☞ 05hr_SSC-HCR_Misc_pt07

☞ Details: Informational hearing to discuss GAO report 05-856 and health care cost, quality and access in Southeastern Wisconsin. Hearing held in Milwaukee, Wisconsin on April 11, 2006.

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Select Committee on Health Care Reform...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (August 2012)

Carol Roessler
Committee Chair,
Notes

Senate Select Committee on Health Care Reform – Milwaukee hearing

Confirmed Invited Speakers – 20 minute maximum

GAO report – (10:00am – 10:20am)

Mike Brady – City of Milwaukee Employee Benefits Manager (suggested by office of Mayor Tom Barrett, who is unavailable)

- Speaking to provide background on the GAO report; may discuss other related issues

(Cong. Paul Ryan unavailable but will submit statement)

Providers

Wisconsin Hospital Association – (10:20am – 11:00am)

Steve Brenton, President

- Response to the GAO report
- Additional comments on the health care environment in SE WI
- Recommendations for health care reform

Bill Bazan, VP, Metro Milwaukee

- Issues specific to health care in SE WI

Wisconsin Medical Society – (11:00am – 11:40am)

George Lange, Society Board member from the Milwaukee area

Cindy Helstad, Health Policy PhD

- Response to the GAO report
- What the Society is doing to work on making the system better
- Thoughts on what the state can/can't do

Other experts

John Torinus, CEO, Serigraph, Inc. (11:40pm – 12:00pm)

- Insights on health care cost drivers
- Private side, market-based solutions

John Rauser, Rauser Agency (12:00pm – 12:20pm)

- Current president of WI Association of Health Underwriters
- Agency specializes in the small business market

Dick Tillmar, Diversified Insurance Services, Inc. (12:20pm-12:40pm)

- Former CEO, TE Brennan Company
- Insights on health care cost drivers
- Background on employee-sponsored healthy lifestyle programs
- Serves on MMAC health committee

Steve Brenton

Hosp & Physicians Plans
6-8 1/2 adm costs

> # people w/ mental Illness.

6-12% adm costs

Posted Price VS Paid Price - view as Property
Pricepoint. org - aggregate Disc.

81% Comm.
57
20 medicaid

Health Plan that sold me policy
Uninsured

Self Pay pay less than 20% ...

Cost sharing

Hosp HSA

May 11 1/2 1 out of 3 = earn less than 40,000 Annual income.

A lot

2005 Hosp's > 6%
medicaid 0

Utilization ->

50% of Gross nat'l product = cost in HC

- Baby Boom
- Technology investments

Support Pregnant [illegible] to delivering [illegible]

Big cost Drivers & what can we do about.

Serigraph   John Torinus

Consumer driven Jan 1, 2004

Flat & slightly 27 mos – H. costs can be managed vs – Double [illegible] Dental, M Health, Chiro, Nurse Dietician on Site. Wellness + Prevention mostly free. Discount = improved [illegible] 699 [illegible] 1600 – [illegible]

Self ins

[illegible] = individual [illegible]

1) Help us manage Health Costs – Engage [illegible]

2) controlling + changing behavior

3) Need market place to work
Reactive VS Proactive

Pine / Ohm Torinus for

Required Health Assessments = free + rigorous

Early + often all early & prevention = free

12%

— no complaints

Sen. Jenkins

1) How to Utilize HC.

Teach — wellness disease mgmt.

Catastrophic in state pool hosp mand.

more as Q would mall groups 1% in all 1 program

30% co Pay 250 Health & 2005

2) How people live their lives — 2 wellness days off

Encourage Communities Pay + Incentives w/ Chronic

FSA Have used

well rooms, inc disincentives disease mgmt Nurse

— fit or trying to get healthy = reward.

3) How follows regime —

How follow treat.

high stone undisciplined inexperienced trade

5% drive 70% costs

care Q

Incentives HSAs + Disincentives

MANDATE TRANSPARENCY

make state costs public.

70% = cronic diseases

Six Sigma — Leonard Berise

Diabetic — Nurse knows

who are coaching

Cronic disease mgmt = biggest payoff.

Depression = 1 of 16 Cronic Diseases

ymcat.

Draftco —

PRO ACTIVE MEDICINE VS REACTIVE

How purchase.

$1 M mo Inell. 300 mil in on.

no disciplines

Incentive Disincentives

Price Q Service.

Competition

820 emp — spouse elsewhere

700 in

11 screens up — price of Hips

Colonoscop | MRI's

Indiv. Resp. wholistic Brown

Transparency — steer to high

Value providers Good Q good price

Switch over per yr.

give employee ck $2,000 to employee

Infant Pig

Not about discounts

70 = Comp 30% = Employee cost

behavior employees

45% people in public

3,084 lyfe. 2,339 couple

1/2 school dist

Regimo will start on Private side.

Most school plans - little inc. + disincent.
Teachers 400% more M.H. than others.

loosing members | loosing take home pay.

Voluntary can stay in 200 ded.
Incentive 1,000 - Here's -
$4,000 - don't spend it to
yours. | may out of pocket. =

Johnson way - pick out QUALITY

~~Drug 40 d~~ Colonosky $500

HSA.
$3,000 to Emp

Mercer Corp
Bonta
Micro NWM Life

"WE COVER EVERYTHING"

ANNUAL ASSESSMENT.

PRODUCTIVITY -

Net - emp share payroll

12% + Employer

Payed 90 / 10 = Insurance Provider
paid by person

Small business Cant afford. 1500 ? yrly
are deductible 2000 per yr.

Hospital = 30,000 per day. appral.

Insurance Co's

Small businesses can not be turned down

Can be charged more premiums based on EXP.

Insurance suppose to cover U catastrophic cost.

Someone Else pay all bills — INCENTIVES

Inspectors - mandate,
Pay for Performance.

Simple Equasion Cost = unit price
+ utilization
How many test use

1 yr. avg. epic ~~test~~ / col. / alcohol / Nutrition
Considerably changed. Portion. control.
More water. Personal trainer 3 days
Drink - Health ~~Assessment~~
Every 8 sec.'s ~~age~~ 50

Center Disease Control. 4
1) genetics = 20%
2) Environment = DK Seattle, tatoos
don't breakdown in system.
3) AC system to V
4) remaining 50% = life style

Employers participate in life style program.
H.C. unlimited limit. life style improvements
↓ absentee ism ↓ H. costs ↓ security
↑ productivity ? "on job" = missing X

DO
Incentives educ. Promote Better health.
Healthiest State in which to live.

Healthy Life styles for our kids - Gov. Prog =
Good - Nurse every 100
25% morbid obese = behavior things ☆
1- Incentive, Plan design - tax incentives ☆ Healthier life style
2- Transparency = Better ☆
3- Consumer Driven H.C. People pay

4 in 4

Incentives for Healthy Outcomes

David Reimer — 3 Big interconnected

500,000 uninsured. ~~se~~ "go to hospital clinics" — costs passed down. Don't get care when should, sicker costs = higher. Get into insurance.

Cost shifting.

Cost containing not able put cost driving mechanisms into balance. Containment not working properly.

Lack rings, incentives, competition, what comp = most needed organized network competing against each other on risk & quality — Deliver better + better care — networks not competing against each other.

Put pieces together wrong way — will have a vehicle pieces separate = network

Transparency Incentives Flex. HSA

12-13 billion cost

Give everyone HSA

tax — Premium credit — pay all or some. Pay out of pocket dollars

lower

incentives

Get rid of deductibles — can't do w/o Fed approval

incentives Improve Life Style

lower assessments

1- Transparency Data (Key) + Quality will create more competition Higher Q, Lower cost. Key.

2- Employers more aggressive w/ H.C. providers

Mike Brady

— City of Milw Employee Benefits Manager.

we would like to see competition

U.S. House of Representatives
Committee on Ways & Means

Sub-Committee on Health

Government Accounting Office
"Federal Employees Health Benefits Program
Competition and Other Factors Linked to Wide Variation in Health Care Prices"

Testimony of the Honorable Tom Barrett
Mayor of Milwaukee

— Ave per month

December 2, 2005

Benefits Mgr,

— Family $1,000 mo

— Couple H/W

— Single $400 mo

Chairwoman Johnson and distinguished Members, thank you for the opportunity to present my views for consideration by the health subcommittee today. I last addressed this committee in July of 2002, when I spoke to you about an amendment I offered as a Member of the House Commerce Committee. The bipartisan Wilson-Barrett amendment reduced geographic disparities in Medicare physician payments. I am pleased that our amendment became law and brought much needed relief to low reimbursement states, like Wisconsin. And thank you for scheduling this important hearing on the Government Accountability Office's (GAO) report on geographic differences in health care prices, costs and spending. It is an honor to meet with you again, this time as Mayor of Milwaukee.

In May of 2002, Representative Paul Ryan of Wisconsin's 1st District and I requested that the GAO conduct a study of variation in health care spending in response to mounting concerns over the rapid growth of health care costs. Representative Ryan and I heard from constituents, including individuals, businesses, and employee groups about soaring medical expenses and double-digit increases in insurance premiums, including significant increases in the Federal Employees Health Benefits Program (FEHB). In reviewing these concerns, we noted that the burden of high health care spending was not evenly distributed throughout the country; that employer health care costs can vary substantially even among cities in the same geographic regions. It was our hope when we made the request to the GAO in 2002, that we would find the means to reduce the burden on areas with the highest cost and we may learn how to better control overall health care expenses. We have a lot to talk about as a result of this report, and I want to thank the GAO for its efforts.

The report clearly identifies that hospital prices, doctor fees, and other health care costs are higher in southeastern Wisconsin than the national average. Other local and national reports, including the recent Mercer report, and the Greater Milwaukee Business Foundation on Health have also concluded that metro Milwaukee's health care costs exceed the national average. Most of us engaged in this discussion throughout Milwaukee and Wisconsin agree on that basic fact. We even may agree on many of the causes of high health care costs. Where we are likely to differ is how to control costs; to slow the trend of skyrocketing expenses; and increase affordability without losing the quality of health outcomes for which Wisconsin is known.

According to the GAO, the higher than average costs in southeastern Wisconsin are attributable to the greater utilization of health services, higher prices charged by doctors and hospitals and "provider concentration" and subsequent lack of negotiating power. When we consider what was not included in the GAO's analysis, it is evident that the entire scope of the problem has not been studied; and that solutions based on the report's conclusions will not lead us to better alternatives. In order to give us a complete picture of Milwaukee and Southeastern Wisconsin's health costs situation, I believe that analysts must evaluate other drivers of health care costs including Medicare and Medicaid reimbursement, healthcare for the uninsured and the underinsured, ethnic and racial disparities with poor health outcomes that lead to more significant treatment; the price of prescription drugs, the nursing shortage, behavioral health, medical technology and

variances in prescribed tests; and even the expense of paperwork. All of those factors and others must be considered before we can accurately diagnose the causes and prescribe the cures. I am pleased, though, that this report has generated so much dialogue in Milwaukee and around the country. That policy makers and health care providers are intensifying discussions as a result of this study can only lead to progress in addressing this very complicated and very serious problem. Perhaps the GAO staff is willing to help to keep us at the table here in Wisconsin by taking another look at the other factors that have kept Milwaukee and Southeastern Wisconsin stuck in a high cost environment.

As Mayor of Milwaukee, retaining jobs and creating more employment opportunities is my number one priority. But excessive health care costs have a negative impact on regional employment expansion, local job creation and economic development initiatives. Business leaders have expressed great concern about their ability to continue to compete in Milwaukee when they see their profits vaporized due to rising employee health care costs. And because of major increases in coverage, employees are faced with higher premiums, higher co-pays, higher deductibles, and are contributing a greater percentage of their take home pay. Health care costs can be an obstacle to Milwaukee's economic health.

There is some good news, though; that over the course of the last few years (and since Representative Ryan and I made our request to the GAO), strides have been made in Milwaukee and Wisconsin to improve quality, provide transparency, and plan for new ways to reduce core costs. Employers in Milwaukee and around the country are becoming more aware of the value of disease management services, risk assessment and wellness programs. Still, the Mercer Health & Benefits survey, released just last week, reported that the cost of providing health benefits in Wisconsin rose 9.2% this year – 31% more than the national average. And that is simply not acceptable.

There remains, then, the need to shed light on a discreet set of issues. As the CEO of the largest city in the state, I will bring together those in Wisconsin, many of whom are in this room today, who have already contributed much to the healthcare debate, and who can help to determine the broader questions that are still lingering as a result of the GAO report.

Thank you again for this opportunity.

- Cost

- Q

- Access

Economic growth + job opp[illegible] Health Care

Helps drive ↑ costs of H.C.

Short Term

Long Term

Reform make a difference

Consumer Driven

Next Budget

~~Data~~ Transparency

07-09

09-11

C
Q
A

Problem —

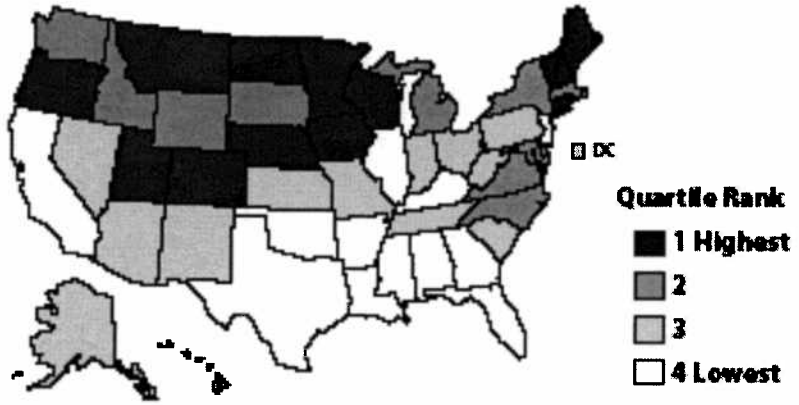
Solutions
what do we do about it?

Consumer [illegible]

State-Level Performance on Medicare Quality Indicators

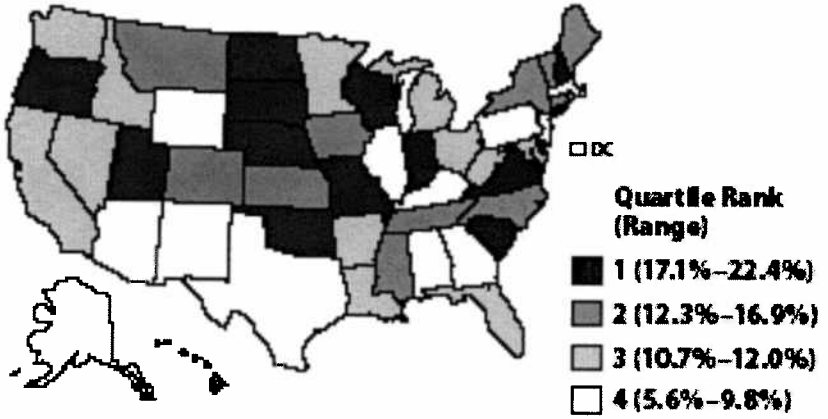
Average state performance on provision of effective care to Medicare fee-for-service beneficiaries, by quartile rank, 2000–2001

Northern and less populous states tended to perform better across 22 indicators of the quality of care delivered to Medicare beneficiaries, including preventive care and/or treatment for heart attack, heart failure, stroke, pneumonia, influenza, diabetes, and breast cancer (see Appendix Table 1a for a list of the indicators included in this ranking).



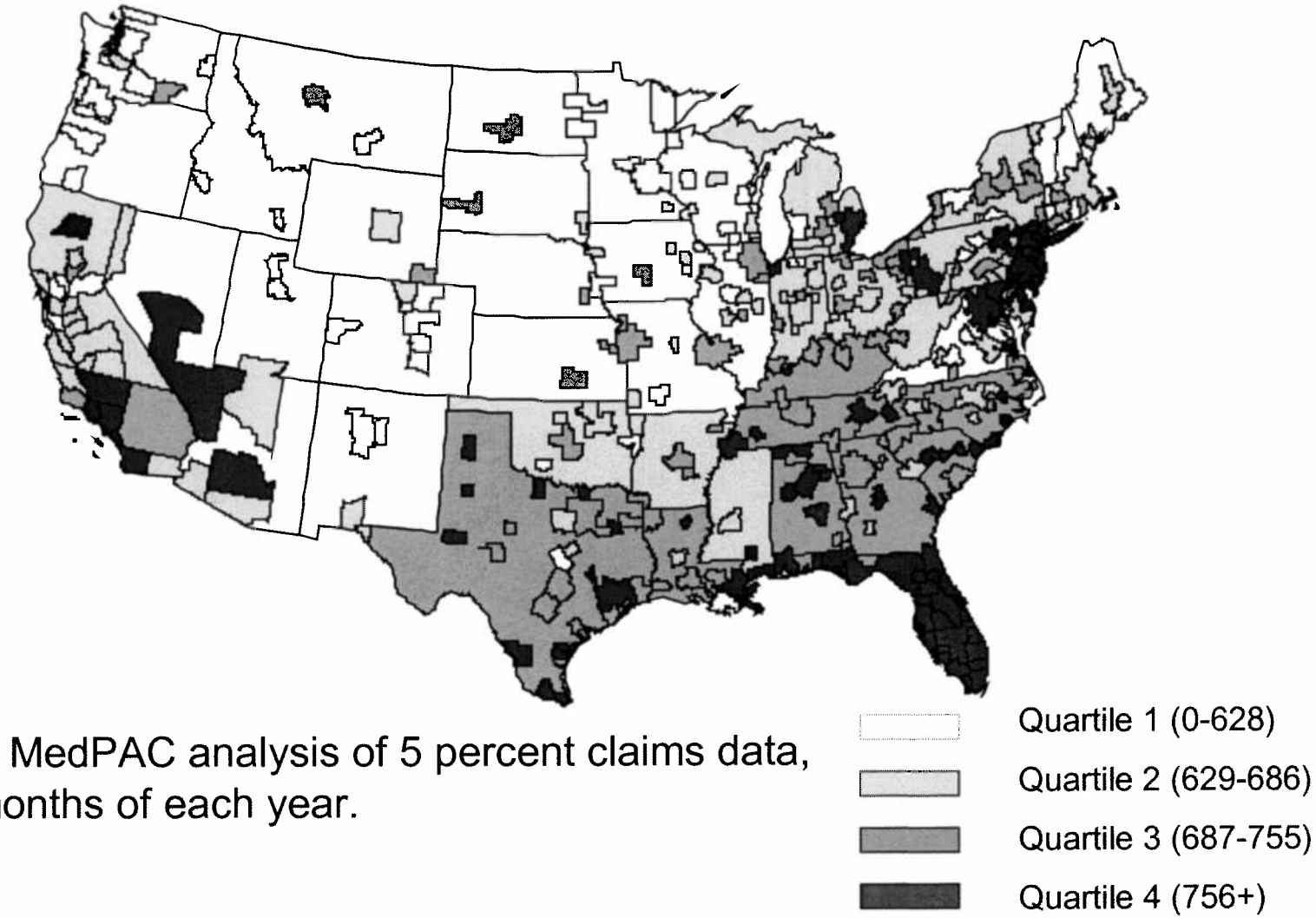
Median relative improvement* in the provision of effective care to Medicare fee-for-service beneficiaries, by quartile rank

From 1998–1999 to 2000–2001, the median state's performance across the 22 quality indicators improved from 69.5 percent to 73.4 percent, representing a 12.8 percent relative improvement.* This is a measure of the degree to which the gap between actual and ideal performance was reduced.



Source: Center for Medicare and Medicaid Services, Medicare Quality Improvement Organization program (Jencks et al. 2003). Adapted and used with permission from: *Journal of the American Medical Association*, Jan. 15, 2003, 289: 310-11. Copyrighted © 2003, American Medical Association. All Rights reserved.
*Relative improvement was defined as absolute change / (100 - baseline).

Average adjusted service use per beneficiary, all services, 1999-2002



Source: MedPAC analysis of 5 percent claims data, first 6 months of each year.

Community PACE & Partnership

Wellness & disease prevention

a lot of Primary care deliver
meds / home / administered
Pharmacist - 12 10-12 meds ↓
to 7

Provider + insurance & save

4.1

GMC — Mike Boldgen

MMAC — Mike Mahoney
in health

WISCONSIN HOSPITAL ASSOCIATION, INC.

Wisconsin Hospital Association Statement
Prepared for the Senate Select Committee on Health Care Reform

Tuesday, April 11, 2006
Milwaukee, Wisconsin

The Wisconsin Hospital Association's statement covers three specific topics that are the focus of this hearing:

1) Observations about the **Government Accounting Office (GAO) report**—GAO-05-856;
2) Concerns about the **unique and problematic characteristics of the health care environment in southeastern Wisconsin**, especially Milwaukee; and
3) Our recommendations regarding current and future health care reform initiatives that can be fostered **via a bold and proactive transparency agenda**.

1) GAO Report 05-856

Our first observation is that this report has been widely discussed without actually being widely read by many pundits. The report's focus on physician and hospital *prices*, as opposed to *actual health care costs*, has created a hugely **misleading** snapshot of overall Wisconsin health care *spending*.

This GAO report places heavy emphasis on physician and hospital prices and compares Wisconsin metropolitan areas with metropolitan areas across the nation, drawing the reader to conclude that something is amiss in the Badger State. But a reader who analyzes the entire report comes to a far different conclusion about Wisconsin health care costs, using the GAO's own analysis. Specifically, well into the document, GAO staff note that **provider prices have only a marginal impact on actual spending**. And unless one factors in the volume of services consumed, there is an incomplete picture of dollars being spent on total health care services. Another way to look at it is, five widgets purchased at $5 ($25) are less expensive than seven widgets purchased at $4 ($28), even though the price of the individual widget may be less. Indeed, the GAO itself states that only about one-third of total cost differences are the result of unit prices.

We noted last year that the GAO report, using five-year-old data, concluded that the La Crosse metropolitan area is the "priciest" in the nation. But the GAO's own chart (page 65) tells a far different story. **When the focus is on actual spending, *no* Wisconsin metropolitan area is found among the top 20 highest spending areas in the nation.** The report does conclude that spending by the FEHP in the Milwaukee/Waukesha metropolitan area is about 11 percent higher than the national average. But that's a far cry from media and pundit speculation.

Also of note, the GAO used national preferred-provider organizations bidding on *small numbers* of employees in each local market. Many businesses located in these markets are able to obtain larger discounts because of the greater volume of employees they can deliver to a local provider. This is another methodological issue that needs to be understood in examining the report.

5510 Research Park Drive P.O. Box 259038 Madison, WI 53725-9038 **P** (608.274.1820) **F** (608.274.8554) **wha.org**

Medicaid Cost Shifting Not Considered

We also know that the GAO report is seriously **flawed** in that it fails to account for ongoing and worsening hospital and physician cost-shifting due to **Medicaid underpayment**. We know that Wisconsin Medicaid payments are among the very worst in the country, paying providers pennies on the dollar for actual costs incurred caring for patients. This "hidden tax" is a significant cost driver that is not accounted for in the *GAO Study*.

From 1997 to 2005...just eight short years...Wisconsin Medicaid hospital reimbursement dropped dramatically from 82 percent of cost to 49 percent. **Government's role in health care reform should begin with paying the cost of its own program.**

The Medicaid cost-shifting issue is particularly severe in the **greater Milwaukee community** where a **handful of hospitals care for close to 40 percent of the state's total Medicaid population**. While the average Wisconsin hospital has about 10 percent of its patient base paid for by Medicaid, the Milwaukee average approaches 30 percent, and for two hospitals exceeds 40 percent! Cost shifting is a huge factor in hospital and physician pricing and its absence in the GAO report is a major public policy shortfall.

Here's the Real Story

Here are two examples of more current and comprehensive data that tell a much different story about health care **charges and spending** in Wisconsin. The conclusion: employers in many Wisconsin metropolitan areas are charged *less* than counterparts in the rest of the nation. And Wisconsin is a veritable *bargain* for the federal government when it comes to Medicare spending on Medicare beneficiaries.

2004 Estimated Medical Charges – Full Commercial Population (not just federal employees)

Metro Area	Per Member Per Month Billed Charges
National Average	$403.01
Green Bay	$338.96
Wausau	$340.93
Appleton – Oshkosh – Neenah	$351.63
Eau Claire	$371.90
Janesville-Beloit	$383.32
Sheboygan	$386.83
Racine	$396.45
La Crosse	$403.09
Madison	$407.40
Milwaukee – Waukesha	$449.64
Chicago	$467.18

Source: Milliman USA – based on actual 2004 data

Medicare Spending Per Beneficiary – 2004

Location	Total Annual Medicare Payments
USA	$6,611
Wisconsin Total	$5,407
Appleton	$4,364
Green Bay	$4,819
La Crosse	$4,444
Madison	$5,213
Marshfield	$5,779
Milwaukee	$5,995
Neenah	$4,974
Wausau	$5,150

40th State with Medicare pmts.

2) Unique and Problematic Characteristics of Health Care Environment in Southeastern Wisconsin

There should be no debate over the fact that access to primary health care services in the Greater Milwaukee Area is in a state of profound crisis. And like education in Milwaukee's public school system, this must be acknowledged as an issue of *statewide significance*. The time has come to shine a bright spotlight on the specifics of this crisis and the fact that identification of solutions must be a statewide public policy priority that requires engagement by the Doyle Administration and by the Wisconsin Legislature.

Considering the following:

- ✓ In Milwaukee, the hospital emergency room has become the venue for primary care, including dental care, for a large and growing number of medically indigent patients who have no primary care home.
- ✓ Milwaukee's four Federally Qualified Health Centers (FQHCs) are "bursting at the seams" and regularly refer patients to hospital ERs. One clinic alone refers 60 patients per day, five days per week.
- ✓ **Bad debt and charity care** numbers now **exceed $160 million** for the nine Milwaukee metropolitan area hospitals serving this population.
- ✓ Just a handful of Milwaukee hospitals and Racine's sole hospital system absorb almost 40 percent of total annual statewide hospital Medicaid losses (approximately **$200 million!**).

The symptoms associated with this access crisis are many—and include infant mortality rates that are among the worst in the nation and untreated chronic disease conditions that become expensive inpatient admissions. **Additionally, the ability of a handful of disproportionally burdened hospitals to manage the uncompensated care burden is not sustainable.**

Hospital Emergency Rooms Dentist
Handfull Hosp provide

2 mkts exceed 50% Bad-medicare

20-30-40%

Minimally, fixing this crisis will require targeted new state funding that focuses on at least two initiatives—**expansion of additional primary care infrastructure**...and...**enhanced Medicaid DSH funding for hospitals that have become *de facto* "safety net" providers of primary care services**.

3) WHA Health Care Reform Recommendations

Here are a few thoughts regarding potential initiatives that can improve access and coverage, and moderate health care costs.

Transparency

Wisconsin is a recognized national leader in the emergence of private sector initiatives that provide relevant quality performance data in an increasingly consumer-driven health care environment. The Wisconsin Hospital Association's **CheckPoint** and **PricePoint** initiatives and the **Wisconsin Collaborative for Healthcare Quality's** health care performance reporting initiative are so well respected nationally (see "Ahead of the Pack" article in November 2005 *Hospitals & Health Networks* magazine) that they are being discussed and replicated by organizations throughout the country. Importantly, quality, safety and pricing information being reported today represents only the beginning of a much larger menu of measures anticipated over the next several years.

The Wisconsin Legislature's recent enactment of the Wisconsin Health Information Organization (WHIO) is another promising development that will likely provide additional information that can be used to advance the larger transparency agenda.

There is agreement by virtually all stakeholders in the health delivery and financing environment that measuring and reporting will lead to greater efficiencies and improvements in patient outcomes. These developments will have a significant impact on lowering health care inflation and WHA is strongly committed to a bold and proactive transparency agenda. We look forward to working with the Wisconsin Legislature to advance that agenda with all due speed. We firmly believe that **transparency is the cornerstone of health care reform** and a key ingredient in achieving a moderation in health care cost inflation.

Additionally, there are a variety of other legislative/regulatory approaches that might be examined to advance access and affordability...the desired outcome of health care reform. Those ideas include:

- ✓ Governor Doyle's **BadgerCare Plus initiative** is a promising proposal that represents a commitment to expand coverage to uninsured children. The initiative suggests the creation of a single health care safety net program accomplished by merging the family Medicaid, BadgerCare and Healthy Start programs. Projected administrative savings combined with predicted efficiencies associated with enrollment in HMOs could largely finance an expansion of families eligible for coverage under the program to 200% of the federal poverty level.

- ✓ Additionally, the Governor's **Healthy Wisconsin program initiative** also deserves additional study and discussion. The initiative suggests charging a working group with exploring the creation of a reinsurance program for small businesses and individuals that

would be designed to cover catastrophic health care costs. Such a program in the State of New York has proven to be highly successful. There are, however, questions to ponder and discuss before this initiative is ready for implementation, but the notion of looking at specific models already working in other states like New York deserves our strong support.

- ✓ The State of Wisconsin must recognize **income tax deductibility of Health Savings Account contributions**. HSAs may not be the entire solution to access and coverage issues, but they represent a real opportunity, especially for individuals and small groups. Our own association's experiment with an HSA has proven to be hugely successful and welcomed by our employees and their families.

Strongly support -
TOBACCO TAX
Medicaid IMP ROVING

? 920 251-9891

Wisconsin Medical Society

Your Doctor. Your Health.

TO: Members, Senate Select Committee on Health Care Reform
Senators Alberta Darling and Carol Roessler, co-chairs

FROM: George M. Lange, MD, FACP

DATE: April 11, 2006

RE: Health Care Costs, Quality and Access

On behalf of more than 11,000 members statewide, thank you for this opportunity to share the Wisconsin Medical Society's thoughts regarding an issue so vital to every Wisconsin citizen: the rising costs of health care. We appreciate you holding this hearing, and hope it is just the first of many collaborations where physicians can work with our health policy leaders in finding ways to provide our state's citizens with the highest quality health care at the most affordable cost.

Joining me this morning is Cindy Helstad, PhD, RN, who has both broad and deep knowledge about the Society's efforts in health care policy. Please feel free to ask either of us any questions following these brief comments.

General Accountability Office Report 05-856

Attached to this testimony you will find Society EVP/CEO Doctor Susan Turney's testimony to the House Ways and Means' Health Subcommittee regarding the Society's concerns about the GAO's methodology and subsequent findings. While the Society continues to have questions regarding the report's accuracy, we want to emphasize that we believe that growth in health care costs is a critical topic in need of discussion and action. Higher costs often means less access to care, which in the long run means Wisconsin's citizens are less healthy than they could be.

Wisconsin Medical Society Efforts On Cost, Quality and Access

In the last two years, the Society has developed a strategic plan focused on health care cost, quality and access, the three main tenets of our 2003 plan for Health System Reform. I would like to highlight a few of the initiatives we have undertaken.

1. **Wisconsin Health Information Organization (WHIO)**

The Society is a founding member of the Wisconsin Health Information Organization, or WHIO. WHIO can help us begin talking the same language by pooling claims data across the delivery system. Rather than getting hung up on charges, costs, payments and discounts, we can begin looking at utilization of services across an episode of care for the same diagnosis. Where variation exists, we can help drive down costs by reforming what is utilized.

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Phone 608.442.3800 • Toll Free 866.442.3800 • Fax 608.442.3802

Historically, the Society has not been at the table to offer solutions affecting unnecessary utilization. That has changed. We are committed to being part of the information-gathering solution rather than simply criticizing others' proposals.

What can the Government do to help our WHIO effort?

- Support data collection from insurance companies, including Medicaid and Medicare data, for the WHIO initiative.
- Help align financing and payment incentives to prevent illness.

2. Wisconsin Health Plan

Over the past year, we have had continued discussions with David Riemer and Representatives Curt Gielow and Jon Richards about the Wisconsin Health Plan. The Society has been a leader in bringing people together to discuss their health reform proposals. The November 2005 issue of the *Wisconsin Medical Journal* provided information on federal, state, and local health care reform proposals. In addition to working toward finding a health system reform proposal that would decrease the number of uninsured and have acceptability by the public, we have also been developing a basic set of health care benefits that would be standard for all Wisconsin residents.

What can the Government do to help with the Society's work on general reform?

- Help us determine if it is politically feasible to take a hard-nosed position about limiting the availability of care in order for more people to have access to health care.
- Support public-private market-driven solutions rather than regulatory ones. We strongly maintain that any plans based on defined contributions, reduced benefit, or medical savings accounts must be coupled with programs that promote and reward appropriate utilization of preventive care, early intervention and appropriate chronic disease management.

3. Society Annual Meeting – Efficiency Proposal

The Society is a policy-driven organization. Every year at our annual meeting ideas are brought forward related to health care policy and a House of Delegates votes on the idea. This year's annual meeting – held just this past weekend in Madison – saw Late Resolution 16 come before the House. That resolution, also attached to this testimony, points out a chronic problem in the everyday practice of medicine that slows down efficiency and creates problems for both physicians and their patients.

Different insurance plans have different pharmaceutical formularies, which often change over short periods of time. Keeping track of which drugs are a part of each patient's insurance plan is an administrative headache, and makes it difficult for physicians to help control costs in this area. If the Government could collaborate with physicians, pharmacists and insurance companies in this area, a solution might be found. Our resolution calls for formularies to be available and updated online.

This is just one example of what physicians think about when considering ways to better the health care delivery system.

What Government Can Do Generally

As the Society resolution on formularies shows, Government does have a potential role in addressing cost, quality and access concerns. The Society believes this power should be used to inspire better public-private communication on how to improve the health care system. WHIO is another fine example – collaboration likely yields better outcomes versus mandates.

The State should resist the temptation to regulate our way out of this problem; instead, the State should use this hearing as an example of a better way to go about finding solutions: gather as many collaborators as possible to discern information that advances understanding about controlling costs and improving quality, then move forward on those ideas.

Again, thank you for this opportunity to provide our thoughts.

LATE RESOLUTION 16 - 2006

Subject: Improving the Formulary Deviation Request Process for Everyone

Introduced by: Daniel Sherry, MD on behalf of District 7 Caucus

Referred to: Health Insurance Coverage & Access

Whereas, Busy physicians are being asked to fill out formulary deviation request forms daily by insurance companies; and

Whereas, Many insurance companies do make it very clear what the formulary alternatives are when a prescription is denied as being "nonformulary"; and

Whereas, Physicians are not reimbursed for their time filling out formulary deviation request forms; and

Whereas, Valuable physician and staff time that detracts from taking good care of our patients is wasted trying to track down formulary deviation request forms, alternative options, and then filling out the forms; and

Whereas, The insurance companies benefit financially from having a formulary with limited choices and should do more to minimize time wasted by physicians; and

Whereas, Most patients do not know if their insurance plan has a formulary or what their options are; and

Whereas, The State of Wisconsin has already demonstrated how to provide a decent formulary online, formulary deviation request forms online, and by offering their formulary on the popular PDA program called Epocrates for its Medicaid, BadgerCare, and SeniorCare programs; and

Whereas, If patients and physicians could easily find online or via Epocrates an insurance company's formulary; and

Whereas, It is in the best interest for physicians and insurance companies to make this process go efficiently for their patients; and

Whereas, All physicians have a fax machine, many have Internet access in their clinics and some have PDAs; therefore be it

RESOLVED, That the Wisconsin Medical Society supports requiring that all health insurance companies doing business in Wisconsin provide:

- An easy to navigate, up to date online formulary for approved prescriptions and deviations;
- Formulary Deviation Request forms and a list of formulary alternatives be both available online and faxed to the physician's office within 24 hours of a denial;
- That the forms faxed to the physician's office by the insurance company contain all of the patient information, insurance identification numbers, claim number and other relevant patient information that the insurance company needs so that the physicians and their staff can easily determine the alternative medication and dosage.

WISCONSIN HOSPITAL ASSOCIATION, INC.

April 11, 2006

TO: Members of the Senate Select Committee on Health Care Reform

FROM: Bill Bazan, V.P. Metro Milwaukee, WHA

RE: Health Care Challenges in Southeastern Wisconsin

The purpose of my testimony today is to present an overview of the health care challenges in southeastern Wisconsin and the manner in which our health care systems are attempting to meet those challenges. In many cases our health care systems are partnering with other organizations, both public and private. In other cases we are going it alone. Given the low rate of Medicaid reimbursement (currently at about 49 cents for each dollar of costs) and the growing number of uninsured and underinsured, the challenges are daunting.

The Milwaukee County General Assistance Program (GAMP): From GAMP's beginnings in 1996-97, our hospitals have partnered with Milwaukee County and the State in providing true safety net coverage and services for nearly 28,000 residents of the county annually. GAMP is not an entitlement program…the money is the money! In order to keep GAMP operating for some of the most needy residents of the county, our health care systems are partnering with the county both in terms of financial assistance ($5.5 M donation over two years to help the county with establishing two 8 bed respite care units and a crisis center for residents with mental illnesses) and in providing health care services to GAMP patients for nearly six months each year without reimbursement at all. This is to ensure that primary care clinics, pharmacies and specialty physicians are reimbursed throughout the year.

The lack of primary care capacity in Milwaukee County: GAMP, Medicaid and uninsured patients have tremendous challenges in finding a primary care home in Milwaukee County. Instead, they look to hospital emergency departments as their primary care provider. Not only does this cause profound backups in the emergency department, it also puts a strain on those patients who truly have emergent care needs. The health care systems of Milwaukee County have formed three years ago a Primary Care Alliance that includes these systems as well as the 4 Federally Qualified Health Centers in the county. The Alliance's purpose is to increase primary care capacity for the most needy of the county's residents. With assistance from the health systems, two new clinics will open up, one on the south side (16th Street Community Health Center) and one on the north side (Milwaukee Health Services). In addition, some of our health systems are assisting clinics operationally (Westside Health Care and Family House to name two such clinics).

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Clinics 36 US #125 - Hospitals

Care coordination 24-7 Shore Info - Hosp Clinics

Meeting the oral health/dental crisis in Milwaukee County: Madre Angela Dental Clinic serves 1400 dental encounters per month for uninsured, GAMP and Medicaid patients. The dental clinic grew out of a joint venture between Columbia St. Mary's, Covenant, and Aurora health systems who are committed to providing dental services to those most in need who cannot find a dentist. In addition, Madre Angela is working with the Milwaukee Public School system in providing dental sealants and oral health examinations to school children. Over 5,000 children have been served. In addition to financial support, the health systems are also providing human resource support in terms of volunteers and grant writing.

Medical care for Katrina evacuees: In the fall of 2005, nearly 1000 evacuees, men, women and children, came to Milwaukee because of the devastation to the Gulf Coast due to hurricane Katrina. All hospitals in southeastern Wisconsin stepped to the plate to assist in the medical care of the evacuees. Medical supplies, pharmaceuticals, prescription drug services, specialty physician services, primary care and in-patient services were provided IMMEDIATELY AS NEEDED without questioning whether or not these services would be reimbursed. One hospital even made their transportation vans available to help evacuees get to the hospital and to specialty physician appointments.

While it is often easy to point fingers and blame agencies and organizations during challenging times, it is also important to recognize the positive effects that are going on. Our Wisconsin Hospitals have strong ties to their respective communities and provide community services that often go unrecognized. When communities work together in partnership, needs are met and problems get solved. It is the hope of the Wisconsin Hospital Association and its member hospitals and health care systems, that all sectors of society recognize the need to work together on issues that effect us all.