☞ **05hr_SSC-HCR_Misc_pt17**

☞ Details: Hearing held in Madison, Wisconsin on June 16, 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)

June 16, 2006
Senate Select Committee on Health Care Reform
Testimony by Tom Korpady on Behalf of the Department of Employee Trust Funds

Under the direction of the State of Wisconsin Group Insurance Board, the Department administers health insurance programs that cover approximately 230,000 state and local government employees, retirees, and their beneficiaries. This health coverage is offered through 16 different insured plans and two self-insured plans. Annual premium exceeds one billion dollars per year, making the program the largest non-federal health program in the state.

The program is divided into two separate plans, the State employee group health program, which covers all state and university employees and retirees, and the Wisconsin Public Employer (WPE) program, which is optionally available to local government employers in the state that participate in the Wisconsin Retirement System. Currently over 340 local governments participate in the WPE, many of which are very small employers.

The State of Wisconsin Employee Group Health Benefit Program has taken a different approach to value purchasing and pay for performance. Building on a successful managed competition approach in effect since 1984, the Group Insurance Board (Board) redesigned the program to incorporate pay for performance techniques while maintaining the value added by the participating health plans. In response to calls for greater employee participation in the cost of their health care, the Board developed a three-tier employee contribution system, carved out coverage for prescription drugs and consolidated the program's huge purchasing power, and created a reward system for health plans that delivered exceptionally high quality care.

The three-tier employee contribution system was developed to address several problems that existed under the old method of determining the employee's share of premium. For almost 20 years, the State would pay up to 105% of the low cost health plan in each county. While this system did create some competition between the plans, it led to some unintended problems. Since the employer contribution was tied to 105% of the low cost plan, plans that bid within 5% of the low cost plan were shielded from the consequences of their bids, because the employee's out of pocket cost would not vary. Therefore, plans strove not to be the low cost plan, but rather to target their bids at 5% above what they estimated the low cost bid would be. This created a situation of shadow pricing that tended to drive up premiums higher than necessary.

The system also failed to account for differences in the risks faced by the participating plans. Plans that could attract a younger and healthier population could easily keep their premiums low, regardless of how efficient they were at delivering care. Plans that attracted older or higher cost enrollees could not compete, even if they delivered care very efficiently.

The Board had, for years, collected HEDIS (Health plan Employer Data Information Set) quality measures from all of the participation health plans. But it did not have a way to reward plans for very high performance under the old premium contribution formula. The HEDIS results were published annually in the Dual Choice Enrollment Booklets, but there was little evidence that members took these measures into account when they made their enrollment decisions.

The new three-tier system has addressed these problems. Under this new system, plans are placed in one of three tiers, and the employee's share of premium varies according to that tier placement. Plans in Tier 1 cost the employee the least; plans in Tier 2 cost the employee more, while plans in Tier 3 cost the employee the most. Plans have a strong incentive to be placed in Tier 1 so as to attract the most enrollees.

Each year, the Board collects from each plan detailed cost and utilization data prior to the plan's bid submission. The Board's actuary evaluates this data, and using the demographics of each plan, and a sophisticated risk adjustment system, compares how cost effectively each plan delivers health care. Because of this risk adjustment, the comparison is accurate, and plans do not benefit by having a younger or healthier population. The plans are then placed in one of three tiers; The most cost effective plans are placed in Tier 1, moderately cost effective plans are placed in Tier 2, and the least cost effective plans are placed in Tier 3.

If the plans' subsequent premium bids match their data submissions, their placement in the tiers remains. If the plans bid higher or lower than their data submissions, their tier placement is adjusted accordingly. Also at this point, plans that have very high quality results are given credit. A plan that may have been originally placed in Tier 2 but had very high HEDIS scores could move into Tier 1. At this point, plans in Tiers 2 and 3 are called in for negotiations.

During the negotiation process, the Board's staff and the actuary reviews the data submission with plan representatives. Areas where the plan may be less cost-effective are identified and quantified. In some cases, plans may be paying very high physician charges, or may have longer average lengths of stay. Plans are advised of specific areas where savings could be achieved based upon the performance of their peers. Finally, each plan is advised of the specific dollar amount that they must reduce their premium in order to be placed in a lower tier. Plans are then given the opportunity to submit a final bid.

This new system has proven to be very effective. Savings from the negotiation process this past year were in excess of $14.5 million.

The other major strategy in the Board's new approach involved changing the way prescription drugs were purchased. In previous years, each plan was responsible for managing and covering prescription drugs. Based on the actuary's analysis of their data, some plans did this very effectively, while others did not do as well. Since prescription drug costs are one of the fastest rising components of health care, the Board felt this area offered a real opportunity for savings. The Board carved the drug coverage out of the

plans and consolidated it under one Pharmacy Benefits Manager (PBM). The PBM that was chosen, Navitus Health Solutions, is a Wisconsin company that was specifically created to respond to the Board's needs. The Board wanted to emphasize quality and safety first, while obtaining the drugs at the lowest net drug spend. The Board demanded complete transparency in all financial transactions with the drug manufacturers and that all rebates and savings from discounts were to be passed through to the plan. This allowed the Board to avoid the misaligned incentives that have been inherent in the more traditional PBM industry.

The new PBM created a Pharmaceutical and Therapeutics (P&T) committee comprised of practicing pharmacists and physicians from all across Wisconsin. This P&T committee developed a formulary of preferred drugs by first deciding on the absolute best drugs in each class. Once those 'best in class' drugs were chosen, the prices were considered and final formulary selections were made.

In order to encourage state employee members to support this formulary, the Board changed the drug benefit under the program from a two-level co-pay structure to a three-level co-pay structure. The first level, comprised mostly of low cost generics, cost $5 per script, the second level, comprised mostly of formulary name brand drugs, cost the member $15 per script, while the third level was comprised of non-formulary drugs, and cost the member $35 per script.

The results from this new PBM initiative have been successful beyond the most optimistic projections. In the first two years, tens of millions of dollars have been saved, and for Plan Year 2005, the State employee plan actually spent over 6% less than it did in Plan Year 2003.

The cumulative results from each of these initiatives have been very encouraging. While most employers are facing double-digit increases in the cost of their health insurance, the State has seen increases of less than 7.5% for the past two years. The premiums for retired State employees actually went down by over 6% last year. At the same time, benefit levels have been maintained and high quality and safety have been encouraged and rewarded.

The Board has been very supportive of wellness and disease management activities, demanding that its health plan partners strive for the highest quality of care, and financially rewarding plans that achieve excellent outcomes. The results are measurable, and reported annually in our Dual Choice Brochure. Remarkably, in almost every category of wellness and disease management, our health plans exceed the national averages. In past years, we have focused on diabetes care, and our plans result in those categories exceed national averages by substantial margins.

In addition, many of our plans offer other wellness benefits, including nurse hotlines, smoking cessation programs, fitness benefits and targeted disease management programs.


FORWARD

WISCONSIN ASSOCIATION OF
HEALTH UNDERWRITERS
Wisconsin's Benefit Specialists

Senate Select Committee on Health Care Reform

Public Hearing

Testimony of Dan Schwartzer

June 16, 2006

We would like to thank the Co-Chairs and the members of the Senate Select Committee on Health Care Reform for allowing us to speak and provide written comment to your committee on this extremely important topic. My name is Dan Schwartzer and I'm here today representing the Wisconsin Association of Health Underwriters (WAHU). We are a trade association made up of insurance agents, brokers and consultants who work directly with your constituents – the individuals, employers and employees – in the financing of their health care. You had the opportunity to meet two of our members who testified before this very committee. Jon Rauser, who is our 2006 State President, spoke to you at the Milwaukee Public Hearing and Chris Lokken, who is our North Central Chapter President, spoke to you at the Eau Claire Public Hearing.

I hope you were able to see the unique perspective and broad knowledge base they are able to bring to this health care reform debate. Like Chris and Jon, those who work in the health care financing industry are highly educated and extensively trained professionals. They have at least their Bachelors Degree and many have Masters Degrees. Some have law degrees, some are actuaries, and many are certified as Registered Health Underwriters and/or Certified Employee Benefit Specialists. To be successful in this industry, the agent/broker/consultant needs to have extensive knowledge of every single aspect of the health care financing industry – from underwriting, claims administration, rating, state and federal insurance laws, HIPAA and COBRA laws, ERISA laws, to state and federal regulations affecting the industry.

Prior to lobbying and representing the Health Underwriters, I spent 17 years in the health care financing industry – from an agent specializing in the small group market, to a benefits consultant dealing primarily with mid to large groups in the self-funded market, to serving as the Regional Director for (then) Wisconsin's largest PPO and Utilization Management firm. Although I am no longer active in this industry, to this day, I am still a licensed intermediary and complete 12 hours of continuing education each year.

It is with our experience, education, and broad knowledge of the health care financing industry that we provide our testimony on health care reform in Wisconsin. Please do not hesitate to contact us if you would like more information or if you have questions regarding our presentation.

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608-268-0200 • Fax 608-241-7790 • www.eWAHU.org

Health Care Reform

Choosing Private Market Solutions over Government Control

Dan Schwartzer

WISCONSIN ASSOCIATION OF HEALTH UNDERWRITERS

Wisconsin's Benefit Specialists

The Problem

- **Health Care Costs**

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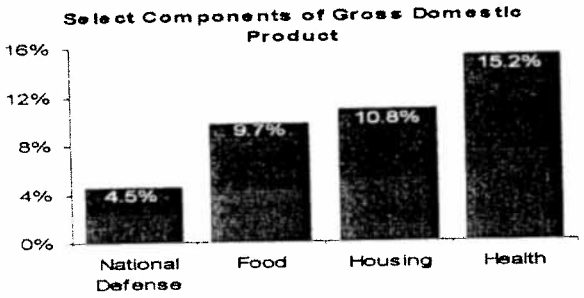
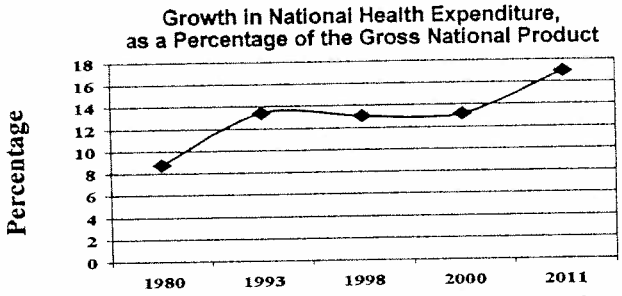
Health Care Cost Crisis



Source:" Health Affairs February 7, 2003.
&
U S Department of Commerce Bureau of Economic Analysis. July 30, 2004.



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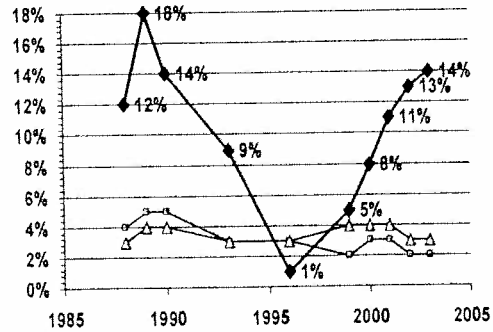
Source: Centers For Disease Control

America is at a crossroad

Health care costs are rising . . .

Employer-based health insurance premiums, overall inflation, worker earnings



Source: EMPLOYER HEALTH BENEFITS 2003 ANNUAL SURVEY. The Kaiser Family Foundation and Health Research and Educational Trust.

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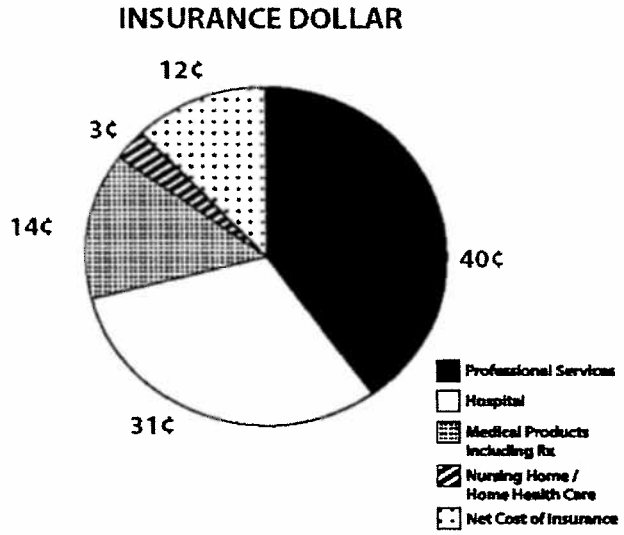
Out of each dollar collected for insurance, 88 cents pays for health benefits—primarily payments for hospitals, doctors, and pharmaceuticals.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Causes

- Components Certainly Include:
  - Reimbursement Rates from Medicaid
  - Tort Reform
  - Aging Population
  - Advanced Technologies
  - Cost Shifting from the Uninsured
  - Shift in Bargaining Power to Providers
  - Government Interference (Mandates)
  - Market Consolidation of Providers & Payers
- But, these are not the root of the cause

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The Root

"The essential problem with the health care industry is that is has been shielded from consumer control — by employers, insurers, and the government."

Regina Herzlinger

- ▶Bachelor's Degree from MIT.
- ▶Doctorate from the Harvard Business School.
- ▶Nancy R. McPherson Professor of Business Administration Chair at the Harvard Business School

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The Root

"The major culprit in the seemingly endless rise in health care costs is found to be the removal of the patient as a major participant in the financial and medical choices that are currently being made by others in the name of the patient."

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Continued

"Patients overuse medical resources since those resources appear to be free or almost free. Producers of medical equipment create new and more expensive devices, even if they are of only marginal benefit, since third-party payers create a guaranteed market. Attempts to rein in those costs have led to a blizzard of paperwork but proven ineffective in controlling costs."

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CATO Policy Analysis No. 211

Completed by:

Stan Liebowitz – Professor of Managerial Economics in the Management School of the University of Texas at Dallas

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3 Major Categories of Excess Costs

- Unnecessary Administrative and Paperwork Costs
- Fear of Malpractice Suits
- But, the Largest Component of Excess Cost **OVERUSE OF MEDICAL RESOURCES**

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Micro Example

- Prescription Drug Costs
- From 1965 to 1990, one of the most stable components of health care
- GNP rose 194%
- Rx Drugs rose relatively close at 250%
  - By Contrast, Hospital Expense rose nearly 500%

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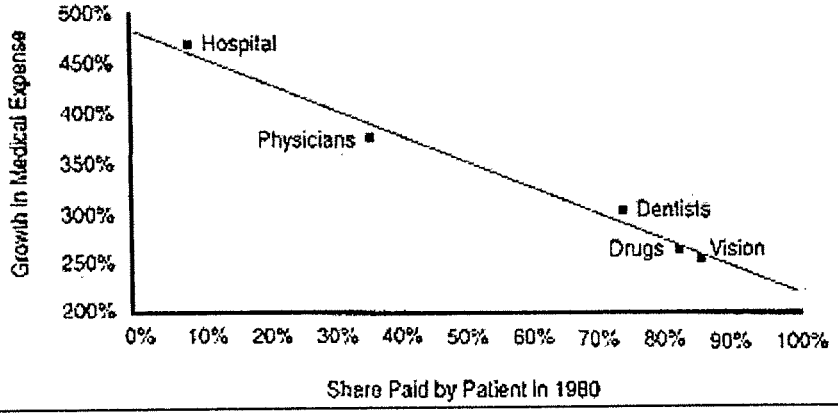
Prior to 1990, drugs were typically paid by patients, who later submitted a claim form to their insurer for partial reimbursement.

Figure 8
Growth of Third-Party Payment and Expenditure



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Why the Increase in Rx Drug Costs?

In the early 90's, health plans changed to the Prescription Drug Card

The Result.....

Buy any drug for ONLY 8 quarters!

PBM Created

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The Removal of the Patient from Payment

- Even though the employee's dollar contribution to health insurance has gone up slightly over the last decade, the employee's share of the total health insurance premium has steadily declined...

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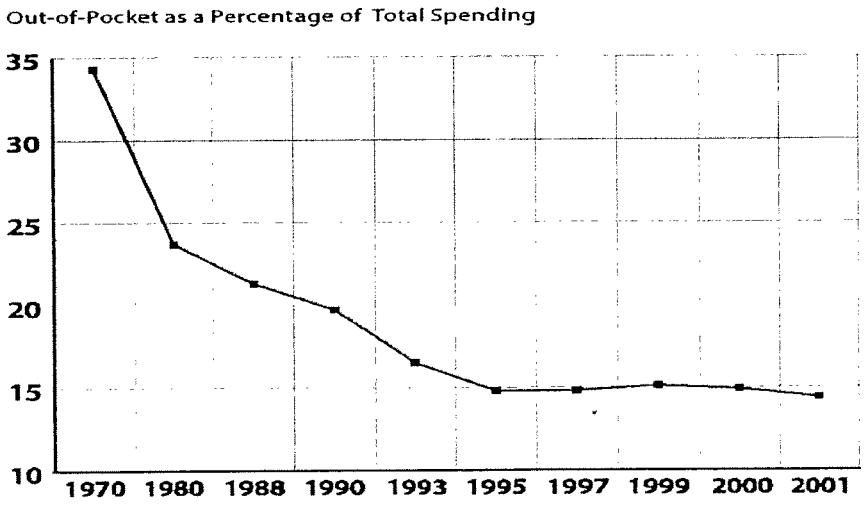
and the employee's out-of-pocket spending for health care services is near a historic low point.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group.

Comparison of Then and Now

- 1983 Traditional Health Plan
  - Average Deductible $200
  - Average Co-Insurance 80%
  - Average Out of Pocket Max $2200
- 2003 HMO Plan
  - Average Deductible $0
  - Average Co-Insurance 90%
  - Average Out of Pocket Max $2,900

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The Solution

- Begin to reduce the share of third party payments
- Give consumers control over their health care decisions and the cost of their health care
- Give providers a reason to be concerned with the cost of the care they deliver
- Embrace Consumer Driven Health Care

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Consumer Driven Health Care:

1. A health care design, program, or system under which the member has a significant personal stake in the outcomes of their health care decisions.

2. "Anything that engages the end user by providing choice, information and... consequences."

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Consumer Driven Health Care:

Plan Design/ Benefit Choice:

- Health Flexible Spending Accounts (FSA)
- Health Reimbursement Arrangements (HRA)
- Health Savings Accounts (HSA + "Qualified" HDHP)

Information/ Employee Education

Wellness

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Cost Shifting vs. CDHP

- Cost Shifting only addresses the issue of premium increases
- Health Insurance is expensive because of Health Care
- If the problem with the cost of health insurance today is the cost of health care; why is it that the traditional "solutions" only have focused on shifting the increased cost to the employee?
- To be successful, we must focus on the cause of the of these cost increases, not the result.

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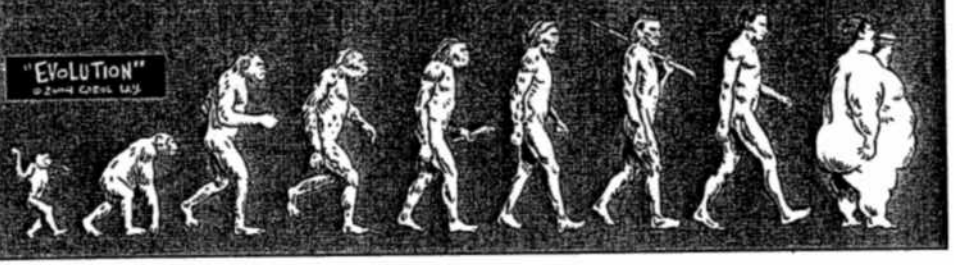
Annual Out-of-Pocket Limits, 2004

	Lowest Offered	Highest Offered	Average Purchased
Indemnity			
Single	$900	$13,000	$2,780
Family	$900	$13,000	$4,075
HSA			
Single	$1,000	$5,700	$2,483
Family	$2,000	$10,000	$4,758
PPO			
Single	$250	$15,000	$3,873
Family	$250	$20,000	$3,616
HMO			
Single	$500	$3,000	$2,906
Family	$500	$3,000	$2,920

Source: America's Health Insurance Plans

Americans are not living healthy

- Today, chronic diseases—such as cardiovascular disease (primarily heart disease and stroke), cancer, and diabetes—are among the most prevalent, costly, and of all health problems.
- Chronic diseases account for 70% of all deaths in the United States.
- More than 90 million Americans live with chronic illnesses.
- The medical costs for chronic diseases (most of which are caused by high-risk behaviors) account for 60% of the nation's $1.4 trillion cost for medical care.



Private Market Solutions v. Government Solutions

- Private Market
  - Adoption of Consumer Driven Plans
  - Introduction of Wellness Plans
  - Transparency Initiatives
- Government
  - Focus on Access to Insurance
  - Focus on Financing Mechanisms
  - Rationing of Health Care

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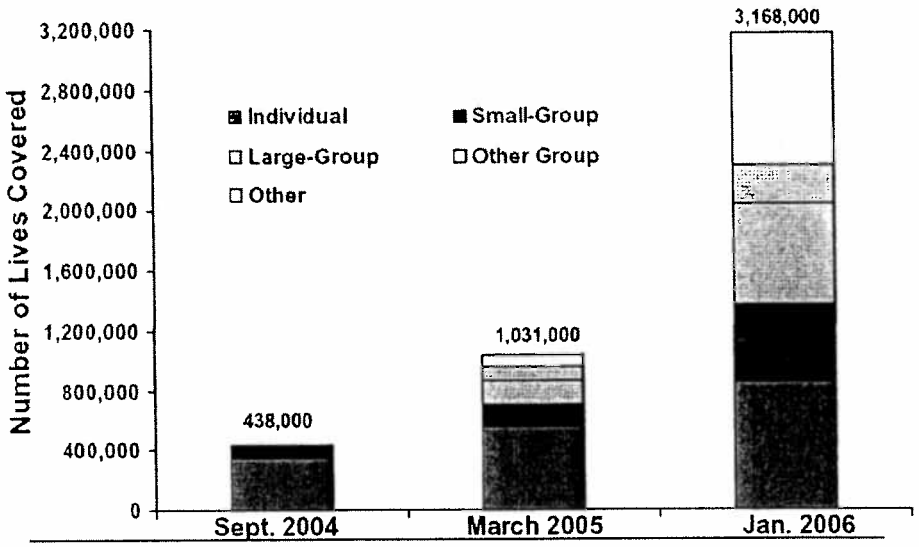
Growth of HSA/HDHP Enrollment from September 2004 to January 2006

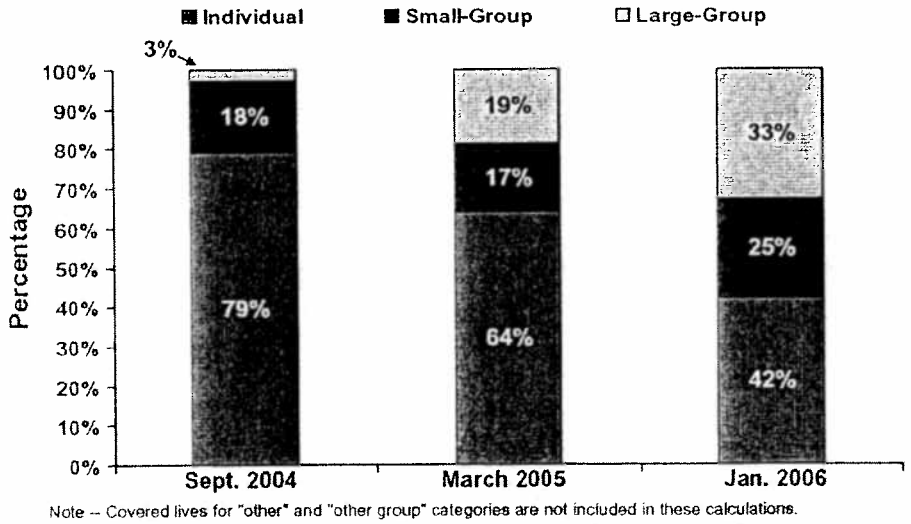
AHIP Center for Policy and Research



Data as of January 2006

Percentage of Lives Covered by HSA/HDHPs, by Market Type

AHIP Center for Policy and Research



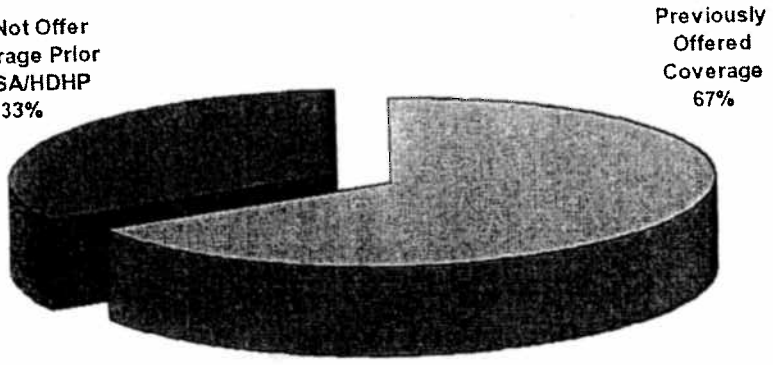
Note -- Covered lives for "other" and "other group" categories are not included in these calculations.

Data as of January 2006

Percentage of HSA/HDHP Policies Purchased by Companies that Previously Did Not Offer Coverage

AHIP Center for Policy and Research

Small-Group Market



Note – Companies responding to this question reported HSA/HDHP enrollment of 209,000 lives in the small-group market.

Data as of January 2006

Myth versus Fact

- HSA's are not just for the wealthy
  - Nearly half of the enrollees have combined family incomes of less than $50,000
- HSA's are not just for the young and healthy
  - The illustration shows all benefit from HSA's regardless of health conditions.
- HSA's do not promote adverse risk
  - Even with different deductibles, the risk remains combined in one pool.
- HSA's do not prevent consumers from getting health care
  - Preventative Care Encouraged

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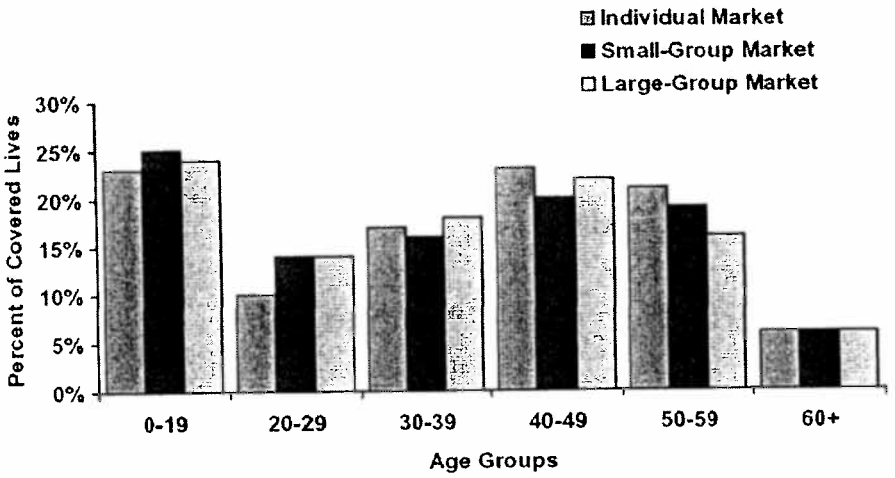
Age Distribution of People Covered by an HSA/HDHPs, All Markets

AHIP Center for Policy and Research



Data as of January 2006

'Traditional' vs. 'HSA':
A Benefit Comparison

Deductible	$250 (x 3 per family)	$2,000 ($4,000 per family)
Coinsurance (Employee cost)	80% (x 2 per family) (20% of $12,500)	100%
Doctor Office Visits/ Routine Care	$25 Copay then 100%	Deductible then 100% Unlimited first dollar coverage for preventive
Physician Services – Other	Deductible then 80%	Deductible then 100%
Hospital	Deductible then 80%	Deductible then 100%
Prescription Drug	$10 / $25 / $50	Deductible then 100%
Maximum Out of Pocket	$2,750/ $5,750 (+ Copays)	$2,000/ $4,000
Lifetime Maximum	$5,000,000	$5,000,000

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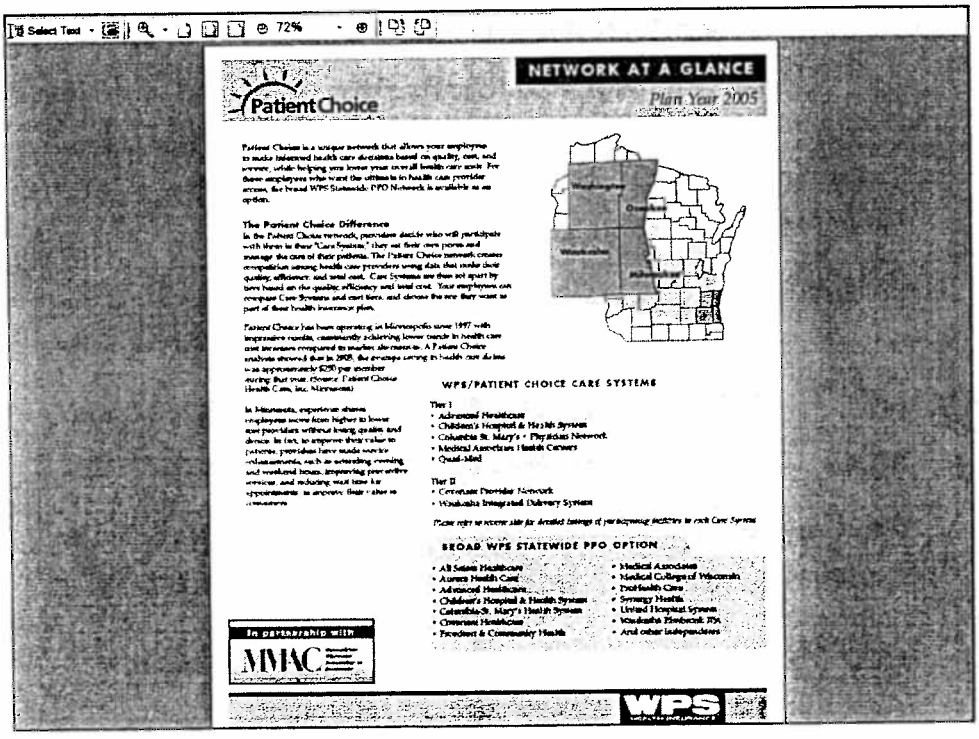
HSA Example	$250 Deductible	$2,000 HSA Plan
33 Year Old Couple with 1 Child	$10,500	$5,400
$4,000 Annual Claims		
OP Expense	$1,000	$4,000
Total Cost	$11,500	$9,400
Net Savings		$2,100[31]



Empowering Consumers

- With Patient Choice, you and each of your family members select a "Care System"—a group of primary care physicians, specialists, hospitals, and other health care professionals and facilities that offer a full range of covered services.
- A Care System Comparison Guide then provides information to help you evaluate these Care Systems across a variety of cost, quality, and service factors, so that you can choose the Care System that's right for you.

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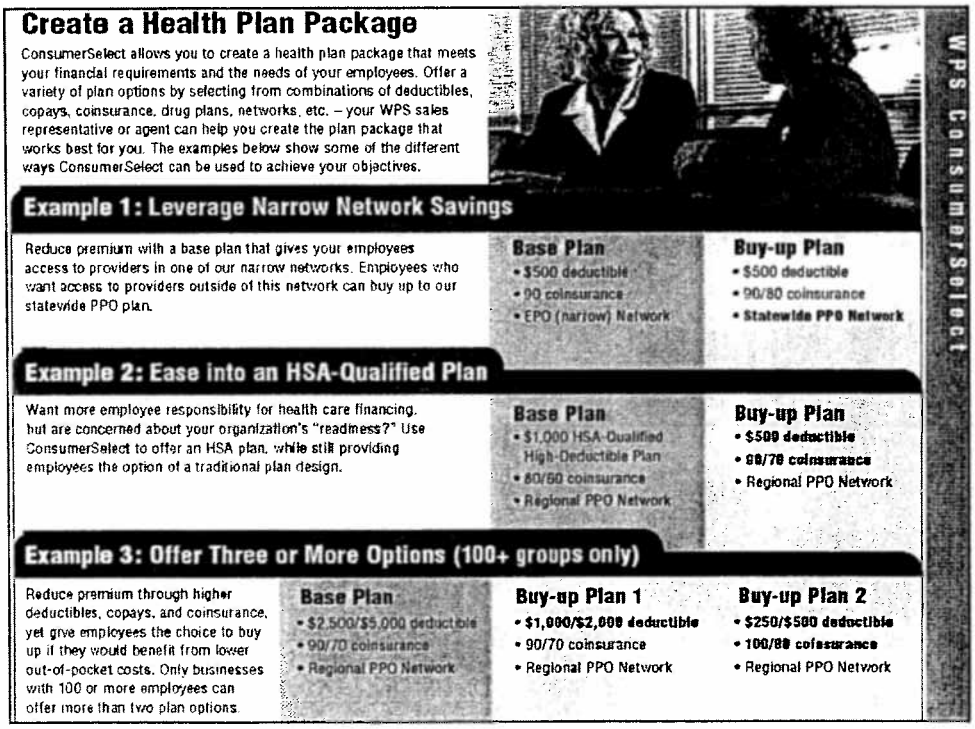

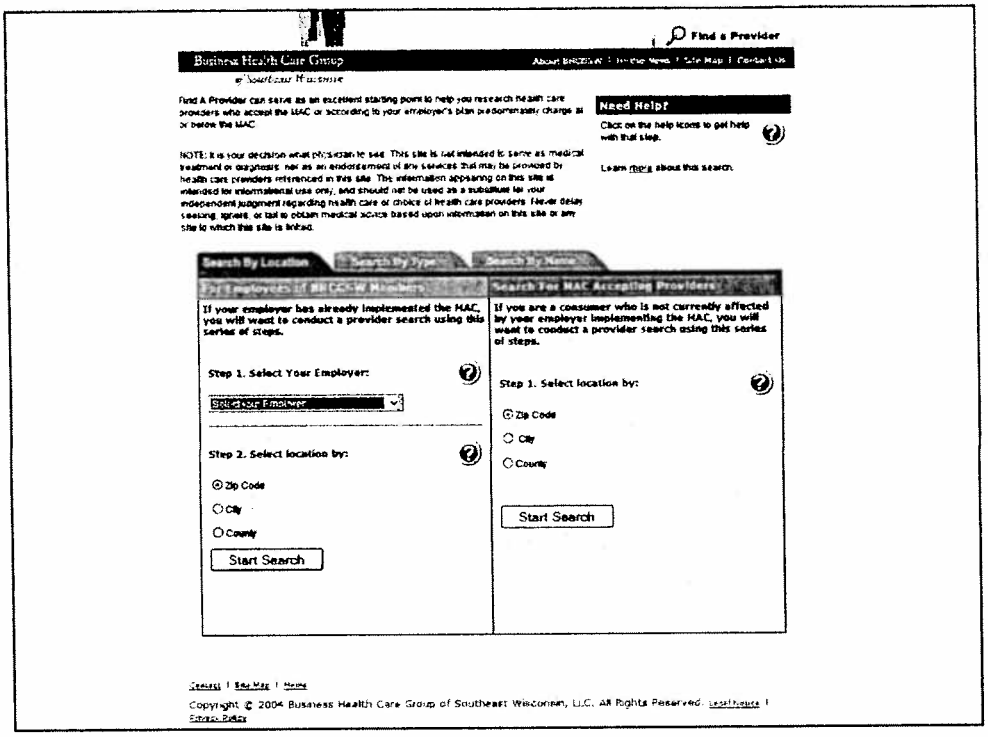
Find a Provider
Business Health Care Group
Need Help!
Search By Location
Search For MAC Accepting Providers
If your employer has already implemented the MAC, you will want to conduct a provider search using this series of steps.
Step 1. Select Your Employer:
Step 2. Select location by:
Zip Code
City
County
Start Search
If you are a consumer who is not currently affected by your employer implementing the MAC, you will want to conduct a provider search using this series of steps.
Step 1. Select location by:
Zip Code
City
County
Start Search
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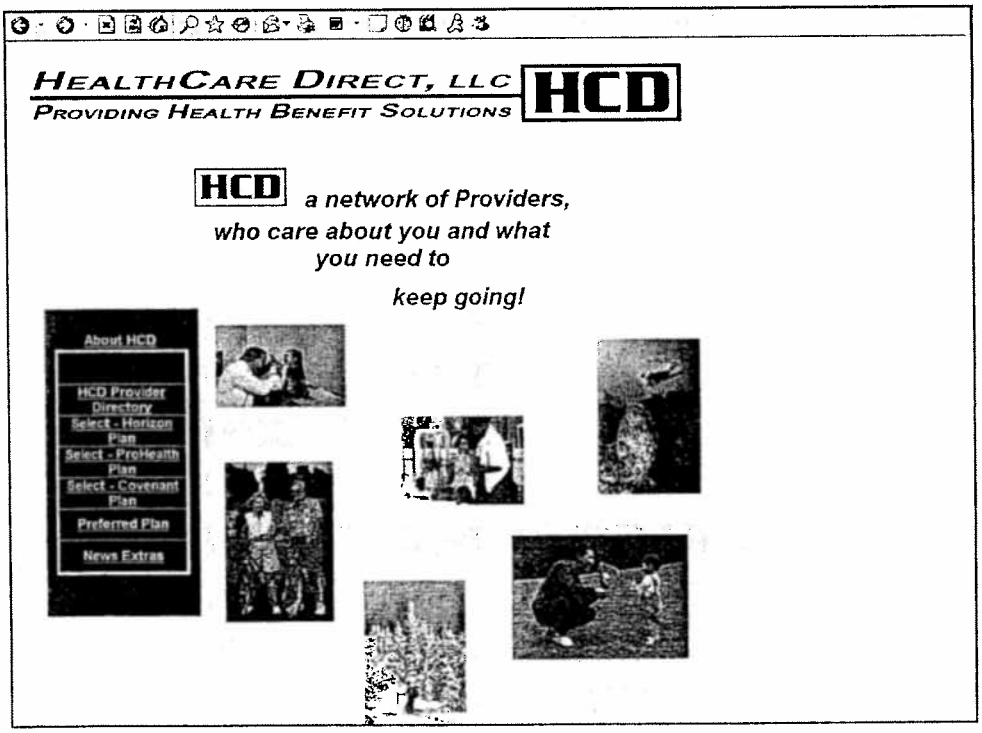
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PROVIDING HEALTH BENEFIT SOLUTIONS
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About HCD
HCD Provider Directory
Select - Horizon Plan
Select - ProHealth Plan
Select - Covenant Plan
Preferred Plan
News Extras

HealthCare Direct Brings You Real Price Transparency and Predictable Employee Benefit Costs

The HealthCare Direct Scheduled Benefit Plan uses 26 Diagnostic Related Groupings, "DRGs". These US Government defined DRGs represent 55% of the average client's annual inpatient hospitalization costs. HCD has negotiated with ProHealth and Columbia/St. Mary's, both efficient high quality hospital systems, to accept these DRG amounts as payment in full until 2008. As the schedule below shows, they increase by only 5% per year.

		Scheduled Allowables and Time Periods		
DRG	DRG Description	10/1/2005 thru 9/30/2006	10/1/2006 thru 9/30/2007	10/1/2007 thru 12/31/2007
527	Implant of Drug-Coated Stent without Heart Attack	$22,439	$23,560	$24,738
526	Implant of Drug Coated Stent with Heart Attack	$25,909	$27,204	$28,564
518	Percutaneous Cardiovascular Procedure without Coronary Artery Stent or Heart Attack	$24,864	$26,107	$27,413
517	Implant of Standard Stent without Heart Attack	$21,000	$22,050	$23,153
516	Implant of Standard Stent with Heart Attack	$25,778	$27,066	$28,420
500	Back and Neck Procedures Except Spinal Fusion, without Complications	$10,479	$11,003	$11,553
498	Spinal Fusion Except Cervical without Complications	$30,377	$31,895	$33,490
497	Spinal Fusion Except Cervical with Complications	$36,960	$38,808	$40,748
494	Laparoscopic Cholecystectomy without C.D.E. without Complications	$14,280	$14,994	$15,744
471	Bilateral or Multiple Major Joint Procedures of Lower Extremity	$34,020	$35,721	$37,507
391	Normal Newborn	$1,155	$1,213	$1,273
373	Uncomplicated Vaginal Delivery	$4,358	$4,575	$4,804
371	Uncomplicated Cesarean Section	$6,458	$6,780	$7,119
359	Uterine & Adnexa Procedures for Non-malignancy without Complications	$10,080	$10,584	$11,113
335	Major Male Pelvic Procedures without Complications	$12,285	$12,899	$13,544
211	Other Hip and Thigh Bone Procedures, Adults, without Complications	$21,840	$22,932	$24,079
209	Major Hip, Knee, Ankle, Foot Surgery, Including Replacement	$26,859	$28,202	$29,612
174	G. I. Hemorrhage with Complications	$8,663	$9,096	$9,550
167	Appendectomy without Complicating Principal Diagnosis without Complications	$11,865	$12,458	$13,081
143	Chest Pain	$6,484	$6,808	$7,148

Sample Comparison of Hospital Costs

HCD
HealthCare Direct

HCD has negotiated guaranteed rates with ProHealth and Columbia/St. Mary's hospital systems. They increase by only 5% per year until 2008.

Charges for these three hospitals are based on Wisconsin Hospital Association data from the 4th quarter of 2004. The data has been increased 5% to account for cost inflation. PPO discounts are then applied as follows: St. Joseph at 25%, St. Lukes at 20%, and Froedtert Memorial at 22%.

DRG	DRG Description	HealthCare Direct negotiated guaranteed hospital fees through 9/30/2006	St. Joseph	St. Lukes	Froedtert Memorial Lutheran Hospital
526	Implant of Drug Coated Stent with Heart Attack	$25,909	$40,475	$41,517	$34,068
		Cost Difference:	56%	60%	31%
174	G. I. Hemorrhage with Complications	$8,663	$12,863	$17,161	$14,182
		Cost Difference:	48%	98%	64%
107	Heart Bypass Surgeries with Insertion of Cardiac Catheter	$47,597	$100,723	$70,127	$65,101
		Cost Difference:	112%	47%	37%
89	Simple Pneumonia, Adults, with Complications	$11,267	$12,093	$15,968	$10,560
		Cost Difference:	7%	42%	-6%
88	Chronic Obstructive Pulmonary Disease	$6,962	$9,089	$12,537	$7,699
		Cost Difference:	31%	80%	11%

Example of Scheduled Benefit Plan

	Hospital A (Participating)	Hospital B	Hospital C
Charge	$3,000	$4,000	$5,000
Schedule Limit	$3,000	$3,000	$3,000
Benefit	90%	90%	70%
Paid by Plan	$2,700	$2,700	$2,100
Paid by Employee	$300	$1,300	$2,900
Amount applied To out of pocket Maximum*	$300	$300	$900

Network Choices

- WPS' *Patient Choice* http://www.wpsic.com
- Business Health Care Group of Southeastern Wisconsin http://www.bhcgsw.org
- Healthcare Direct www.hcdnetwork.com
- Health EOS by MultiPlan www.healtheos.com
- Blue Cross Blue Shield www.bcbswi.com
- UnitedHealthcare https://www.geoaccess.com/uhc/po/Default.asp

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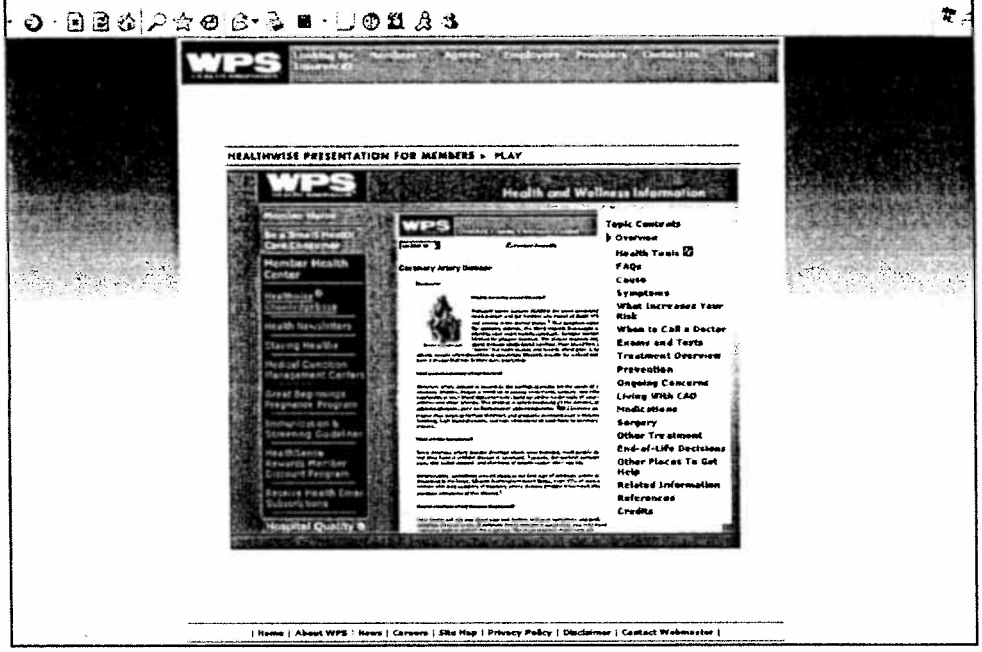
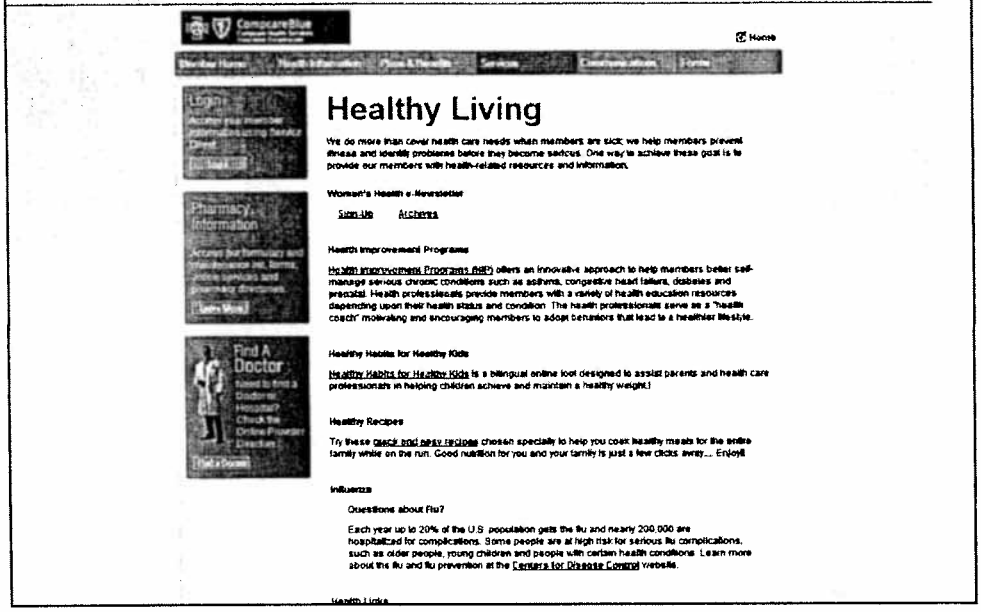
"Healthwise", Health Information - WPS

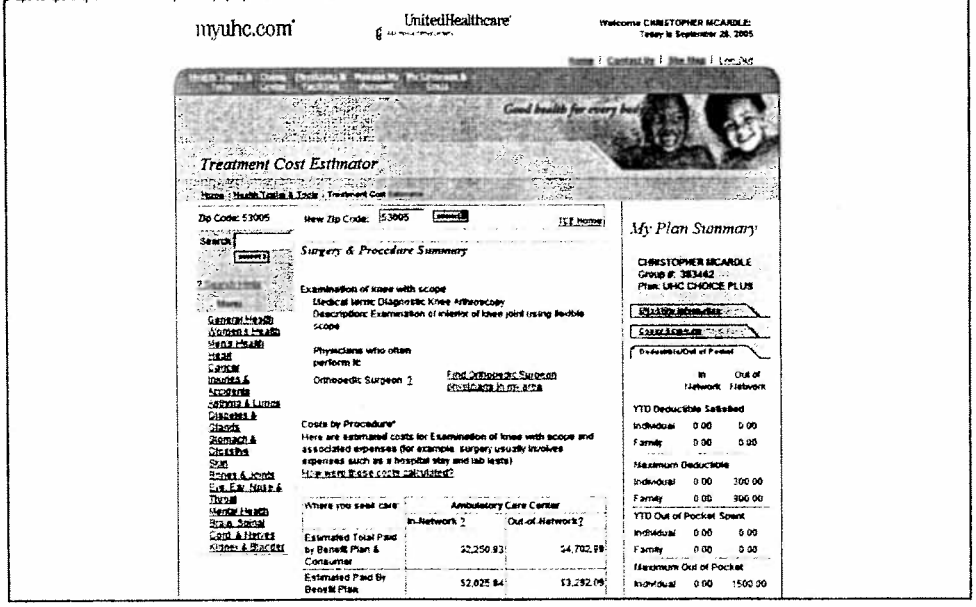


Coverage Information - Humana

Healthy Living (wellness) – Blue Cross Blue Shield



Treatment Cost Estimator - UnitedHealthcare



Transparency Initiatives

- Health Click Wisconsin
  - Collaborative for Health Care Quality
  - WHA's PricePoint
  - WHA's CheckPoint
- Wisconsin Health Information Organization

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Legislator's Dilemma

- It has taken decades to erode the free market components of our health care system
- It will take some time to get back to a true free market driven system
- Legislators have to answer to their constituents during the course of a two year legislative cycle.

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What Can Legislator's Do?

- Educate constituents on the real solution, but also the real timeline
- Don't be a barrier to market correction
- Begin to move public sector in the same direction as private sector
- Encourage expansion of CDHC & other true market reforms
- Keep the playing field level

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THANK YOU

- Questions?

- Dan Schwartzer
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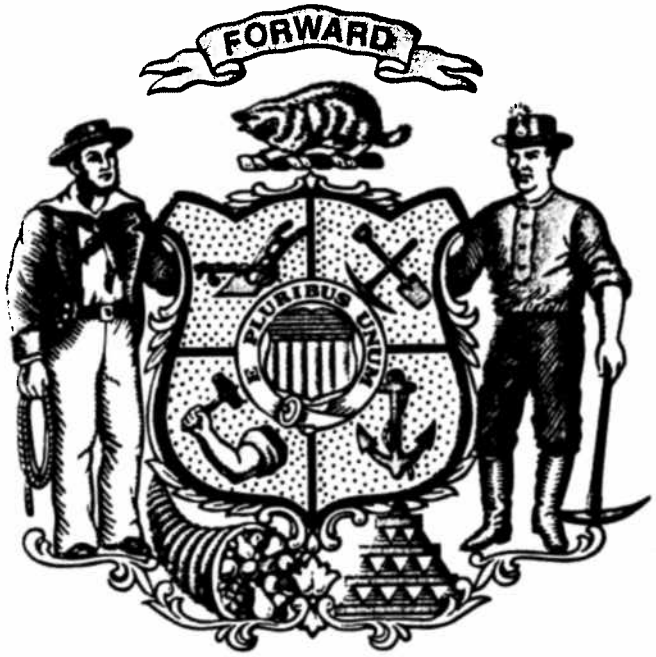
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Keep copy

Malszycki, Marcie

From: Dan Schwartzer [dan@ewahu.org]
Sent: Sunday, July 02, 2006 1:44 PM
To: Sen.Roessler; Sen.Darling; Sen.Olsen; Sen.Erpenbach; Sen.Miller
Subject: Additional Information

TO: Senate Select Committee on Health Care Reform Members
FROM: Dan Schwartzer

Sorry for the delay, but the following is the information I discussed during my testimony about the average premium increases for HSA's versus traditional plans. Thanks again for the opportunity to testify and if you have any questions, please do not hesitate to contact me.

Thanks.

Dan Schwartzer

Survey: Consumer-Driven Health Plan Cost Growth Significantly Slower Than Other Plans
Tuesday January 24, 10:30 am ET

WASHINGTON, Jan. 24 /PRNewswire/ -- The cost of health plans that encourage members to be better health care consumers grew at a significantly slower rate in 2005 than other types of plans, U.S. employers reported in a survey released today by the Deloitte Center for Health Solutions.

The cost of consumer-driven health plans -- such as health savings accounts or health reimbursement arrangements -- increased by an average of 2.8 percent from 2004 to 2005, according to the survey of 152 major U.S. employers. That compares to an 8 percent increase in total premiums for health maintenance organizations, an 8.5 percent increase for point-of-service plans and a 7.2 percent increase for preferred provider organizations. Traditional or indemnity plan costs increased 6.4 percent last year, according to the survey. The average for all types of plans was 7.3 percent.

"Employers are increasingly turning to consumer-driven health plans to reduce costs and help workers and their families make better health care decisions," said Tommy G. Thompson, the independent chairman of the Deloitte Center for Health Solutions. "Not only do companies protect their bottom lines, they help make employees better health consumers."

The survey also found that businesses are projecting similar rates of cost growth in 2006, including 2.6 percent for consumer-driven health plans, 7.4 percent for health maintenance organizations, 7.3 percent for point-of-service plans, 7.5 percent for preferred provider organizations, and 6.6 percent for traditional or indemnity plans. The average for all types of plans is projected to be 7.1 percent.

Not surprisingly, 40 percent employers said consumer-driven health plans offer "the most effective approach for managing costs and maintaining quality care," while 35 percent said preferred provider organizations were the most effective. Eighteen percent selected health maintenance organizations, 6 percent said point-of-service plans, and just 1 percent said traditional or indemnity plans.

Consumer-driven health plans combine discounts inherent in managed care programs with incentives to encourage members to become better consumers of health care. Typically, these plans are designed using accounts -- tax-advantaged health savings accounts or health reimbursement arrangements -- that often include some level of employer contribution, in combination with front end deductibles. They also provide the member with tools that provide clinical, cost and quality information so they can make personal health decisions that best meet their needs.

"They encourage employees to become consumers of health care and provide them with the tools necessary to understand how to work with their physicians to get the right care, in the right setting, at the right time," said Barbara Gniewek, principal and health care industry leader of Deloitte's Human Capital practice.

The survey, held in conjunction with Deloitte Consulting LLP's Human Capital practice and co-sponsored by The ERISA Industry Committee, was conducted over four weeks in December and early January. Results were presented by Secretary Thompson at the 2006 Health & Human Capital Management Congress on Tuesday.

"In addition to cost savings, consumer-directed health plans can offer employees an additional tool to save money tax free for retiree health," said Edwina Rogers, Vice President Health Policy for The ERISA Industry Committee. "Further, many of our members are aggressively working to supply their employees with quality and efficiency information on health care providers."

A Deloitte study released in November found that 43 percent of U.S. companies either have a consumer-driven health plan in place (22 percent) or will be offering one in the next two years (21 percent). Another 51 percent said they are reviewing consumer-driven options and may offer one in the near future if they can be proven to be attractive to employees while saving money.

Malszycki, Marcie

From: Rieselman, Brian J.
Sent: Monday, July 03, 2006 2:20 PM
To: Rieselman, Brian J.
Subject: A.G. Lautenschlager NEWS / Announces Medicaid Fraud Conviction of Milwaukee Man

PEG LAUTENSCHLAGER
ATTORNEY GENERAL

NEWS RELEASE

For Immediate Release
July 3, 2006

For More Information Contact:
Michael Bauer 608/266-7876

ATTORNEY GENERAL PEG LAUTENSCHLAGER ANNOUNCES MEDICAID FRAUD CONVICTION OF MILWAUKEE COUNTY MAN

MADISON – Attorney General Peg Lautenschlager announced today that William Powell, 64, of Milwaukee appeared before Milwaukee County Circuit Court Judge Michael B. Brennan and entered a guilty plea to two counts of misdemeanor Fraudulent Insurance and Employee Benefit Claim. Powell filed false claims and overcharged the state's Medicaid program.

"The Wisconsin Department of Justice vigorously pursues persons who seek to defraud the state Medicaid program, winning multiple convictions against violators every year," Lautenschlager said. "Such actions represent one of the many important responsibilities DOJ is entrusted to fulfill on behalf of Wisconsin citizens."

Powell was immediately sentenced to one year probation. As a condition of probation, Powell must pay $22,008.43 in restitution. Powell paid $9,892.00 at sentencing. As further condition of probation, Powell will surrender his Medical Assistance Provider Number for himself and his company, Metro Care Transport, Inc., Powell must also complete 50 hours of community service.

According to the Department of Justice's criminal complaint, Powell was the owner of Metro Care Transport, a specialized medical vehicle transportation service which provides transportation to disabled Medicaid recipients to medical appointments. In some circumstances a "second attendant" is necessary to accompany the driver of the vehicle to assist in the movement and transport of the disabled individual. These trips are reimbursed by the Medicaid program at a higher rate than trips where a second attendant is not necessary. Between January 2000 and December 2004, Powell billed the State Medicaid program for trips claiming a second attendant was provided when, in fact, a second attendant was not provided.

The case was prosecuted by Assistant Attorney General Frank Remington.

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Tax incentives

- About 11 million workers are offered employer sponsored insurance but decline. Possibility for future discussion--providing tax credits to low-wage workers for payment of their share of the ESI premium.

NCSL

From NCSL Trip to Denver.
June 11–13th, 2006

Consumer Directed Health Care

- Health Savings Accounts established in federal law 12/8/03. They are tax-free financial accounts designed to help individuals save for future health care expenses.
- Four federal requirements: covered by a high deductible policy of at least $1,000 for an individual or $2,000 for family; no other insurance, such as a spouse plan; under age 65, cannot be a dependent on someone else's policy.
- In 2005, among all firms offering health insurance coverage, 2.3% offered an HSA qualified plan with about 810,000 enrolled.
- According to an industry survey, 40% of new HSA buyers had incomes of $50,000 or less and at least 30% were previously uninsured.
- State laws and regulations passed in 2004-06 now play a role in the use of health savings accounts, through insurance regulation, measures that encourage development or offering of HSAs, and/or laws that provide state tax exemptions to parallel federal tax treatment.
- For more information go to http://www.ncsl.org/programs/health/hsa.htm

NCSL