☞ **05hr_SSC-HCR_Misc_pt24**

☞ 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)

State Representative
JON RICHARDS
Assistant Democratic Leader
SERVING MILWAUKEE'S
EAST SIDE, DOWNTOWN AND
BAY VIEW NEIGHBORHOODS

We Need More Affordable, More Accessible Health Care in Wisconsin

- Health care costs are rising higher every year (9% in Wisconsin alone) and so is the number of the uninsured.
- 500,000 people in Wisconsin are currently without health insurance.
- Wisconsin has 8 of the top 10 U.S. cities with the highest physician fees.[1]
- Wisconsin ranks 2nd highest in terms of health care premiums in the U.S.[2]
- Wisconsin workers have seen a 49.3% rise in out of pocket health care costs from 2000-2004, more than four times the wage increases over the same period of time.[3]
- Milwaukee exceeds the U.S. average for overall spending on health care by 27%[4]
- Milwaukee exceeds the U.S. average for hospital costs by 63%[5]
- Milwaukee doctor prices exceed the U.S. average by 33%[6]
- This trend cannot continue. A century ago we pioneered Worker's Compensation and Unemployment Compensation as big solutions to the problems of that time. <u>We need big solutions to the problem of our time -- affordable health care.</u>

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[1] GAO-05-856 FEHBP Health Care Prices, September 2004.
[2] Expansion Management magazine, February 14, 2005.
[3] National Practitioners Databank Reports, 1992-2002
[4] GAO-04-1000R, Milwaukee Health Care Spending, August 2004.
[5] GAO-04-1000R, Milwaukee Health Care Spending, August 2004.
[6] GAO-04-1000R, Milwaukee Health Care Spending, August 2004.


FORWARD

Wisconsin Health Plan
Letter/email feeback

From: jim.weber@preventiongenetics.com
To: Rep.Gielow; Rep.Richards
Cc: Rep.Vruwink; Sen.Lassa
Subject: Universal health care

Dear Representatives Gielow and Richards,

I'm the President and founder of a new biotechnology company in Marshfield, WI. Our company, PreventionGenetics, currently provides generous health and dental insurance benefits to our employees. However, if costs continue to rise at ~12% per year, we won't be able to afford to do this for long.

I've read a little in the Milwaukee Journal and heard a little on WPR about your plan for universal health coverage in our state. Although, of course details of any such plan are critically important, in principle you can count on me as a strong supporter. I would be happy to testify before state committees on behalf of a reasonable plan. You can add me to your list of supporters.

In Marshfield, which is in the geographic center of the state in a relatively rural area, we have the blessing of the Marshfield Clinic. The Clinic provides surprising good quality of care for such an area. Unfortunately, the drawback of the Clinic is that they are the ONLY practical option for health care in our community, and they are also very expensive. PreventionGenetics currently pays 85% of the Marshfield Clinic health insurance premiums for our employees. Although our plan also has significant deductibles that the employees must pay, the average annual cost per employee to the company is about $10,000, and is increasing at the rate of 10-15% per year. We want to take good care of our employees, but with inflation at about 3% we can't contend with such massive increases. We would welcome an alternative that would provide good quality care at an affordable cost that, at worst, keeps pace with inflation.

Health care financing in the U.S. is badly broken and urgently needs to be repaired. We pay 50-100% more than other developed nations, and our health isn't any better (actually it may be worse). The success of our state's and nation's businesses is critically dependent on such reform. We cannot compete with foreign companies when we are burdened with these massive health care costs.

Sincerely,
James L. Weber, Ph.D., President
PreventionGenetics LLC
3700 Downwind Drive
Marshfield, WI 54449

From: MDougherty@dsmfg.com
To: Rep.Richards
Subject: Health care proposal

Dear Representative Richards,
I heard a presentation by Rep. Gielow on a statewide health insurance purchasing system at the WMC board meeting on June 9th. I've also been following some of the press coverage as the proposal has been unveiled.

I sincerely appreciate the efforts that you and Representative Gielow have put into this proposal. While there are several issues that must be resolved, the proposal does an excellent job of addressing many of the systemic problems that must be corrected to sustain the concept of employer funded health care here in Wisconsin.

The problems we face today will not be resolved with employer purchasing pools, catastrophic plans, HSA's and most of the other methods currently being used to address the situation. A far more comprehensive and innovative solution, such as yours, is the only way to implement meaningful, systemic change.

Please keep up the good work and do not be deterred by the barrage of criticism and rhetoric that you will face. There are many "stakeholders" who profit from the current flawed system and they will fight to preserve the status quo. However, we must find a solution that is best for the citizens of our state.

Sincerely,
Michael J. Dougherty
D&S Manufacturing

From: jimwamic@chorus.net
To: Rep.Gielow; Rep.Richards
Subject: Wisconsin Health Plan

Dear Representatives Gielow and Richards

I have read that you have introduced Assembly Bill 1140. Thank you for doing so. I believe the number one concern of many residents in the state of Wisconsin is the availability and affordability of health insurance. Those that have the coverage struggle with the enormous premium increases of recent years. If one does not have insurance and the medical facility is willing to treat them, live in constant fear that any injury or illness will ruin them financially.

I am President of the Wisconsin Association of Mutual Insurance Companies. We have a 2 person staff and one staff member has health insurance through her husband's employer. Our Association does not qualify for group health insurance so purchasing affordable coverage for me is most difficult.

Our membership is comprised of roughly 70 small property and casualty insurance companies scattered throughout the state of Wisconsin. While a few companies employ as many at 10 employees, the vast majority of them employ only 1 or 2 employees. They have the same problem! They are in the insurance business and many of them can not buy affordable health insurance for themselves and their families.

It just doesn't seem to make a lot of sense. Let us assume you have 2 employees with exactly the same duties, same age, same sex, and same health history and one works for a large company and one for a small employer... The one that works for a large company is able to get health insurance on a group basis with guarantee issue and no pre existing conditions exclusions. However, the individual that works for the small employer with only 1 employee can not get the same coverage.

Thank you again for introducing this bill and if there is something that I can do to help this along please let me know. I am sure that our association members would also be helpful in this cause.

Jim Tlusty
WAMIC President

From: leipnitz@charterinternet.com
To: WHP Website
My name is Beth Ford and I attended your presentation on AB1140 at the Good Morning Menomonie Chamber of Commerce breakfast meeting on 5/25/06. I already agree with more than 70% of this bill and will back your bill 99.9% if I know it would cover individuals such as myself. I have a pre-existing medical condition that does not allow me to purchase private health insurance coverage. My husband is a self-employed farmer and I work for a small business that does not provide health insurance coverage. In the past I have purchased the state's high risk insurance plan (HIRSP) but the premiums have become more than our budget can afford at this time. Would AB1140 cover individuals as myself? I also know several other people with the same problems – two are now purchasing HIRSP and the others had privately purchased health insurance and are continuing with the same carriers no matter how high the premium rates go, just so they have insurance. I will appreciate your response to my question and Thank You for your attention to this matter. I returned to work after your presentation on 5/25 and spoke to everyone I saw that day about AB1140. I made copies of your material and also gave those to everyone. Something must be changed about the health care coverage and I hope your plan is holding some of the answers. I have also passed your name and information to husband's civic and business organizations. I am hoping they will contact you for possible presentation dates.
Thank You
–Beth Ford

From: pmcneil@wi.rr.com
To: WHP Website
I was at your presentation last week in the Dells and want to applaud your efforts. I am involved in real estate and the group home business and health insurance as it stands is unobtainable for most caregivers and many realtors. Let me know if you need any volunteers. Thanks again!

Regards,
Patrick C. McNeil
Spinnaker Team/
Realty Executives Lakeshore
409 E. Silver Spring Drive
Whitefish Bay, WI 53217

From: jarvy33@yahoo.com
To: WHP Website
I am a member of the Machinists Union, and am very supportive of the efforts to deal with the health care issue on a state level. I am familiar with the AFL-CIO proposal and I do believe a single-payer system is the most beneficial. However, after reading the general details of this plan, I would support it if a plan of this type were brought before the state legislature. Any plan must cover all residents and be proportionally funded by all. This plan covers all, is fairly funded by all, and is portable. I would not discourage union members from supporting a plan similar to this so long as it maintains those fundamental provisions. It is sad, however, that the health care system seems to care as much about the health of insurance companies as the citizens. The health care system should serve the needs of the people. I believe we demonize the single-payer concept, even though studies have shown clearly that a single-payer system is the most efficient. The health insurance industry (lobby)has shown its concern with self-preservation with the efforts put into misinformation regarding a single-payer system (like Medicare). Everyone wants to protect Medicare for the elderly, yet for some reason, a plan similar to it would be terrible for the rest of the population. Who are we hurting, the elderly or ourselves? If it's a bad system, why do it to our elderly? If it's a good system, why don't we do it for ourselves?
Brian Jarvensivu

From: Sally@SchoolHouseGB.com
To: WHP Website
I attended the meeting in Ashwaubenon last week and support your efforts fully. You are absolutely correct--something must be done--even if it's not perfect. Please don't be discouraged.

As a small business owner, my husband and I pay about $700 per month for $2500 deductible, 80/20 coverage for ourselves. Your plan would save us money and, at the same time, improve coverage. And we could afford to pay to 3% for our employees. So, from my perspective, GO FOR IT!
If you have an e-mail list to keep interested parties in the loop, please add my name.

Sally Sieber
SCHOOL HOUSE, Co-owner
ASHWAUBENON INDEPENDENT BUSINESS ASSN (AIBA), President
Green Bay WI

From: elaine.scholl@kohler.com
To: WHP Website
As a trustee of the village of Cedar Grove, I am a subscriber to The Municipality publication. I read Dan Thompson's synopsis of your plan in the January issue and subsequently went to the website. While I haven't studied the details in depth, I am excited at the prospect of Wisconsin being a leader in contained health costs available to all while not taxing the people beyond their capabilities. I am looking forward to your plan getting more exposure in Madison. If there is anything I as an individual or Cedar Grove as a governmental body can do to assist the project, please let me know. Thank you.
Elaine Scholl
Cedar Grove, WI

From: martindock@aol.com
To: WHP Website
I've read over the Fact Sheet. This is an exciting and terrific opportunity for Wisconsin and I completely support it. I just wish our legislators would do the same. I pay too much in health insurance with a $5,000.00 deductible--I'd rather be paying into a program that will be there for me through good health AND bad health. Let this plan be the priority in 2006. I wish my daughters and I could enroll now.
Deidre A. Martin

From: margopaints@Charter.net
To: WHP Website
I am a huge supporter of this plan. As a self-employed wife and mother to an "uninsurable" husband and son, I have had far too much experience with the horrors of our current medical system. We have gone through all kinds of financial gymnastics to be able to get appropriate medical care for our family. We can not get--at any cost--the medical insurance that we help provide with our tax dollars for the many government employees. This would offer us the opportunity to expand our business.

I would be delighted to help in any way I can. How many people do you need to have in a group before it is worth your coming to talk to them? Do you have guidelines for the groups that you will talk to?

If I can help you in any way, please feel free to contact me at the above e-mail or my phone.
Margo Miller

From: rdean@selecticd.com
To: WHP Website
We have a small two person business. Because of our size (under 50 employees), we have no negotiating leverage on our health care. We currently have an MSA but we are seeing our premiums increasing by more than 25% each year. I have reviewed your proposed program and it appears to help small business.
Robert Dean

From: kldean@earthlink.net
To: WHP Website
Thank you so much for addressing this most important domestic issue. I am very excited about the proposed plan and would be willing to help work towards its implementation. My husband and I own a small business and currently have an HSA, which has worked well for us.
However, we are still beholden to the large insurance company we are with, who has raised our monthly premium 20-25% every 9 months for the last 5 years. (And we haven't even had to use the insurance!) We have tried to switch to other companies but have been rejected for very minor reasons. We feel like prisoners of this broken system and we are very interested in being part of a solution!
Karen Dean

From: waynehans@charter.net
To: WHP Website
I am a 51 year old owner of a residential construction co. in Eau Claire. What started out as a no frills but reasonably priced group plan through the Wisconsin Home Builders Assoc. has turned into a cash eating premium monster. Increases of 24%, 42%, etc. have driven one married and older employee out, prevented a new employee with a family from joining and have left me with no choice but to get out. Premiums are twice our house payment. It is either pay one or the other.

I looked at the plan provisions for everyone across the board and the employer contributions. It appears that I could pay the 8% and 9% premium tier on all my employees, thereby covering all of them and save over $4000 per year from what I am now paying on our family and my 50% share of two young, single employees. The 100% coverage for physicals and cancer screenings sounds like great preventative medicine.

The big question is "Will the proposed payroll tax rates cover the costs over the long run?" I would hate to see huge increases in the rates. I feel the fairly large deductibles will help prevent people from over utilizing the plan, a real killer for $0 deductible PPO's.

I hope that you can work out details and move ahead to implement the plan.
Sincerely,
Wayne S. Hanson

From: paul.hartlaub@aurora.org
To: WHP Website
I am a Family Practitioner specializing in Preventive Medicine and Public Health. I have just heard about and reviewed the plan - it makes a lot of sense, and I think it is on the right track with potential to cover the uninsured and put more emphasis generally on prevention, leading to a more economically and humanistically favorable HEALTHcare (rather than SICKcare) system.

If there is any way I can further support this project, please let me know.
Paul Hartlaub, MD, MSPH
Associate Professor, UW Medical School, Milwaukee Clinical Campus

From: bherrmann5@msn.com
To: WHP Website
Thank you for bringing a proposal to address the issue of health insurance coverage. I believe that Wisconsin has the opportunity to pilot a plan which will give coverage to ALL of our citizens. The proposed plan also addresses the need for consumer responsibility by using co-pays. I have been a public health nurse for almost 30 years and the number of the uninsured in our community is frightening. I strongly feel, that we as a society, have the responsibility to make available basic health care to all of our citizens. Again thank you for your courage.
Barbara Herrmann

From: fraunies@wctc.net
To: WHP Website
First off - this is EXCITING!! I hope it is successful! I'm employed by a small outpatient mental health clinic as the office manager here in central wisconsin and we have no medical benefits offered to us! We work in the "medical" field....yet can not afford benefits to the employees. We're a "for-profit" clinic, but if you were to see the books the term "for profit" fits quite loosely! Anyway, I'm writing, first because I am having trouble reading the documents - only partial documents come through - can I get a hard copy somewhere...or maybe emailed to me? Second, GOOD LUCK....this is much needed and I'm sure a long road is ahead. My concern is - managed care was suppose to "solve" our healthcare crisis (or so we were told back in the late 80's and early 90's) and all that has done is created more havoc to the system. One HMO actually told me when we were trying to negotiate a better rate for our services that we could raise our rates to cover the loss that the HMO was going to be giving us. (Doesn't take a rocket scientist to figure out what happened to the system when EVERYONE started raising their rates to cover the losses from the HMO's).
...anyway....good luck and best wishes!
Crystal Fraundorf

From: Amy@nurseinc.net
To: WHP Website
As a health care provider, consumer, business owner, advocate and mother I am deeply interested in the Project and feel I can contribute to the conversation. As a business owner of 3 successful health care companies for the last 18 years and one that provides health care benefits to my staff and is facing a 37% increase in premiums.... there is much to discuss. Please contact me at your earliest convenience.
Amy L. Kirkland

From: pyakes@alumni.marymount.edu
To: Rep.Gielow
Subject: Wisconsin Health Plan

Dear Representative Gielow,
I commend you and Representative Jon Richards for bringing forward the Wisconsin Health Plan for consideration. I am a wife, working mother, advocate and steering committee member of the Wisconsin Coalition for Fairness in Mental Health and Substance Abuse Insurance. I am concerned with Wisconsin's outdated insurance mandate for mental health and substance abuse treatment and that the context of the major reform you have proposed does not include nor address the elimination of existing mandate minimums for mental health and substance treatment.
Ten years ago and counting, my family was thrust into the world of stigmas and discrimination, not only by our health insurance provider, but by society's lack of education and awareness of mental illness. Our twelve year old daughter, the middle child of three children, was diagnosed with severe Anorexia Nervosa. Anorexia Nervosa is labeled by the insurance industry as a mental illness. Even though Eating Disorders are acknowledged in the DSM 1V, most Wisconsin health

insurance companies limit treatment coverage to the mandated coverage passed in 1985. My husband and I did not have the viable option to negotiate expanded mental health and substance abuse benefits with his employer. We made the attempt more than once, but it was extremely difficult to persuade the employer and co-workers the need for increased mental health and substance abuse benefits for our family or their families. Death was at our daughter's door.

Our story, pain and loss does not describe what my family has had to encounter. Yet, I believe the creation of a standardized health plan for Wisconsin families and residents would remove what businesses and legislators have argued as a "viable option". It has never been a "viable option" to my family, not once in ten years! Nor has it been a "viable option" for the hundreds of suffering Wisconsin families and victims of eating disorders, who desperately contact me for help, share their stories and/or in need of a support system. We need to eliminate the mandated minimums for mental health and substance abuse. It is time Wisconsin legislators moved beyond the argument/debate of insurance coverage, thereby saving the lives of our children, family units thus ending the stigma and discrimination. Victims of mental illness and substance abuse have "beautiful minds" deserving a quality of life.

A ten year debate with employers, insurance companies, legislators and lobbyist co-incided with our fight to save our child from a life-threatening illness. Fighting for fairness in insurance coverage at the same time a life-threatening illness covert's a child's life must stop now. Never should it have been my family's reality.

I am available for discussion, opinions and concerns that you may have. I hope to hear from you.
Sincerely,
Penny Yakes

From: mrothschild@bus.wisc.edu
To: Rep.Gielow; Rep.Richards
Subject: guaranteed health coverage

Dear Representatives Gielow and Richards--

Congratulations on proposing a guaranteed health coverage plan. My area of work is social marketing and I'd like to suggest an amendment to your plan that would lower its cost and make it more appealing to your opponents.

Your plan has the goal of better health coverage. I would suggest that the goal should be better health, and one means to that goal should be better health coverage.

In social marketing, we would like to use people's own self interest to get them to behave in a way that benefits the larger community. In the current case, we would like to motivate the residents of the state to take better care of their own individual health. In your plan, we would give each person a share of the premium to pay based on their health and their effort at improving or maintaining their health. A reasonable level of compliance could lead to no cost for the citizen. Similarly, we would have flexible rates for employers based on how they create a healthy and motivating environment for their work force. As firms and workers develop such plans, health will improve, health care costs will decrease, and all will benefit in their own self interest.

I have been working with the National Cancer Institute for the past year in developing a model for such a plan; there have been a number of successful implementations of such plans around the country that have lowered costs for employers and led to a healthier work force. For example, social marketing rewards owners for offering healthier food in vending machines and cafeterias, and offers healthier food at lower cost to employees. Employers can be assisted in developing physical activity plans, and workers health costs can be lowered when they are able to document participation. There are many similar examples I could share with you.

I was pleased to see that your plan focuses on the employer and the work place, as the employer has strong self interest in lowering health care costs in order to increase profits. Unfortunately your plan (as outlined in the local papers) doesn't take advantage of these natural allies who would benefit from a plan that is in their own self interest.

I would urge pursuit of the following anonymous quote: "Organize policy and strategy until self interest does what justice requires". Many of your opponents on this issue have a libertarian bent; a social marketing perspective allows for a mandated program that contains free choice with respect to how the participants behave and pay. By offering free choice and self interest, we may achieve better health coverage, better health, and lower total costs for all of Wisconsin. Perhaps Wisconsin can be a model of better health and lower costs for other states to follow.

This model of social marketing has been used elsewhere in Wisconsin. The Department of Transportation developed a pilot program to reduce alcohol impaired driving (the "Road Crew"). Crashes were reduced by 17% in the first year in test communities, the communities are now self sustaining in their programs, and the DOT has recently asked us to expand our program into other communities. The logic of social marketing would be very appropriate for your proposed plan as well.

I would be pleased to meet with you and/or your staff to pursue these issues. My apologies for not responding sooner, but I was away at a social marketing conference and just returned.

--Michael Rothschild Emeritus Professor
School of Business University of Wisconsin

From: ejcurran@custompowertech.com
To: curt@curtgielow.com; Rep.Richards
Subject: Feedback for Curt Gielow and Jon Richards - 23rd and 19th State Assembly Districts

Curt and Jon,

I followed up on a 620 WTMJ radio newscast yesterday and was informed that you were proposing the "creation of a statewide health insurance purchasing pool to make it easier for businesses trying to cope with the rising cost of coverage".

I am very interested in learning more about your proposed plan.

I am a Design Engineer at Custom Power Technology, a small business (eight full time employees) located in Menomonee Falls, WI. I am the companies representative for medical insurance.

At CPT, each employee is self-insured (not in a "pool"). Over the last 5 years we have changed insurance carriers several times. Each time, because the rates increased dramatically (50%). Unfortunately, each time we changed insurance carriers, any medical treatment received over the last 5 years is considered a "pre-existing condition" and is no longer covered by the new carrier. All of us, as a result, are paying in full for any further treatment of the pre-existing conditions, as well as the increased medical premiums. We are caught in the insurance company game of signing on at a lower rate, and then jacking up the rate after a year, resulting in less coverage each time because of newly added pre-existing conditions.

Please send me any information you have on your proposed plan, and how I can keep abreast of your progress.

Also, once I have seen what your plan is about, if the plan seems to make sense, I would be glad to contact other representatives to show my support of your proposal.

Earl Curran
Principal Engineer
Custom Power Technology, Inc.
N93 W14605 Whittaker Way
Menomonee Falls, WI 53051

From: llblsa2@sbcglobal.net
To: Rep.Richards
Subject: State health insurance

Dear Representative Richards:

I just read about your initiative on health insurance in the Journal-Sentinel. First off, congratulations on your courage and foresight in proposing this change.

I am a family physician, who has worked on this issue for years in both public and private ways. I would like you to hear one of the latter in case it gives you good ideas for your bill.

I was approached by the CEO of a local company in 1994 (another time of rapidly rising health care costs), and we discussed the good and bad aspects of indemnity, HMO, and other insurance plans. We crafted a plan for his company that went like this:

1) Everybody chose a primary care physician (employee and family choice; each individual could choose a different one even in the same family)
2) Visits to primary care were FREE to the patient.
3) Visits to hospitals and specialists stayed under a deductible/coinsurance model.

That's it. Primary care doctors were paid generous capitations for the patients who chose them, paid on a monthly basis.

What happened? The company's health care costs dropped 35% the next year. Yes, you read that right: thirty five percent drop in health care costs. This is the power of people getting access to preventative and early intervention care from primary care physicians. They have run this plan for 10 years now, saved somewhere above $2 million in the process (for a company averaging about 450 employees over that 10 years (that's over $400 in savings per person per year). They recently had a change in both CEO and vice president of HR and they completely reviewed the plan and put it up against competitive bids from insurance companies; they have retained it. Over the last five years, the rates that they pay the primary care physicians has risen just 14%. No primary care physician has EVER voluntarily left the plan. Pretty good results from a simple plan.

It is also a (I think) politically sellable plan. Why?

1) Everyone gets a personal physician
2) Hospitals and specialists do not have to change as their billing issues stay the same (puts a lot of lobbyists on the sidelines)
3) Insurance companies are still in the mix, as they would provide the hospital and specialist insurances (more lobbyists on the sidelines)
4) Primary care physicians do well (if everyone in the state is covered under this plan, average PC physician will see a significant increase in income with less hassle)--lobbyists in favor!
5) Lower costs,
6) Capitations make the cost of primary care predictable

7) This could be funded (by my admittedly amateur calculations) for a payroll tax in the 0.7% range.

I would be glad to provide more details if you are interested.

Again congratulations, and best of luck with your bill. If it fails, think about my idea as a fall back position.

Sincerely,
Leigh LoPresti, M.D.

From: lawrenceandersen@earthlink.net
To: Rep.Richards
Subject: Health Insurance Tax Proposal

Mr. Richards,

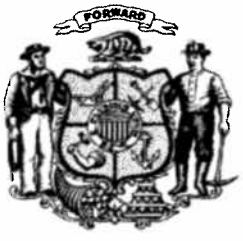
I read an article in the Milwaukee Journal-Sentinel about the joint proposal for health insurance tax that you made with Representative Gielow.

I believe that this is just the type of solution that we need to cover the growing number of uninsured people in this state. The bargaining power available for such a large pool of insured people would help control the costs of health insurance for everyone in the state.

I would like to offer my assistance in moving this proposal forward. Please contact me if there is anything I could do to help. I am a unemployed/retired software engineer currently paying for insurance through the state's HIRSP program.

Thank you,
Lawrence P. Andersen


WISCONSIN STATE LEGISLATURE


FORWARD

WISCONSIN HEALTH PROJECT

Controlling costs Expanding access

www.wisconsinhealthplan.org

WISCONSIN HEALTH PROJECT

Assembly Bill 1140

Rep. Curt Gielow (R-Mequon)
Rep. Jon Richards (D-Milwaukee)

THE WISCONSIN HEALTH PLAN – AB 1140

Guiding Principles

Market-Based Solution

- *-Private Corporation*
- *-Large Purchasing Pool*
- *-Competition and Incentives*

Consumer Responsibility

- *-Sensitivity to Cost and Quality*
- *-Cost/Quality Data Transparency*
- *-Wellness/Lifestyle Incentives*

THE WISCONSIN HEALTH PLAN – AB 1140

Key Elements

(1) Health insurance for Wisconsin residents

(2) Choice of health care plans and providers

(3) Fair and simple financing mechanism

THE WISCONSIN HEALTH PLAN – AB 1140

Health Insurance Purchasing Accounts

All Wisconsin Residents Under 65 Unless:

-Not here for 6 months
-Not a "permanent" Wisconsin resident
-In prison or other institution
-Federal employees
-Covered by Medicaid or BadgerCare

Two Parts:

-HSAs: Adults get $500 annually for health services
-Premium Credit

THE WISCONSIN HEALTH PLAN – AB 1140

The Premium Credit

Uniform medical, hospital, and Rx health insurance benefit package from <u>all</u> health care plans

Preventive care

<u>No</u> cost-sharing

Cost Sharing

-Deductible:	*Children $100*	*Adults $1200*	
-Co-insurance:	*Children* 10-20%	*Adults* 10-20%	
-O.O.P. max:	*Children $500*	*Adults $2000*	*Families $3000*

Catastrophic Care

<u>No more</u> cost sharing

Private Health Insurance Purchasing Corporation

Wisconsin Residents

Premium Credits

Tier 1
-NO EXTRA PAYMENT
-LOWEST COST
-HIGH QUALITY

Tier 2
-EXTRA PAYMENT
-HIGHER COST

Tier 3
-HIGHEST PAYMENT
-HIGHEST COST

THE WISCONSIN HEALTH PLAN – AB 1140

How the Plan Controls Health Costs:
Strong Consumer Incentives

Incentive #1: Choose Tier 1 Plans

-Individuals: Avoid Extra Premium Costs
-Insurers: Want to Offer Tier 1 Plans
-Providers: Want to BE in Tier 1 Plans
-Can Only Be Tier 1 by Lowering Costs

THE WISCONSIN HEALTH PLAN – AB 1140

How the Plan Controls Health Costs:
Strong Consumer Incentives

Incentive #2: **Choose Appropriate Care**

-Use Preventive Care: No Cost

-HSAs + Deductibles + Co-Insurance:

  -Discourage Unnecessary Care

  -Encourage *Shopping* for Best Price

-All Lower Total Cost

THE WISCONSIN HEALTH PLAN – AB 1140

How the Plan Controls Health Costs:
Strong Consumer Incentives

Incentive #3: **Maintain a healthy lifestyle**

-Individuals: Bigger HSAs

-Employers: Lower Assessment

-Less *need for care* = lower *total* costs

THE WISCONSIN HEALTH PLAN—AB 1140

Additional Opportunities to Reduce Costs

Transparency: Costs and Quality

Simplified billing

Advanced Technology

THE WISCONSIN HEALTH PLAN

Financing the Plan

Employee assessment: 2% of Social Security wages

Employer assessment: 3% to 12% of Social Security wages

- 3% up to $50,000 of wages
- 4% at $100,000 of wages
- 5% at $150,000 of wages
- 6% at $200,000 of wages
- 7% at $250,000 of wages
- 8% at $300,000 of wages
- 9% at $350,000 of wages
- 10% at $400,000 of wages
- 11% at $450,000 of wages
- 12% for over $500,000 of wages

Most employers would pay *LESS* than the 15-16% of payroll the average firm now pays.

A UNIQUE OPPORTUNITY

Boosting Wisconsin's New Economy

Lower and Stabilize Employers' Health Costs

Promote an Entrepreneurial Business Climate

Create a Healthier Workforce

Cut Property Taxes

Cut Business Taxes

WISCONSIN HEALTH PROJECT

Controlling costs • Expanding access

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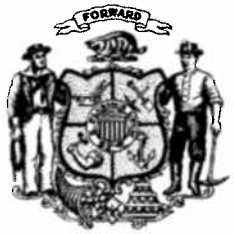
WISCONSIN STATE LEGISLATURE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Concept Paper
on the Development of

Assembly Bill 1140
The Wisconsin Health Plan

www.wisconsinhealthplan.org

A Collaboration of:
The Wisconsin Health Project
David Riemer and Lisa Ellinger

and

Rep. Curt Gielow (R-Mequon)
Rep. Jon Richards (D-Milwaukee)

Proposed in June 2005
Revised in April 2006

The Wisconsin Health Plan – Assembly Bill 1140

Executive Summary
The Wisconsin Health Plan seeks to address Wisconsin's triple crisis in health care: the skyrocketing cost of health care, increasing numbers of uninsured, and the ever-present deficit in the state's Medicaid program.

Wisconsin-specific data show that employers now spend an average of **15%** of payroll for the health care premiums of their employees. Health care costs are rising **10-25%** per year, and the result is an adverse economic effect on wages, profits, job creation, and new investment in Wisconsin.

Wisconsin has been a national leader in having low rates of uninsured in our state. Yet over 500,000 Wisconsinites -- 10% of the population -- have no insurance coverage at some point over the course of the year. Conservative estimates suggest that 5% of our population is not covered on any given day. Lack of insurance is a significant factor in premature death, unnecessary illness and bankruptcy, and the trends in this area are getting worse, not better.

Wisconsin's Medicaid program is facing a structural deficit because costs and caseloads are rising much faster than state revenues. The state has relied on short-term fixes to get by thus far, but the ongoing structural deficit in this $4 billion program continues to undermine other state priorities.

The Wisconsin Health Plan provides a new way to pay for health care in Wisconsin. This proposal creates an effective purchasing pool and incorporates "consumer driven" incentives to promote health care quality and use market forces to drive down health care costs.

The proposal has three simple components:

- All Wisconsin residents (under age 65) own a **Health Insurance Purchasing Account;**
- All participants have an **annual choice** of health care plans and providers similar to the current state employee health plan;
- The program is financed through a **fair and simple** mechanism.

The plan is structured in a way that would free up nearly $1 billion in the state's biennial budget. The Wisconsin Health Plan proposes to use this revenue to cut taxes on businesses and individuals. The details of the plan follow.

Participation: Who is Covered?
The Wisconsin Health Plan covers all Wisconsin residents less than 65 years of age, with a few exceptions. The plan does not cover any person who:

- has resided in Wisconsin less than six months (newborns with parents who have lived in Wisconsin for six months are covered);
- claims residency in another state or jurisdiction for Wisconsin income tax purposes;
- is institutionalized;
- is an employee of the federal government; or
- is eligible for Medicaid or BadgerCare (see more on this in the "**Merging Programs**" section below).

Benefit Structure: Health Insurance Purchasing Accounts
All eligible Wisconsin residents receive a "Premium Credit," which the participant uses to purchase health insurance from competing, qualifying health insurance plans. In addition, all adults (age 18-64) also receive a Health Savings Account (HSA), funded at $500 each year.

HSAs can be used to pay for a wide range of medical care. Extensive information on "qualifying" medical expenses is available at: http://www.health--savings--accounts.com/qualified-expenses.htm

Benefit Package: What is Covered?
The Premium Credit pays for a benefit package that covers medical care, hospital care, and prescription drugs. All participants receive a limited, evidence-based set of preventive care services with no cost sharing. The applicable deductibles, co-insurance, and out-of pocket maximums are listed below.

For Children (age 0-17):

- an annual deductible of $100;
- preventive dental care with no cost sharing;
- co-insurance (between 10-20%) for medical and hospital care;
- co-insurance and co-pays for prescription drugs;
- an annual out-of-pocket maximum of $500.

For Adults (age 18-64):

- an annual deductible of $1,200;
- co-insurance (between 10-20%) for medical and hospital care;
- co-insurance and co-pays for prescription drugs;
- an annual out-of-pocket maximum of $2,000;
- an annual "family" out-of-pocket maximum of $3,000.

Pre-existing conditions: Participants who move to Wisconsin after the inception of the program must provide evidence of health insurance coverage substantially similar to the health insurance provided by this program for the year prior to enrolling in the Wisconsin Health Plan. Those unable to do so will not receive coverage for pre-existing medical conditions until they have lived in Wisconsin for two years.

Program Administration: The Private Health Insurance Purchasing Corporation
The program is administered by the Private Health Insurance Purchasing Corporation of Wisconsin, a private corporation governed by an eight-person Board of Directors responsible for establishing and operating the health insurance purchasing program. Board members include two gubernatorial appointees and one representative from each of the following organizations:

- Wisconsin Manufacturers and Commerce
- Milwaukee Metropolitan Association of Commerce
- National Federation of Independent Business / Wisconsin
- Wisconsin AFL-CIO
- SEIU Wisconsin State Council
- Wisconsin Farm Bureau

All major Board decisions require seven of eight votes. Board meetings are held in public, and subject to open meetings and open records law. The Board is required to submit annual reports to the Legislature, and the Legislative Audit Bureau is required to conduct a comprehensive audit at least every two years. The Board is responsible for choosing and overseeing an Executive Director and other staff, as well as approving all major contracts.

Participant Choice and Incentives: The Keys to Controlling Health Care Costs
As mentioned above, all eligible Wisconsin residents receive a "Premium Credit," which they direct to the health care plan of their choice. Any insurer (for example, HMOs, PPOs, or indemnity carriers) licensed to sell health insurance in Wisconsin -- and that meets specified financial, coverage area, and disclosure standards -- is qualified to compete to provide insurance coverage. The competing insurer plans are placed into three "tiers" based on risk-adjusted cost and quality measures.

Participants have a clear financial incentive to choose the "Tier 1" health care plans because their Premium Credit covers the full cost of the monthly premium for these plans, with no additional out-of-pocket payment. Participants who opt for higher-cost plans ("Tier 2" or "Tier 3") are required to pay a portion of the premium to enroll.

This system not only provides a powerful incentive to participants to choose the low-cost Tier 1 plans, but also motivates the insurers to be designated low-cost Tier 1 plans and encourages providers to be associated with those plans – thus controlling health care costs.

The Private Health Insurance Purchasing Corporation is responsible for choosing an administrator to serve as the "trustee" of the Health Insurance Purchasing Accounts, to educate participants about how to use the accounts, and to transfer the Premium Credits to selected plans. The dollar value of the Premium Credit is adjusted to reflect age, gender, and other appropriate factors. In other words, plans are paid according to the "risk" of their enrolled population. The Private Health Insurance Purchasing Corporation also retains a small portion of the Premium Credits to compensate health care plans that incur disproportionate risk. The Private Health Insurance Purchasing Corporation may also retain a portion of the Premium Credits to directly provide the prescription drug coverage.

Financing the Program: The Employer and Employee Assessments
NOTE: The funding mechanism described below is not included in AB 1140. This aspect of the legislation is a work in progress, and the assessment described below is considered a starting point for discussion.
Any firm or person operating in Wisconsin that must file form "941" or schedule "SE" is required to pay an assessment to finance this program. The assessment starts at 3% of the first $50,000 of Social Security wages, and gradually increases up to a cap of 12%. The assessment rises .02% for each additional $1,000 of wages. The following bullets illustrate the assessment rate at key points in the schedule:

- 3% up to $50,000 of wages
- 4% at $100,000 of wages
- 5% at $150,000 of wages
- 6% at $200,000 of wages
- 7% at $250,000 of wages
- 8% at $300,000 of wages
- 9% at $350,000 of wages
- 10% at $400,000 of wages
- 11% at $450,000 of wages
- 12% for payrolls greater than $500,000

Businesses with less than $500,000 in annual wages are assessed based on estimates they make of annual payroll that are reconciled at the close the calendar year.

Employees are required to pay a flat assessment equal to 2% of their Social Security wages.

The assessment is collected by the Wisconsin Department of Revenue and can only be increased through an act of the state Legislature. If the Private Health Insurance Purchasing Corporation determines that the assessment will not generate sufficient funds to pay for the health insurance benefits described above, it must present options to the Legislature to raise revenue and lower costs. If the Legislature does not act, the Corporation must reduce the HSA funding or other benefits. The Corporation also has the authority to direct any surplus revenues to a reserve fund, increase the HSA funding or other benefits, or recommend an assessment decrease to the Legislature.

Collective Bargaining Agreements: An employer with a collective bargaining agreement that provides for health insurance coverage and that is in effect upon the inception of this program is excluded from the full assessment. The exemption applies to any employee who is covered by the agreement and lasts for the duration of the existing coverage. Those employees are not covered by this program until the collective bargaining agreement ends.

Special Assessment for Wisconsin Residents Working Out-of-State: Individuals whose earnings from Wisconsin employers are less than $10,000 annually if filing singly ($20,000 if married and filing jointly), but whose Adjusted Gross Income (AGI) is more than $20,000 if filing singly ($40,000 if married but filing jointly), will be subject to a special assessment. This is to account for the fact that out-of-state employers cannot be assessed for the cost of this program, but their employees benefit as residents of Wisconsin. The assessment equals the lesser of:

- 10% of the difference between AGI and Wisconsin earnings, or
- $2,000 if filing singly or $4,000 if married and filing jointly.

This rule also applies to non-working residents with low earnings but high income who benefit from the program.

Merging Programs: Medicaid and BadgerCare
Initially, the Wisconsin Health Plan calls for the Medicaid and BadgerCare programs to continue to operate in their current form. The only proposed change pertains to the funding mechanism for the programs.

Currently, state government provides funding for Medicaid and BadgerCare from General Purpose Revenue (GPR), which is used to leverage matching funding from the federal government. Under this proposal, the GPR dollars currently provided by the state government for "family"* Medicaid and BadgerCare are replaced by funding from the employer and employee assessments.

This proposal also requires the Department of Health and Family Services (DHFS) and the Private Health Insurance Purchasing Corporation to jointly develop a plan to fold low-income residents eligible for the family portion of Medicaid and BadgerCare into the Wisconsin Health Plan. If the Legislature concurs with the plan developed by DHFS and the Corporation, DHFS is required to seek a waiver from the U.S. Department of Health and Human Services to implement this merger and obtain an acceptable federal match for state health insurance expenditures for our low-income population.

Economic Development: Tax Cuts for Businesses and Individuals
As explained above, under the Wisconsin Health Plan proposal the state government no longer pays the $500 million GPR spent each year for family Medicaid and BadgerCare. The Wisconsin Health Plan proposes to use this funding to cut the following taxes on Wisconsin businesses and individuals:

- eliminate the personal property tax paid by businesses,
- double the Earned Income Tax Credit for low-income workers,
- phase out the corporate income tax.

By lowering most employers' health care costs and eliminating two major business taxes, the Wisconsin Health Plan will substantially reduce the cost of doing business in Wisconsin and help stimulate economic growth in the state.

**Note: This proposal only applies to the "family" portion of the Medicaid and BadgerCare programs, and does not impact funding for the "elderly and disabled" Medicaid programs.*

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Assembly Bill 1140 is available at: http://www.legis.state.wi.us/2005/data/AB-1140.pdf

What is the Wisconsin Health Project?
The Wisconsin Health Project is a new, grant-funded, non-profit program designed to tackle the two major health care problems facing Wisconsin: a large and growing uninsured population, and double-digit increases in health care costs. The Project includes both short-term initiatives aimed at providing insurance access and lowering prescription drug costs, as well as the major long-term initiative of building consensus across traditional ideological and political divides about how to expand health insurance coverage and lower health care costs in Wisconsin.

The Project was established in September 2004 and receives major financial support from two Milwaukee-based foundations: The Brico Fund and The Argosy Foundation. Additional funding has been provided by the David and Julia Uihlein Charitable Foundation. The New Hope Project of Milwaukee serves as the fiscal agent for the Project.

Staff of the Wisconsin Health Project
David Riemer – Project Director
Governor Jim Doyle appointed Mr. Riemer to serve as the State of Wisconsin Budget Director in December 2002. He served until October 2003, when he left to run for Milwaukee County Executive. Mr. Riemer served as Director of Administration for the City of Milwaukee from December 1988 to September 1993 and again from June 1996 until January 2002. Mr. Riemer also worked as Milwaukee Mayor John O. Norquist's Chief of Staff from September 1993 until June 1996.

From 1985 to 1988, Mr. Riemer was employed by Time Insurance Company in Milwaukee as Counsel for Cost Containment and later as Director of Managed Health Care Development. Mr. Riemer served in 1983 as Counsel for Health Care Financing with the Wisconsin Legislative Fiscal Bureau, where he assisted the Joint Committee on Finance and members of the Legislature in formulating the health care cost containment provisions included in the 1983-85 Biennial Budget Act.

Mr. Riemer worked in Washington, D.C., from 1981-82 as Senior Staff Director for Human Resources with the National Conference of State Legislatures. From 1978-81, he was Counsel to the U.S. Senate Subcommittee on Health and Scientific Research, chaired by Senator Edward M. Kennedy. He served from 1976-78 as Special Counsel to the Wisconsin Department of Health and Social Services, and from 1975-76, he served as Legal Advisor to Governor Patrick Lucey. Mr. Riemer is a graduate of Harvard Law School and Harvard College.

Lisa Ellinger – Assistant Director
Ms. Ellinger joined Governor Jim Doyle's Office as the Health and Human Services Policy Advisor in January of 2003, and was the lead staff in the creation and development the Governor's KidsFirst initiative, announced in May 2004. Before joining the Governor's staff, Ms. Ellinger worked in the state legislature as a legislative research assistant in both the State Senate and State Assembly.

From 1994 to 1997, Ms. Ellinger worked in marketing and public relations for Lunar Corporation (since acquired by GE Healthcare), and worked for the UW-Madison Medical School Office of Rural Health from 1993-94. Ms. Ellinger has a B.S. in Journalism and Political Science from UW-Madison and a Masters Degree from the UW-Madison LaFollette School of Public Affairs.

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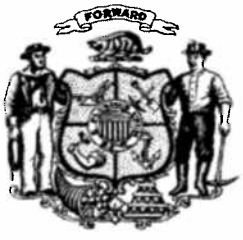
WISCONSIN STATE LEGISLATURE


FORWARD

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

December 22, 2005

TO: Representatives Curt Gielow and Jon Richards
State Capitol

FROM: Eric Ebersberger, Marlia Moore and Charles Morgan

SUBJECT: The Wisconsin Health Plan

In response to your request, this memorandum provides a description of the Wisconsin health plan (WHP), a proposal that would significantly change the funding and delivery of health care services to most state residents who are under 65 years of age. In addition, you asked that this office review some of the calculations and assumptions that the authors used in developing the plan.

Introduction and Overview

The plan was developed by Mr. David Riemer and Ms. Lisa Ellinger, of the Wisconsin Health Project, state legislators, and others who have submitted suggestions and comments on early versions of the proposal. The proposal has changed somewhat since it was initially made public in June, 2005. Consequently, the information provided in this memorandum is based on an understanding of the current plan, which may be subject to additional revisions. At this time, a draft of the proposal is not available for legislative consideration.

To facilitate comparisons with information that is currently available regarding health care costs and wage data, the figures presented in this memorandum reflect 2005 estimates. However, the WHP authors anticipate that this proposal would be considered by the Legislature in spring, 2007, and enacted as part of the 2007-09 biennial budget. The provisions relating to establishing a new entity, the Health Insurance Purchasing Corporation, would take effect immediately following the enactment of the enabling legislation. The WHP authors anticipate that individuals would choose health plans and establish health care purchasing accounts in 2008, so that by January 1, 2009, health costs would be paid from these accounts.

Summary in Brief. The proposal would create an assessment employers and employees would pay that would be based on a graduated percentage of the social security wages the employer pays. All assessment revenue would be used to support: (a) "premium credits," which would be used by all Wisconsin residents under the age of 65 (with limited exceptions) to purchase health

insurance from competing, qualifying health insurance plans; and (b) health savings accounts for each adult, funded at $500 per year. Each of these qualifying health plans would provide basic preventive care, which would include dental coverage for children, without requiring policyholders to share in the cost of these services. However, for other services, the plans would have an annual deductible of $100 per child, $1,200 per adult, and coinsurance requirements that would be limited to ensure that policyholders do not incur out-of-pocket costs that exceed $500 for children, $2,000 for adults, and $3,000 for families. Employers would no longer offer their employees health care coverage, unless they wished to contribute to their employees' HSAs, or enhance the "core" benefits that would be available to their employees.

Initially, the assessment revenue would also be used to support the state's share of the costs of providing health services to low-income families that are currently enrolled in the medical assistance (MA) program, which would reduce the amount of general purpose revenue (GPR) that would be needed to support these programs. By replacing a portion of the GPR funding currently budgeted for MA with revenue from the assessment, the proposal would: (a) reduce or eliminate the personal property taxes paid by businesses; (b) increase the earned income tax credit for low-income employees; and (c) reduce or phase-out the corporate income tax.

Summary of Plan

Funding. When fully implemented, the plan would have four primary sources of funding: (1) assessments on employers; (2) assessments on employees of firms that are subject to the employer assessment; (3) special assessments on certain employees that would be covered under the plan who work in out-of-state firms; and (4) federal matching funds the state currently receives that support benefits to certain MA and BadgerCare enrollees.

Employer Assessment. The WHP would finance health care for all Wisconsin residents who are under 65 years of age, with limited exceptions, through an assessment on employers and employees. Each employer, including an employer that is currently self-insured, that is required under federal law to file an employer's quarterly federal tax return (Form 941) or a self employment (SE) tax form would be required to pay an assessment.

The assessment would be graduated, based on the social security wages each employer pays. All employers would pay an assessment equal to 3% of the first $50,000 of social security wages. For each $1,000 increment of additional social security wages, the assessment would be increased by 0.02%, applying the new rate to all wages, until the assessment reaches 12% at $500,000 of social security wages. A 12% assessment would be applied to all firms with wages that exceed $500,000.

Employee Assessment. All employees would be required to pay a flat assessment that would be equal to 2% of their social security wages.

Families with income that exceeds 150% of the federal poverty level that are enrolled in BadgerCare are currently required to pay a monthly premium equal to approximately 5% of the family's income. Since workers in these families would pay the employee assessment, the proposal would repeal the BadgerCare premium requirement at the time the employee assessment is implemented. In 2005-06, it is estimated that these BadgerCare families will contribute approximately $6.9 million toward the cost of BadgerCare program costs. Consequently, if the BadgerCare premium requirement were repealed, state funding would be needed to replace the premium revenue as a source of funding for BadgerCare benefits.

Assessment on Certain Employees who Work Out-of-State and Individuals with Non-Wage Income. The WHP would also impose a special assessment on certain Wisconsin residents who work out-of-state and individuals who benefit from the WHP that have non-wage income. For example, individuals whose earnings from Wisconsin employers are less than $10,000 annually ($20,000 for married individuals who file joint tax returns), but whose adjusted gross income is greater than $20,000 ($40,000 for married individuals who file joint tax returns) would be subject to this assessment. This group of individuals would be covered under the WHP, but their out-of-state employers could not be assessed. The amount of the assessment would equal the lesser of: (a) 10% of the difference between the individual's or couple's adjusted gross earnings; or (b) $2,000 for individuals who file singly or $4,000 for married individuals who file joint tax returns.

All of the assessment rates would be established in state statute. Consequently, the rates could only be changed through the enactment of legislation. The Wisconsin Department of Revenue (DOR) would collect the assessments.

Medical Assistance and State Children's Health Insurance Program (BadgerCare) Federal Matching Funds. Currently, the state receives federal matching funds to support the costs of providing services to individuals enrolled in MA and BadgerCare. After the WHP is implemented, it is possible, following federal approval and the enactment of additional state legislation, that families with dependent children who are currently enrolled in MA and BadgerCare would instead enroll in the WHP. If this occurs, it is assumed that these federal matching funds would remain available to support a portion of the costs of the WHP. This component of the plan is discussed later in this paper.

Eligibility and Coverage. The plan would provide health care coverage for most Wisconsin residents under the age of 65, as described below.

Eligibility. Initially, the plan would provide health care coverage for all Wisconsin residents under age 65, with limited exceptions. Exceptions would include persons residing in Wisconsin for less than six months, persons claiming residency in another state for income tax purposes, federal government employees, institutionalized persons, and persons eligible for MA or BadgerCare. (It is possible that certain MA and BadgerCare recipients could be eligible for the WHP once the state received required approvals from the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services.) In addition, potential WHP participants who move to Wisconsin

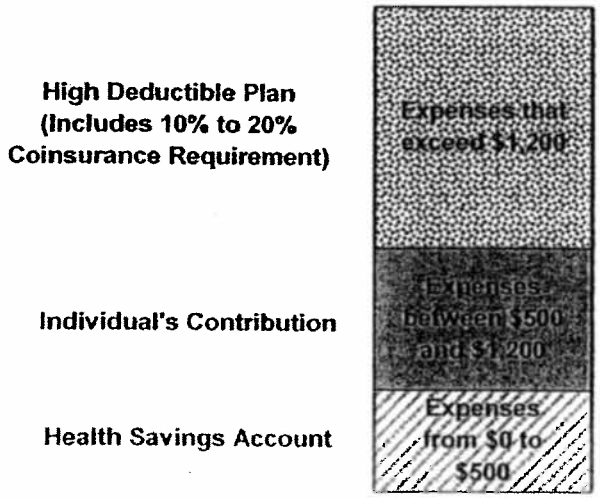
would have to provide evidence of health insurance coverage substantially similar to the health insurance provided through the WHP for the year prior to enrolling in the WHP, otherwise they would not receive coverage for pre-existing medical conditions until they have lived in Wisconsin for two years.

Plan Design. All eligible Wisconsin residents under age 65 would own a health insurance purchasing account, and all eligible adults would receive a health savings account (HSA) funded at $500 per year. The health insurance purchasing account would provide a benefit package covering medical care, hospital care, prescription drugs, and a limited dental benefit. Adults would be responsible for paying an annual deductible of $1,200 and coinsurance for medical care, hospital care, emergency care, and prescription drugs. However, the annual maximum out-of-pocket costs an individual would pay would be $2,000. For children, the annual deductible would be $100 and the out-of-pocket maximum would be $500. The out-of-pocket maximum for families would be $3,000.

The following chart and table illustrate the total annual medical costs that would be paid by the HSA, the high deductible plan, and a single employee, using several examples of health care costs the employee incurred during the course of the year.

Wisconsin Health Plan

Examples of Coverage for an Individual



Medical Expenses	HSA	High Deductible Plan	Individual's Out-of-Pocket Costs
$300	$300	$0	$0
600	500	0	100
1,000	500	0	500
3,000	500	1,530	970
5,000	500	3,230	1,270
15,000	500	12,500	2,000

Similar tables could be constructed to identify costs for families covered under the WHP. However, the total costs the HSA, the high deductible plan, and the family would incur would depend on the amount and type of medical expenses each family member received.

Policies funded under the plan would cover all pre-existing conditions an enrollee may have. However, individuals who become Wisconsin residents after the plan is implemented and who are unable to demonstrate that they had health insurance coverage substantially similar to the coverage under the WHP for the year prior to enrolling in the WHP would have to wait two years before the WHP would cover services to treat their pre-existing conditions.

Any insurer licensed to sell health insurance in Wisconsin could compete to provide policies under the WHP as long as the policy meets standards developed by the Health Insurance Purchasing Corporation (HIPCo, described below), which would place competing insurer plans into "tiers" based on risk-adjusted cost and quality measures. Insurers would submit the prices of their plans to HIPCo, which would make adjustments to the prices to account for the health and demographics of the individuals that would be covered under the plan. HIPCo would then assign each of the policies into one of three "tiers." The plans that HIPCo designates as "Tier I" plans would be those plans that have the lowest (risk adjusted) prices, and that score the best based on several quality measures. The premium credit an individual receives would cover the entire cost of a "Tier I" policy -- enrollees would not pay any portion of the premium for these plans. However, enrollees would be required to contribute toward the premium cost of a Tier II or Tier III policy.

Administration. The WHP would be administered by a Health Insurance Purchasing Corporation (HIPCo), a private, nonprofit, corporation governed by a nine-person board of directors that would be responsible for establishing and operating a health insurance purchasing program. Board members would include two gubernatorial appointees and one representative from each of the following organizations: (a) Wisconsin Manufacturers and Commerce; (b) the Milwaukee Metropolitan Association of Commerce; (c) the National Federation of Independent Businesses (Wisconsin); (d) the Wisconsin American Federation of Labor and Congress of Industrial Organizations (AFL-CIO); (e) the Service Employees International Union (SEIU) State Council; and (f) the Wisconsin Farm Bureau. HIPCo would be responsible for providing information on the WHP to all of the plan's enrollees.

All major board decisions would require eight of nine votes. The board would hold public meetings, and would be subject to open records law. In addition, the board would be required to submit annual reports to the Legislature, and the Legislative Audit Bureau would be required to conduct a comprehensive audit at least every two years. The WHP board would select and oversee a WHP director and would approve all major contracts.

MA and BadgerCare. Initially, the proposal would affect the MA and BadgerCare programs in two ways. First, a portion of the assessment revenue would replace GPR funding that is currently budgeted to support MA costs associated with services provided to certain families with dependent children. Second, the premium requirement for BadgerCare would be eliminated at the time DOR begins collecting revenue from the employee assessment. It is possible that, following the plan's implementation, this group of MA and BadgerCare enrollees would no longer receive health services under these two programs, and instead, be enrolled in the WHP.

Review of Methodology and Key Assumptions

The following table identifies the WHP authors' current estimates of revenue and costs of the WHP.

Summary of WHP Authors' Revenue and Cost Estimates
($ in Millions)

Revenue	
Assessments	
Employer Assessment	$10,656.0
Employee Assessment	1,952.9
Assessment for Out-of-State Employees and Individuals with Non-Wage Income	60.0
Total	$12,668.9
Costs	
Premium Credits	$9,594.4
Administration and Profit	834.3
Health Savings Accounts	1,575.1
HIPCo Administration	112.2
Subtotal -- Wisconsin Health Plan	$12,116.0
State Costs of Providing Services to Certain MA Recipients (Payment to the MA Trust Fund)	$523.0
State Cost of Eliminating BadgerCare Cost-Sharing Requirement	$6.9
Total Costs Funded from Assessment Revenue	$12,645.9
Contingency Reserve	$23.0
Total	$12,668.9

The revenue and cost figures in the previous table are discussed below.

Plan Costs

Premium Credits (Net Medical Payments). To estimate medical payments participating insurers would pay on behalf of WHP participants, the authors retained the actuarial services of Reden & Anders, Ltd. Reden & Anders used its national database containing calendar year 2003 baseline data on approximately 5.5 million persons related to billed charges per patient and utilization per patient by age, sex, and major medical service category. The company then adjusted its data by a factor of 1.03, to reflect that that billed charges for medical services in Wisconsin exceed the national average by 3%, based on the company's medical expense models. Reden & Anders also adjusted the baseline data to account for increasing utilization and unit costs, and factored in estimates of provider discounts as applied to inpatient facility care, outpatient facility care, professional services, prescription drugs, and "all other services." The Reden & Anders analysis then accounts for annual deductibles, copayments, and the proposed out-of-pocket maximums to project annual net paid medical costs by multiplying a per-member-per-year medical payment rate for all WHP participants, male and female, ages 0 through 64, and adding those figures.

Reden & Anders' total estimate of net medical payment ($11,024.9 million), is meant to represent the annual amount that participating insurers would pay for the medical treatment of WHP participants, net of the insurers' administrative expenses and profit. (This number differs from the figure in the table on page 6 because the estimated costs of providing premium credits to the MA and BadgerCare population ($1,430.5 million) have been subtracted to reflect that the MA and BadgerCare population would not be initially covered under the WHP.)

According to the company, the Reden & Anders database comprises nationwide data from a few large health insurers, primarily from large health maintenance organizations (HMOs). HMOs are health insurance plans that usually limit coverage to care from physicians who work for or contract with the HMO. Generally, in an HMO, a participant must choose a primary care physician who coordinates all care and makes referrals to any specialists that may be required, and must use the doctors, hospitals and clinics that participate in the plan network. No benefits are paid for non-emergency benefits provided outside the HMO network. HMOs stress preventive care, early diagnosis, and treatment on an outpatient basis. Given that its database comprises a high percentage of data submitted by HMOs, Reden & Anders chose to add a 5% "utilization/care management" factor across all service category costs to reflect that the WHP may provide less focus on coordinating service utilization through a primary care physician. That is, Reden & Anders assumes that WHP participants will use 5% more services than they would if, for example, they were participating in a traditional HMO. This utilization rate increase is in addition to the general assumption that utilization of all services will increase 1% to 2% annually.

Arguably, the Reden & Anders assumption that utilization of medical services under the WHP model will be 5% greater than under an HMO model must be balanced against the

assumption that the combination of high deductible health plans and health savings accounts will encourage individuals to make health care decisions based on information on service cost and quality. Specifically, patients responsible for high deductibles will have an incentive to use only care that is medically necessary, which would presumably reduce utilization rates. In fact, one criticism of HDHPs is that they will discourage the use of needed health care services, particularly among low-income persons.

The actuary's assumptions regarding provider discounts significantly affect the cost estimate, and therefore should be closely reviewed. Reden and Anders assumed that the plan would pay providers the following discounts from billed charges: (a) for inpatient hospital services, 40%; (b) for outpatient hospital services, 45%; (c) for professional services, such as physician services, 45%; (d) for prescription drugs, 18%; and for all other services, 40%. The actuary indicates that these discounts are commonly used in projecting plan costs. It is not the WHP authors' intent to change the rates at which health care providers are reimbursed for services once the WHP is implemented. Consequently, it would be helpful to compare the current reimbursement rates for each of these services with the actuary's assumed discounts.

With the exception of hospital data, limited information is available on reimbursement health care providers currently receive, expressed as a percentage of their billed charges. Aggregated information from the Wisconsin Hospital Association's 2004 fiscal survey shows that the discounts hospitals receive vary significantly by payment source, including: (a) 61% for Medicare; (b) 72% for MA; (c) 42% for other public sources; (d) 23% for commercial payers; and (e) 5% for other payers. Since only individuals who are not eligible for Medicare or MA would enroll in the WHP, it would seem appropriate to compare the current discount applicable to hospital services for commercial payers (23%), with the actuary's 40% to 45% discount assumptions.

The Medical Society of Wisconsin cannot provide information on payment rates for physician services, as a percentage of billed charges. However, the Society's Vice President of Government Relations indicates that anecdotal information suggests that discounts for commercial payers is probably less than 10%, and that the 45% discount the actuary used is more reflective of Medicare reimbursement.

Finally, the Reden and Anders analysis assumes that individuals in families with dependent children that are enrolled in MA and BadgerCare would instead be enrolled in the WHP, and would incur the same average expenses that other WHP enrollees would incur. This assumption is consistent with the initial proposal, but not the current proposal. Consequently, the current number of MA and BadgerCare enrollees would need to be subtracted from the population the actuary used to reflect the population that would be initially covered under the WHP. Although the figure in the table on page 6 for premium credits ($9,594.4 million) reflects an attempt to make this adjustment, additional work on this change to the initial plan may be needed.

In summary, the Reden and Anders estimates of the costs of providing premium credits to individuals enrolled in the WHP should be updated to reflect the current plan description. In

addition, several of the assumptions used by the actuary should be reconsidered, or additional justification for the assumptions the actuary used should be provided. It may be helpful to retain a different actuary to estimate premium costs so that the two estimates could be compared.

Administration and Profit. The WHP authors attribute a rate of 8% to insurer administration expenses and profit and add it to the net medical payment rates to estimate the total premiums that would be charged by WHP participating insurers. NorthStar Economics, Inc. (NorthStar), a Madison based economic consulting and research firm hired to review the WHP model, compared the estimate to percentage rates attributable to administration and profit for conventional health insurance plans and among large self-insured plans, and found the 8% assumption to be "reasonable and perhaps a bit conservative."

HIPCo Administration. The authors estimate that the cost for HIPCo to administer the plan would be approximately $112.2 million. This figure is derived by multiplying an estimated monthly cost per enrollee ($2.30) with the projected number of enrollees (4,064,000), then multiplying by 12 to produce an annualized cost. The administrative fee is based on the fee that the state pays to administer the state employees' health plan. HIPCo's costs would also include contracting with a purchasing administrator to perform certain education and enrollment functions. HIPCo would be responsible for reviewing each qualifying plan to determine whether it meets the WHP's standards, assigning each plan to one of three "tiers," and ensuring that each person who is eligible to participate in the plan receives the premium credit and a HSA. NorthStar found the cost basis assumption to be reasonable, given that the HIPCo, similar to the state, should enjoy economies of scale in administering a program.

The purchasing administrator would enroll qualifying residents and assign each enrollee a health insurance purchasing account, which would include a premium credit. The premium credit would equal the risk-adjusted cost of any Tier I bid. Qualifying residents would choose a health care plan by notifying HIPCo of their choices. HIPCo would then inform each plan: (a) who selected the plan; and (b) the dollar amount (the risk-adjusted premium credit) that HIPCo would transfer to the chosen plan each month for the 12-month period. If a qualifying resident selects a Tier II or Tier III plan, the qualifying resident and the plan would work out an arrangement under which the resident would pay the extra, out-of-pocket amount that would be required to join a Tier II or Tier III plan.

Health Savings Accounts. From the revenue generated by the employer assessment, the WHP would provide $500 toward an HSA for each adult ages 18 through 64 in the WHP. HSAs are tax-free savings accounts set up as personal accounts, owned by individuals even if established or contributed to by others. HSA beneficiaries may pay for qualified medical expenses from their accounts. Interest earned on HSAs is not taxed, and unused funds carry over to the following year. Individuals' contributions to HSAs are tax deductible from an individual's federal taxes up to statutory maximums. For 2005, the general limits are $2,650 for individuals and $5,250 for families. Under current state law, contributions to an HSA and earnings on an HSA are included in an individual's income for purposes of state income tax, that is, the contributions and earnings are not tax free. Individual eligibility for an HSA is conditioned on participation in a high

deductible health plan (HDHP), defined as one that has at least a $1,000 deductible for self-only coverage and a $2,000 deductible for family coverage. Given the proposed $1,200 annual deductible for the plans proposed under the WHP, they would seem to qualify as HDHPs. A HDHP must apply the deductible for all services except those deemed preventive.

Although there is no requirement that an HDHP provide preventive care benefits, an HDHP may provide preventive care benefits without a deductible or with a deductible below the minimum. For these purposes, preventive care includes, but is not limited to: (a) periodic health evaluations, such as annual physicals; (b) routine prenatal and well-child care; (c) child and adult immunizations; (d) tobacco cessation programs; (e) obesity weight-loss programs; and (f) screening services for various types of diseases and disorders. The plan's authors note that all WHP participants will "receive a limited, evidence-based set of preventive care services with no cost-sharing." Preventive benefits not subject to cost-sharing under the WHP would include pre-natal care and post-partum well-baby care, recommended child immunizations, annual physicals for children (0-17), annual gynecological exams for older girls and women, annual physicals for older men, colonoscopies when indicated, and a preventive dental benefit (including check-ups, coatings, and sealants) for children generally between ages two through 15. Thus, fewer preventive benefits not subject to cost-sharing are provided under the WHP than would be allowed under federal law.

Several studies in the past two years have resulted in reports highlighting the advantages and disadvantages of HSAs. One study released by the Commonwealth Fund concluded, in part, that HSAs will be unaffordable for the uninsured because the plans' out-of-pocket costs, including deductibles, would be too expensive for many low-income persons. While the WHP, as currently structured, would provide a HDHP for each qualifying adult and $500 towards an HSA, the proposed deductible for an adult is $1,200 and the out-of-pocket maximum is $2,000, leaving the individual responsible for $700 of the deductible and $1,500 of the out-of-pocket maximum. Since the WHP would not provide for premium or deductible subsidies, it is likely that some low-income individuals would be unable to fund their share, leading to cost-related access problems.

Another study released in December, 2005 by the Commonwealth Fund concluded that persons with a combination of HDHPs and HSAs exhibit more cost-conscious behavior in their health care decisions compared with those having comprehensive insurance. However, the study also found that very few people have the cost and quality information from their health plans to make informed decisions about their medical care. The study also found that persons enrolled in HDHPs are more likely to avoid or delay needed medical care and pay more of their own money for care when they do obtain it, than people who are enrolled in comprehensive insurance plans. Again, the $500 HSA stipend under the WHP model would mitigate this potential problem to some extent, but not entirely.

WHP Revenue

As noted above, the WHP model proposes to generate revenue primarily through assessments on employers and employees. The employer assessment would assess the first $50,000

of total social security wages at 3%; and then add a 0.02% assessment for each additional $1,000 of social security wages, applying the new rate to all wages, until the assessment reaches 12 percent at $500,000 of social security wages. A 12% assessment would then be applied to all firms with wages that exceed $500,000. Employees would be assessed at 2% of their social security wages and net earnings from self-employment.

The WHP would also impose a special assessment on Wisconsin residents working out-of-state to account for the fact that employers in other states cannot be assessed for WHP costs. Under the proposed special assessment, persons whose earnings from Wisconsin employers total less than $10,000 annually, but whose adjusted gross income exceeds $20,000 annually, would be subject to a special assessment. (The limits for married persons filing jointly are $20,000 and $40,000 respectively.) The amount assessed would be the lesser of: (a) 10% of the difference between the person's adjusted gross income and Wisconsin earnings; or (b) $2,000 if filing singly, or $4,000 if married and filing jointly. For purposes of its model, the WHP assumes that 30,000 individuals will be affected by this assessment and would pay $2,000 each, for a total of $60,000,000. Based on census bureau data and Wisconsin income tax return data, NorthStar concluded that more than 30,000 Wisconsin residents working out-of-state would be affected by this provision. On that basis, NorthStar concludes that the WHP revenue estimate for this category is conservative, but also cautions that a $2,000 assessment may create an incentive for some Wisconsin residents to relocate to the neighboring state in which they work. Given that many of these Wisconsin residents may now be insured through their out-of-state employers, this is a valid point; however, whether the $2,000 assessment is enough to prompt someone to move out of Wisconsin will likely depend on many factors. Without additional, specific studies, it is not possible to estimate the ultimate financial impact of the proposed assessment on Wisconsin residents working out of state.

The assessments could only be increased through legislation. The WHP assumes that the Wisconsin Department of Revenue (DOR) will collect the assessment. The WHP proposal does not include a fiscal estimate of the start-up costs or annual costs that DOR would incur in collecting and enforcing the assessment.

Based on estimates of Wisconsin's total payroll from the state Department of Workforce Development (DWD), and estimates of statewide wages from the Social Security Administration (SSA), the WHP authors estimate that the employer assessment would generate $10.7 billion and the employee assessment would generate $2.0 billion were they in effect in 2005. In addition, the above-mentioned assessment on Wisconsin residents working out-of-state would generate $60,000,000. Therefore, total annual WHP revenue is estimated at approximately $12.7 billion. A review of the methodology used to derive these estimates suggests that these estimates appear to be reasonable.

Population Served

In arriving at estimates of the population that would be covered through the WHP, the authors used U.S. Census Bureau data and assumed that 4% of adults ages 18 to 64 would be

excluded; and 3% of children would be excluded. NorthStar found the assumptions to be reasonable.

Effect on Medical Assistance and BadgerCare

Initially, revenue from the employer assessment would replace GPR funding that would otherwise be budgeted to support the state's share of the costs of providing "Family Medicaid" coverage. "Family Medicaid," refers to MA coverage for families with dependent children, which includes two primary groups: (a) individuals who qualify because they meet MA eligibility standards based on the former aid to families with dependent children (AFDC) program; and (b) individuals who meet "Healthy Start" criteria, which includes pregnant women and children up to age six in families with countable income up to 185% of the federal poverty level, but who do not meet the AFDC-related criteria. This change in the source of the state funding for the Family Medicaid program would not affect any other aspect of the MA program, such as program eligibility, coverage and delivery of services, and provider reimbursement.

It is estimated that the GPR cost of funding services to the Family Medicaid recipients will be approximately $523.0 million in 2005-06 and approximately $542.0 million in 2006-07. In 2005-06, it is estimated that the average monthly number of individuals enrolled in Family Medicaid groups will be approximately 429,900.

However, under the proposal, the board and DHFS would develop a plan to integrate this group of MA and BadgerCare recipients into the WHP. The board and DHFS would then submit the plan to the Legislature, and, if approved, to the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) for approval of any waivers that would be necessary to implement the plan. DHFS must request a waiver of federal MA law if the state proposes changes to the MA and BadgerCare programs that would conflict with current federal requirements regarding eligibility, benefits, or administration. Waiver requests must be submitted to CMS in written form, and any changes discussed in waiver requests could not be implemented until CMS approval was granted. The state could use the assessment revenue to fund the state's share of this group's costs whether or not such a waiver is granted by CMS, but this group could not be integrated into the WHP unless and until such a waiver was granted by CMS

If Family Medicaid and BadgerCare recipients were incorporated into the plan, they would receive health insurance purchasing accounts, and would annually choose a health care plan. New cost-sharing requirements would apply to this population, which would likely be greater than the nominal out-of-pocket costs they currently pay under these programs. Because the WHP differs significantly from the current Family Medicaid and BadgerCare programs, the plan's authors acknowledge that careful consideration would need to be given to any proposal to integrate this group into the larger WHP population.

In considering whether to integrate the Family Medicaid and BadgerCare populations into the WHP, DHFS and the HIPCo board would need to: (a) analyze the differences in the costs of providing services to current Family Medicaid and BadgerCare recipients and others that would be

covered under the WHP; (b) consider the current MA and BadgerCare recipients' ability to meet cost-sharing requirements under the WHP; and (c) consider the effect on the rest of the MA program if approximately 50% of current MA recipients receive health care coverage under the WHP. Because the rates paid to MA providers who serve this population are typically deeply discounted, it is possible that the state's share of the costs for this group would be higher under the WHP than under the current MA and BadgerCare programs.

Current Health Care Spending in Wisconsin

As noted in an issue brief written by David A. Kindig, MD, PhD, and published in June, 2000, by the University of Wisconsin's Population Health Institute, "it is not easy to get accurate and current data on health expenditures. Even the national expenditure levels estimated annually by the Office of the Actuary of the Health Care Financing Administration are based on major data collection efforts. Public expenditures such as for Medicare and Medicaid can be determined from public records, but almost all private expenditures including those for drugs, long term care, copayments and deductibles must be estimated."

In May, 2003, the Department of Health and Family Services (DHFS) published a report entitled "Health Care Costs in Wisconsin 1980-2002." In the report, DHFS estimated Wisconsin's expenditures through 2002 based on national estimates and projections. Using national health care expenditure data collected by the HealthCare Financing Administration (HCFA, now CMS) from 1998, DHFS projected Wisconsin's expenditures through 2002 using assumptions of average annual increases. DHFS estimated personal health care expenditures in 2002 to be $26.3 billion, or $4,822 per person. In its report, DHFS points out that Wisconsin lacks an accounting system for tracking Wisconsin specific total health care costs. Therefore, any point in time estimates must be based on projections from data that are often several years old.

The most recent Wisconsin-specific data on personal health care expenditures published by the federal Department of Health and Human Service's Centers for Medicare & Medicaid Services (CMS) dates back to 2000 and lists total expenditures as $22.4 billion. Based on CMS data as cited by the Kaiser Family Foundation, the average annual percent growth in personal health care expenditures in Wisconsin for fiscal years 1980 - 2000 is 8.4%. Assuming an 8.4% growth in expenditures from 2000 to 2005, total personal health care expenditures in 2005 in Wisconsin would be estimated to be $33.5 billion. For purposes of comparison with estimated WHP costs, Medicare and Medicaid expenditures and other expenditures by persons 65 years of age and older must be subtracted from this estimate. The resulting estimate, as shown in the following table, is that, in 2005, personal health care expenditures in Wisconsin in 2005 for those under age 65 is $21.4 billion -- or $8.7 billion more than the estimated WHP costs as listed above.

Estimated Total Personal Health Care Expenditures (PHCE) in Wisconsin in 2005

Estimated total PHCE in Wisconsin in 2000 (Per Kaiser Family Foundation summary of CMS data.)	$22.4 billion
Estimated average annual percentage growth in PHCE 1980 - 2000 (Per Kaiser Family Foundation summary of CMS data.)	8.4%
Estimated PHCE in Wisconsin in 2005 based on 2000 data and average annual growth.	$33.5 billion
Estimated PHCE by persons 65 and older in Wisconsin in 2005 (Based on estimate of 36%, using CMS data through 2000.)	$12.1 billion
Estimated total PHCE in Wisconsin in 2005 for persons 64 and younger	$21.4 billion

One explanation for a portion of the difference in the estimated costs of the WHP and the estimate based on CMS data is that the WHP costs do not include out-of-pocket costs. According to CMS data from 1987 through 2000, out-of-pocket expenditures such as deductibles, copayments, and payments for services not covered by insurance constitute 46% of household spending on personal health care. Household spending in turn accounts for 33% of total PHCE. By these estimates, therefore, out-of-pocket expenditures account for 15% of total PHCE. Adding an estimated 15% to the estimated WHP costs amount to $2.2 billion, accounting for 25% of the $8.7 billion difference between the estimated PHCE in Wisconsin in 2005 and the WHP Costs. However, given that the WHP proposal includes relatively significant levels of cost-sharing in the form of deductibles, coinsurance, and out-of-pocket maximums, out-of-pocket payments could account for an even greater portion of the difference.

Also, the WHP cost estimates represent the amount necessary to provide the mandated minimum Tier I coverage that would be provided to Wisconsin residents. Employees and residents would be free to elect coverage above and beyond the minimum provided. However, all additional funding for coverage above the Tier I level would be paid by individuals and/or employers. It is not clear how WHP Tier I coverage levels compare with the average health plan offered by Wisconsin employers. It is possible, for example, that some individuals and/or employers would have to pay above and beyond their WHP assessments to provide a level of coverage equivalent to that currently provided. The additional payments would further account for the difference between the estimated PHCE in Wisconsin in 2005 and the WHP cost estimates.

In addition, as mentioned previously, actual provider reimbursement discount rates may differ, perhaps substantially, from those assumed to be the industry standards by Reden & Anders in its actuarial analysis. Provider discount rates that are less than those assumed by Reden & Anders would increase the estimated costs of the WHP.

Current Costs of Employer-Provided Health Care in Wisconsin. In the concept paper on the WHP as revised in November 2005, the plan's authors estimate that "employers now spend an average of 15% of payroll for the health care premiums of their employees." The plan's authors have clarified that the 15% figure represents an estimate of the total health insurance premium -- including the employee's share -- as a percentage of the total wages of firms offering insurance to their employees in 2005.

As shown in the table below, the plan's authors estimate that, in 2003, Wisconsin private sector employers and their employees in the following size categories, on average, paid the following percentages of payroll as premiums based on Wisconsin-specific wage data from the Department of Workforce Development, U.S. Census Bureau data, and Medical Expenditure Panel Survey (MEPS) data as analyzed by the federal Department of Health and Human Services, Agency for Healthcare Research and Quality.

Private Sector Firm Size	Health Ins. Premium as a % of All Wages
Fewer than 10 Employees	16.4%
10 - 24 Employees	12.3
25 - 99 Employees	9.4
100 - 999 Employees	13.1
1000 or More Employees	11.6
All Insuring Firms	11.8

The authors further estimate that health insurance premiums represented 19.2% of total state and local government wages in 2003 in Wisconsin. The authors then combine the public and private sector data to estimate that, statewide, in 2003, health insurance premiums represented 12.8% of wages among insuring employers.

To arrive at their 2005 estimate that health care premiums represent, on average, nearly 15% of wages, the plan's authors relied on national data from the Kaiser Family Foundation. Specifically, the authors assume that U.S. workers' earnings increased by 2.2% and 2.75%, and that health insurance premiums increased by 11.2% and 9.2% in 2004 and 2005, respectively. The authors estimate that total health insurance premiums represent 13.7% of all wages in 2005 (as opposed to just the wages of firms offering insurance). Total wages plus benefits constitute total compensation; thus health insurance represents a lesser percentage of total compensation than of total wages. The authors compare the estimated 15% of total wages for 2005 to the 5% to 14% assessment that employers and employees would share under the WHP depending on the firms' payroll.

A Kaiser Family Foundation study based on the foundation's annual employer health benefits survey indicates that health insurance premiums rose, on average, 9.2% in 2005, and also indicates that the increase in premiums is about three times the growth in workers' wages and more than twice the inflation rate. According to a 2005 survey of employers conducted by Mercer Health

& Benefits, however, the employers' share of health benefit costs rose just 6.1% in 2005. According to the Mercer survey, many employers used cost shifting to lower their 2005 health benefit cost increases. The Mercer survey results indicate that, while the average employee contribution as a percent of premium was unchanged, employers used greater cost-sharing at the point of service to shift more costs to employees. For example, a greater percentage of employer-sponsored plans now require high deductibles and coinsurance payments than in years past. The Kaiser Foundation survey also indicates that more employers are choosing to offer their employees high deductible plans, although, according to the survey, fewer workers have enrolled in those plans.

The Kaiser Family Foundation survey, which evaluated 2,013 businesses with three or more employees, also indicates that, nationwide, fewer businesses (60%) are offering health insurance coverage to their employees in 2005 than in 2000 (69%). The Kaiser Family Foundation estimated that nearly 58% of Wisconsin's private sector businesses offered health insurance to their employees in 2003.

In estimating the costs of the WHP, the authors assume a $1,200 deductible for adults and a 15% coinsurance rate. For employers already moving toward plans requiring higher deductibles and coinsurance for employees, the WHP may not depart much from current practice. However, it is not known how many Wisconsin employers currently offer such plans. Additionally, it is not known whether the premiums paid as a percentage of total wages for Wisconsin firms currently offering HDHPs exceed the premiums proposed in the WHP.

A Kaiser Family Foundation report on 2003 health care expenditures in Wisconsin based on MEPS data indicates that, on average, employers contributed 78% of the cost of employment-based health insurance, with the individual employee contributing the remaining 22%. Nationwide, according to the Kaiser Foundation, in 2003 employers contributed 83% of health insurance costs, and employees 17%. Under the WHP, employers with payrolls exceeding $500,000 would contribute an amount equal to 12% of an employee's annual social security wages, and the employee would contribute 2%, equaling an 86% cost contribution share for the employer and a 14% share for the employee. However, the listed employer/employee percentage splits for the Kaiser Family Foundation and the WHP data do not include the additional cost-sharing borne by employees in the form of deductibles and coinsurance.

Whether an employer or employee would be better off under the WHP would depend on the costs and benefits of his or her current plan. Employees who currently have coverage more generous than that offered by the WHP's Tier I coverage would face higher out-of-pocket costs under the WHP, unless their employers placed additional funding in the employees' HSAs, and/or paid for Tier II or III coverage. Employers may benefit if, for the amounts paid under the WHP assessment schedule, their employees would have equivalent or better coverage than what they currently provide. Employers currently providing greater coverage than what would be provided under the WHP plan's Tier I coverage may choose to pay more to provide additional coverage for their employees, or may choose to scale back to Tier I coverage and save money. Employers in industries that must aggressively compete for employees may have to provide funding for coverage greater than that provided in Tier I of the WHP plan. Also, large national employers located in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June 15, 2005

Mr. David Riemer
Project Director
Wisconsin Health Project
2821 N. 4th Street, Suite 211
Milwaukee, WI 53212

RE: An Interim Report on the Wisconsin Health Project

Dear Mr. Riemer:

For the last several weeks, with the helpful assistance of Lisa Elllinger and you, we have been reviewing an economic model for financing health care in Wisconsin. This model is part of the Wisconsin Health Project which is examining alternative ways to extend and finance health insurance coverage to the citizens of Wisconsin.

As you requested, we have analyzed the basic concepts, assumptions and calculations of this economic model. This letter serves as an interim report on our work in this matter. We report below our findings to date and would anticipate that we will complete our work by July 1, 2005.

Administrative costs: The model assumes a rate of 8% for administrative costs (including profit). We have checked a number of published sources and have called insurance industry people to test the reasonableness of that assumption. The rate for large self insured plans is 5-6% or about 25% less than the estimate in the model. The administrative cost level, including profit, risk bearing and marketing for conventional health insurance plans ranges from 11-16%. For the type of plan envisioned by the economic model, a plan that more nearly resembles a large self insured plan with a risk reserve, we think that the 8% assumption is reasonable and perhaps a bit conservative.

Estimate of the insured population: The model assumes that the insured population consists of all persons living in Wisconsin who are 0-64 years of age. This number is adjusted downward for certain exceptions such as residency of less than six months; coverage under federal, military or Medicare; those receiving institutional health care in prisons and other facilities; and those who refuse coverage or who can't be located to enroll in the plan. The

original model adjusted the age 0-17 population downward by 2% and the age 18-64 population down by 4% to account for those factors.

We have examined a number of data sources published by the U.S. Census Bureau to test those reduction levels and have concluded that the reduction for age 0-17 population is low (and could conservatively be raised to 3%) and that the reduction for the age 18-64 population of 4% seems reasonable.

The Wisconsin estimated payroll: The model uses an estimated Wisconsin payroll derived from Department of Workforce Development as the basis for calculating premium revenues that are the major financing source for purchasing health insurance coverage in this plan. There are two main statistical sources that report total Wisconsin payroll. These sources are the Wisconsin Department of Workforce Development (DWD) which tabulates salary and wages for workers covered under unemployment insurance and the U.S. Social Security Administration which reports salary and wages subject to the Medicare tax. In the calendar year 2002, the DWD figure is about $5 billion less than the Social Security figure. The model uses the more conservative DWD figure to project payroll for 2005 and beyond.

It appears to us that the difference between the DWD and Social Security payroll numbers is largely explained by the out of state earnings of Wisconsin residents. DWD's payroll numbers measure payroll paid by Wisconsin employers to their workers regardless of place of residence. Thus a person who works in Wisconsin but lives in Michigan is included in the DWD Wisconsin payroll numbers.

On the other hand Social Security measures payroll based upon the residence of the worker. Thus a Wisconsin resident who earns a paycheck in Illinois is counted in the Wisconsin Medicare payroll.

According to U.S. Census data, approximately 52,000 people live in other states and work in Wisconsin and 102,000 people live in Wisconsin and work in another state. A check of the personal income data that is compiled by the Bureau of Economic Analysis (BEA) shows that Wisconsin is a net importer of earnings from surrounding states. About 60% of the variance in the DWD and Social Security payroll numbers is accounted for by the out of state earnings of Wisconsin residents.

In our opinion, the use of the lower DWD payroll data is conservative and probably understates the payroll base for calculating health insurance premiums.

Wages for the self employed: In determining the total payroll basis for calculating health insurance premiums, the model adds self employment earnings to the wage and salary payroll. The estimate for self employed earnings used in the model comes from the taxable amount of self employment earnings as reported by the Social Security Administration. This data is reported on a state by state basis and the amount reported for self employment in Wisconsin in 2002 is $4.8 billion.

BEA data for Wisconsin reports proprietor income of $10.8 billion in 2002. Proprietor income may, however, include income that is not subject to the Medicare tax such as dividends paid to the owner of a business.

We may be able to get further definition on the BEA data but until that time, we believe that the use of the Social Security self employment data in the model is reasonable and conservative.

Wage inflator: To calculate the payroll base (including self employment earnings) for 2005 and forward, the 2002 base payroll numbers are projected using proxies for wage and salary growth. The original model used actual and estimated increases in the Medicare payroll to calculate future payroll levels through 2005. The actual and estimated increases in payroll subject to the Medicare tax are national data as reported by the Board of Trustees of the Hospital Insurance Trust Fund.

After examining several data sources, we believe that a better source of increases in payroll can be found in the Quarterly Personal Income data reported by the Bureau of Economic Analysis. BEA's data is state specific and Wisconsin payroll data for wage and salary disbursements is available though the last quarter of 2004. Based upon that data and calculations of wage and salary disbursements, we would recommend that the Wisconsin payroll data be adjusted by 2.5% for 2003, 3.3% for 2004 and 7% for 2005.

Health insurance premium inflators: In calculating the current cost of health insurance premiums to employers, the model projects increases in health insurance premium costs for 2003, 2004, and 2005. The rates of increase are derived from data published by the Kaiser Family Foundation.

We have checked out this data and are also looking at data on fringe benefit costs for employers that are compiled by the U.S. Chamber of Commerce. At this point we believe that the data used in the model is appropriate but will have further thoughts on this data in our final report.

The "Entrepreneurial Effect": One of the issues that needs further analysis is the "entrepreneurial effect" of the model. Put simply, what will be the effect of the assessment of health insurance premium costs on small employers and the self employed in Wisconsin? It seems to us that there are potential positive and negative effects. On the one hand, the availability of a health insurance independent of source of employment may encourage greater numbers of people to consider starting up new businesses or acquiring businesses. We have encountered at least anecdotal information that losing health insurance coverage is a barrier to developing new entrepreneurial activity.

On the other hand, it is possible that health insurance assessments may have a negative effect on existing and new start up businesses. We believe that this is an important issue for self employed individuals that have high incomes and for small businesses that have small payrolls in "mom and pop" operations. The model envisions an 8% premium cost on the first $100,000 in payroll or self employment earnings. This may pose problems in marginal businesses who cannot afford the premium cost.

The entrepreneurial effect is a serious issue that deserves greater study. That study might include an assessment of the business impact of the proposed model and ways to offset any negative effect. With regard to the latter, there may be modifications to the model that would ease the impact of the premium cost. For example the premium schedule might exclude the first $50,000 of income or rate schedule could start out at a much lower rate and ramp up more rapidly as earnings or payroll approach the $200,000 level.

We will continue to study this issue further and our findings and thoughts will be included in the final report.

Other data points: There are several other data points in the model that we will check in the next two weeks. These data include administrative fee costs, marketing costs, and the number of high and low wage earners. They are fairly minor parts of the model but deserve analysis to insure the integrity of the model.

Conclusion: This interim report is a summary of our work to date on this project. There is a considerable volume of data and detail that we would be glad to share with you should you need it.

Our analysis to date has shown several things. First the computations in the model are correct. Second, the theoretical framework of and rational for the model is sound. Third, most of the assumptions can be supported with published data and the assumptions seem reasonably conservative.

We will continue to work on this project and will complete our final report by July 1, 2005.

Thank you for the opportunity to work with you on this most important project.

Sincerely,

David J. Ward, Ph.D.
President, NorthStar Economics, Inc.