMMITTEE 4/86-4/90
CHAIRMAN 87/88 - Coordinated County Real Estate needs, Drafted original Real Estate Ordinance for the County, "Sold" Home West & 37 acres vacant county land during tenure
PUBLIC PROTECTION & JUDICIARY COMMITTEE
8/83-4/86 - Liaison to Sheriff's Dept., Oversight of District Attorney's Dept., the Clerk of Courts' & Corporation Counsel's Departments, Participated on the Metropolitan Police Task Force Committee
CULTURAL AFFAIRS COMMITTEE including Executive Board & Sesquicentennial Committee

8/83 — **APPOINTED** to the Dane County Board from seven (7) candidates to fill a vacancy, by the County Board Chairman.

1986/89 — Appointed to **STATE JUDICIAL COUNCIL - SMALL CLAIMS COURT COMMITTEE**, Revised Small Claims & Garnishment Laws Law AB309

9/87 - 12/89 — Appointed to the **COUNCIL OF BUSINESS & EDUCATION PARTNERSHIPS** by Governor Thompson

OTHER EXPERIENCE

Member **UW-Madison School of Human Ecology Board of Visitors** 1996-Present
Member **Edgewood College Alumni Advisory Board** 1993-Present Chairman 1997 & Member 1984-87
Member **UW Comprehensive Cancer Center** 1994-Present
Ltd. Partner Golden State Warriors Basketball Team, Calif. '85-'95
Salvation Army Advisory Board 1985-90
Greater Madison Convention & Visitors Board 1985-90
Architectural Review Committee for the Rural Insurance Company's Old Sauk Trails Research Park Development, design & landscape review 1988-4/92

1995 Distinguished Professional Alumni Award-Edgewood College
Omicron Nu, Academic Society 1985-present
Named "Know Your Madisonian 1985" by Wisconsin State Journal

INTERESTS

Reading, Travel, Oriental Art, Family Genealogy

REFERENCES Upon Request

RADIOLOGY ASSOCIATES OF THE FOX VALLEY S.C.

1209 S. COMMERCIAL ST.
NEENAH, WISCONSIN 54956

TIMOTHY T. FLAHERTY, M.D., F.A.C.R.
(414) 722-1582

May 27, 1997

MAY 29 1997

Senator Rodney Moen
P.O. Box 7882
State Capitol, Office #403-H
Madison, WI 53707-7882

Dear Senator Moen:

I have been recently notified of my nomination by Governor Thompson to serve on the Board of Trustees of the Medical College of Wisconsin for a six year term.

This nomination requires Senate confirmation and I am asking for your support. If I can answer any question prior to your consideration please do not hesitate to contact me at the numbers listed below.

Thank you for your consideration.

Sincerely,

Timothy T. Flaherty, M.D.

TTF:sj

Home: 414-722-8600
Office: 414-722-1582