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☞ Details: Review of Health Care in Western Wisconsin. Hearing held in Eau Claire, Wisconsin on May 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)

WISCONSIN LEGISLATIVE COUNCIL
ACT MEMO

2005 Wisconsin Act 368 [2005 Assembly Bill 387]	Nursing Student Loan Program

The Higher Educational Aids Board (HEAB) administers the Nursing Student Loan Program. Loans under the program may be used to defray the cost of tuition, fees, and expenses for persons enrolled in the following programs in Wisconsin:

- A program that confers an associate degree in nursing;
- A program that confers a bachelor's degree in nursing;
- A program that confers a second degree that will make a person eligible to take the nursing licensure examination.

The maximum amount of loans that a person may receive during a fiscal year is $3,000. The maximum total amount of loans that a person may receive under the program is $15,000.

If a loan recipient completes his or her program of study and is employed full time as a nurse in Wisconsin, HEAB must forgive 25% of the loan's principal and interest after the first year of employment, and another 25% of the loan's principal and interest after the second year of employment.

2005 Act 368 does the following:

1. Provides that persons enrolled in programs in Wisconsin that confer master's or doctoral degrees in nursing are also eligible for loans under the program;
2. Provides that the loan forgiveness provisions of the program apply to loan recipients who are employed full time in Wisconsin as nurse educators.

Effective Date: May 4, 2006.

Prepared by: Mary Matthias, Senior Staff Attorney May 1, 2006

MM:ksm

One East Main Street, Suite 401 • P.O. Box 2536 • Madison, WI 53701-2536
(608) 266-1304 • Fax: (608) 266-3830 • Email: leg.council@legis.state.wi.us
http://www.legis.state.wi.us/lc

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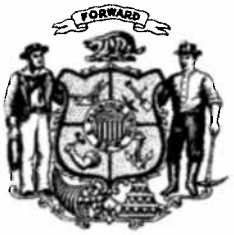

WISCONSIN
CITIZEN ACTION

PRESS ADVISORY

May 4, 2006

CONTACT: **Darcy Haber 608-256-1250 ext. 16**
cell (608) 235-7471

Grassroots Groups Hold *Real* Health Care Forums with *Real* Solutions

May 11th Senate Select Committee hearing dismissed as a charade

WHAT: Two Grassroots Health Care Forums entitled:
Affordable Health Care NOW!
Taking the Next Step toward Affordable Health Care in WI.

WHY: In stark contrast to the charade presented by the Senate Select Committee on May 11, this forum will inform people about real health care solutions and what it will take to get them enacted.

WHEN &WHERE: **Eau Claire** Forum: **10:00am Saturday, May 13th 2006.** Will be held in the Council Fire Room - Davies Center on the UWEC Campus. Reliable parking at the Water Street Parking lot by the Haas Fine Arts Building.

Independence Forum. **2:30pm Saturday, May 13th 2006** at the St. Peter's and Paul's School. 36100 Osseo Road

WHO: Concerned community members, health care advocates, Wisconsin Citizen Action, Progressive Media Network, Coalition for Wisconsin Health

Presentation Details:
Wisconsin Health Security Act presented by Dr. Linda Farley
Wisconsin Health Care Partnership Plan presented by Kathleen Vinehout
Wisconsin Health Care Plan presented by Lisa Ellinger, Wisconsin Health Project
Action Plan for Affordable Health Care. Closing and call to action by Darcy Haber, Wisconsin Citizen Action

WISCONSIN
CITIZEN ACTION

PRESS RELEASE

May 5, 2006

CONTACT: **Darcy Haber 608-256-1250 ext. 16**
cell 608-235-7471

Grassroots Groups Take the Next Step to Affordable Health Care

Eau Claire and Independence. All local citizens are invited to attend a grassroots health care forum this Saturday, May 13t. Two health care forums will be held that day, one in Eau Claire at 10am and one in Independence at 2:30pm. The events are free and open to the public.

The forums will present several health initiatives that have been introduced into the Wisconsin legislature this year. Attendants can expect not only to familiarize themselves with the various plans, but also to learn how to take the next steps to get affordable health care in Wisconsin.

The three plans that will be explained include the Wisconsin Health Security Act (SB388/AB807), presented by Doctors Linda and Eugene Farley, The Wisconsin Health Plan (AB1140) presented by Lisa Ellinger of the Wisconsin Health Project, and the Wisconsin Health Care Partnership Plan (SB 698) presented by Kathleen Vinehout, a farmer and former health policy professor from Buffalo County.

Finally, the moderator, Darcy Haber of Wisconsin Citizen Action, will close by laying out how we all can become active in solving Wisconsin's health care crisis. "This forum isn't about deciding which plan is the best one – its about showing that there are many ways we can achieve affordable health care --as long as we hold our legislators feet to the fire on the issue."

Vinehout, who is running for Senate in the 31st Senate District to make health care reform a priority, stated, "we can and must do better. People shouldn't have to plan their lives around health care. We all need to work together to make this happen."

The forums are sponsored by the Coalition for Wisconsin Health, the Progressive Media Network, and Wisconsin Citizen Action. Recently, Wisconsin Citizen Action, a statewide grassroots citizens group, recent opened an office in Eau Claire.

WHEN & WHERE: **Eau Claire** Forum: **10:00am Saturday, May 13th 2006.** Will be held in the Council Fire Room - Davies Center on the UWEC Campus. Reliable parking at the Water Street Parking lot by the Haas Fine Arts Building.

Independence Forum. **2:30pm Saturday, May 13th 2006** at the St. Peter's and Paul's School. 36100 Osseo Road


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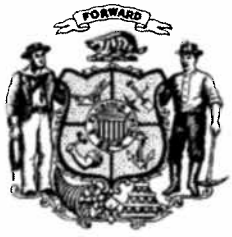
FORWARD

Stegall, Jennifer

Subject: FW: Public Hearing-Health Care Reform-5/11/06

From: DAN AND SHELLEY [mailto:dsaces@charter.net]
Sent: Monday, May 08, 2006 5:08 PM
To: Stegall, Jennifer
Subject: Public Hearing-Health Care Reform-5/11/06

Hi Jennifer,

My name is Shelley Ekblad, and I am a nurse anesthetist from E.C. I would like to provide testimony on behalf of the Wisconsin Association of Nurse Anesthetists (WANA) during the public hearing on Thursday. Can I be placed on your agenda for the morning? I will be happy to provide written testimony for all of the legislators present. Could you email or call me regarding this request? Also, could you let me know if I should arrive promptly at 10:00am or later during the hearing? Thank you very much .

Shelley L. Ekblad, CRNA, M.S., APNP

715-828-8977

715-831-9415

dsaces@charter.net

JS called Shelley on 5-9-06 ... Yes she will attend. Doesn't want to testify 1st but would like to testify earlier rather than later.


WISCONSIN STATE LEGISLATURE


FORWARD

Stegall, Jennifer

Subject: FW: Speakers for the Eau Claire hearing

From: Stegall, Jennifer
Sent: Tuesday, May 09, 2006 12:30 PM
To: Mnuk, Katie
Subject: RE: Speakers for the Eau Claire hearing

Tell me about it, squeezing work on this committee into everything else that has been going on has been kind of crazy. Anyway, I don't need to hear from people. Committee members just like to have an idea of who they may hear from. It is an open public hearing so anyone can testify. I was more or less trying to figure out if there were community leader type people or people who are engaged in the issue that Ron specifically wanted to be there. I just didn't want any question of me from him like why wasn't so and so invited? Given its his area of the state I thought there might be certain people he'd like to attend.

I will carry on with the contacts I have made. As soon as I have the names I need from R.J. Prilot, I'll send out a list of speakers to everyone.

Thanks,
Jennifer

From: Mnuk, Katie
Sent: Tuesday, May 09, 2006 12:21 PM
To: Stegall, Jennifer
Subject: RE: Speakers for the Eau Claire hearing

Jen, it's been so crazy until this week that I haven't had much chance to focus on this. Do you need names in order for them to testify? I talked with one constituent yesterday whose client may come in to testify, but they were still trying to decide. . .

From: Stegall, Jennifer
Sent: Tuesday, May 09, 2006 11:16 AM
To: Mnuk, Katie
Subject: Speakers for the Eau Claire hearing

Hey Katie,

Have you confirmed with anyone who would like to offer testimony on Thurs.? I have a list of the folks I have been working with but am waiting for names from WMC before distributing it to committee members. Let me know if you have any names I should add to the list.

Thanks,
Jennifer

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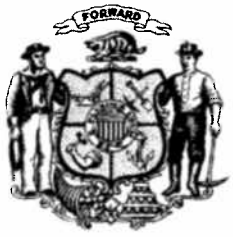

Stegall, Jennifer

Subject: FW: Select Committee on Health Care Reform

From: Malszycki, Marcie
Sent: Wednesday, May 10, 2006 4:15 PM
To: Stegall, Jennifer
Subject: FW: Select Committee on Health Care Reform

CR email

From: Mike Dougherty [mailto:MDougherty@dsmfg.com]
Sent: Wednesday, May 10, 2006 4:03 PM
To: Sen.Darling; Sen.Roessler
Subject: Select Committee on Health Care Reform

Dear Senators Darling and Roessler,

I will not be able to attend the public hearing in Eau Claire on May 11th so I would like to submit my comments and recommendations in writing.

D & S Manufacturing is a 155 employee business located in Black River Falls. We provide metal fabricating and machining services to our customers which include several large Wisconsin manufacturers. We continue to face increased competition from foreign suppliers which requires us to continually reduce our operating costs and lower our prices.

Health care costs currently represent 5% of our sales and 18% of our payroll cost. We have worked to contain these costs by increasing employee contributions, reducing coverage and consolidating providers into a single network. We are also in the process of implementing a wellness program.

I believe that no single business or group of businesses will be able to resolve the fundamental causes of rising health care costs. Restoring consumerism to health care will not do enough and it seems to me that our success in negotiating provider discounts could actually make the situation worse by increasing cost shifting.

It is time for our State government to enact legislation that will provide uniform health coverage to all Wisconsin residents. Our current system is cumbersome and ineffective. Costs are being shifted from uninsured and underinsured to the insured population. The present insurance system is too bureaucratic and expensive and creates excess costs between the patient and the provider.

It is my understanding that there are currently three major initiatives underway in Wisconsin. They are as follows:

- The Wisconsin Health Plan – www.wisconsinhealthproject.org
- The Coalition for Wisconsin Health – www.wisconsinhealth.org "Wisconsin Health Security Act" (SB388/AB807))
- The Wisconsin Health Care Plan (SB698)

In my opinion, these plans are all good "works in progress". I currently favor The Wisconsin Health Plan because I think it is the most well developed plan and probably has the best chance of success. I encourage your committee to use these initiatives as building blocks and move forward to enact legislation that will provide uniform health insurance coverage to all Wisconsin residents.

Michael J. Dougherty
President
D&S Manufacturing
Ph. 715-284-5376 ext 316
Fax 715-284-4084
Email mdougherty@dsfmg.com
Website www.dsmfg.com


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E PLURIBUS UNUM

WISCONSIN LEGISLATURE

P. O. Box 7882 Madison, WI 53707-7882

FOR IMMEDIATE RELEASE

For More Information, Contact: May 11, 2006

Senator Carol Roessler 608-266-5300
Senator Alberta Darling 608-266-5830

JOINT STATEMENT ON RECENT SENATE REPUBLICAN HEALTH CARE REFORM ACCOMPLISHMENTS

"Senate Republicans are moving forward in our efforts to create and implement market-based health care solutions that put the consumer in charge of their own medical care. The Senate Select Committee on Health Care Reform was formed for use as a vehicle to identify new and innovative ways to lower the over cost of health care.

The Legislature has repeatedly passed tax incentives to expand **Health Savings Accounts**. Despite the Governor's vetoes, we know HSAs work for small businesses and consumers. In fact, 31% percent of HSAs enrollees were previously uninsured.

Likewise, prudent choices on health care require full information. Wisconsin is one of the first states in the nation to require transparency in health care costs through the **Health Care Transparency Act**, otherwise known as HCTA. Now law, a state repository is an invaluable tool for consumers to compare costs and drive down prices.

We have created **Health Care Cooperatives** in order to increase consumer's market power in negotiating with health plan providers for coverage, through use of health benefit purchasing cooperatives. By approving new **Medical Malpractice Caps** on non-economic damages, we have ensured a stable legal environment and keep our medical professionals practicing in rural Wisconsin.

By any measure, it's perfectly clear that Senate Republicans have already passed meaningful health care reform legislation, and we remain committed to continue working to make sure Wisconsin has the best health care system in the nation."

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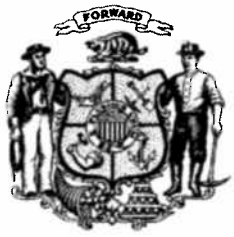
WISCONSIN STATE LEGISLATURE


FORWARD

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COOPERATIVE of Eau Claire

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Eau Claire, WI 54702-3217

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Testimony Presented to the Senate Select Committee on Health Care Reform

Presented by Peter Farrow,
CEO and General Manager
Group Health Cooperative of Eau Claire
May 11, 2006

Thank you Co-Chairs Roessler and Darling, and members of the Committee, for the opportunity to appear before you and provide testimony. I also want to thank you for bringing the Committee to the Chippewa Valley to learn more about what is happening here and gather ideas on how to improve the future of health care.

My name is Peter Farrow. I am the CEO and general manager of Group Health Cooperative of Eau Claire.

Group Health is a non-profit, member governed cooperative providing health insurance coverage to its members in Western Wisconsin. At present, we provide insurance services to just under 60,000 members enrolled either as individuals, employer groups, or the Wisconsin Medicaid/BadgerCare program. For four of the last five years Group Health has had the highest member satisfaction rate among health plans in Wisconsin and ranks consistently in the top 5 percent of health plans nationally.

Improving health care is a daunting challenge. As consumers, providers and payers, we all live in a world in many ways governed by rules and practices created by the federal government. In providing overarching requirements and coverage through several sources, the federal government's policies and payment structure have a significant impact on how health care is consumed and delivered. But the complex system of federal-based health programs is slow to change.

In addition to the challenge posed by the influence of the federal government, our health care payment system is all wrong. Most reform experts agree that a key problem is that our system is structured to pay incrementally, meaning for each service provided. As a result, we get incremental thinking. If a procedure isn't done right the first time, they get paid to do it again. Providers have no incentive to focus on long term outcomes or on quality, and actually have a disincentive to pursue quality. That's not a knock on providers. It's simple human nature that they respond to what they are paid to focus on. In our current system, that means volume, not quality or long term cost.

Recognizing these limitations, our challenge is to identify opportunities that move us toward a better health care environment that we can accomplish locally.

Albert Einstein once said, "The significant problems we face cannot be solved at the same level of thinking we were at when we created them." To drive significant improvement in health care, we need to rise to a different level of thinking that is prepared to challenge every aspect of what we do.

Here's an anecdote to start looking at something outside the box. In rural Taiwan, town residents pay their local physician when they are healthy. When they get sick, they don't have to pay the physician. What better incentive to focus on prevention than that? They get what they pay for.

In addressing the issue of the cost of health care, Dr. Donald Berwick, President of the Institute for Healthcare Improvement and a recognized health care reform leader, has said, "It's time to end the myth that we don't have enough money in American healthcare. We have 40% too much."

The reform discussion really breaks the question into two sets of issues. One is how to maximize our health care value, meaning getting both quality and efficiency out of the system. The second is the appropriate way to pay for it.

For years too much effort focused on the second question of who should pay for health care. On the commercial side, this focus led to efforts of shifting costs to employees, limiting networks, and chasing discounts. On the government side it led to reducing reimbursement rates for services. All this has accomplished is cost shifting, either from employer to employee, or between payers and providers. In the end, nothing has been done to address the value of health care.

For this reason, most of my testimony will focus on the first question of improving health care demand and supply.

So how do we maximize value? Simply, we break down the answers into two categories.

1. Reduce the overall demand for health care by improving overall health and creating more effective health care consumers.
2. Increase the quality of the health care supplied which will in turn reduce the cost.

So how do we reduce demand?

Wellness Programs:

Ten years ago, a New England Journal of Medicine article documented that as much as 70% of health care costs come from illnesses that are preventable.

As employers and consumers, we can focus on wellness programs to begin preventing those avoidable costs. Recently published and validated studies have reported that comprehensive employer-based wellness programs have generated returns on investment of greater than 4 to 1, meaning for every dollar invested, they reduce employee health-related costs by more than $4. Group Health employees recently finished their first year in an on-site wellness program. While some of the payoff takes more than a year to be recognized, our 140 employees' and family members' health care costs stayed basically flat from 2004 to 2005. At the same time, employers in the Cooperative that do not have wellness programs experienced trend increases around 10 percent.

Wellness programs work. The challenge for employers is to create a new cost line on their expenses in the hopes of reducing cost in the future. Any encouragement, such as greater tax incentives for employers to begin aggressive wellness programs will pay great dividends.

Disease Management:

Insurers have generated improved health status and reduced cost through the implementation of disease management programs. These programs typically focus on a certain condition, like diabetes, and work to educated members on how to better manage their chronic condition and how to better interact with their health care providers to do so. These programs were designed in this way because at the time it was the best way to broadly identify a population that can be helped through case management. The problem was that it was not as cost effective as it could be because relatively stable diabetics would be enrolled alongside unstable diabetics with multiple complicating conditions. Stable diabetics do not need assistance, but did generate administrative cost in this structure.

Over the next several years, this design for disease management will be replaced by various types of predictive modeling. The method being implemented by Group Health is a system that looks back at six months worth of claims data and running the data through complex analysis systems. From there the modeling system can, with surprising accuracy, predict the 1 or 2 percent of our population that is most likely to experience a preventable high-cost event. Usually these are people with multiple chronic conditions. Once identified, our case management nurses can assist the member to determine why their health is not stable, whether it's not taking prescribed medication, getting in for treatment or checkups as recommended or a similar challenge. A plan can be designed for the member and the nurses will check with them to assist them accomplish that plan. In this way, our member is helped to achieve improved health and at the same time prevent a high cost event - a win for everyone.

Early results of these programs indicate overall cost savings of 5 to 10% may be possible. That's almost rolling back the health care cost clock one year.

Arguably, greater savings are available in programs like the Health Insurance Risk Sharing Plan, Medicaid and other government programs that focus on populations with chronic conditions. Currently many of our state run programs have no incentive to change their case management structures. Ensuring that state programs aggressively pursue new processes and technologies to improve care coordination will lead to significant cost savings.

Health Improvement Statewide:

Having discussed a few very local ideas that Group Health has engaged in to reduce the demand for health care, I want to add a suggestion that looks statewide and that can be implemented by the State.

Several years ago, states sued tobacco companies to recover part of the health care costs known to be caused by smoking. After receiving billions of dollars, states did nothing to actively stop the way they incur those costs. Many passive programs, like quit lines that advise smokers were implemented, but few things more aggressive than that were done.

We know smoking generates health care costs. The Centers for Disease Control estimates the U.S cost of excess medical expenditures due to smoking is over $75 billion per year.

Private employers have taken steps to decrease smoking by providing cessation classes, adding costs to the insurance premiums for smokers or banning employees from smoking.

Frighteningly, one of the populations whose health is most harmed by smoking are young children. Children exposed to smoke have far greater incidences of asthma, ear infections and respiratory illnesses. In our own Medicaid Managed Care program, we regularly cover an expensive drug called Synagis to prevent a disease called RSV, a respiratory disease that can be very serious for infants. Many times the reason we cover this drug is because there is a smoker in the home of that newborn – one indication of increased risk of infection. Synagis costs just over $1000 per treatment and requires five to six treatments in a typical cold and flu season. That means the State regularly pays over $5,000 so that a newborn baby can live with a smoker.

If we know smoking adds costs, and we know it is an avoidable cost, why does our state Medicaid program continue to cover costs incurred by smoking?

It is an idea that I have mentioned several times over the last few years, but I believe the State should pursue the idea of not covering adults in Medicaid

unless they are non-smokers or actively participating in a smoking cessation program.

At first blush I know this sounds like a crazy proposal wrought with complications. It is not a perfect idea and it needs detail, but unless we are willing to aggressively look at solutions in a whole new way, we will not impact health care demand. I believe that the improved health and costs savings far outweigh the cost of implementation and compliance.

Improving Supply of Health Care:

Having discussed some demand opportunities, I'd like to shift to ways that we can improve the supply of health care. There is general agreement among health care experts that raising the quality of health care provided will lead to significant cost savings through improved efficiency.

Is improved quality necessary?

- A large study conducted by RAND Health reported three years ago that when Americans receive health care, they receive the recommended form of care only 55% of the time. This number is not based on controversial forms of care, but on widely accepted protocols across a wide range of conditions.
- In its report on the state of U.S. Health Care, the Institute of Medicine published estimates on the number of deaths due to medical errors in the United States. Even using their low estimate of 44,000, deaths due to medical errors would be the 8th leading cause of death in the U.S. (more than car accidents, breast cancer, or AIDS). The high estimate of 98,000 would be more than the three combined.

How can we improve quality of health care?

Six Sigma in Health Care:

Six Sigma is a successful process improvement discipline that was born in the manufacturing environments of companies like GE and 3M. Recently, the technique has been brought to health care as a means to improve quality in both delivery of care and the administration of health care.

Three years ago, Group Health Cooperative, in partnership with Marshfield Clinic, Sacred Heart Hospital, Saint Joseph's Hospital and the Chippewa Valley Technical College began a Six Sigma for Health Care training program for staff members. Through these programs, teams have implemented dozens of projects that have either improved care quality or improved the administrative efficiency of providing the care. In addition to several administrative projects, at

Group Health, we have had clinical programs in our chiropractic and dental clinics that have already shown documented improvement.

Experts like Don Berwick see great opportunity in applying disciplined improvement in health care and speculate that the use of evidence-based, or research-based, medicine could reduce health care costs by more than 25%.

Group Health's $500,000 Inspiring Health Care Innovation Grant Program:

Following the idea that human nature drives people to act in ways that they are paid to act, Group Health sought to create a program that would reward providers for more aggressive pursuit quality. For years we attempted to achieve this goal through contract incentives, but found that this method did not lead to significant or broad-based improvement.

As an alternative, two months ago Group Health announced the funding of a $500,000 grant program for Western Wisconsin health care providers to encourage the implementation of quality improvement programs. In essence, the Cooperative is taking a small portion, just under one half of one percent, of our revenue and investing it in the suppliers of our members' health care. The grant will encourage the development of disciplined process improvement programs in health care, or accelerate existing programs.

This sends a message to area providers that our members are serious about quality and the Cooperative is willing to be a collaborative partner in the pursuit of quality. More details of the grant program are available at http://grant.group-health.com/.

State Level Reforms:

There are reform opportunities at the State level. Encouraging providers to implement disciplined improvement programs can be accomplished through incentive programs.

For example, by adding a .4% bonus for provider payments, Medicare boosted voluntary data reporting to over 50% of participating providers, and when they increased the bonus to 2%, voluntary reporting jumped to over 95%. Rather than simply increase payment levels in government programs, far greater return can be generated by targeting increased spending at quality improvement. While politically more difficult in the short term, the result would reduce long term pressure on public spending.

Data Reporting:

The State has done quite a bit to encourage the collection of useful provider data. Thanks to both State and private efforts, Wisconsin is among the

recognized leaders nationally in health care data collection. As we have learned here, private data collection will probably move faster and more effectively than government collection. The State should continue to encourage the collection of data. However, I believe that user perspective on that data is necessary. In my opinion, I think that for quite some time, quality data will be most useful in encouraging providers to share best practices and encourage improvement through competition of quality data. Despite claims of the power of the consumer movement, I believe that consumers will have a hard time sorting data and making decisions based on it.

Medical Liability Reform:

Wisconsin just passed a new medical liability reform. In essence it is the same model that was passed a decade ago. That model made Wisconsin a leader in liability reform and clearly prevented the national medical malpractice crisis from occurring here. I believe that medical liability can be a tool to promote increased quality in health care and that it is time to begin exploring new structures for liability reform.

It is widely recognized that improved use of evidence-based treatment protocols – those backed by research and science – will improve care quality. If we know that to be true, it should be possible to create a liability framework that establishes lower liability limits for a clinician practicing evidence-based treatment than one that is not following established guidelines of care. Put into place, this one standard could overnight change the landscape of how care is provided.

Again, I recognize that this concept has hurdles to implementation, but I believe it is possible and very worthwhile.

Who Pays For What:

The second question discussed is who should pay for what part of health care, or how do we finance health care. This is an important public policy question, but not one that will ultimately lead to improvement in the health care cost equation. For this reason I have not focused on it much here.

There are areas where I believe important impacts can be made at the state level. The first is mandated benefits for group health insurance.

Mandated Benefits:

Increasing costs clearly threaten the future of employer-based health care coverage. This source of coverage has been the backbone of our working-age

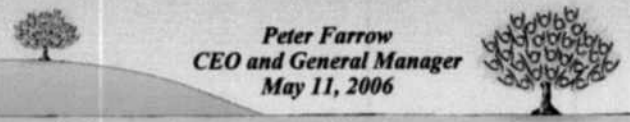
population for decades and should continue to be. But, mandated benefits and other requirements threaten the future of employer-based coverage for small and medium businesses.

Ironically, as we speak the U.S. Senate is discussing legislation that would bypass state mandated benefit requirements. Unfortunately, many key consumer protection functions would be thrown out in the process. This legislation is not to pass this year federally, but it will be back. Wisconsin should follow the lead of other states and allow the offering of a reduced-mandate alternative, when offered to an employer alongside a policy including mandates. Small employers and their employees shouldn't have to choose between a full, higher-cost package or nothing.

This list of activities and ideas is just a part of the opportunities we have to improve health care. In this complicated environment, one thing is clear: every player in the system, whether consumer, provider or payer, has opportunity to improve their role in the health care system.

Thank you again for your time and attention. I would be happy to discuss any of these ideas further or answer any questions you may have.

Testimony Presented to Senate Select Committee on Health Care Reform



Peter Farrow
CEO and General Manager
May 11, 2006

GROUPHEALTH
COOPERATIVE of Eau Claire
A personal touch. A proven choice.

Group Health Cooperative

- Began coverage in 1977
- Member governed
- Independently owned and governed
- Just under 60,000 total covered members in 27 counties in Western Wisconsin
- 2006 revenue will exceed $150 Million

INSPIRING HEALTHCARE INNOVATION

What's Wrong?

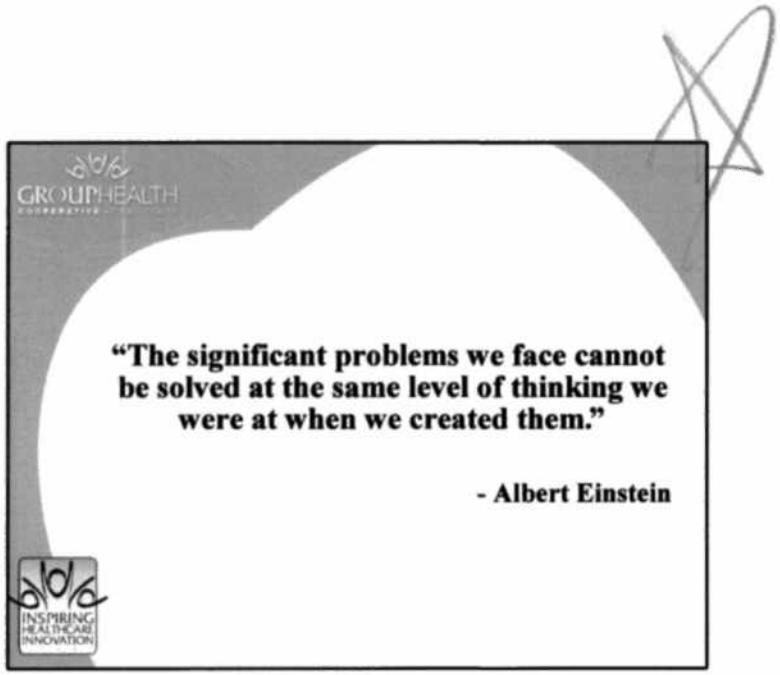
- U.S. Health Care System is designed to pay providers based on incremental services.
- In the end, the system is perfectly designed to get what we pay for – incremental thinking focused on volume of services rather than quality or value.

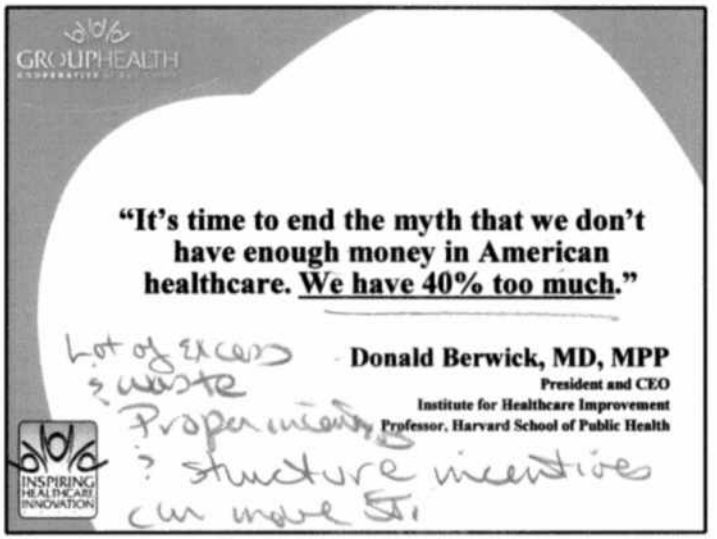
INSPIRING HEALTHCARE INNOVATION

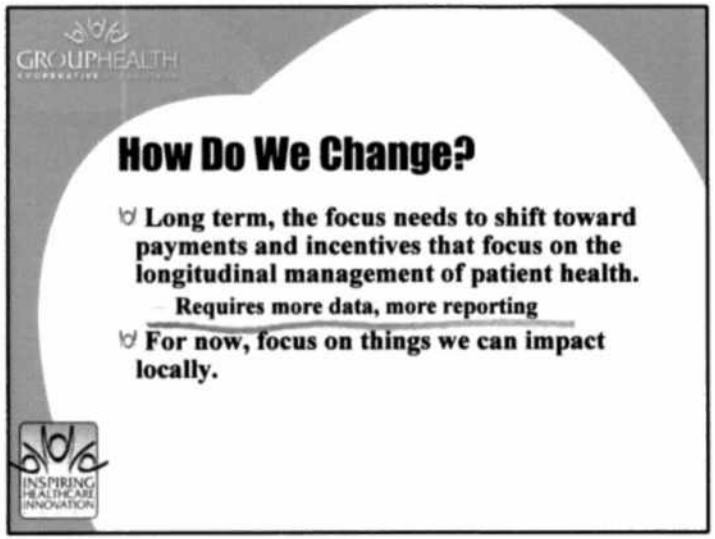
How Do We Change?

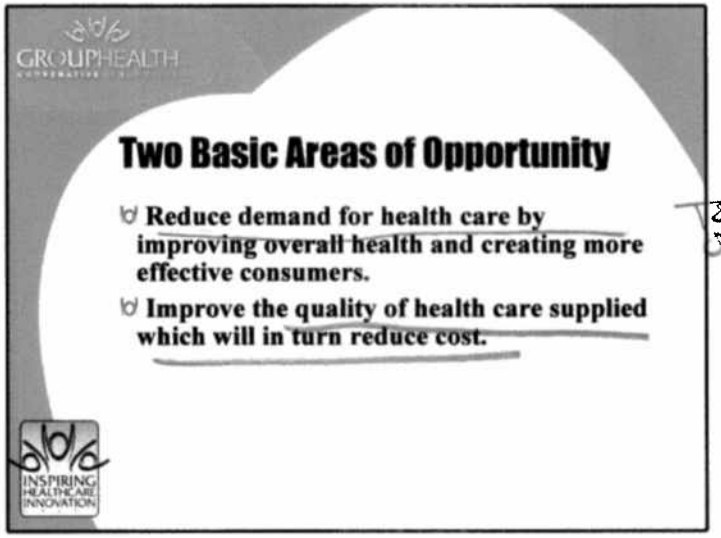
- Old Solutions:
  - Increase employee cost sharing
  - Limit networks
  - Chase discounts
- These strategies focus on shifting cost from one group to another (either between employer and employee, or payer and provider). In the end, they don't address the issue of cost, just who pays.

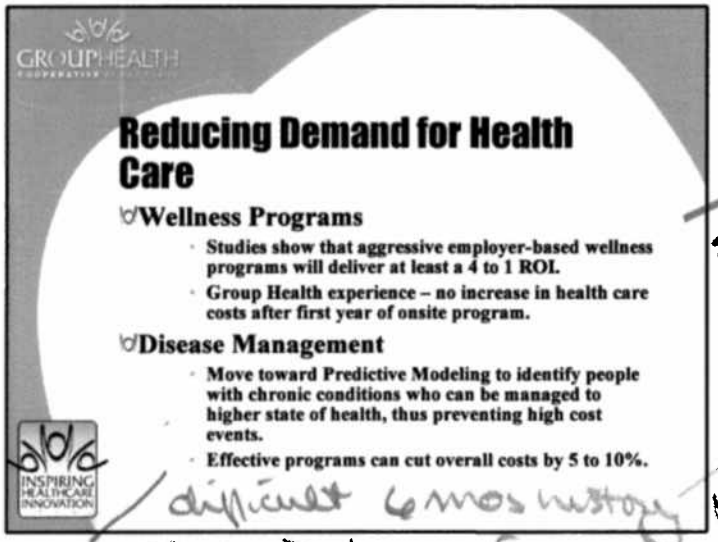
INSPIRING HEALTHCARE INNOVATION

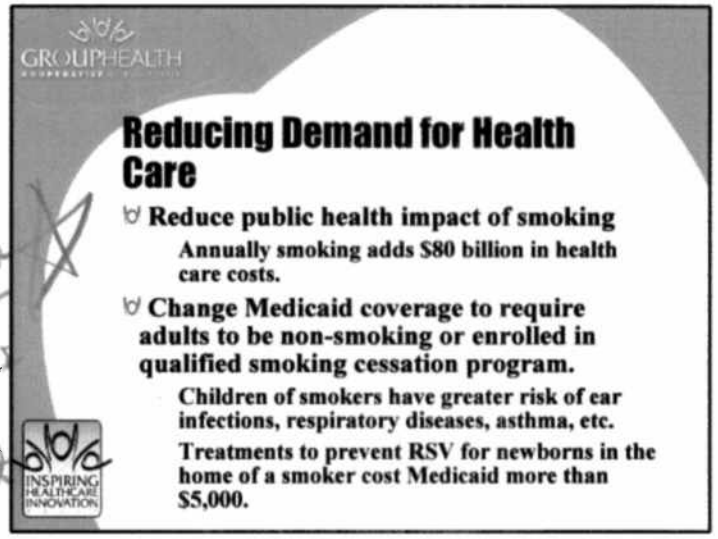

GROUPHEALTH
"The significant problems we face cannot be solved at the same level of thinking we were at when we created them."
- Albert Einstein
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
"It's time to end the myth that we don't have enough money in American healthcare. We have 40% too much."
Donald Berwick, MD, MPP
President and CEO
Institute for Healthcare Improvement
Professor, Harvard School of Public Health
INSPIRING HEALTHCARE INNOVATION

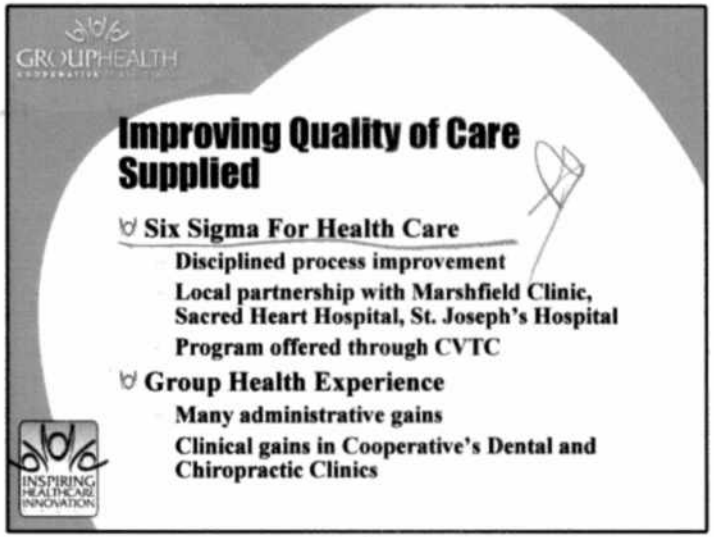

GROUPHEALTH
How Do We Change?
Long term, the focus needs to shift toward payments and incentives that focus on the longitudinal management of patient health.
Requires more data, more reporting
For now, focus on things we can impact locally.
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
Two Basic Areas of Opportunity
Reduce demand for health care by improving overall health and creating more effective consumers.
Improve the quality of health care supplied which will in turn reduce cost.
INSPIRING HEALTHCARE INNOVATION

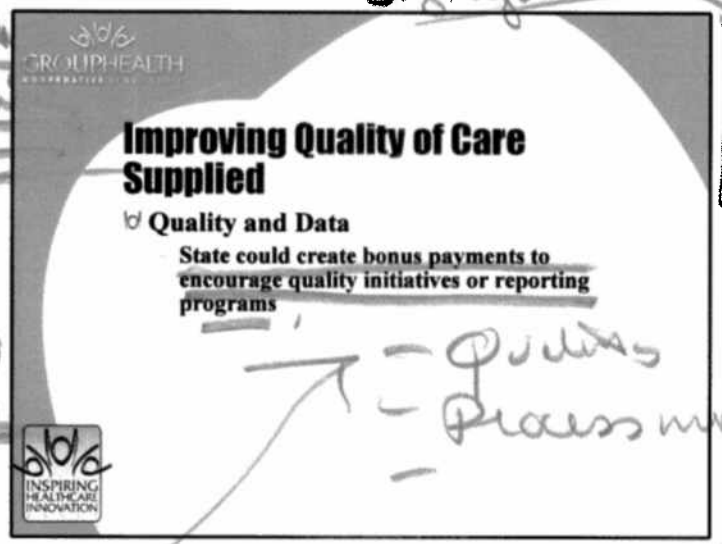

GROUPHEALTH
Reducing Demand for Health Care
Wellness Programs
Studies show that aggressive employer-based wellness programs will deliver at least a 4 to 1 ROI.
Group Health experience – no increase in health care costs after first year of onsite program.
Disease Management
Move toward Predictive Modeling to identify people with chronic conditions who can be managed to higher state of health, thus preventing high cost events.
Effective programs can cut overall costs by 5 to 10%.
INSPIRING HEALTHCARE INNOVATION

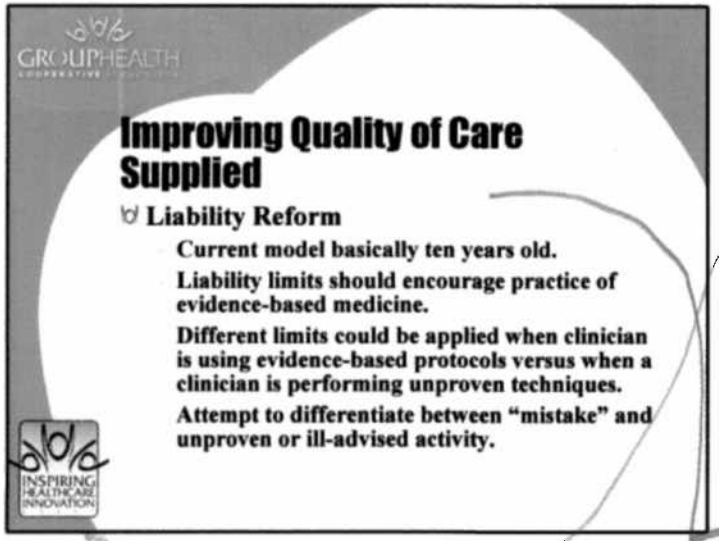

GROUPHEALTH
Reducing Demand for Health Care
Reduce public health impact of smoking
Annually smoking adds $80 billion in health care costs.
Change Medicaid coverage to require adults to be non-smoking or enrolled in qualified smoking cessation program.
Children of smokers have greater risk of ear infections, respiratory diseases, asthma, etc.
Treatments to prevent RSV for newborns in the home of a smoker cost Medicaid more than $5,000.
INSPIRING HEALTHCARE INNOVATION

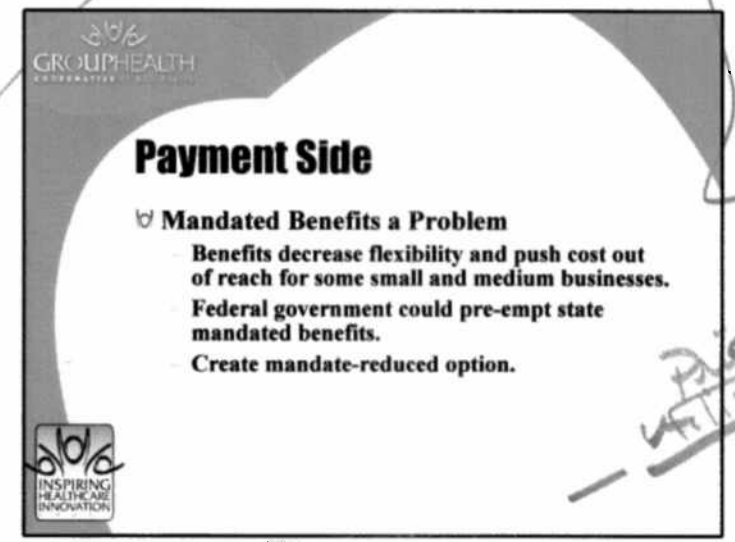

GROUPHEALTH
Improving Quality of Care Supplied
Is Better Quality Necessary?
When they receive health care, Americans receive appropriate care 55% of the time.
(RAND Study, 2003)
Even using low estimates, deaths due to medical errors would be the 8th leading cause of death in the U.S. (more than car accidents, breast cancer, or AIDS).
(Institute of Medicine, 2000)
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
Improving Quality of Care Supplied
Six Sigma For Health Care
Disciplined process improvement
Local partnership with Marshfield Clinic, Sacred Heart Hospital, St. Joseph's Hospital
Program offered through CVTC
Group Health Experience
Many administrative gains
Clinical gains in Cooperative's Dental and Chiropractic Clinics
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
Improving Quality of Care Supplied
Improve Quality of Care to Lower Cost
Create Incentives and Pressure for Providers to Change.
$500,000 in Grants to Providers for Quality Improvement Projects
Goal: Local Cost Reduction Through Improved Care Delivery
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
Improving Quality of Care Supplied
Quality and Data
State could create bonus payments to encourage quality initiatives or reporting programs
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
Improving Quality of Care Supplied
Liability Reform
Current model basically ten years old.
Liability limits should encourage practice of evidence-based medicine.
Different limits could be applied when clinician is using evidence-based protocols versus when a clinician is performing unproven techniques.
Attempt to differentiate between "mistake" and unproven or ill-advised activity.
INSPIRING HEALTHCARE INNOVATION


GROUPHEALTH
Payment Side
Mandated Benefits a Problem
Benefits decrease flexibility and push cost out of reach for some small and medium businesses.
Federal government could pre-empt state mandated benefits.
Create mandate-reduced option.
INSPIRING HEALTHCARE INNOVATION

GROUPHEALTH

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Websites:

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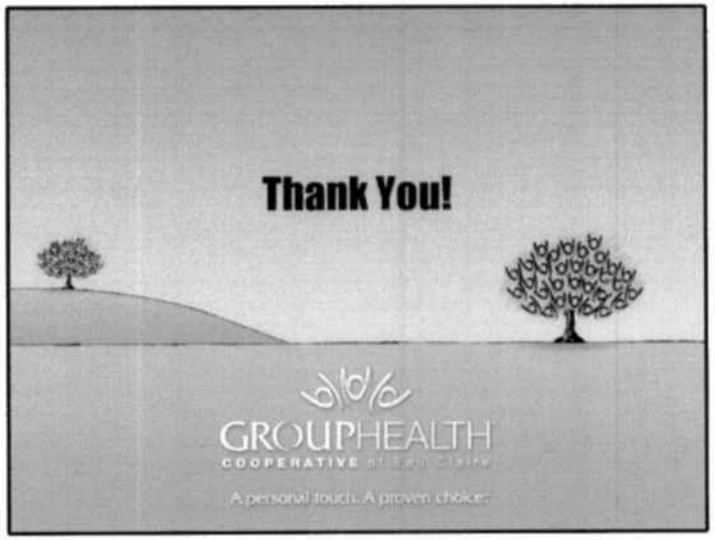
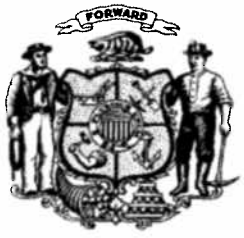
www.forwardhealthandwellness.com
http://grant.group-health.com

INSPIRING HEALTHCARE INNOVATION




WISCONSIN STATE LEGISLATURE


FORWARD

Presented by:
David B. Fish
Executive Vice President
May 11, 2006

A SAFETY NET ...

As we look across Wisconsin and see our 5.5 million residents, I would ask ... Do Wisconsinites really want to slow the growth in their use of health services ... OR ... DO THEY JUST WANT TO HAVE MORE FOR LESS? How best should we utilize $52.8 billion dollars (our state budget) to ensure that all Wisconsinites are able to experience a quality of life that is reflective of the greatness of our state? Focusing specifically on health care – how do we provide a strong Wisconsin "safety net" for our friends and neighbors who currently lack health care coverage?

St. Joseph's Hospital, of Chippewa Falls, is a not-for-profit hospital, owned and operated by the Hospital Sisters of the Third Order of St. Francis. They have been serving our Community and surrounding area for over 123 years. St. Joseph's Hospital is a short-term acute care facility and is designated as a Disproportionate Share Hospital (DSH). In FY 2004, 3,563 inpatient days or 22.2% of our inpatient service was provided to Medicaid recipients. If you were to look at all of Wisconsin's hospitals – excluding Critical Access and Specialty Hospitals, our hospital – based upon Medicaid utilization – has – percentage wise – the 7th highest Medicaid utilization in the State. In rural areas, one can find low incomes and poverty – this is a phenomenon that is not limited to inner city – Milwaukee.

As you know, Wisconsin's current Medicaid Disproportionate Share Program is intended to provide "special payments" to high Medicaid utilization hospitals. State funding for Medicaid DSH payments has not kept

up with hospital expense inflation or rising utilization. In fact, DSH payments haven't increased for about a decade.

For more than 40 years, Medicaid has served as the nation's health care safety net providing access to health services for those who cannot afford insurance in a dynamic and changing economy. This role has never been more critical than it is today with so many children, poor, disabled, and elderly individuals relying on Medicaid for care. The program now serves more people than Medicare (53 million vs. 41 million). To my way of thinking, it has become the largest health insurance program in the United States.

Wisconsin not-for-profits hospitals are the backbone of our State's health care safety net, providing care to all patients who come through their doors, regardless of their ability to pay. But, hospitals experience severe payment shortfalls when treating Medicaid patients.

In 2005, it is estimated that Medicaid paid Wisconsin hospitals just 49 cents for every $1.00 it cost to provide care to Medicaid patients – a total of $546 million less than what it cost Wisconsin hospitals to provide the care.

At St. Joseph's Hospital we were under-funded even worse than the state average, Medicaid only covered 41 cents for every $1.00 it cost St. Joseph's Hospital to treat Medicaid patients for a total of $3.8 million in 2004. Compare that to the national average whereas hospitals receive 90 cents for every dollar it costs to provide care. This means some Wisconsin hospitals like St. Joseph's are receiving just $99 for outpatient surgeries that cost **thousands** to perform

- These costs have to be made up somewhere and that's where Wisconsin employers are forced to absorb these unpaid costs through higher insurance premiums, a Hidden Health Care tax of approximately $450 million in 2004 and $546 million in 2005.

- When we look at our State and this program, we see the following trends:

    - Aging of the population
    - Erosion of employment-sponsored insurance coverage

- dramatically increasing cost in Medicaid (exceeds cost of primary and secondary education, and at times, compromises our state's ability to invest in other priorities

- State Medicaid expenditures draw down millions in federal matching dollars. For every dollar that Wisconsin cuts from its Medicaid Budget, it is equal to a loss of $1.50 in funding. Increasing funding also increases federal matching dollars coming to Wisconsin.

RECOMMENDATION

There are many cost drivers that state-elected officials cannot control – like the massive capital investments that are required in advancing and acquiring of health care-related technology. Yet, one area that you can impact is more appropriately funding the government's health care programs like Medicaid. This will slow growing health care costs and slow the using levels of cost shifting necessitated by payment shortfalls, and thereby slowing the growth of the "Health Care Hidden Tax" on Wisconsin employers and employees.

Any federal action to address the current Medicaid funding crisis or to change the program's structure should not place further financial pressure on our state or diminish coverage for the children, poor, disabled and elderly Americans who rely on this program for health services. I encourage you to insist that our Congressional Representatives vigorously oppose the Administration's proposal to cut Medicaid spending through the regulatory process. The solution to Medicaid's problem is not harsh spending cuts.

Payers, purchasers, providers, beneficiaries, and business understand that they must help create a healthier Medicaid Program. You must insist that the federal government provide our state with clear and concise information on its standards and expectations for running this program. Accountability has to exist with purchasers and providers to promote fair and effective management of the program. Medicaid health plans should publicly disclose information on quality improvement efforts, beneficiary education, outreach initiatives, and providers' payments. Providers must demonstrate that they meet recognized quality standards for delivering safe and cost effective care. Also, positive incentives to help beneficiaries change unhealthy behavior should be a part of every Medicaid Program.

Talking about positive incentives to help change unhealthy behavior, I encourage you (just as the Wisconsin Hospital Association has) to raise the tax on tobacco by at least $1.00 or more per pack and use those revenues to pay for Wisconsin's health care programs like Medicaid, as well as tobacco prevention programs. In the Medicaid program, 14% of all funds are used for treating smoking-related illnesses. Raising this type of tax will prevent almost 10,000 deaths associated with smoking in Wisconsin, over a five year period.

We need to simplify Medicaid's complex and rigid eligibility and benefit rules. The program should encourage the use of disease and chronic care management for elderly and disabled patients, whose average cost of care, is more than six times that of pregnant women and children.

We should also look at how we provide long-term care under Medicaid. Medicaid covers 60% of all nursing home residents and represents half of all long-term care spending. Why not encourage a more robust private long-term care market through savings accounts or tax credits, etc.?

Bottom line: Anything we do at either the Federal or State levels concerning Medicaid reforms must be based on sound policies that help the program fulfill its mission of improving the health of our neediest citizens.

-Crisis in Dental Access –

Based upon St. Joseph's Hospital's first-hand experience ... I would tell you in our area and probably in many other areas of our state – there is a Dental Access Crisis for the neediest, the poorest, and the most marginated among us. As we saw a growing number of children and adults presenting themselves to our Emergency Service – due to incessant pain from rotting teeth, severe tooth aches, abscesses, etc. Given the limited number of dentists in our area (and the fact that only 80 dentists a year graduate from Wisconsin – of which only 40 are actually from our state) and the fullness of their practices, no wonder there is currently over 600 children and adults on area waiting lists needing various types of dental services.

When people utilize an Emergency Service to deal with dental problems – it is exceedingly expensive, it does not inclusively deal with or completely eradicate the problem and all-in-all is not the most effective way of helping those in need.

What a miserable way to exist – for everyone.

In 2001 we decided (along with others – through Chippewa Falls 2010 *Achieving a Healthier Community* to aggressively work on improving access to dental care for the underserved and uninsured in Chippewa County. In January, 2002, the Chippewa Oral Health Initiative was formulated and intentionally focused on three initiatives: Prevention, Public Policy Public Awareness, and immediate care needs. These groups worked on advocacy efforts, fluoride, addressing pop (soda) being available in local schools, providing additional dental services (*Give Kids a Smile Day),* etc. (Every school child in Chippewa County is given a toothbrush, toothpaste and information on the importance of brushing your teeth. Chippewa County Department of Public Health developed in 2003, their first Seal a Smile Program to provide sealants for 2nd and 5th graders in county schools). Throughout this time, St. Joseph's Hospital worked with CESA 11 and the Oral Health Initiatives Group to open a dental clinic on our campus. In 2003, this became a reality, yet woefully inadequate to meet the area dental needs.

It was in 2002 that we approached the Marshfield Clinic indicating our interest in working with them to replicate the Federally Qualified Dental Clinic they operate in Ladysmith.

After six long and very demanding years of effort, a Federally Qualified Dental Clinic – operated by the Marshfield Clinic will become a reality in Chippewa Falls. Ground breaking for the new and expanded facility happens next week.

Simply, Wisconsin must become better aware of oral health and its interconnectedness to overall health. Oral health affects self-esteem employability, and overall well-being. Data on rural oral health is limited; yet, factors we must be sensitive to and willing to address are:

- Lack of adequate transportation
- Lack of fluoridated community water supplies
- High rates of poverty
- Larger percentage of elderly population
- Lower dental insurance rates

- Provider shortages
- Difficulty for providers willing to treat Medicaid patients (low reimbursement rates, paperwork burdens, perception of a higher percentage of broken appointments, etc.)

Things we ought to consider in Wisconsin:

- Creating some type of loan repayment program that would cover dentists and other allied health professionals that provide oral health care.
- Our Dental School in Milwaukee – to create a residency or internship requirement for dental students to increase their practical experience and their service to underserved communities. And, lastly, expand the scope of practice for hygienists.

-Slowing Health Care Costs –

Wisconsinites deserve meaningful information about the price and quality of their health care and Wisconsin hospitals and the Wisconsin Hospital Associate are committed to sharing information that will help consumers make important decisions about their health care.

The basic blueprint of a consumer-directed health plan involves a high deductible health insurance policy and a health savings account from which the employee pays the deductible and co-pays. The Wisconsin Hospital Association and all of Wisconsin's not-for-profit hospitals are committed to helping consumers become more active participants in decisions related to their care.

While health care is delivered in a more competitive environment these days, Check*Point* – a web-based source of information, gives consumers information on 14 clinical procedures that medical experts agree should be provided during a hospital stay and five measures that show efforts towards preventing errors. Also, there are eight measures showing how well hospitals prevent surgical infections. Check*Point* has produced results also by helping Wisconsin's hospitals to improve the quality of care they provide:

Check*Point* provides:

- Information to purchasers to aid in benefit design.
- Information to consumers about the types of health care that research has demonstrated leading to the best outcomes.
- Information to consumers to facilitate their choice of insurance plan provider.
- Information to hospitals for continuous quality improvement.
- Encouragement of collaboration among health care providers to educate consumers in understanding and interpreting publicly reported data.

In the coming years, all of us will need to keep an "eye out" to see if consumers are becoming better ... more educated health care consumers. We need to be sure that employees who lack basic health care literacy understand these types of plans because they are confusing. These populations will struggle with this type of plan and how it works. People who do not have access to resources that can help them be a better consumer could also potentially struggle with these plans.

In February 2005, the WHA Information Center launched PricePoint – a free, publicly available web-based tool for comparing hospital prices.

It provides:

- Aggregate "discount" information for each hospital for the three major kinds of health care coverage – private insurance, Medicare and Medicaid. This information allows users to understand how hospitals' charges compare to the amount of revenue they actually collect for services provided to the three patient categories.
    - Aggregate "discount" information for each hospital for the three major kinds of health care coverage: private insurance, Medicare and Medicaid.

This information allows users to understand how hospital charges compare to the amount of revenue they actually collect for services provided to the three patient categories - hospital charges for all Wisconsin Hospitals, all services, and the average length-of-stay.

Accurate and timely data is the foundation of a well-functioning efficient health care market. The Wisconsin Hospital Association continues to strive to be a national leader in the area of public reporting, as the program

expands to include new data, additional measures, and adopts a collaborative approach to encourage providers to collect and share even more information.

As an aside, the experience of the WHA Information Center in privatizing a state government program shows convincingly that private-sector performance is superior.

- WHA Information Center produces quarterly data sets an average of three months faster than did the Bureau of Health Information.
- WHA Information Center's web site provides more current and comprehensive hospital charge information than did the state's web site.
- In 2005, WHA Information Center is expanding hospital data collection to include all hospital outpatient services, to provide consumers, purchasers, and policymakers with more comprehensive hospital pricing transparency.

All of the above at minimum should provide a foundation for a more informed discussion between consumers and insurers and providers of care.

The General Assembly needs to work diligently at increasing all of Wisconsin's awareness of the fact that the previously mentioned information is available to consumers and your constituents.

In summary: there are no simple solutions to how best we strengthen this state's and our nation's health care system and its programs. To tell an employer – if you want an immediate absolute positive health care impact when hiring – don't hire anyone who smokes, don't hire anyone who is over weight, and be sure any potential hireree has an excellent driving record and always uses his/her seat belt – all of this can positively and immediately impact a company's overall health care costs.

Do Wisconsinites really want to slow the growth in their use of health services ... or do they just want more for less?

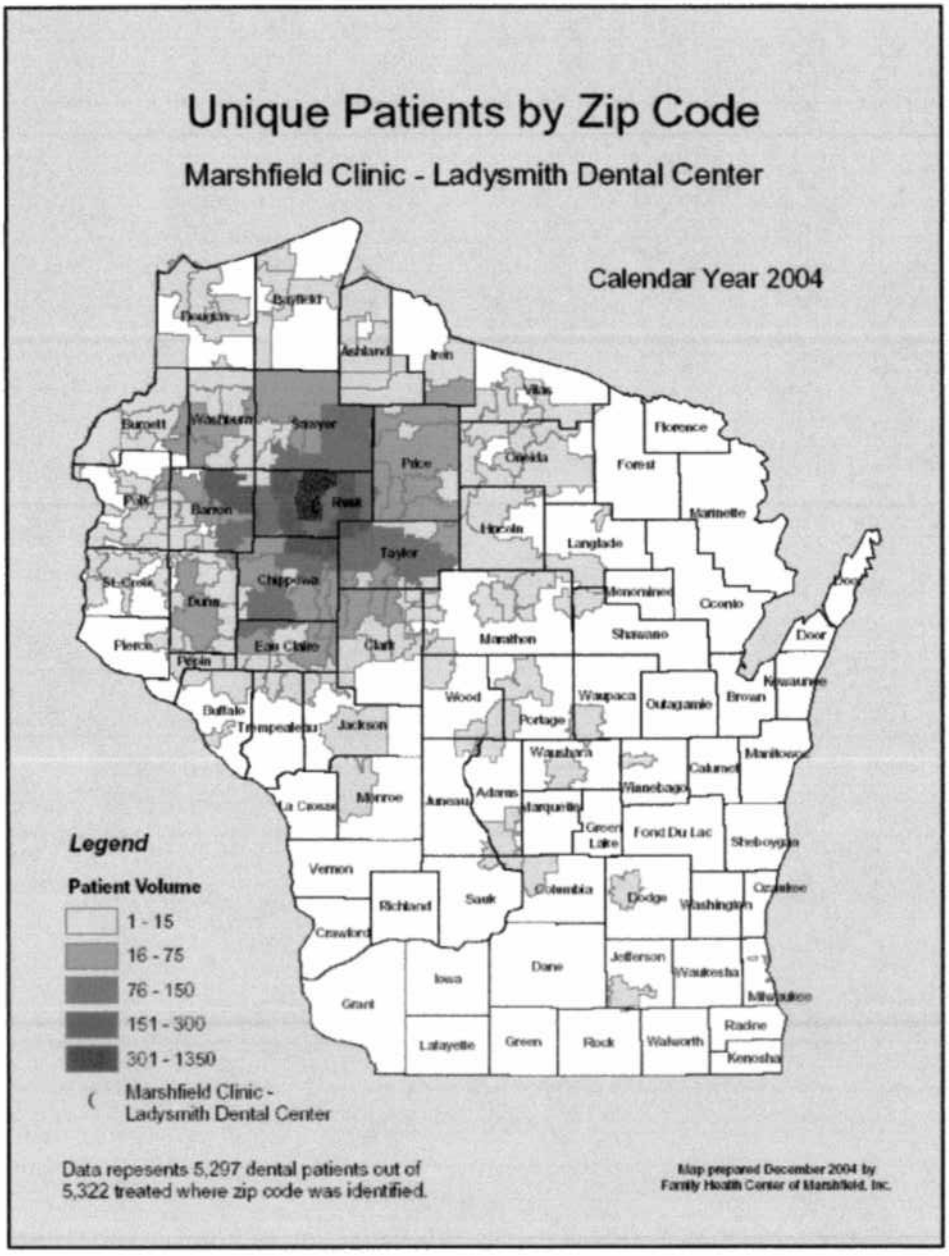
Administration: Advocacy: 06-05 Testimony
/dann

WHAT DOES MEDICAID PAY
St. Joseph's Hospital, Chippewa Falls?

Procedure	Charge	Medicaid Pays
Colonoscopy	$1,199.00	$99.00
Endoscopy	1,087.00	99.00
Cataract	3,549.00	99.00
Biopsy	3,308.00	99.00
Knee Surgery	5,535.00	99.00
Carpal Tunnel	3,189.00	99.00
Cholecystectomy	8,607.00	99.00

Patient Demographics

There are approximately 600 Chippewa County patients on the Ladysmith Dental Center's waiting list.

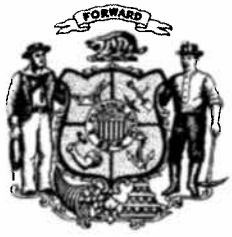


unique patient data ladysmith dental center, calendar year 2004

5/10/2006

MARSHFIELD CLINIC

WISCONSIN STATE LEGISLATURE



SENATE HEALTHCARE HEARING
EAU CLAIRE, WI. MAY 11, 2006

PRESENTER:

JERRY HAMILL, CPA, RETIRED
FORMERLY CONTROLLER MARSHFIELD CLINIC AND
DIRECTOR OF FINANCE, GROUP HEALTH COOPERATIVE

TAXPAYER CONCERN:
PUBLIC EMPLOYEES IN WISCONSIN HAVE INORDINATELY HIGH COST HEALTHCARE PLANS

The Wisconsin taxpayers pay too high a share of the health care plans given to state, county and other public employees. Private employers require their employees to pay a higher percentage of the monthly premiums than is required of public employees. Example: Today Excel Energy testified that their employees pay about 20% of premiums plus copays. Most private sector employees pay more than 20% of premiums plus copays. Some also have annual deductibles before any insurance payment.

Eau Claire County employees pay about 3% of premiums. Teachers, city and state employees likewise pay a VERY LOW or no percentage of premiums.

LEGISLATIVE SOLUTIONS:

1. Collective bargaining regulations must be modified so that comparables from the private sector have significant consideration in negotiations and arbitration. One method would be to admit into consideration the percentage of premiums paid by employees for the largest private employers in the area (i.e. SMSA).

2. Private sector comparables should also be mandated for consideration for the amount of copays required of employees per visit.

3. Public sector employees usually have the HIGHEST benefits package among the many plans offered by the insurance carrier. Theirs is the "Cadillac" of benefit plans. The benefit packages should not be allowed to be greater than the average of the 5 largest private employers in the area , unless a commensurate additional cost is added to the employees' share of the premium.

4. Public sector employees not only are allowed to retire earlier than private sector employees, but they also are allowed to use UNUSED SICK DAYS to pay for their share of premiums after they retire. Most private sector employees LOSE their unused sick days when they retire. Over a few years transition period, the legislature should mandate that UNUSED SICK PAY be forfeited for no value given at the time of retirement.

Thank you for your consideration of my recommendations as a concerned taxpayer.

Jerry Hamill, CPA
4506 Kensington Ct.
Eau Claire, Wi. 54701
715-834-3318

Common Pool
sick