☞ **05hr_SSC-HCR_Misc_pt11**

☞ 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

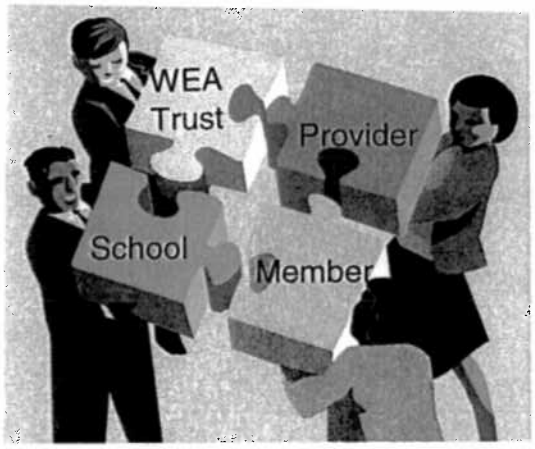
- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
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

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

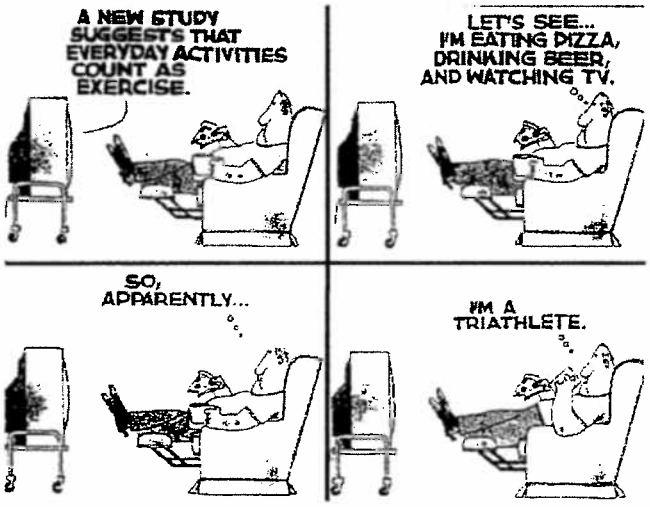
Escalating Health Care Costs

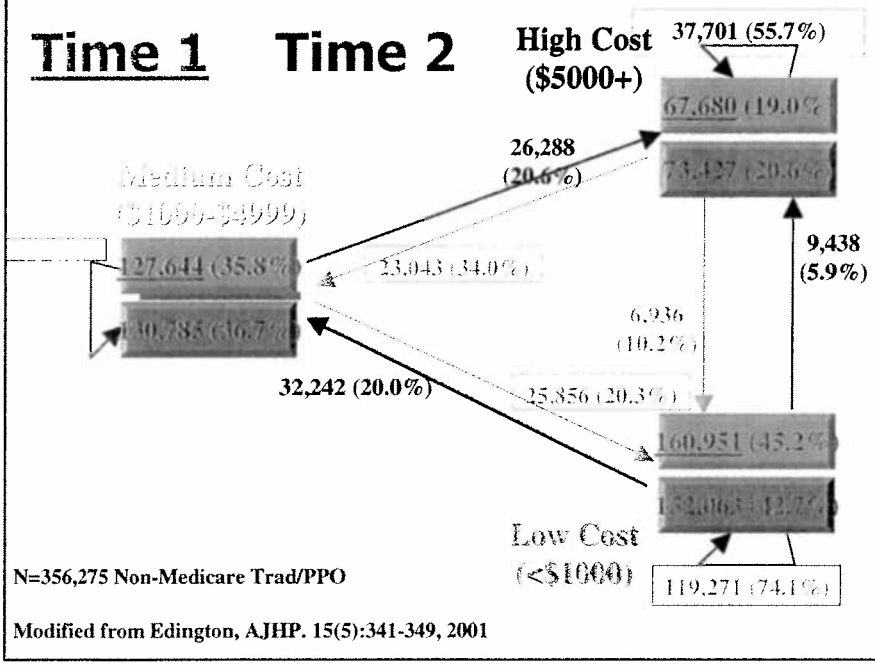
Lynn Odette
WEA Trust
May 11, 2006

Building a unique partnership and a healthy community

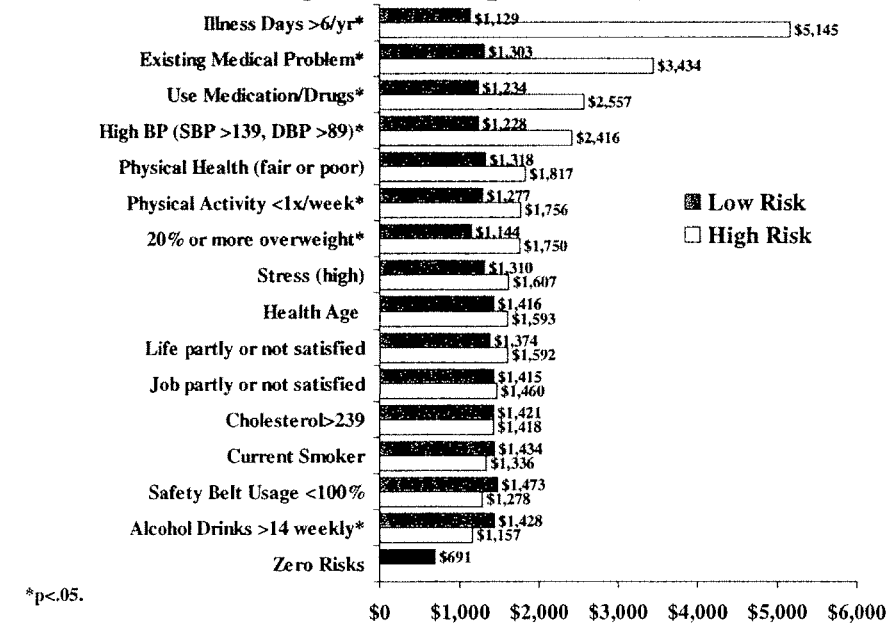


Take charge of your health





Medical/Drug Cost Comparison by Risk Status



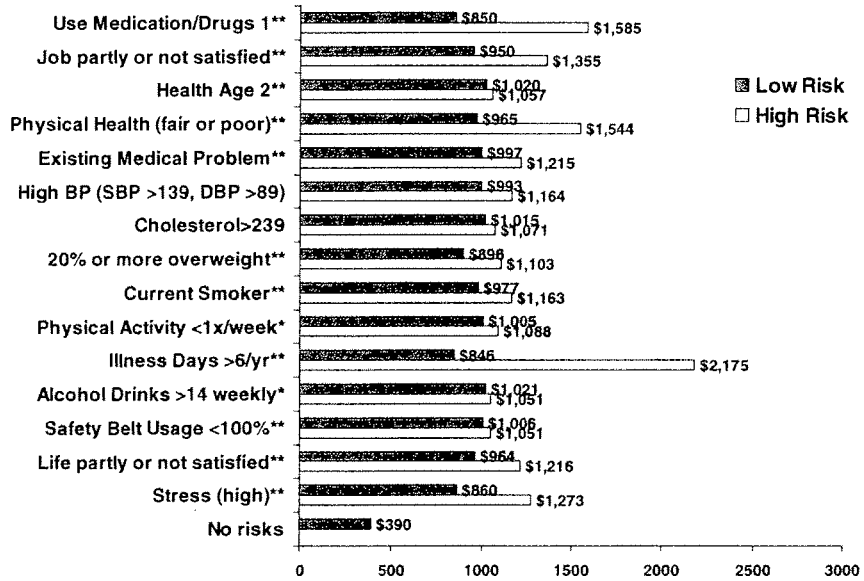
*p<.05.

Yen, Witting, Edington. AJHP. 6:46-54, 1991

Productivity
Disability
Presentee

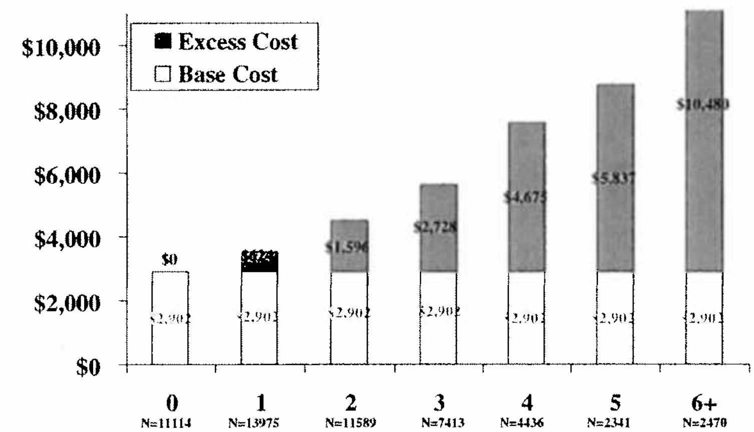
Cost follow risk.

Total Disability Cost by Risk Status
1998-2000 Mean Annual Costs



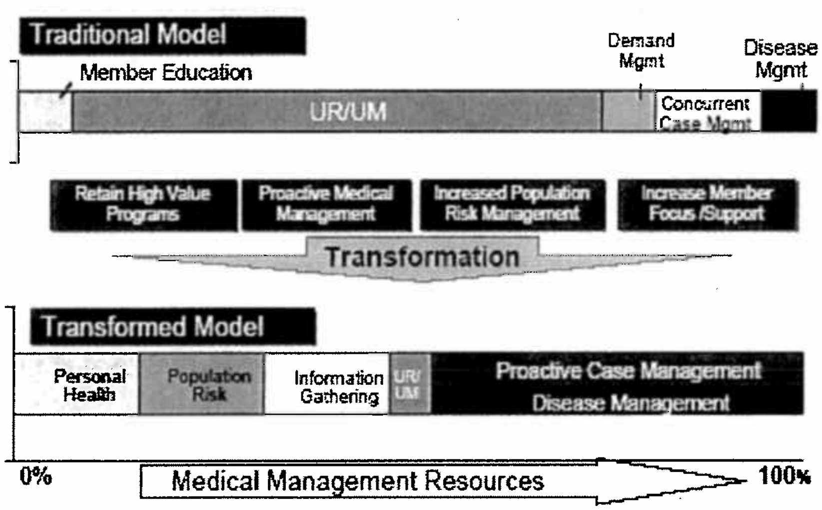
Wright, Beard, Edington. JOEM. 44(12):1126-1134, 2002

Typical Annual Medical/Drug Costs*
Excess Costs due to Risk Status



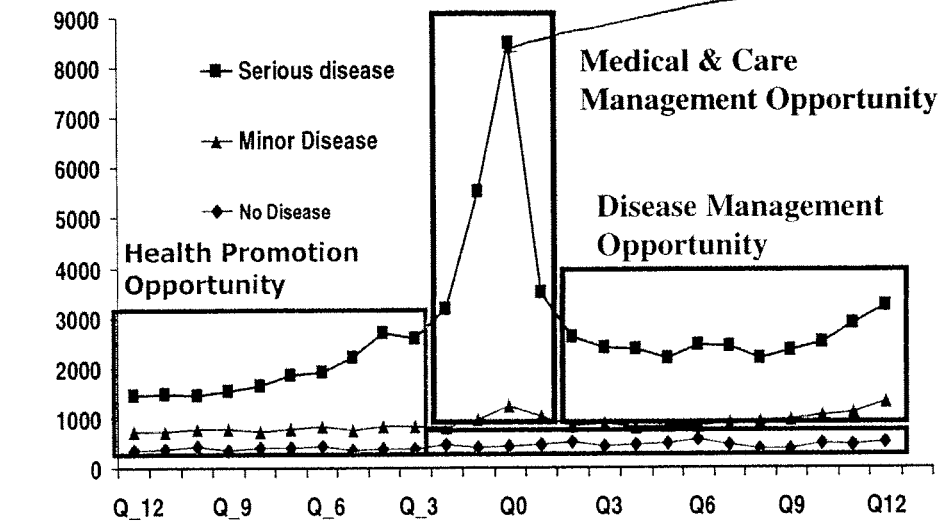
*2004 HRA: 2003 average annual medical/drug costs (paid amounts).
HRA participants N=53,338.

Transforming Medical Management



$Back — all about teaching
— Personal responsibility.

Where are the Opportunities for Population Health Management?

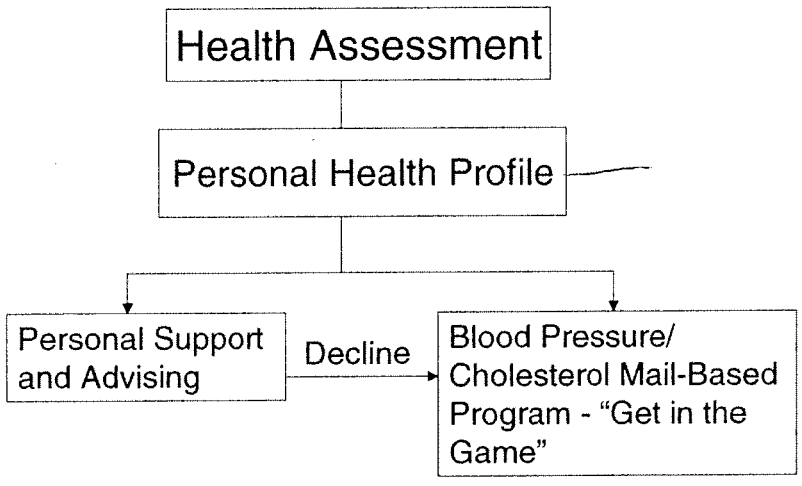


Medical and Drug Costs only

critical incident back 12 qtrs

Predictive Modeling Which 1. Key Impact PRO.

WEA Trust Health Assessment Program



Health Risk Assessment Appraisal

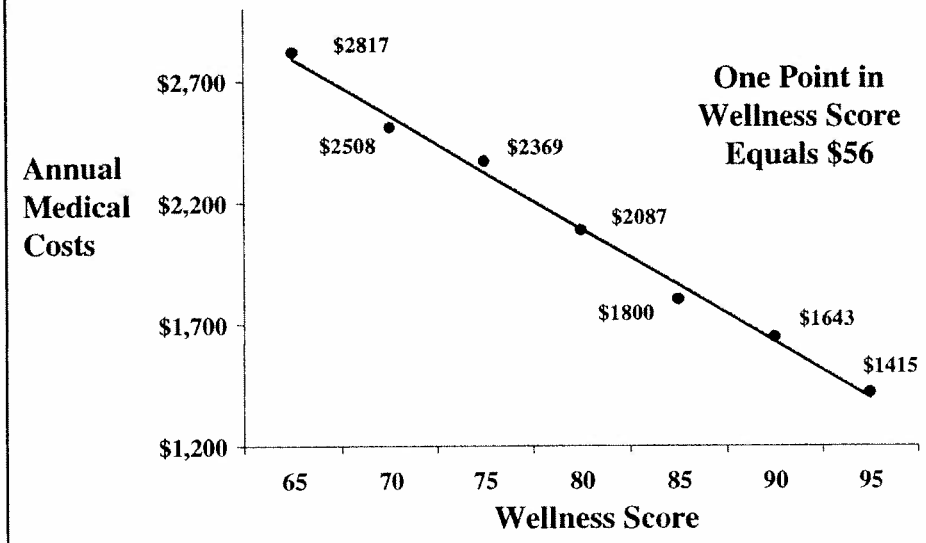
CURE Technology

UM Michigan

Predictive modeling.

email web

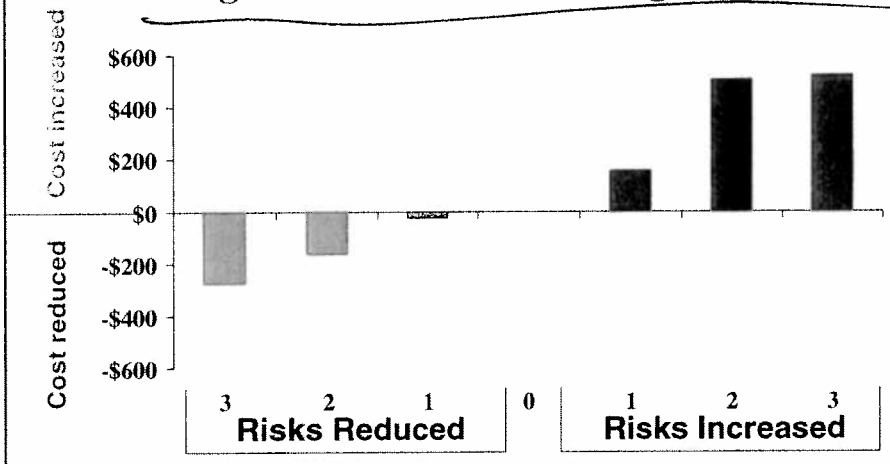
Relationship Between Annual Medical and Pharmacy Costs and Wellness Score



Yen, McDonald, Hirschland, Edington. JOEM. 45(10):1049-1057, 2003.

Every wellness score = $56 Annually

Change in Costs follow Change in Risks



Overall: Cost per risk reduced: $215; Cost per risk avoided: $304
Actives: Cost per risk reduced: $231; Cost per risk avoided: $320
Retirees<65: Cost per risk reduced: $192; Cost per risk avoided: $621
Retirees>65: Cost per risk reduced: $214; Cost per risk avoided: $264

Updated from Edington, AJHP. 15(5):341-349, 2001.

Less $ to Prevent Risk vs $ to Avoided

Health Promotion Opportunity

Member Resources:

- Nurse Line
- Maternity Education Program
- Health Assessment (HA) Program with Personal Support and Advising or Mail-Based Cholesterol and Blood Pressure Materials
- Tobacco Cessation Program
- Online Medical Guide
- *Partners in Health* Newsletter

Health Promotion Opportunity

School District Resources:

- Flu Vaccination Program
- Consultation-Developing Wellness Teams and Programs
- Lending Library
- Medical Self-Care Book
- Critical Incident Stress Management
- District In-Service
- Staff Wellness Grant
- SWL Annual Workshops
- *Wellness Connection* Newsletter
- SWL Resource Center on Web
- Wellness Presentations

PBM Pharmacy Benefit Mgmt.
Biological specialists Special disease -

Biological drug MS. New formulate 10-20,000

Medical and Care Management/ Disease Management Opportunity

- Asthma Care Program
- Heart Care Program
- Diabetes Care Program
- *Kids in Control!* Pediatric Diabetes Care Program
- Oncology Program
- Transplant Care Management
- High-Risk OB/ Maternity Education
- Hypertension/ Hyperlipidemia
- General Care Management

Findings: Health risk shift

	2004 (Baseline)	2005	Percentage in Change
Low Risk	62.9%	72.8%	+9.9%
Medium Risk	36.0%	23.4%	-12.6%
High Risk	1.1%	3.8%	+2.7%

N=950-members who received multiple mailings in the "Get in the Game" program

Findings: Health risk shift

	2004 (Baseline)	2005	Percentage in Change
Blood Pressure (139/89 or less)	71.4%	42.5%	-28.9%
Cholesterol (239 or more)	48.6%	18.0%	-30.6%

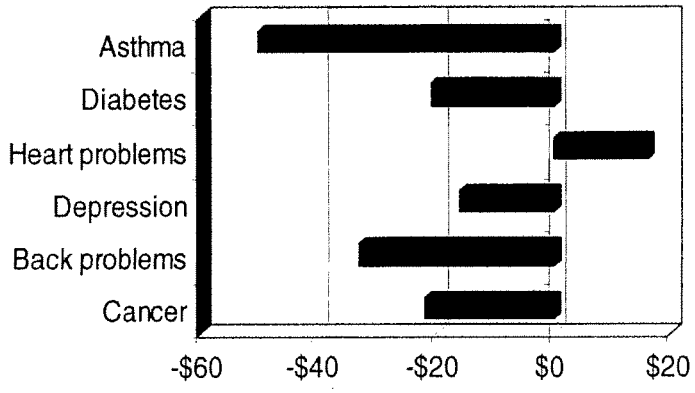
N=950-members who received multiple mailings in the "Get in the Game" program

Findings: Health risk shift

	2004	2005
Wellness Score	82.0	86.1

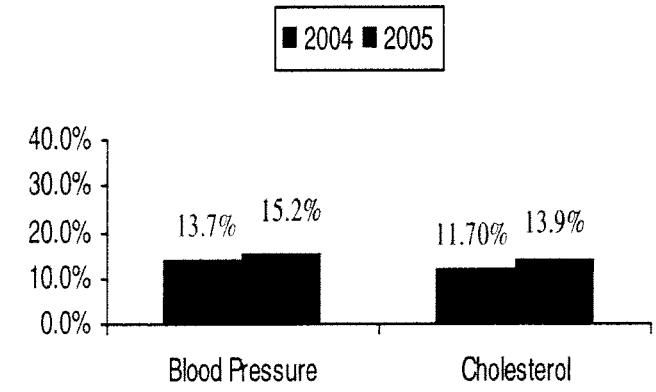
N=950-members who received multiple mailings in the "Get in the Game" program

Program results: HA participants' costs are less than non-participants



N=52,883 HA participants in 2004 (and eligible in both 2003 & 2004).
Represents paid/per year/per member for ICD-9 claims.

Percent of people who are taking medication/under medical care 2004 vs. 2005



N=18,015 2004 & 2005 HA participants.

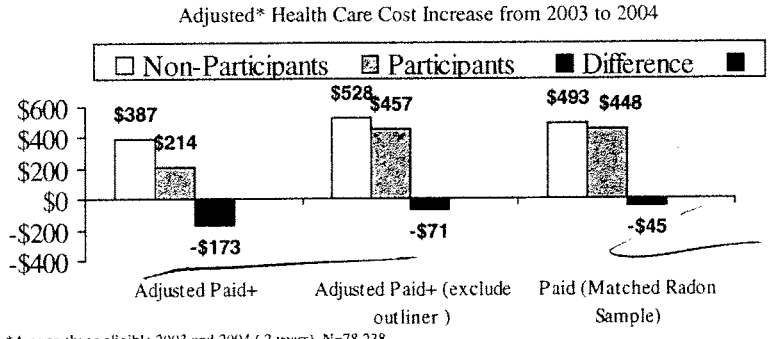
Impact of Disease Management Programs

Asthma care results:

- Average asthma-related claims: $3,772 (telephonic program)
- Average asthma-related claims: $4,988 (mail program)
- Average asthma-related claims: $5,829 (no program)

Overall Program Impact on Health Care Cost

The 2004 program showed a positive impact on 2004 overall health care costs (medical plus drugs) - a saving of $45 to $173 per eligible participants. The positive impact is primarily from the medical costs ($48 to $166), There was no notable program impact on drug costs

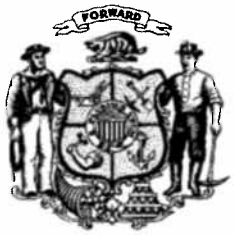


*Among those eligible 2003 and 2004 (2 years), N=78,238
+ Adjust for age, gender, member status, outliner, previous program participation (1999 ~ 2002 StayWell program) and 2003 medical costs.

Staff Wellness Grant

- Eligible for $5-10 per completion
- Minimum grant of $300 with 25% participation
- Activities must address two out of three prioritized health risks
- Minimum of 75% of grant dollars used for measurable activities
- No food or water may be purchased with grant money

WISCONSIN STATE LEGISLATURE



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Health Care Reform Committee
May 11, 2006

Good morning and thank you for the opportunity to speak to you about healthcare issues in Wisconsin.

My name is Christine Kistner. I have lived in western Wisconsin for over 35 years, currently in Colfax. I am a single parent of three young adults and I am a proud public employee: I have worked for 16 years for Dunn County Human Services in the Economic Support Section. Before that, I worked as a Certified Nursing Assistant at the Dunn County Healthcare Center. I am also a member of the American Federation of State, County, and Municipal Employees, a public/private employee union, currently serving as President of my local union as well as on the Executive Board of AFSCME Council 40. I am also a volunteer at the Free Clinic of the Greater Menomonie Area, which serves individuals and families without any health care coverage at no cost.

As you can see, I have several areas from which I have had experience dealing with health care issues in Wisconsin.

Experienced gained as Local Union President/member:

In my role as President/member of my local union, I have served on the bargaining committee many times. In every session, health insurance is one of the major issues of discussion. Our health insurance coverage is a self-funded plan, covering both the full-time represented and un-represented employees of Dunn County, and those part-time employees and retirees who choose to pay the full premium for coverage. Our plan is a preferred provider plan, with users paying more of the costs if seeking care outside of the network of providers.

During the last bargaining session, I served on a focus committee for health insurance that was comprised of both union and county board representatives. This committee investigated many ways to provide the best value for the taxpayer and the user. We had presentations from insurance company representatives who provided us with detailed comparisons between the plan we had in place and changes we proposed that we thought may reduce costs, or at the very least keep them at the same level. The representatives themselves could not define exactly why all-around costs for health care coverage were increasing.

Some of the suggestions investigated included switching our self-funded plan for an HSA plan, purchasing a defined benefit plan offered by a company, as well as adjusting the out-of-pocket maximums, co-pays and the deductibles for the self-funded plan.

We discovered that real savings would not be realized by utilizing an HSA, nor the defined benefit plan. Our focus committee's recommendation to the full bargaining team in order to

maintain coverage was to increase the costs the users paid out of pocket: the yearly deductible, as well as the co-pays for office visits and prescriptions drugs, increased incrementally. Even with passing the increases on to the user, the overall monthly premium for each participant plan had to be increased.

Experience gained as Executive Board member for AFSCME Council 40:

In the time that I have served on the Executive Board of AFSCME Council 40, I have had the opportunity to be in the role of the employer in dealing with health care coverage for the Council's employees. Recently, having been offered a better rate and an assurance that our certain increase for 2006 would not be as great as what we'd been facing with our previous company, we changed plans and providers. We were told that there were two major claims, a cancer and a heart attack in 2005, that caused a 29% increase for the 2006 rates.

Experience gained in my employment with Dunn County:

My responsibilities as a W2 Specialist 2 with Dunn County include the processing of applications for the State's Medicaid/BadgerCare program. On a daily basis, I hear from the people of Dunn County who have inadequate health care coverage, costly health care coverage, or no health care coverage at all. These folks are individuals, families, and sometimes employers looking for relief from the ever-rising costs of plans they offer their employees. Most contacts are families with health care costs sometimes so great that they cannot afford to pay their other living expenses.

In Dunn County, we have seen our Medicaid/BadgerCare numbers increase from 2,826 recipients in June 1999 to 6,771 recipients in April 2006. The BadgerCare program, which began in July 1999, accounts for 906 of those recipients. Statewide, for the same time period, the increase was from 395,336 recipients to 849,324 recipients. The BadgerCare program accounts for 92,651 of those recipients. (statistics available at dhfs.wisconsin.gov/medicaid)

Dunn County is one very few counties in Wisconsin that has a general relief program to help those who are not eligible for Medicaid/BadgerCare pay for health care costs. Participants are required to reimburse the county for costs incurred at Medicaid rates.

The Free Clinic of the Greater Menomonie Area utilizes volunteers to deliver health care to persons with varied acute and chronic medical conditions. I am in the 'intake role'—a role that determines if people can be served by the free clinic. In this role, I have seen a large number of people who have not had medical care for many years because they have no health insurance and cannot afford to pay for care. I feel their conditions were worse than if they had been able to seek care at the onset of symptoms.

Experience gained as a single parent of three young adults:

I am the parent of three young adults, who are now facing the loss of health care insurance as they become ineligible to be covered by a parent's health insurance plan, like so many of their peers. Health insurance is not available to them, at an affordable cost, either privately purchased or through an employer. My oldest son takes medications daily that cost approximately $200 per month. He does not earn enough to pay for these medications, but is not eligible to be covered by any State-sponsored Medicaid/BadgerCare. When he is not eligible to be covered by my plan, I honestly do not know how we will manage to ensure he has the medications he needs every day.

Conclusion and suggestions to investigate as solutions:

Wisconsin has been a leader in the nation in many areas, and ending the health care crisis should be our next success. The total amount of money that is paid by individuals and employers for health insurance coverage; the Medicaid/BadgerCare per capita rates and fees-for-service; the hidden costs of unpaid medical bills; and the donations solicited for 'free clinics', is not known to me, but must be staggering. Some ideas that should be investigated are:

1) ***Consolidating health care costs by allowing every Wisconsin resident to have access to a plan similar to the BadgerCare program after having passed financial testing.*** Non-financial tests such as age or being a parent should not be a barrier to eligibility. Many people that I speak to who are not eligible because they do not have children or their children are age 19 or older, or because they have access to insurance through their employer, state they would gladly pay the monthly premium if only they could have more affordable coverage. Even some employers would agree.

2) ***All employers pay into one plan for every employee, family or single rates, similar to the initiative suggested by the AFL-CIO, for basic and catastrophic care. Unemployed or retired workers could be considered for eligibility for a plan such as suggested above.***

3) ***Require all employers to pay 80% toward the monthly premium for health insurance for their employees, if they employ a certain number of employees.***

4) ***Create one plan that covers all levels of government employees, patterned after the Wisconsin Retirement Fund.*** This will reduce the costs to local and state government by consolidating the administration of health care plans, with contributions from employers and employees.

These are simply a few suggestions, and I do not claim to be an expert. There are many ideas to explore and I applaud you for your efforts.

Thank you for your time.

Wisconsin Medicaid

Recipients by County/Tribe for Each Month and Year

County or Tribe: **Dunn**

2006	JAN	FEB	MAR	APR	MAY	JUN	JUL	A
AFDC	1,656	1,683	1,687	1,696	0	0	0	
BadgerCare	866	875	895	906	0	0	0	
Healthy Start	1,279	1,253	1,299	1,336	0	0	0	
Family Planning Waiver	1,658	1,603	1,614	1,586	0	0	0	
Family Coverage Total	**5,459**	**5,414**	**5,495**	**5,524**	**0**	**0**	**0**	
Foster Care	26	28	24	23	0	0	0	
Medicare Beneficiaries	40	42	37	45	0	0	0	
Well Woman Program	1	1	1	1	0	0	0	
Other Coverage Total	**67**	**71**	**62**	**69**	**0**	**0**	**0**	
MAPP	84	85	87	84	0	0	0	
Nursing Home	165	167	170	170	0	0	0	
SSI	665	659	659	660	0	0	0	
SSI-Related	85	88	89	90	0	0	0	
Waiver	157	160	167	169	0	0	0	
SeniorCare	7	6	6	5	0	0	0	
Persons With Disabilities & Elderly Coverage Total	**1,163**	**1,165**	**1,178**	**1,178**	**0**	**0**	**0**	
Total Coverage	***6,689***	***6,650***	***6,735***	***6,771***	***0***	***0***	***0***	

2005	JAN	FEB	MAR	APR	MAY	JUN	JUL	A
AFDC	1,682	1,738	1,784	1,781	1,765	1,700	1,648	1
BadgerCare	911	900	880	856	854	835	848	
Healthy Start	1,130	1,138	1,123	1,182	1,172	1,147	1,169	1
Family Planning Waiver	933	1,161	1,300	1,458	1,515	1,525	1,544	1
Family Coverage Total	**4,656**	**4,937**	**5,087**	**5,277**	**5,306**	**5,207**	**5,209**	**5**
Foster Care	20	22	21	25	25	27	31	
Medicare Beneficiaries	29	30	30	33	33	32	35	
Other	2	2	2	1	1	1	0	
Well Woman Program	2	3	3	2	2	2	2	

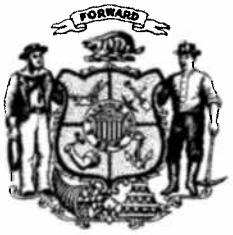
Other Coverage Total	**53**	**57**	**56**	**61**	**61**	**62**	**68**	
MAPP	75	70	69	70	68	71	72	
Nursing Home	173	173	172	171	174	175	173	
SSI	662	666	660	661	661	667	658	
SSI-Related	107	105	106	101	108	98	93	
Waiver	127	133	137	138	140	142	147	
SeniorCare	10	10	10	10	9	9	6	
Persons With Disabilities & Elderly Coverage Total	**1,154**	**1,157**	**1,154**	**1,151**	**1,160**	**1,162**	**1,149**	**1**
Total Coverage	***5,863***	***6,151***	***6,297***	***6,489***	***6,527***	***6,431***	***6,426***	***6,***
2004	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	1,413	1,432	1,493	1,533	1,526	1,535	1,586	1
BadgerCare	1,024	1,016	1,019	1,042	1,021	979	959	
Healthy Start	1,116	1,121	1,142	1,145	1,135	1,074	1,110	1
Family Planning Waiver	787	810	833	836	837	834	842	
Family Coverage Total	**4,340**	**4,379**	**4,487**	**4,556**	**4,519**	**4,422**	**4,497**	**4**
Foster Care	30	31	28	27	26	22	21	
Medicare Beneficiaries	27	28	30	25	29	28	30	
Other	0	0	0	0	0	0	0	
Well Woman Program	4	5	5	5	6	6	5	
Other Coverage Total	**61**	**64**	**63**	**57**	**61**	**56**	**56**	
MAPP	46	50	55	57	59	63	61	
Nursing Home	174	174	174	177	179	174	178	
SSI	634	642	645	651	655	647	650	
SSI-Related	97	98	97	102	105	107	102	
Waiver	132	128	120	127	126	122	123	
SeniorCare	9	7	7	7	8	8	9	
Persons With Disabilities & Elderly Coverage Total	**1,092**	**1,099**	**1,098**	**1,121**	**1,132**	**1,121**	**1,123**	**1**
Total Coverage	***5,493***	***5,542***	***5,648***	***5,734***	***5,712***	***5,599***	***5,676***	***5,***
2003	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	1,219	1,222	1,279	1,274	1,278	1,270	1,236	1
BadgerCare	999	1,002	974	976	981	977	999	
Healthy Start	1,108	1,122	1,077	1,119	1,111	1,131	1,139	1
Family Planning Waiver	6	62	120	197	299	357	438	
Family Coverage Total	**3,332**	**3,408**	**3,450**	**3,566**	**3,669**	**3,735**	**3,812**	**3**

Foster Care	32	32	29	24	25	24	25	
Medicare Beneficiaries	35	36	31	32	32	29	29	
Well Woman Program	4	4	4	4	4	4	4	
Other Coverage Total	**71**	**72**	**64**	**60**	**61**	**57**	**58**	
MAPP	28	27	26	27	28	30	33	
Nursing Home	162	168	170	166	162	167	169	
SSI	563	564	564	570	574	569	588	
SSI-Related	106	103	98	96	94	98	100	
Waiver	202	203	204	207	205	203	179	
SeniorCare	4	3	3	3	5	5	5	
Persons With Disabilities & Elderly Coverage Total	**1,065**	**1,068**	**1,065**	**1,069**	**1,068**	**1,072**	**1,074**	**1**
Total Coverage	***4,468***	***4,548***	***4,579***	***4,695***	***4,798***	***4,864***	***4,944***	***4,***
2002	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	983	1,021	1,054	1,091	1,124	1,152	1,162	1
BadgerCare	911	891	888	896	905	865	897	
Healthy Start	1,034	1,021	1,018	1,007	1,070	1,056	1,031	1
Family Coverage Total	**2,928**	**2,933**	**2,960**	**2,994**	**3,099**	**3,073**	**3,090**	**3**
Foster Care	56	58	51	50	46	51	45	
Medicare Beneficiaries	42	40	37	38	40	41	44	
TB-Related	3	4	4	4	4	1	0	
Well Woman Program	0	0	1	1	1	1	1	
Other Coverage Total	**101**	**102**	**93**	**93**	**91**	**94**	**90**	
MAPP	14	18	23	25	23	27	29	
Nursing Home	171	169	162	162	163	165	168	
SSI	658	639	629	623	626	624	624	
SSI-Related	105	110	106	108	102	103	101	
Waiver	123	147	153	157	160	157	158	
SeniorCare	0	0	0	0	0	0	0	
Persons With Disabilities & Elderly Coverage Total	**1,071**	**1,083**	**1,073**	**1,075**	**1,074**	**1,076**	**1,080**	**1**
Total Coverage	***4,100***	***4,118***	***4,126***	***4,162***	***4,264***	***4,243***	***4,260***	***4,***
2001	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	681	690	675	670	635	627	649	
BadgerCare	736	751	778	788	805	798	800	
Healthy Start	967	961	1,001	1,028	1,064	1,068	1,051	1

Family Coverage Total	**2,384**	**2,402**	**2,454**	**2,486**	**2,504**	**2,493**	**2,500**	**2.**
Foster Care	56	57	59	65	61	62	60	
Medicare Beneficiaries	46	46	45	47	42	45	46	
Other Coverage Total	**102**	**103**	**104**	**112**	**103**	**107**	**106**	
MAPP	7	7	8	10	10	10	10	
Nursing Home	169	169	168	165	166	168	166	
SSI	710	708	701	699	686	671	672	
SSI-Related	94	93	96	98	92	97	100	
Waiver	70	71	73	72	91	112	114	
Persons With Disabilities & Elderly Coverage Total	**1,050**	**1,048**	**1,046**	**1,044**	**1,045**	**1,058**	**1,062**	**1.**
Total Coverage	***3,536***	***3,553***	***3,604***	***3,642***	***3,652***	***3,658***	***3,668***	***3,***
2000	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	729	716	712	732	726	700	633	
BadgerCare	643	663	703	741	765	774	760	
Healthy Start	911	918	925	950	954	968	934	
Family Coverage Total	**2,283**	**2,297**	**2,340**	**2,423**	**2,445**	**2,442**	**2,327**	**2.**
Foster Care	45	49	51	52	55	48	53	
Medicare Beneficiaries	37	37	38	42	41	39	44	
Other	0	0	0	0	0	0	0	
Other Coverage Total	**82**	**86**	**89**	**94**	**96**	**87**	**97**	
MAPP	0	0	0	0	1	5	6	
Nursing Home	163	165	167	171	171	169	170	
SSI	732	720	726	721	724	729	728	
SSI-Related	89	85	91	93	99	97	96	
Waiver	52	52	53	56	53	51	51	
Persons With Disabilities & Elderly Coverage Total	**1,036**	**1,022**	**1,037**	**1,041**	**1,048**	**1,051**	**1,051**	**1.**
Total Coverage	***3,401***	***3,405***	***3,466***	***3,558***	***3,589***	***3,580***	***3,475***	***3,***
1999	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	799	779	760	812	815	802	778	
BadgerCare	0	0	0	0	0	0	93	
Healthy Start	910	911	894	865	864	849	846	
Family Coverage Total	**1,709**	**1,690**	**1,654**	**1,677**	**1,679**	**1,651**	**1,717**	**1.**
Foster Care	39	39	42	42	42	52	45	

Medicare Beneficiaries	50	45	47	45	47	44	40	
TB-Related	1	1	3	3	3	3	3	
Other Coverage Total	**90**	**85**	**92**	**90**	**92**	**99**	**88**	
Nursing Home	182	181	183	185	181	181	179	
SSI	777	772	768	761	758	756	747	
SSI-Related	96	101	93	92	87	84	87	
Waiver	51	50	46	52	53	55	51	
Persons With Disabilities & Elderly Coverage Total	**1,106**	**1,104**	**1,090**	**1,090**	**1,079**	**1,076**	**1,064**	**1**
Total Coverage	***2,905***	***2,879***	***2,836***	***2,857***	***2,850***	***2,826***	***2,869***	***2,***
1998	**JAN**	**FEB**	**MAR**	**APR**	**MAY**	**JUN**	**JUL**	**A**
AFDC	943	908	904	877	874	857	853	
Healthy Start	813	840	839	857	846	834	867	
Family Coverage Total	**1,756**	**1,748**	**1,743**	**1,734**	**1,720**	**1,691**	**1,720**	**1**
Foster Care	37	39	39	40	46	47	45	
Medicare Beneficiaries	53	46	51	62	59	56	56	
TB-Related	1	2	2	2	2	2	2	
Other Coverage Total	**91**	**87**	**92**	**104**	**107**	**105**	**103**	
Nursing Home	198	197	193	188	178	177	179	
SSI	782	783	784	784	781	784	776	
SSI-Related	72	76	81	81	79	86	91	
Waiver	43	44	49	53	54	51	49	
Persons With Disabilities & Elderly Coverage Total	**1,095**	**1,100**	**1,107**	**1,106**	**1,092**	**1,098**	**1,095**	**1**
Total Coverage	***2,942***	***2,935***	***2,942***	***2,944***	***2,919***	***2,894***	***2,918***	***2,***


WISCONSIN STATE LEGISLATURE


FORWARD

STATEMENT

OF

MARSHFIELD CLINIC

PRESENTED BY

ROBERT PHILLIPS, M.D.

11 MAY 2006

Chairperson Darling, Senators Olson, Roessler, Erpenbach, Miller and Brown, staff and citizens of west central Wisconsin, I am Dr. Robert Phillips, Medical Director of Government Relations for Marshfield Clinic. Our new President, Dr. Karl Ulrich, sends his regrets. He is unable to speak to you today due to a previous commitment. This statement is a message Marshfield Clinic has been conveying since 2002, and I believe it will be helpful to your deliberation.

I would like to briefly describe Marshfield Clinic. Then I will make a few comments on the rising costs of medical care in Wisconsin and what should be done to address their root causes. I hope that by the end, I will have conveyed two main ideas for your consideration.

Marshfield Clinic is one of the largest group medical practices in the country, currently comprised of 732 physicians in 86 specialties, and 5,910 additional staff, disbursed among 41 clinical centers in 31 communities in northern, central and western Wisconsin. We see patients from every county of the state, from every state in the nation, and from 23 foreign countries. Our annual patient visits number 1.8 million.

Marshfield Clinic's mission is to serve patients through accessible, high quality health care, research and education. The Clinic is operated as a charitable organization with all Clinic assets held in a charitable trust. Our research foundation is the largest private medical research facility in the State, currently conducting hundreds of medical research studies and contributing over 100 scientific papers annually to the peer-reviewed scientific literature. Our graduate medical education program, in conjunction with Saint Joseph's Hospital and the University of Wisconsin, trains graduate physicians in the

specialties of internal medicine, pediatrics, combined medicine-pediatrics, general surgery, and dermatology. The Clinic is the sole sponsor of Security Health Plan of Wisconsin, Inc., a not-for-profit HMO that insures 119,000 people. We believe ourselves to be a state-of-the art health care system, and we believe Marshfield Clinic to be among the health industry's leaders in integrated rural health delivery, computerized medical records, farm health and safety, epidemiology, areas of medical genetics, food safety, and population health initiatives such as improving immunization rates, and working with communities to improve general health.

Marshfield Clinic partners with a federally funded Community Health Center to serve eligible uninsured and underinsured people. We partner with the State on BadgerCare. When patients who are not eligible for these and other programs come to us with no means to pay, we take care of them anyway. We limit neither access nor treatment to any patient based on their ability to pay.

We are alarmed by the rising costs of care, the growing number of people who cannot afford health care, and the increasing frustration and dissatisfaction of the public relative to the health care system. We are dedicated to controlling health care costs. We, like everyone else, hope for a health care system that can be relied upon to uniformly provide safe, effective, affordable care for ourselves, for our children and for our grandchildren, no matter where they may live, regardless of who may or may not employ them, and regardless of their age, gender, ethnicity, belief system, or socio-economic status.

That is not the case today. Today's health care system is more properly characterized as a "non-system." Overall, it is delivering exactly what one would expect from a product or service whose components were designed over decades by hundreds of thousands of different people without specifications, without an overall plan, and without the requirement that the various elements should fit together effectively into an integrated whole. There is huge variation at every level—variation in expectations, accessibility, treatment methods, utilization, record keeping, insurance coverage, payment rules, regulations, population demographics, etc., etc. The medical industry is at least a decade behind the rest of America in the applications of computer science, and only large medical organizations can even begin to afford the sophisticated computer systems that offer the potential to simultaneously lower costs and improve quality. The nation's medical schools are not training the mix of physician specialists that the country needs. The specialty mix is instead driven by a reimbursement system that disproportionately rewards costly interventional procedures over preventive care. Indeed, the reimbursement system, which is predominately oriented to episodes of care instead of the continuum of care, actually creates obstacles to cost effective behavior. For example, Medicare will not pay thousands of dollars for the home administration of some antibiotics, but it will pay tens of thousands to have the same patient admitted to a nursing home for the identical treatment. There is little support to apply proven methods to standardize to the best cost-effective practices, otherwise known as disease state management systems.

For example, Marshfield Clinic testified in Washington in April 2002 to the Health Subcommittee of the Committee on Ways and Means regarding disease state

management for patients who require chronic anticoagulation. Between 7% and 10% of these patients can be expected to require expensive hospitalization for complications of treatment. With a standardized protocol for patient education and nurse monitoring and follow up, the rate can be reduced to under 2%. If this system were applied to all anticoagulated Medicare patients in our service area, Medicare could avoid $28,000,000 annually in hospital costs. However, Medicare has no mechanism to reimburse the $3,000,000 that it would cost Marshfield Clinic, or anyone else, to implement such a program.

Additional health care cost drivers include: rising costs of technological advances, defensive medicine, tort reform (which I know you are deliberating changes to), legislative mandates, drug costs, Medicare's billion dollar underpayment to Wisconsin and the impact of shifting those costs to the private sector, and so forth.

The thought I would like to offer is this. All of these issues are interconnected. Few, if any, are isolated problems. Few, if any can be fixed quickly; and none of the fixes will be durable unless done in the context of the overall health care system. We need, as a state and as a nation, to reach agreement on the nature and causes of the problems; and then, more importantly, so that we can all align our efforts, we need to subscribe to a common vision or plan for what the future health system ought to be and how it ought to work. Only then can the industry rationally undertake to execute the well-known formula to reduce costs and improve quality. The formula is: 1) Standardize everything to the best-proved method; and 2) Continuously eliminate waste in the system. A guiding future vision already exists, and it is waiting for subscribers.

The National Academy of Sciences was chartered by Congress in 1863 to advise the federal government on scientific and technical matters. The Institute of Medicine, established in 1970, is the branch of the Academy that advises on matters pertaining to the health of the public. The general public first became widely aware of the Institute of Medicine in 1999, when it published its now famous report, *To Err is Human: Building a Safer Health System*. This report, as we all now know, brought to light the extent of medical mistakes and safety issues, and its recommendations are being quoted and pursued across the nation, particularly with respect to computerized systems to prevent medication prescribing errors.

In the Spring of 2001, the Institute of Medicine published its far more comprehensive report on the quality of health care today, ~~entitled~~ *Crossing the Quality Chasm: A New Health System for the 21st Century*. The report in one-way or another addresses virtually everything under discussion here today. It is critical of ~~today's healthcare~~ system as inconsistent, highly inefficient, and largely failing at translating available knowledge into practice. It states that the American healthcare system is in need of fundamental change, and that Americans frequently cannot count on receiving care that meets their needs and care that is based on the best scientific knowledge available. The IOM offers the vision of a system transformed into one that is: 1) Safe (avoiding injuries to patients from care intended to help them); 2) Effective (services based on scientific knowledge, and refraining from providing services of little or no benefit); 3) Patient-centered (respectful of and responsive to individual patient preferences); 4) Timely (reducing harmful waits and delays); 5) Efficient (avoiding waste of resources and

energy); and 6) Equitable (consistent care that does not vary in quality because of race, gender or socioeconomic status).

The IOM report squarely places patient needs at the center of the system, and advocates that changes and actions should be measured not by how they may affect one or another segments of the industry, but rather by how they affect patients. It emphasizes information technology and advocates shared knowledge, free flow of information among providers, decision support systems and evidence-based decision making, anticipation of needs instead of reaction to events, continuous decrease in waste, and cooperation among clinicians as the norm. It recommends standardization of care for 15 very expensive chronic conditions that include hypertension, diabetes, heart attacks, cholesterol, asthma, cancer, back problems and depression.

It recommends that all members of the health care team become proficient in information technology; that we develop methods to manage the growing medical knowledge base; coordination of care across patient conditions, settings, and time; continuous advancement of team effectiveness; and incorporation of outcome measurements into daily work. It recommends a national commitment and financial support to build a national health information infrastructure, with a goal to eliminate most handwritten clinical data by the end of the decade.

The report is critical of current payment policies and recommends changes in the payment system that will remove barriers to quality, provide fair payment for good clinical management and quality improvement, and alignment of financial incentives with

the implementation of processes based on best practices. It recommends modification in the way the government regulates healthcare professionals and changes in the professional liability system.

It recommends that all organizations in the healthcare system should adopt an explicit purpose of improving the health and functioning of the people of the United States, and that all organizations should pursue the six aims for improvement.

I believe this landmark report of the Institute of Medicine has correctly formulated the problem and that it has, more importantly, crafted the plan and the roadmap for durable solutions that will, over time, simultaneously and dramatically improve quality and lower costs.

I believe that the State of Wisconsin should be an early and explicit endorser of the Institute of Medicine report, and that future legislative and regulatory efforts should be directed at achieving its six articulated aims, for a 21st century health system that is safe, effective, patient centered, timely, efficient, and equitable.

Thank you. I am happy to respond to any questions you may have.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Senate Committee on Health Care Reform
Hearing May 11, 2006
Eau Claire, Wisconsin

2 1/2 employees
(or $300 per month)

In 2003, I was paying $20,000 per year for two family policies covering me, my wife and one employee and his family. My other employee got his health insurance through his spouse. That fall I received notice that my insurance company was being acquired by a larger company for market share reasons, not cost efficiency reasons and that our premiums would be going up by $600 per month, or $7,200 per year. I realized that I could not afford to pay this 36% increase, so I dissolved our small group plan. My wife and I each got policies through HIRSP for what we had been paying, and my employee and his family went on the group policy offered by his wife's employer, of which that employer paid half. I reimbursed my employee for his half of his wife's policy, so my health insurance cost stayed the same for 2004, but his wife's employer's cost of doing business went up by $700 per month or $8,400 per year because she chose to take advantage of the group policy they offer.

Since then, my costs under this arrangement have increased in two years to $26,000 per year. That additional money is money that is not available for wages, bonuses, equipment upgrades, advertising, community support, or anything other than health insurance.

Faced with a change in his marital status my other employee decided to move on. Because rising health insurance costs are eating up an ever increasing portion of my gross revenue, I am not planning to replace him and assume the heavy burden of paying for the health insurance costs of another family. Employment opportunities and entrepreneurship are stifled by the difficulty in obtaining and the high costs of individual and small group policies.

Pre-existing conditions that often come with maturity make health insurance increasingly expensive and difficult to qualify for. The rising number of uninsured cause the premiums of the remaining insured to increase to cover the cost of sometimes unreimbursed care. A recent report says that amount is over $900 per year for every uninsured person.

There are currently three proposals before the state legislature to provide universal or near universal coverage. The Wisconsin Health Security Act SB388/AB807 would establish a publicly financed system for all the residents of Wisconsin.

The Wisconsin Health Plan AB1140 would establish a joint employer/employee financed system for all the residents of Wisconsin.

The Wisconsin Health Care Partnership Plan SB698 would establish an employer financed system for the vast majority of the residents of Wisconsin.

In my situation, both the Wisconsin Health Plan and the Wisconsin Health Care Partnership plan would cut my costs by at least half, freeing up money for other business uses and eliminating the time and angst expended in dealing with the present system.

NFIB

Sincerely,

Russell R Ratsch

Russell R. Ratsch, P.E.
President
Ratsch Engineering Company, Ltd.


FORWARD
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Wisconsin Dental Association (WDA) Testimony to the Select Committee on Health Care Reform

Health Care in Western Wisconsin

Public Hearing
May 11, 2006
Presented By: Dr. Kent Vandehaar, WDA Trustee

Good morning Chairpersons Roessler and Darling and members of the Select Committee on Health Care Reform. Thank you for holding this public hearing today. My name is Dr. Kent Vandehaar, and I am a general dentist who practices in Chippewa Falls. As an active member of the Wisconsin Dental Association (WDA) and a volunteer member of the WDA Board of Trustees, I am here to represent the WDA and provide information regarding the realities of the practice of dentistry and how they relate to cost, quality and access to dental care in Wisconsin.

To begin, you need to be aware that the practice of dentistry and delivery of oral health care differ significantly from the medical model. In dentistry, prevention is, and always will be, the core precept for the delivery of oral health care. Dentistry's emphasis on fluoridation, properly placed sealants, routine dental exams and early restorative care has created important barriers to the development of dental disease. Additional preventive efforts such as patient education, healthy dietary habits, personal oral hygiene practices and consumption of appropriate fluoride supplements are also important and should be addressed by individuals along with routine dental office visits to help prevent decay. While these preventive efforts can not eliminate all dental disease, they will greatly improve the overall health of the average dental patient.

It is worth noting that Wisconsin has enjoyed many successes with regard to the implementation of community water fluoridation. Of the Wisconsin residents who use public water, 90 percent receive the health benefit of fluoridated water, which improves health while saving thousands of dollars in long-term dental costs. Many of these successes have been spearheaded by local dentists and community activists and provide continuous benefits to people residing in those communities. I am disappointed to say that my own community of Chippewa Falls rejected a fluoridation referendum in April 2004. In my practice, the rate of new and reoccurring cavities is very high. It is my personal opinion that the lack of water fluoridation in Chippewa Falls plus the large quantities of soda

consumption contribute to this high rate of caries. One of the most cost-effective ways of saving on dental costs is by doing our best to promote water fluoridation at the local level and by reaching out to residents who use well water to make it as easy as possible for them to receive fluoride supplements.

Many of you may have children who have never had a dental cavity. Much of the reason for that level of success has been dentistry's focus on comprehensive prevention, including access to fluoridation supplements, healthy diet, routine oral health care habits, regular examinations by a dentist and access to appropriately prescribed preventive services. While dentistry has made great strides in prevention, licensed dentists and oral health care professionals struggle constantly with the growing reality of excessive soda consumption. In addition to the obvious obesity issues, excessive soda consumption has a direct negative impact on oral health. The sugar and acid in soft drinks can lead to the weakening of tooth enamel which results in cavities. Excessive soda consumption reverses the otherwise lasting effects of oral health efforts, often resulting in the need for costly restorative care.

Unfortunately, despite recent successes in prevention of childhood and teenage dental disease, it is a sad fact that the majority of dental disease occurs in a relatively small percentage of the population. It's no secret to anyone on this panel that the Medicaid population is underserved. The State's dental Medicaid program is not sufficiently funded and, as a result, many Medicaid enrollees are unable to access needed dental care. Untreated dental disease and lack of regular oral health care habits, make their cases some of the most heartbreaking and complicated we encounter. While preventive services are beneficial, they need to be provided in conjunction with a dentist's examination and diagnosis and will be successful only if accompanied by a broader patient commitment to care for and value their own oral health. Placement of sealants and application of fluoride varnishes will not achieve the desired results unless each individual patient is also committed to a healthy diet and routine dental hygiene habits (daily brushing and flossing). There are individuals out there – both inside and outside of the Medicaid population – who, for whatever reasons, fail to care for their own oral health. It is these individuals who, regardless of receiving sealants or fluoride varnish applications, will eventually need more invasive and costly restorative services. Increased public education is needed to truly change negative habits; positive lifestyle habits can have a tremendous effect on obtaining long-term cost-savings in dental care.

Many of us in the dental profession have seen the excitement of some policymakers who tend to regard sealants and fluoride varnishes as "**the solution**" to dental access problems within the Medicaid population. While the future of dentistry is bright and the promise of reductions in dental disease exciting, current preventive services can be successful only if accompanied by healthy diet, regular oral health care habits and regular examinations. Specifically for at risk populations, a dental home must be established in order to

ensure follow-up care, retention of sealants and continuous education. For sealants to be most effective, they should be applied after diagnosis, in an environment that assures isolation and reexamination on a regular basis so that failure is detected before serious consequences occur.

In order for real progress to be made towards solving the State's Medicaid access problem, an additional financial investment needs to be made by the State. The 2003 Dental Workforce survey, conducted by the Department of Health and Family Services, indicates that 94% of Wisconsin's licensed dentists are able to accept new patients into their practice. Wisconsin dentists have the capacity to increase their current patient load; however, inadequate funding of the State's Medicaid program means that most dentists have been forced to limit their Medicaid population because the program is simply economically infeasible. For an example, dentists receive anywhere from 40-45% of their fee from the state's Medicaid program; with an average office overhead (which doesn't include any salary for the dentist) of between 60-70%, dentists aren't even close to being able to cover their staffing and operation costs. It is important to note that dentists do give generously of their time and services. In 2005, WDA dentists donated over 2 million dollars in free care to over 14,000 patients. The State can not rely on charitable care to fulfill the oral health needs of the large number of people currently enrolled in the State's dental Medicaid program.

Unlike the medical model, dentists do not shift costs from one segment of the population to others with better coverage programs or more financial resources. If dentists were to shift costs from the under funded Medicaid program to private sector patients, the cost of dental care would increase to a level where private pay patients would have trouble justifying the expenditure of their discretionary dollars for services until the need for care became urgent. This would lead: (1) to the delay of routine restorative and preventive dental care for many private sector patients, likely meaning that the services they would eventually require would be more complex and costly; and (2) to decreasing the number of private sector patients to whom the costs for the under-funded Medicaid program could be shifted. This could result in a negative spiraling effect where more and more private pay patients would delay dental care to avoid the added expense from cost-shifting, eventually requiring more costly services, and ultimately leading either to uncontrolled cost increases (like we are seeing in the medical cost-shifting model) or to the collapse of a system unable to sustain itself primarily on payments from private pay patients in need of emergency dental care.

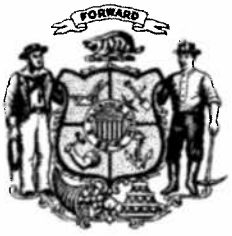
Instead of encouraging dentists to cost shift, as many public advocacy groups have done, the (WDA) recommends that the State fund reimbursement for dental procedures at the 75th percentile of the most recent American Dental Association (ADA) fee survey for our region of the nation. This has been a proven solution in states where this level of funding has been adopted.

Furthermore, the WDA has pushed for the introduction of 2005 AB 1198, "Two Cents for Tooth Sense," which would implement a soda purchasing fee equivalent to two cents per twelve-ounce can of soda, with the revenues being set aside in a dental Medicaid trust fund to support an increase in the reimbursement rates to the 75th percentile. As previously stated, there is a strong connection between poor oral health and excessive soda consumption, establishing a legitimate basis for earmarking soda-fee revenues for the specific purpose of improving access to dental care under the State's Medicaid program. I encourage those of you who are worried about the oral health care status of the Medicaid population to support AB 1198 and provide Wisconsin's Medicaid enrollees with the necessary access to the types of dental services they actually need, not simply random applications of sealants and fluoride varnishes.

As state legislators, I hope you will recognize that the dental profession has been successful in achieving cost-savings for consumers by promoting community water fluoridation initiatives as well as by working to educate the public on the importance of moderating their consumption of soda, taking care of their own oral health at home, and routinely visiting a dentist. To improve the oral health of Medicaid enrollees, we recommend that the State make a meaningful investment in the dental Medicaid program which, along with reimbursement rate increases, could include a comprehensive oral health awareness effort to educate all ages of Medicaid enrollees on the importance of being responsible for implementing healthy dietary and dental hygiene habits at home. As has been proven by thousands of young Wisconsin adults who have never experienced a dental cavity, true dental prevention and cost-savings require a more comprehensive approach than simply providing sporadic access to a couple of well-known preventive services that should, in any event, be applied only after a dental diagnosis determines whether they are appropriate to the condition of any given patient.

We hope that the State legislature does its best to implement a comprehensive approach to ensure that more patients are aware of the necessity of taking ownership in maintaining their own oral health and that all individuals have access to a dental home where a broad array of dental services are available. If greater numbers of patients learn to value their own role in preventing dental disease and if the state policies can encourage the concept of establishing a "dental home" for patients, then true long-term cost-savings can be realized by a much wider portion of our population in the future. Thank you for your time and attention. I would be happy to answer any questions you might have.

WISCONSIN STATE LEGISLATURE



Stegall, Jennifer

From: Malszycki, Marcie
Sent: Tuesday, May 16, 2006 8:23 AM
To: Stegall, Jennifer
Subject: FW: Testimony

Attachments: Healthcare_forum.doc; ATT1199919.txt


Healthcare_forum.doc (24 KB)


ATT1199919.txt (64 B)

CR email

-----Original Message-----
From: Breisch [mailto:breischf@uwstout.edu]
Sent: Monday, May 15, 2006 9:56 AM
To: Sen.Roessler
Subject: Testimony

Dear Senator Roessler,

Thank you for holding a forum on Health Care Reform in Eau Claire.

I did not have written testimony when I spoke, but had an opportunity to put together key points since that time.

I would appreciate it if you would share the attached written testimony with the rest of the members of your committee.

Thanks,
Margaret Breisch
Menomonie Area School Board member
N6820 539 st.
Menomonie WI 54751
715-235-7124

TO: Select Committee on Health Care Reform
Senator Carol Roessler, Chair

FROM: Margaret Breisch
School Board Member, Menomonie Area School District
N6820 539 St
Menomonie WI 54751

SUBJECT: May 11 2006 Health Care Reform Forum / follow-up testimony

Thank you for holding a hearing on Health Care Reform in Eau Claire. Unfortunately, I did not have time to prepare written testimony prior to your hearing. I was less prepared to speak than I would have preferred. Let me take this opportunity to highlight some key points.

1) Many excellent ideas were presented related to reducing costs. However, even if all ideas were adopted and we were able to reduce costs by 50%, we still face the challenge of keeping up with the cost of advancements in technology. Unless the increases in costs can be limited to increases in income, a 50% reduction in costs only provides a few years relief after which we are back into the same situation we face today.
2) One factor that drives up the cost of health care is the "value added" component. Advances in medical procedures provide new opportunities for services. If a new procedure is developed that can save a life of a loved one, we want the procedure to be available for that loved one, regardless of cost. We need determine the answer to questions centered on what medical procedures constitute basic rights of all. We then need to design a plan to ensure all have access to those basic rights.
3) Many at the hearing spoke of cost shifting. When I spoke, I emphasized the circular nature of the problem: The underinsured and uninsured shift costs to the insured that raises premiums which makes health insurance premiums even less affordable which increases the number of underinsured and uninsured which creates and even larger cost shift that makes health insurance premiums even more unaffordable.
4) I commented that 67% of our teachers enroll in the family health insurance plan. If there was more equity between the health insurance packages of the public sector and the private sector, we would expect only about 50% of working families to take the insurance plan of our school district. Possibly the Legislative Fiscal Bureau could do a cost analysis of the savings that could be recognized by the state if only 50% of the working couples took insurance through the public employer. It would give us a rough idea of how many dollars would be available to subsidize a system that ensures all receive basic coverage.
5) I believe most businesses that offer health insurance plans spend about 15% of their payroll on health insurance premiums. The state may be able to save a tremendous number of dollars if they could create incentives that would reduce the number of public employees taking health insurance through the state rather

than through their spouse's employer. If those dollars were combined with dollars already being spent on health care entitlement programs, along with a payroll tax, we may be able to fund a single payer system. I do not know what the payroll tax would need to be. However, if most businesses are already paying 15% of their payroll on health insurance, they would be coming out ahead if we could run a program on a 6% payroll tax.

6) I shared with you that I believed our clinics and hospitals should not be for profit because then the focus would be on serving the stockholders rather than serving the patients.
7) I shared with you that I believed employers need to do a better job educating their employees about the value of benefits. It needs to be understood that a $15,000 benefit is actually better than $15,000 in salary due to the tax break and lower costs that come from group buying power. When employees do not understand this, it often results in low morale when more and more of their earnings come in the form of benefits rather than salary.
8) I shared with you that our school district's health insurance costs are higher than our special education costs. Also, our health insurance costs are rising at a faster rate than our special education costs.
9) I shared with you that we cannot afford to put off plans to address the affordability of health insurance due to the cost of providing early retirement benefits for teachers. The plans saved many taxpayer dollars when implemented in the late 1970's. However, the cost of providing health insurance to early retirees only amounted to about 10% of a starting teacher's salary. Now the cost is closer to 45% of a starting teacher's salary. Increases in the cost savings are tied to increases in the salary schedule (about 2% per year), while increases in the cost of providing the benefit is tied to increases in health insurance costs. The plans have become unsustainable because the cost increases do not fall under the Qualified Economic Offer (QEO) and must be funded within revenue limits.
10) According to The Coalition for Wisconsin Health, "Between 1970 and 1996, the number of health administrators increased more than 20 fold, while the number of physicians and other clinical personnel increases about 2 ½ fold." My sense is that costs would go down considerably if there were less plans to administrator.
11) I support a single payer healthcare system.