☞ **05hr_SSC-HCR_Misc_pt23**

☞ Details: Hearing held in Madison, Wisconsin on July 26, 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)

Newby

The LEWIN GROUP

The Wisconsin Health Care Plan (WHCP) for Workers and Dependents in Wisconsin: Cost and Coverage Impacts

Final Report: Introduction and Key Assumptions

Prepared for:
The Wisconsin AFL-CIO

Prepared by:
The Lewin Group, Inc.

September 25, 2003

THE WISCONSIN HEALTH CARE PLAN FOR WORKERS AND DEPENDENTS IN WISCONSIN: COST AND COVERAGE IMPACTS

The purpose of this study is to estimate the impact of adopting a Wisconsin Health Care Plan (WHCP) to provide health insurance to all workers and their dependents in Wisconsin. Under WHCP, all employers would pay a uniform community rated assessment for each worker, who automatically would be enrolled in the program along with their dependent spouse and children. The program would cover a broad range of health services including prescription drugs and mental health services. The plan would require co-payments of $15.00 per visit with a $300 deductible ($600 family). Employers would be permitted to provide supplemental coverage for services not covered under WHCP.

As a means of controlling costs and improving quality, the program would emphasize primary care and the use of evidence based best practices. All participants would be required to select a primary care provider who would be responsible for coordinating care for each patient. The primary care physician would be able to help avoid medical errors such as drug/drug interactions by assuring compatibility of care provide to patients with multiple conditions who are seeing multiple physician specialists. The increased reliance on primary care providers would also avoid unnecessary use of costly physician specialist services. As an incentive to use primary care services, a co-payment of 25 percent would be required for all physician specialist services obtained without referral from their primary care physician.

The program is designed to reduce health spending while at the same time expanding coverage. Substantial savings are expected under the program due to administrative simplification and bulk purchasing for prescription drugs and durable medical equipment. As an additional step to control costs, the program caps the rate of growth in per-capita spending under the program not to exceed the national average rate of increase in per-capita health spending. Savings from this provision could be substantial because per-capita spending in Wisconsin has been growing faster than the national average in recent years.

In this paper we describe the WHCP proposal for Wisconsin workers and dependents and summarize the assumptions used to estimate its effects. We then present estimates of program's impact on health spending for households, employers, and the state and federal governments. For illustrative purposes, we assume that the program is fully implemented in 2003. A description of the data and methods used is presented in the Appendices to this report.

A. THE WISCONSIN HEALTH CARE PLAN PROGRAM FOR WORKERS AND DEPENDENTS

The key provisions of the Wisconsin WHCP program for workers and dependents are summarized below:

1. Coverage

All workers and their dependents in Wisconsin would be covered under the program except those covered under Medicare or the CHAMPUS/TRICare program for military dependents.
The program covers all workers and dependents in the state including federal, state and local government employees. Employees of non-profit organizations are also covered.

All workers are covered regardless of the number of hours they work. Coverage is also extended for two months following layoff. Employers are not permitted to "opt-out" of the program, although some groups with existing collective bargaining agreements would be permitted to delay participation until after their current contracts expire. The proposal would also permit self-employed individuals and retirees to "buy-in" to WHCP at cost.

2. Covered Services

Services covered under the plan include:

- Hospital Inpatient;
- Hospital Outpatient;
- Physician Services;
- Routine Physical Exams;
- Diagnostic testing;
- Oral Surgery (for injury to natural teeth only);
- Maternity care;
- Emergency Care;
- Ambulance Services;
- Physical/Speech Therapy;
- Skilled Nursing Facility;
- Chiropractic and Podiatric care;
- Mental Health;
- Substance Abuse; and
- Prescription drugs.

The program would not cover:

- Long-term care;
- Vision; and
- Dental.

3. Emphasis on Primary Care

All participants would be required to select a primary care physician who would be responsible for coordinating care for people with chronic conditions and those receiving care from multiple specialists. As an incentive for people to access care through their

primary care provider, the plan requires a substantial co-payment for physician specialist services provide without referral from a primary care physician.

The process of coordinating care can reduce the incidence of medical errors such as drug-drug interactions for chronically ill patients receiving care from multiple specialists. It is also likely to lead to lower costs because primary care providers typically require fewer tests and less intensive care. Savings have been documented in plans using this model.

4. Point-of-Service Cost Sharing

There would be a $15.00 co-payment for each visit with an individual's primary care provider and all physician specialist services provided on referral from their primary care provider. As discussed above, specialist services provided without referral from their primary care provider would require a co-payment of 25 percent.

There would be co-payments for each drug prescription of $15.00 for generics and $20.00 for brand name drugs. There would be a deductible of $300 per person and $600 per family and no lifetime limit on Benefits. Balance billing is prohibited under the proposal for all but the allowable co-payments and deductibles.

5. Financing

Employers would pay a uniform assessment for each worker. The assessment would be set at a level sufficient to pay the full cost of the program (reflecting administrative savings) less offsets from reduced spending under current public programs (i.e., Medicaid, Relief Block Grant Program etc.).

The assessment would be a community rated amount that is the same regardless of single or family coverage status.

The employer would pay the full amount of the assessment. Employees would not contribute to the cost of the WHCP coverage. The amount paid for part-time workers would be the same as the amount paid for full-time workers.

6. Supplemental Employer Benefits

Employers would have the option of providing wrap-around coverage for services or costs that are not covered by WHCP including dental and vision care. The portion of supplemental benefits paid by the employer is permitted to vary by employer.

7. Disposition of Medicaid and BadgerCare

These programs would be retained. However, the new program would be primary payer for workers and dependents with Medicaid and BadgerCare providing "wrap-around" coverage for eligible people.

We assume that a Medicaid waiver is obtained so that both the state and the federal share of the savings to Medicaid and BadgerCare would be transferred to the new program to offset the amount of the assessment.

8. Provider Payment Levels

Payments to providers would be based upon private-payer rates rather than Medicaid or Medicare payment levels. However, provider payment rates would be reduced to reflect:

- Estimated administrative savings for providers under the system;
- Reduced cost-shifting for uncompensated care; and
- Reduced cost-shifting for Medicaid/BadgerCare underpayments for working participants and their dependents.

Over a phase-in period of two years, payment rates would be adjusted to reflect estimated provider administrative cost savings (i.e., fully phased-in at the start of in the third year of the program).

9. Bulk Purchasing

The WHCP program would centralize purchasing for prescription drugs and durable medical equipment, which would create opportunities to obtain greater rebates and price discounts from suppliers. We assume that the plan would negotiate discounts for prescription drugs similar to those received by the current Medicaid program (approximately 20 percent). We assume similar discounts for purchased of durable medical equipment.

10. Provider Payment Updates

Annual increases in provider payment rates for each health service would be capped so that per-capita spending under the program grows no greater than the national average rate of growth in per-capita health expenditures.

11. Labor Management Commission

The WHCP proposal would include the establishment of a commission composed of labor and business representatives that would be charged with developing policy for the program. This would give the program flexibility in addressing issues as they arise. The cost estimate presented below reflects the assumptions on program features described above and could change substantially as these provisions are modified.

12. Workers Compensation

The Workers Compensation program would remain unchanged under the program. It would coexist with the WHCP in the same way that it now coexists with existing employer health benefits programs.

B. Key Assumptions

Our analysis includes several key assumptions concerning the utilization of health services under the program and savings from administrative simplification and bulk purchasing. We also made certain assumptions concerning the economic impacts of the program that are based upon the available research in these areas. These assumptions are summarized below. A detailed description of the data and methods used is provided in the appendices to this report.

1. Services Utilization for the Uninsured

We assume that uninsured persons who become covered under the program would use health care services at the same rate reported by currently insured persons with similar age, sex and health status characteristics. This assumption encompasses two important effects. First, the increase in access to primary care for this population would result in savings due to a reduction in preventable emergency room visits and hospitalizations. Second, there would be a general increase in the use of elective services such as primary care, corrective orthopedic surgery, advanced diagnostic tests, and other care that the uninsured either forego or delay.

Using this methodology, we estimate that health spending among the currently uninsured population would increase. That is, savings from improved primary care would be more than offset by increased use of elective care. We estimate that the uninsured in Wisconsin will consumed about 523 million in health services in 2003, including free care (valued at cost) and services purchased out-of-pocket. We estimate that if these individuals were to become insured, utilization of health services would increase by about 67 percent.

2. Utilization for Underinsured

Many of the insured have policies that do not cover certain services such as prescription drugs. In this analysis, we assume that utilization of these services by persons who currently do not have coverage for these services would increase to the levels observed among insured covered persons with similar demographic and health status characteristics.

3. Cost Sharing and Health Services Utilization

The program would require patient co-payments of $15per outpatient visit along with a $15 co-payment per generic prescription and $20.00 for brand drugs. These cost sharing levels are similar to those in many existing plans. Consequently, we show no increase in utilization due changes in co-payments under the proposed system except were discussed below. (Studies suggest that plans without co-payment requirements are generally expected to result in increased utilization of health services.)

4. Increased Emphasis on Primary Care

The program would encourage the use of primary care by requiring each Wisconsin resident to select a primary care provider and by imposing a 25 percent co-payment on specialist services provided without a referral. This is expected to reduce costs by encouraging prevention and assuring coordination of care provided to patients seeing multiple physician specialists. Also, primary care physicians typically have lower charges than specialist physicians and usually use fewer expensive diagnostic services. The process of coordinating the care received by patients seeing multiple providers could also reduce the cost of medical errors and improve quality.

The experience of HMOs provides an example of how increased reliance on primary care can affect costs. HMOs typically emphasize primary care as a means of controlling access to specialists and reducing unnecessary tests, resulting in an overall reduction in utilization. Although the available evidence indicates that managed are plans achieve lower costs largely through selective contracting (i.e., volume price discounts), utilization of health services is typically lower than in other types of plans. For example, one study showed that health services utilization in IPA HMOs is about four percent lower than in other types of health planes (IPA HMOs saved an additional 15 percent through selective contracting).[1] There is evidence that savings are higher in staff and group HMO models.

Based upon this evidence, we assume that a shift to primary care would result in an overall reduction in utilization of about four percent. We applied this assumption to all workers and dependents in Wisconsin who are not already enrolled in an HMO.

5. Elimination of Managed Care Programs

The WHCP program model would eliminate enrollment in managed care plans for workers and their dependents. This would eliminate managed care savings from provider discounts and the utilization management performed by private health plans. This could result in increased acute care utilization and costs.

However, we assume that these cost increases would be avoided under WHCP as follows:

- **Provider Discounts** – Plans would no-longer negotiate discounts with providers, which typically reduce managed care plan costs by about 15 percent. However, provider payment rates under WHCP would be set at levels equal to the average amounts currently received from all payers net of any negotiated discounts. This assures that there will be no net increase in costs as the program is adopted.

- **Utilization Management** – As discussed above, HMO utilization management typically reduces health services utilization by about 4 percent. However, due to

[1] The Lewin Group In., "New Evidence on Savings from Network Models of Managed Care," (a report to the Healthcare Leadership Council), Washington DC, May 1994.

coordination of care through primary care providers, we assume that there would be no increase in utilization for people currently covered under HMOs.

6. Bulk Purchasing

We assume that the program would receive rebates for prescription drug purchases equal to those received under the Medicaid program. This amounts to a rebate of about 20 percent compared with an average rebate of about 8 percent under private health plans.[2] This results in a net savings of 13 percent for prescription drugs under the program (i.e., the amount paid under Medicaid for drugs is about 13 percent lower that what private insurers pay).

We assume that the program would be able to achieve similar savings for purchases of durable medical equipment.

7. Administrative Costs

In this analysis, we estimated savings in administration based upon a prior Lewin Group study of the impact of a single-payer model on administrative costs, which we have updated with recent data for Wisconsin.[3] These savings include:

- **Insurer Administration** - The WHCP program would extend large-group economies of scale throughout the health care system by covering all workers and dependents under a single health insurance mechanism. This would eliminate the costs associated with underwriting and transitions in coverage, and would reduce the cost of maintaining the linkage between employers and their source of insurance.

- **Physicians Administration** - This approach would substantially reduce claims-filing costs for physicians by standardizing the means of reimbursement through a single program and by providing full reimbursement through a single source using a standardized electronic claims-filling process. Standardization of coverage would also reduce physician costs related to adjudication of claims and negotiation of selective-contracting arrangements.

- **Hospital Administration** – The WHCP would reduce hospital administrative costs by standardizing reimbursement methods and providing a uniform list of covered services for all workers and dependents in the state.

We assumed that the cost of administering WHCP coverage would be similar to administrative costs under the Medicare program (modified to reflect administrative simplification), which can be thought of as a single source program for the elderly.

---

[2] "Prescription Drug Coverage, Spending, Utilization, and Prices," (Report to the President from the Department of Health & Human Services), April 2000

[3] Sheils, et al., "O Canada: Do We Expect Too Much From Its Health System", *Health Affairs*, Spring 1992;

Our estimates of the savings in hospital administration are based upon an analysis of hospital spending data for Wisconsin hospitals, which we supplemented with highly detailed hospital cost accounting data for hospitals from other sources. These data show hospital costs for about 39 separate categories of overhead and administration including fiscal services, data processing, billing, collections, education and research.

We estimated administrative savings for physicians using data provided by the Medical Group Management Association (MGMA) which provides administrative costs data by function for physician practices. We used these data to identify the categories of administration that are attributed to the administrative functions that would be eliminated or simplified under WHCP.

A discussion of the data and methods used to develop these administrative savings estimates is presented in ***Appendix C*** of this report.

8. Employer Response

Our assumptions concerning the employer response to the WHCP include:

- **Wage effects** – Changes in employer costs under the proposal are assumed to be passed-on to workers in the form of wages. Increases in employer costs are assumed to be passed on to employees in the form of reduced wages. Conversely, savings to employers are assumed to be passed on to workers as wage increases over time. This automatically affects tax revenues from income and sales taxes. These adjustments are expected to take the form of changes in the rate of increase in wages for affected workers over time.

- **Employer supplemental coverage** – Employers are assumed to provide supplemental coverage for services that they now cover under their plans, which would not be covered under the Wisconsin WHCP. These services typically include dental, orthodontia, vision and eyeglasses.

9. Buy-in for Self-Employed and Retirees

As discussed above, the proposal permits the self-employed and retirees to "buy-in" to WHCP at cost. However, by making enrollment for these groups optional, those who enroll will tend to be those with higher health care costs who will generally find that the assessment is less than what they would have to pay in the insurance market. To correct for this "adverse selection" (i.e., the disproportionate accumulation of higher cost people in the WHCP), we assume that separate assessments are calculated for these two groups so that the premium is calibrated to reflect the actual costs of those enrolling. Consequently, we show no net-increase in costs from opening the program to these groups.

For illustrative purposes, we assume that all self-employed people take coverage under the WHCP. The retiree buy-in would typically be relevant to only early-retirees who are not covered under Medicare. Early retirees who are working in retirement also would be covered under the WHCP based upon their current employment status. The buy-in

provision would be relevant only to early retirees who: do not work; are not the spouse of a worker in the WHCP; and are not already covered under an employee retirement health benefits program. We assume that these individuals buy-in to WHCP if they are currently purchasing insurance on their own in the non-group market.

C. Estimated Costs and Impacts

We present our estimates in two ways. First, we present estimates of the cost and coverage impacts of each provision of these proposals assuming full implementation in 2003. Thus, for illustrative purposes, we assume that the provider payment adjustment for administrative costs is fully phased-in. These estimates are useful for comparing program impacts at the current levels of the uninsured and health care costs, and reflect the ultimate intended program. Second, for budgetary purposes, we also present year-by-year cost estimates for 2004 through 2013, which reflect the expected dates of program implementation for such things as the phase-in of the provider payment adjustment.

1. Sources of Coverage

The number of uninsured people in Wisconsin would decline from our estimate of 628,700 persons in 2003 to 83,500 people under the WHCP program. This is an 87 percent reduction in the number of uninsured in the state.[4] Those who remain uninsured typically would be non-workers who are not eligible for Medicare or Medicaid. Some also would be Medicaid eligible people who have not enrolled.

The WHCP proposal would change the source of insurance coverage for most non-elderly people in Wisconsin. Based upon our simulation, we estimate that there would be about 4.2 million persons enrolled in the public plan (***Figure 1***). The program would include every Wisconsin resident except those who are covered by Medicare or CHAMPUS and persons not attached to the work force as a worker or a dependent.

The number of people with employer coverage as their primary source of insurance would decline from about 3.5 million persons under current law to 175,000 persons under the WHCP. Those who continue to have employer coverage as their primary source of insurance would include non-working early retirees who are not covered under Medicare or CHAMPUS. In addition, many workers would have supplemental insurance through their employer to cover services covered under their existing plan that are not covered under WHCP (numbers not shown in ***Figure 1***).

Private non-group coverage (currently 207,000 persons) would be virtually eliminated as these individuals become covered under the WHCP model. This reflects the fact that most of those who purchase non-group coverage are workers and dependents, all of who would become covered under WHCP.

---

[4] All population counts in this analysis represent average monthly enrollment by coverage source.

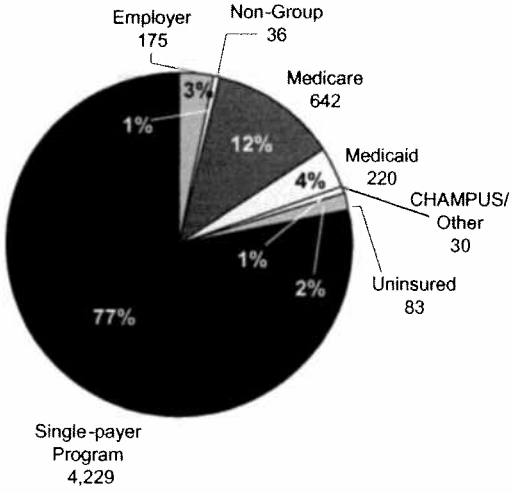
The number of persons with Medicaid/BadgerCare as their primary source of coverage (i.e., excludes Medicare dual eligible enrollees) would decline from about 362,000 to 220,000 persons. Those who continue to have Medicaid as their primary source of insurance would be persons not associated with the workforce.

Figure 1
Distribution of People by Source of Coverage under Current Policy and the WHCP Proposal in Wisconsin for 2003[a/]
(in thousands)

Current Policy

Employer Coverage	
Workers and Dependents	3, 718
Retirees	57
Private Non Group	207
Medicare	642
Medicaid	680
CHAMPUS/Other	30
Uninsured	628
Total Population	**5, 415**

WHCP Proposal



Total Population = 5,415

a/Does not sum to total because some people have more than one source of coverage
Source: Lewin Group estimates using the Health Benefits Simulation Model.

Figure 2 summarizes the transitions in sources of coverage under the WHCP.

2. Total Health Spending

We developed estimates of the impact of the WHCP proposal on total health spending in Wisconsin for all types of health services. This includes spending covered by all payers including public programs, private insurance and family out-of-pocket spending. Total health spending in Wisconsin for all health services is projected to reach about $29.2 billion in 2003 (see ***Appendix B***).[5] We estimate that total health spending would declined under WHCP by about $1.8 billion even though the program increases the number of persons with health coverage.

[5] Smith, S., "The Next Ten Years of Health Spending: What Does the Future Hold?," *Health Affairs*, Volume 17, Number 5.

Figure 2

Coverage Transitions Under the WHCP Proposal in Wisconsin in 2003 (in thousands)

Average Monthly Coverage by Primary Source of Insurance								
		Coverage Under the WHCP						
Coverage Under Current Policy	Total	Wisconsin Health Care Plan (WHCP)	Employer	Non-group	CHAMPUS	Medicare	Medicaid	Uninsured
Employer	3,545	3,370	175	0	0	0	0	0
Non-Group	207	172	0	36	0	0	0	0
CHAMPUS	30	0	0	0	30	0	0	0
Medicare	642	0	0	0	0	642	0	0
Medicaid	362	142	0	0	0	0	220	0
Uninsured	629	545	0	0	0	0	0	83
Total	5,415	4,229	175	36	30	642	220	83

Source: Lewin Group estimates using the Health Benefits Simulation Model.

As discussed above, we assume that under the WHCP, use of health services by newly insured people would increase to levels reported by insured persons with similar age, sex, income and self-reported health status characteristics. Based on this assumption, we estimate that the net increase in health spending for previously uninsured persons would be about $410 million (*Figure 3*). This is an estimate of the net change in utilization for this group which reflects reduced hospitalizations for preventable conditions offset by increased utilization of preventive care and increased use of elective procedures.

Figure 3
Changes in Wisconsin Health Spending Under The WHCP Program in 2003
(in millions)

	Amount in Millions
Current Health Spending [a/]	$29,238
	Increases in Utilization
Utilization Change for Uninsured	$410
Utilization Change for "Underinsured"	$166
Reimbursement Effects Payments for Uncompensated Care $239 Reduced Cost Shifting [b/] ($239)	--
	Spending Offsets
Increased Primary Care Emphasis	($392)
Bulk Purchasing of Prescription Drugs and Durable Medical Equipment	($241)
Administrative Costs Insurer Administration ($902) Hospital Administration ($214) Physician Administration ($587)	($1,703)
Net Change in Spending	
Net Change	($1,760)

a/ Excludes public health, research and construction.
b/ Assumes that provider payment levels are adjusted downward to reflect the reduction in uncompensated care expenses.
Source: Lewin Group estimates using the Wisconsin version of the Health Benefits Simulation Model (HBSM).

There also would be an increase in utilization for previously "underinsured" people. Many insured individuals do not have coverage for some of the services that would be covered under the uniform benefits package. For example, many private plans do not cover prescription drugs and psychiatric services. We assume that utilization of these services would increase to levels reported by persons who have coverage for these services with similar age, sex, income and health status characteristics. The net increase in spending for the underinsured would be $166 million in 2003.

The expansion in coverage under the program would nearly eliminate provider uncompensated care, which is typically treated as an expense to the provider. Thus, provider payments would be reduced to reflect the reduction in uncompensated care expenses resulting from the reduction in the number of uninsured under the program.

The spending increases under the program would be partly offset by the use of financial incentives designed to encourage use of primary care (i.e., requiring patients to have a primary care physician and requiring a 25 percent co-payment for use of specialist care without a primary care provider referral). We estimate that the savings from increased use of primary care would be about $392 million.

Under the WHCP program, centralized purchasing of prescription drugs and durable medical equipment would create opportunities for greater price discounts from suppliers. Using the assumptions described above, we estimate savings from bulk purchasing of prescription drugs and durable medical equipment to be $241 million.

The use of a single source system would result in a reduction in administrative costs of $1.7 billion. The program would extend large-group economies of scale throughout the health care system by covering all working individuals and their dependents under a single insurance mechanism. We estimate that insurer administrative costs would be reduced by $902 million under the program.

The WHCP program would also significantly reduce administrative costs for hospitals by standardizing reimbursement methods and providing a uniform list of covered services for all workers and dependents in the state. The program also would reduce claims filing costs for physicians. Also, standardization of coverage would reduce physician costs related to claims adjudication and negotiation of selective-contracting arrangements. We estimate that hospital administrative costs would be reduced by $214 million and that physician administrative costs would be reduced by $587 million. (see ***Appendix C***). As discussed above, provider payment levels would be reduced over a period of two years to reflect estimated provider administrative savings.

The net effect of these changes in spending under WHCP would be an overall reduction in health spending of about $1.8 billion if implemented in 2003.

Figure 4 presents the net-change in spending for the Wisconsin state and local governments, the federal government private employers and households assuming that the employer assessment is set at a level sufficient to fully fund the program. (As discussed above, the employer and the employee pay an assessment for each worker). We present the initial cost impacts before employers respond to the changes in employee health benefits costs with changes in wages. We also present these estimates after these wage effects. The program's impact on these payers for care is discussed in the following sections.

FIGURE 4
Estimated Change in Health Care Expenditures Under WHCP by Class of Payer in Wisconsin for 2003 (in millions)

	Before Wage Effects	After Wage Effects [a/]
Federal Government	$(74)	$36
State and Local Governments	($355)	($341)
Private Employers	$936	$(67)
Households	($2,267)	($1,388)
Net Change in Health Spending in Wisconsin		
Net Change in Total Health Spending	($1,760)	($1,760)

Source: Lewin Group estimates using the Wisconsin Version of the Health Benefits Simulation Model (HBSM).

3. WHCP Program Costs and Revenues

Total expenditures under the single-program program would be about $9.5 billion in 2003 (*Figure* 5). This includes the cost of all benefits payments ($9.2 billion) and the cost of administering the program ($331 million).

As discussed above, we assume that the program would be designed so that in the first year of the program, provider payment levels would be equal to the average payment levels for covered services in the current system (i.e., averaging across Medicare, private insurance, etc.). Under these assumptions, total benefit payments before adjustments for savings under the program would be $10.5 billion. This reflects the increase in utilization for previously uninsured persons discussed above and savings due to increased use of primary care.

Provider payment levels would be reduced by $1.3 billion to reflect reduced provider costs for uncompensated care and administrative costs. This reflects the fact that providers will receive payments for services that would have been counted as uncompensated care under current policy ($231 million). This included administrative savings that will be realized by providers under the program ($801 million) (these savings would be phased-in over a period of two years), and savings from bulk purchasing of prescription drugs and durable medical equipment ($241 million).[6] It also reflects an offset for reduced provider expenditures for uncompensated care.

The WHCP program would be partly funded with savings to other public programs resulting from the program. Medicaid spending would be reduced by $327 million as working participants and their dependents become covered under the program. This includes the state share of these savings ($129 million) and the federal share ($198 million). As discussed above, we assume that the state obtains a waiver to retain the federal share of these savings to help pay for the program.

[6] This adjustment is needed to account for the fact that uncompensated care is currently financed through the cost shift.

Figure 5
Sources and Uses of Funds Under the WHCP Program in 2003
(In millions)

Uses of Funds			Sources of Funds	
WHCP Program Benefits Payments		$9,187	**Medicaid and SCHIP Savings** [a/]	$327
Benefits at Current Payment Rates	$10,460		State Share $129	
Bulk Purchasing Savings	($241)		Federal Share $198	
Reduced Cost Shifting	($231)			
Hospital Admin. Savings	($214)			
Physician Admin Savings	($587)			
Program Administrative Costs		$331	**Other State and Local Public Programs** [b/]	$132
			Total Intergovernmental Transfers	**$459**
			New Revenues	
			Employer Assessment [c/]	$9,059
			Employer Share (100%) $9,059	
			Employee Share (0%) NA	
			State Income Tax Loss from Wage Effect [d/]	$14
			Total New Revenues	**$9,073**
Total Program		**$9,518**	**Total Sources of Funds**	**$9,518**

a/ Savings to the Medicaid program for workers and dependents who become covered under the program are assumed to be used to help fund the program.

b/ State and local government funding for programs that would become covered under WHCP are assumed to be used to help finance WHCP.

c/ The program would require a monthly assessment of $264 per worker.

d/ The increase in employer health spending under the program would result in reduced wages and an associated reduction in state income tax revenues.

Source: Lewin Group Estimates

Funding for other public benefits that would become covered under the WHCP would be transferred to the program. Savings to other public programs also would be transferred to the program. These include the Relief Block Grant Program, state and local funding of mental health programs, and funding for public clinics. Total savings would be about $132 million.

We also estimate that there would be a small increase in state income tax revenues due to changes in wage levels resulting from the program. As discussed above, changes in employer costs are passed-on to employees in the form of changes in wages, with an associated impact on state tax revenues. We estimate that tax revenues would actually increase by about $66 million under the proposal. Taxes increase because the workers who benefit the most from the program are higher-wage workers in firms that already offer insurance, most of whom who are in higher tax brackets (i.e., have high marginal tax rates). (These effects are discussed below.)

The remainder of the program would be financed with the employer assessment. The assessment would be about $264 per worker per month. This would raise about $9.1 billion in revenues for the program.

We also estimate that state and local government employee benefits programs would see savings under the program. We estimate that total spending by state and local governments (including education) for workers, dependents and retirees will be about $1.8 billion in 2003 (excludes worker premium contributions). We estimate that under the WHCP, the assessments they would pay for their workers would be less than what they now spend for employee health benefits by about $341 million. We assume that all of these savings are retained by state and local governments.

* * * * * * * *

WHCP Design Alternatives

The estimated cost impacts of the WHCP presented above reflect one specific design of the program. The cost impacts on individuals and employers could be very different with changes in specifications of these plans. In this section, we illustrate the sensitivity of our cost analysis changes in key provisions of the proposal concerning employer assessments and variations in the design of the program. The design features of the plan that we examined include:

- Assessments for Part-Time Workers;
- Reduced Assessments for Small Employers; and
- Phase-In of Savings to Providers.

Assessments for Part-Time Workers

Under the plan discussed above, the assessment is $264 per worker per month, regardless of their employment status. Thus, the amount of the assessment for a part-time worker is the same as the assessment for a full-time worker. About 17 percent of all workers work less than 35 hours per week. About 6 percent work fewer than 20 hours per week.

In this scenario, we assume that the assessment is reduced by half for all part-time workers. The loss of revenue is assumed to be recovered by increasing the assessment by the amount needed to fully fund the program. For example, if the assessment were reduced by half for all people working less than 20 hours per week, the assessment amount would need to be increased from $264 per worker per month to about $272 in order to keep the program fully funded (***Figure 10***). It the assessment were to be reduced by half for all employees working under 35 hours per week, the assessment would need to be increased to $289 per worker per month to fully fund the program.

The reduced assessment for part-time workers would tend to have its greatest impact on firms that do not now offer insurance. About 31 percent of uninsured workers work less than 35 hours per week, compared with about 8 percent of workers that have coverage from their employer. For example, if the assessment were reduced by half for people working less than 35 hours per week, the net increase in costs for non-insuring firms in Wisconsin would drop from about $2.0 billion to about $1.9 billion, which is a savings of about 7 percent. There would be a corresponding increase in costs for firms that currently offer coverage.

Figure 10
WHCP Assessments Under Alternative Discounts For Part-Time Workers

	Monthly Assessment	Net Change in Cost to Private Employers (millions)		
		Currently Insuring Firms	Non Insuring Firms	All Firms
WHCP as Proposed	$264	$(1,061)	$1,997	$936
WHCP with 50% Reduction for Employees Working Less Than 20 Hours Per Week	$272[a/]	$(1,028)	$1,964	$936
WHCP with 50% Reduction for Employees Working Under 34 Hours Per Week	$289[a/]	$(928)	$1,864	$936

a/ The assessment is assumed to be increased so that the program is fully funded with the 50 percent reduction in assessments for people working part-time.

Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

Reduced Assessments for Small Employers

Under the WHCP model analyzed above, the assessment is the same for all workers regardless of the size of firm. The program could be modified to provide a 50 percent discount of the assessment for small employers. The assessment would be increased from $264 per worker under the current version of the model by the amount needed to fully fund the program. For example, reducing the assessment by 50 percent for all firms with under 50 workers, the assessment would need to be increased to $322 per worker per month to fully fund the WHCP (***Figure 11***).

Firms that currently do not provide coverage would benefit the most from discounts in the amount paid by small firms. About 51 percent of all uninsured workers are in firms with under 50 workers, compared with about 21 percent of workers in firms that currently offer coverage. The 50 percent discount for firms with under 50 workers would reduce the cost of the WHCP program to firms that do not now offer coverage from about $2.0 billion to about $1.7 billion, which is a savings of about 14 percent. This would result in a corresponding increase in costs for currently insuring firms. However, the impact will differ widely by industry and other employer characteristics.

Figure 11
WHCP Assessments Under Alternative Discounts for Small Employers

	Monthly Assessment	Net Change in Cost to Private Employers (millions)		
		Currently Insuring Firms	Non Insuring Firms	All Firms
WHCP as Proposed	$264	$(1,061)	$1,997	$936
WHCP with 50% Reduction for Firms with Under 10 Workers	$290 a/	$(911)	$1,847	$936
WHCP with 50% Reduction for Firms with Under 25 Workers	$305 a/	$(871)	$1,807	$936
WHCP with 50% Reduction for Firms with Under 50 Workers	$322 a/	$(774)	$1,710	$936

a/ The assessment is assumed to be increased so that the program is fully funded.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).

An alternative approach would be to reduce the assessment for small firms with low-income workers only. For example, we estimated the impact of reducing the assessment by half for firms with under 10 employees where the average salary per worker is $20,000 or less. This would increase the monthly assessment from $264 to $271 for 2003.

Phase-In of Savings to Providers

As discussed above, we assumed that the adjustments to provider payment levels for administrative savings would be phased-in over a period of two years. *Figure 12* presents estimates for assessments and program costs under two alternative assumptions on the phase-in of these savings adjustment. These are: immediate savings adjustment; and a four-year phase-in of savings.

Figure 12
WHCP Program Costs and Assessment Under Alternate Offsets for Provider Savings [a/]

	Immediate Offset for Provider Savings [b/]		Four-year Phase-in of Offset for Provider Savings [c/]	
	Program Costs (billions)	Assessment	Program Costs (billions)	Assessment
2003	$9.5	$264	$11.0	$288
2004	$10.2	$275	$11.6	$297
2005	$11.5	$299	$12.0	$306
2006	$12.3	$308	$12.6	$316
2007	$13.1	$326	$13.1	$326
2008	$14.0	$345	$14.0	$345
2009	$14.9	$365	$14.9	$365
2010	$15.9	$387	$15.9	$386
2011	$17.0	$409	$17.0	$409
2012	$18.2	$433	$18.2	$433

a/Projections reflect requirements that per-capita spending under the program is constrained to grow no faster than the national average rate increase in per-capita spending.
b/Assumes that provider payment rates are reduced immediately in the first year of the program to reflect savings to providers in administration and uncompensated care.
c/Assumes that the adjustment to provider rates for savings is phased-in over a period of four years, starting in the second year of the program.
Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM).


FORWARD
E PLURIBUS UNUM

Mike Rayome

Why Should Wisconsin Businesses Support SB 698

Companies have tried:

- Cost Shifting
  - Higher deductibles
  - Raising employee contributions
  - HMO's, PPO's
  - Consumer driven plans with VERY high deductibles!
  - Dropped insurance coverage
  - Relocated or closed their business

The cost of healthcare

Graphic Packaging Pays $506,000/Mo.
Employees pay an additional $82,500/Mo.

If the Company paid only $340/employee it would have $300,000/Mo.

This would also make Wisconsin an attractive place to invest or re-invest in Wisconsin jobs and/or equipment.

We provide our employees

- A clean and safe place to work for 522 employees in Wausau, 290 employees in Menasha, and 7500 employees worldwide.
- $18.34/Hour
- Plus:
  - Health, Dental, Life Insurance Coverage
  - Non-Contributory Pension Plan
  - 401 (k) Plan Match
  - Short-Term Disability
  - 12 Paid Holidays
  - Up to 7 weeks of paid vacation
  - Tuition reimbursement

Labor negotiations

- We used to negotiate a new labor agreement in 7-8 meetings
- Last contract we spent 8 days talking about healthcare coverage and the many different carriers and plans.
- We could have been talking about ways to grow these plants, and make them even more productive.
- It is time to get healthcare off the bargaining table, and level out the cost equation.

Why Should Wisconsin Businesses Support SB 698?

Answer: It is good for Wisconsin businesses and the families that depend on them.