☞ **05hr_SSC-HCR_Misc_pt26**

☞ 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)

Monday Aug. 2011

Medicaid

(6)

Sept. 27th

Small business
Purc. drugs:
NCSL Speaker.

Dirigo Health = maine/illinois
= Bad.

Subsidized mandate like
Program
Home Base
"Better way to do it" —
Stein — to insured individ
Us insured. - -

Carol Roessler Committee Chair Notes

(4)

Time get H care
off Big 9
$5-600,000 plans
warn per month
83,000 — Employee amount,
< 1400

1 Clinic — 80-100 day.
Plans. —

Taking away Pay for Corps

Flat $ amount.

levels
e 98 - Spreads
Risk
Risk Diff Carriers
Savings to Big small's

#6 Aug 18th

Chuck Benedict

Terry Musser

John Townsend.

Held

WI Health Project

WORK in PROGRESS

"Keep people at table talking"

3 70% solution.

hold nose

Who pays US

↓ Costs

Pay for performance

↑ Cost purchasing power

Canada wait X's Violation of human rights

Repair vs Replacement.

Glasses Under Medicare?

Access & benefits = ↓

50% of Bank.

± deaths = 19.3 deaths in 1st yr. of life

no access to prenatal care

4 yo else where

Mass NY

Guaranteed I + CR

Issue CR.

also have CI in individu

requires state participation

Joe = Leann

More efficiently

Uses health savings acct.

Competition + incentives

Private sector mgmt.

Competition
Private sector management.
premiums
contracts
Consumer choice
Wellness & life style incentives.

Phase out corp income tax

1 — Groups -
Position vote.
ET
Unanimous

- Increase earned income for low income.
- Provide.
- Education + incentives.

Mandate coverage, assessment

—

Out of state benefit.
Resident

TIERS Effectiveness + Cost

Joe Leanan

E Health insurance.
< $50,000

Distribution all
along line over age 45

Maine. -
= 65% Claims processed
electronically."

Premium Subsidy Flaws

Targeted specialty
- uninsured target
& then more in to
"insured"

Mass — Assurant.
30% of H. SA.

What problem to
Uninsurable - H.R.P.
— F.A.
— Subsidized Plans Tax incentive
low cost benefit plan.

— looking- small detail solutions
— Insig- affordable Plans.
LT H insurance incentives.

Manage Care = increased costs.
Rate ban — expansion.

" High Risk Pools
" Fed funds are
Probably on the way."

LIST Billing checkout.

" Ind. Ins Payments
Not tax deductable
they should be - CR=me!!!

Select Committee on Health Care Reform

The committee will hold a public hearing on the following items at the time specified below:

Wednesday, July 26, 2006
10:00 AM
411 South
State Capitol

The Committee will hear from invited speakers only to present and discuss various health coverage proposals:

Rep. Curt Gielow, Rep. Jon Richards, Mr. Joe Leann, Ms. Lisa Ellinger, Wisconsin Health Plan (2005 Assembly Bill 1140)

Mr. David Newby with AFL-CIO, Wisconsin Health Care Partnership Plan (2005 Senate Bill 698)

Sen. Mark Miller, 2005 Senate Bill 388

Mr. J.P. Wieske, Council for Affordable Health Insurance

Senator Carol Roessler
Co-Chair

Senator Alberta Darling
Co-Chair

WISCONSIN HEALTH PLAN
UNIVERSAL AND CONSUMER-DRIVEN

POLICY OPTIONS

MEDICAID REFORM

1. Put HD/HSA incentives into Medicaid program, ala Oklahoma, South Carolina, Florida.
    a. Medicaid now at $1.1 billion, up $600 million since 1997.
    b. Also for BadgerCare and HIRSP.

MANDATE TRANSPARENCY for all procedures over $500. This is simply a pre-EOB.

2. Some providers plans have already made their net prices transparent.
    a. Such as ProHealth and Business Group on Health Care for Southeastern Wisconsin
    b. Aetna doctors in eight markets
    c. Cigna for imaging
    d. United Health Group for dentists
    e. Medicare for 30 hospital procedures
    f. Dartmouth-Hitchcock Medical Center for 75 services
    g. Mayo Clinic in Jacksonville, FL
    h. Wisconsin Hospital Association shows sticker prices and hospitals average discounts. Serigraph shows comparisons on 14 hospital procedures.

CATASTAPHIC

3 Ala Doyle plan, install statewide catastrophic pool to provide one layer of universal coverage. Funding could come through some funding mechanism as for the Patient Compensation Fund. TAX ON MEDICAL TRANSACTION

STATE EMPLOYEES

4. Add HD/HSA options to state health care plans.
    a. Incentivize state employees to go to at least $1500 deductible.

SMALL BUSINESS

5. Allow small businesses to join state pool at full costs. The catastrophic pool removes the employee trust fund resistance due to adverse selection.

MEDICAL SCHOOLS

6. Fund extra costs of state's medical schools out of patient compensation fund.

WELLNESS PREVENTION

7. Create 50% tax credit for corporate wellness and prevention programs.

Comp.
- Incentives
- Disincentives


FORWARD
E PLURIBUS UNUM

Summary of Florida's New Medicaid Model

Goal: To empower participants to choose coordinated health care plans that best meet their needs, while encouraging innovation, efficiency, and improvements in the caliber and availability of health care

Implementation: First to pilot counties, Duval and Broward in 2006, and expand reform to rest of Florida within 5 years after review results.

Characteristics:

-Participants use counselors to choose best plan for them

-Participants can also opt out of Medicaid plans and use state-paid premium to purchase insurance in private market.

-Medicaid is risk-adjusted, higher premiums will be paid for sicker people.

- This aims to reward healthy lifestyle choices and offers financial incentives to managed care plans to identify illnesses early and appropriately manage diseases.

-Encourage networks of doctors, hospitals, pharmacies, and other providers with common service goals.

- These networks will offer innovative service plans and benefit packages to compete with insurers and HMO's for Medicaid patients.

-Use the free market system to drive inefficiencies and fraud out of the system. Health care providers will search for ways to raise the quality of care and lower costs.

Reason for Reform: Florida Medicaid costs have risen 120% since 1999 costing $15.5 billion in 2005 (1/4 states budget). Their Medicaid costs have risen 13% each year in contrast to general revenue growth of only 5.5%. At the current rate, Medicaid would consume 60% of the state's budget by 2015.

FLORIDA'S HEALTH AT RISK

Fourth in a series of educational briefs on issues impacting Florida's families

Understanding Florida's Medicaid Reform Legislation

INTRODUCTION

On June 3, 2005 Florida Gov. Jeb Bush signed historic legislation aimed at reforming Medicaid, the health insurance program for more than 2.1 million low-income families, elderly and disabled Floridians. The legislation (Senate Bill 838 or SB 838) permits the state to submit a "Section 1115" Medicaid waiver proposal to the federal government and to implement his reforms on a pilot basis.[1]

The bill makes many changes to the state's Medicaid program, some of which do and do not require a waiver of federal Medicaid law. This brief, however, examines only those sections of the legislation which relate to the Medicaid "Empowered Care" Section 1115 waiver proposal the state will soon be submitting to the federal government for approval.[2]

Gov. Bush has proposed a major restructuring of Florida's Medicaid program premised on the notion that fostering competition among private insurance carriers and provider networks would save the state money without compromising the quality and scope of services that Medicaid beneficiaries receive.[3] To accomplish this goal, the governor has proposed developing individually risk-adjusted premiums for beneficiaries within an overall limit on Medicaid spending. Managed care plans would be required to provide federally-mandated benefits, but plans would have the flexibility – at least for adult beneficiaries – to determine the amount, duration and scope of the benefits Medicaid beneficiaries will receive.[4]

SB 838 permits the governor to seek a waiver from the federal government which generally conforms with the structure of the state's proposed "Empowered Care" reform, but provides for extensive legislative oversight and ongoing public input. **(See Figure 4 on page 3).** SB 838 requires the full Legislature to vote again twice on the issue - first to permit implementation of the waiver once it is approved by the federal government, and, second to permit statewide expansion of the pilot sites.

Even with the passage of SB 838 there are still many important details missing concerning the structure of the governor's proposal. For example, there is still no information on the budget and financing implications of the proposal. As such, it will be important for legislators and their constituents to examine the details of the waiver as they become available and the process moves forward.

1 The Medicaid Reform Act offers significant opportunities for the public to provide input into the reform process. **See Figure 4 on page 3.** The governor is encouraging public input into the process. It will be of vital importance for the public to examine the details of the state's Section 1115 Medicaid Reform Waiver proposal, as well as the various analyses required by SB 838, to understand the impact of the proposed changes. For more information on what a Section 1115 waiver is, see a previous Policy Brief in this series; "What Could a Waiver to Restructure Medicaid Mean for Florida?" *Winter Park Health Foundation.* April 2004. Available at http://www.wphf.org/access/pubs/Medicaid.pdf . For a national overview of recent Section 1115 waiver activity, see Artiga, S. and Mann, C. *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) March 2005.

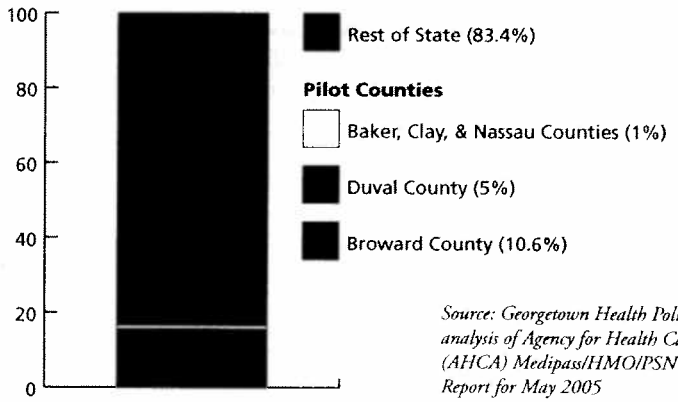
2 The authorization for a Medicaid managed care pilot program is found at Section 409.91211 as created by SB 838.

3 For more information on the governor's proposal, see the state's website www.empoweredcare.com. Also see a previous brief in this series: "Issues to Consider in Gov. Bush's 'Florida's Medicaid Modernization Proposal.'" *Winter Park Health Foundation.* March 2005. Available at www.wphf.org/access/pubs/Medicaid3.pdf

4 See "Issues to Consider" as cited in previous footnote. Also see "Frequently Asked Reform Questions" on www.empoweredcare.com where it is stated "Plans will set varied benefit packages that will be tailored to meet individual needs of beneficiaries," on p. 4.

Figure 1: Florida Medicaid Enrollment

2.1 million as of May 2005



Source: Georgetown Health Policy Institute analysis of Agency for Health Care Administration (AHCA) Medipass/HMO/PSN Enrollment Report for May 2005

WINTER PARK HEALTH FOUNDATION

Who will be affected by the Legislature's action?

SB 838 specifies that the state must first implement the reform in two counties – Broward and Duval. Then the state may proceed to expand the pilot sites to include Baker, Clay and Nassau counties – more rural counties adjacent to Duval County. Approximately 16 percent of Florida's Medicaid beneficiaries live in these counties – 10 percent in Broward County alone **(see Figure 1 on page 1)**.[5]

Broward County: Approximately ten percent of Florida's population, as well as approximately 10 percent of its Medicaid enrollees, live in Broward County,[6] which lies north of Miami. Broward is an ethnically diverse county with 20 percent of its residents being African-American (as compared to 15 percent statewide)[7] and a large retiree community. Medicaid enrollment in Broward grew at roughly the same rate as in the state overall for the last year.[8] Currently, Broward has seven capitated managed care plans operating with approximately 78,660 or 35 percent of its Medicaid population enrolled.[9]

Duval and surrounding counties: Approximately 5 percent of the state's population and its Medicaid beneficiaries reside in Duval County – primarily in the city of Jacksonville. Duval is also diverse with 28 percent of its residents being African-American (15 percent statewide).[10] However, unlike Broward County, Medicaid enrollment in Duval County actually declined over the last year.[11] Duval currently has only one HMO with 40,274 persons – or 43 percent of its Medicaid eligible population – enrolled in capitated managed care.[12] The surrounding predominantly rural counties currently have no capitated managed care operating for their Medicaid beneficiaries. **Figure 2** displays the counties where HMOs currently enroll Medicaid beneficiaries, including MediKids.

5 It is unlikely, however, that all Medicaid beneficiaries will be enrolled in the pilots. See section below on *Who will be enrolled in the demonstration pilots?*

6 *Broward County QuickFacts from the US Census Bureau* available at quickfacts.census.gov/qfd/states/12/12011/html

7 Ibid.

8 Center for Children and Families (CCF), Georgetown Health Policy Institute analysis of AHCA enrollment data from May 2004 to May 2005. Overall enrollment grew by 3.5 percent statewide and enrollment in Broward County increased 3.4 percent.

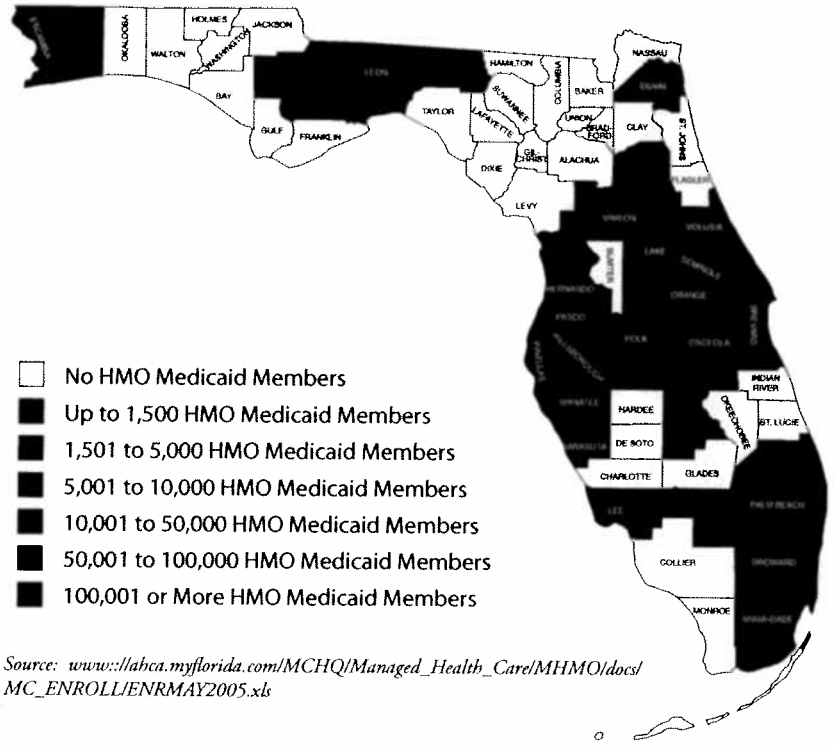
9 Agency for Health Care Administration (AHCA) Medipass/HMO/PSN Enrollment Report for May 2005.

10 *Duval County QuickFacts from the US Census Bureau* available at quickfacts.census.gov/qfd/states/12/12031.html

11 CCF analysis of AHCA enrollment data from May 2004 to May 2005 shows a decline of 1,011 enrollees in Duval County.

12 ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/ENRMAY2005.xls

Figure 2: Current Medicaid HMO Enrollment, May 2005



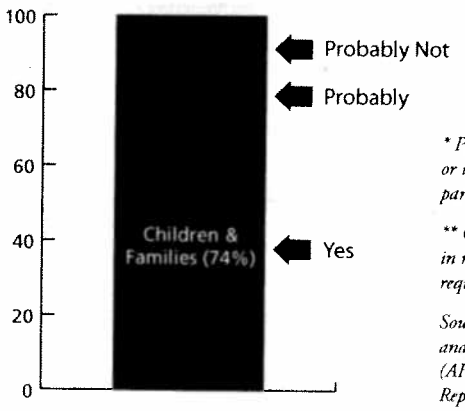
Source: www://ahca.myflorida.com/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/ENRMAY2005.xls

Who will be enrolled in the demonstration pilots?

Under SB 838, the governor and the Agency for Health Care Administration (AHCA), which administers Florida's Medicaid program, are authorized to determine which populations

Figure 3: Who Will Be Required to Participate in Broward County?

Total Medicaid Enrollment in Broward County = 224,743



***Revised June 27, 2005**

** People with disabilities who are not on Medicare or institutionalized will probably be required to participate.*

*** Others, including people on Medicare and in nursing homes, are probably unlikely to be required to participate.*

Source: Georgetown Health Policy Institute analysis of Agency for Health Care Administration (AHCA) Medipass/HMO/PSN Enrollment Report for May 2005

will be required to participate in the demonstration programs. Based on available information from the state, it is likely that all children (both those in Medicaid and the state's Title XXI Healthy Kids program), their parents, pregnant women and disabled persons who are not institutionalized will be required to participate.[13] These groups comprise the vast majority of persons eligible for Medicaid. In Broward County, for example, children and parents comprise 74 percent of Medicaid enrollees **(see Figure 3 on page 2).** Persons with Medicare coverage who receive financial assistance with their premiums, the so-called "dual-eligibles," will likely not be required to participate.

Special populations: SB 838 requires the state to address certain special populations in the waiver proposal. The state must "develop and recommend a *service delivery alternative* for children having chronic medical conditions."[14] In addition, SB 838 requires the state to "develop and recommend *service delivery mechanisms within capitated managed care plans*" for Medicaid-eligible children in foster care and persons with developmental disabilities.[15] It will be important to examine the precise details in this area when the waiver proposal is released.

Persons over 60: One area that will also await further details from AHCA relates to Medicaid beneficiaries who are over 60. In a separate section of the bill, SB 838 grants the state authority to seek Section 1115 waiver authority from the federal government to establish an "integrated, fixed-payment delivery system for Medicaid recipients who are 60 years of age or older," also on a pilot basis in two areas of the state.[16] The 60+ waiver is not the subject of this brief, and the program is likely to be structured differently,

13 See *Empowered Care: A Proposed Concept for Florida Medicaid* March 14, 2005, pps. 6-7. It is possible that children with chronic medical conditions will be exempted. See section on Special Populations.

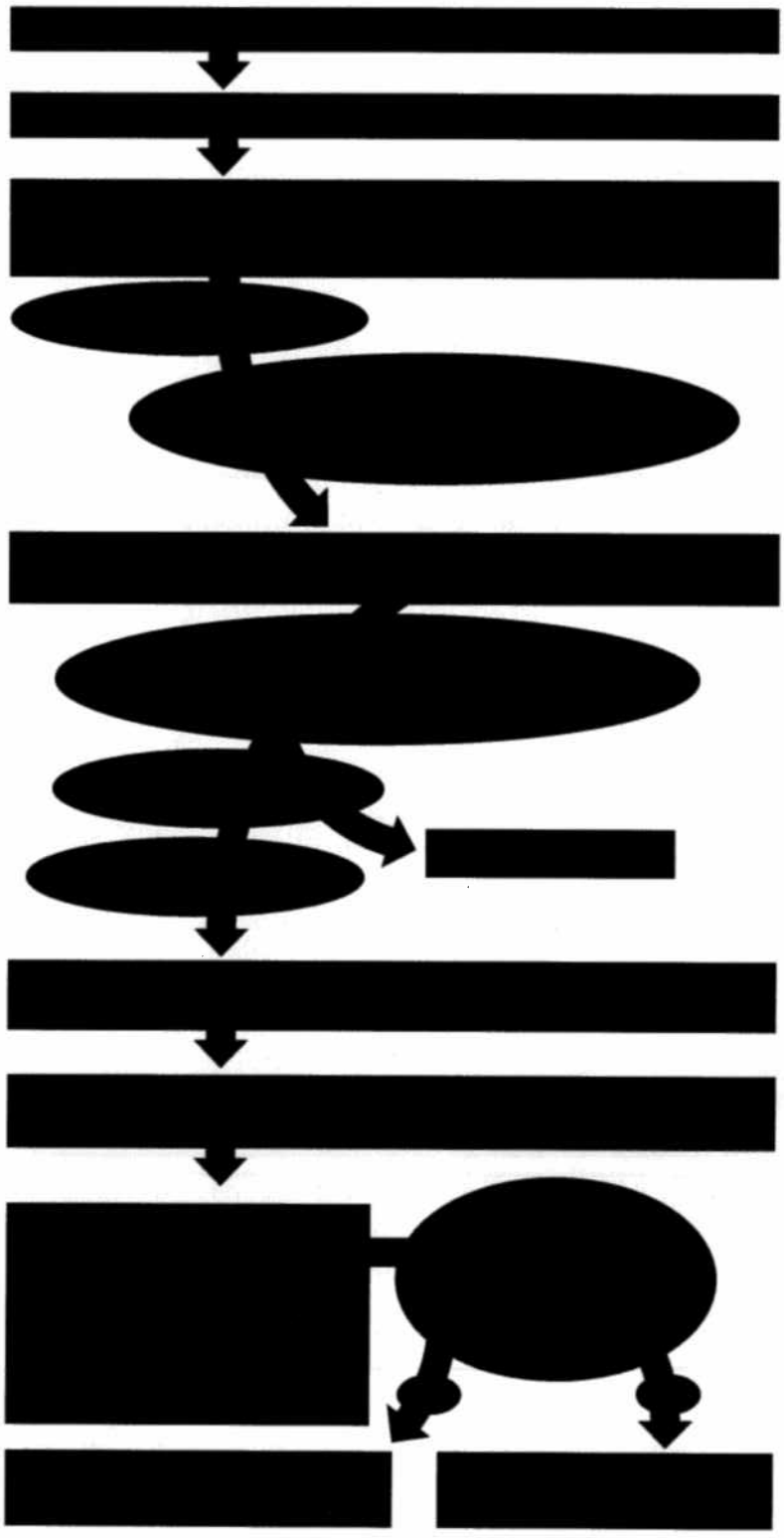
14 Section 409.91211 (3)(bb) found in SB 838 at p. 66 lines 24-25. Emphasis added.

15 Section 409.91211 (3)(cc) and (dd) found in SB 838 at p. 67 lines 4-16. Emphasis added.

16 Section 409.912 (5) found in SB 838 at p. 16.

Figure 4: Florida Section 1115 Medicaid Reform Waiver Process

The circles indicate opportunities for public input. Suggestions or comments can be emailed to empoweredcare@ahca.myflorida.com.



but there are many questions about how the two waivers will interact. For example, will Medicaid beneficiaries over 60 be excluded from the "Empowered Care" pilot sites? Will the programs be implemented in different counties? Will the financing structures be similar in the two waivers? All of these questions will need to be addressed and considered when the waiver proposals become available.

What is the process and timeline established by the Legislature?

As mentioned above, the Legislature incorporated many checks and balances to provide oversight as the proposal moves forward. **Figure 4 (on page 3)** provides an overview of the process as established by SB 838.

How does the federal waiver process work?

Florida, like other states, has already engaged in extensive negotiations with the federal government to shape its waiver proposal.[17] After the waiver is formally submitted to the federal government, both the Center for Medicare and Medicaid Services (CMS) and the White House's Office of Management and Budget (OMB) will consider the application and the budget for the state's proposal. There is no formal procedure for the public or local, state and federal elected officials to submit comments to CMS once the waiver is submitted, but this often occurs. Approval from the federal government, assuming it is given, could come in as little as a few months.[18] If the state receives approval from the federal government, the state is required by SB 838 to submit the approved waiver, along with an implementation plan, for approval by the full Legislature before AHCA can begin developing regulations and move to implement the plan.

Under SB 838, pilot programs will be established in the chosen counties for up to 24 months during which time they will be comprehensively evaluated by the Legislature's auditing arm, the Office of Program Policy Analysis and Government Accountability (OPPAGA), and the Auditor General. According to SB 838:

The evaluation must include assessments of cost savings; consumer education, choice, and access to services; coordination of care; and quality of care by each eligibility category and managed care plan in each pilot site.[19]

The evaluation must also describe legal and administrative barriers encountered in the pilot sites and make recommendations regarding statewide expansion of the program. The evaluation must be submitted to the Legislature no later than June 30, 2008, and once the evaluation has been completed, the state can seek approval from the full Legislature to take the program statewide.

What did the Legislature say about benefits?

The governor's "Empowered Care" proposal includes a complex three-tiered system of benefits: 1) "Comprehensive Care," a basic package of benefits that beneficiaries will choose but is likely to vary by plan (at least for adults); 2) "Catastrophic Care," for beneficiaries who run out of their "comprehensive" benefits; and 3) "Enhanced Care," an account reserved for those beneficiaries who engage in "healthy" behaviors.[20] Many questions exist about what these benefits will consist of, as well as how the different tiers will interact. The governor's proposal would require participating plans to offer federally-mandated benefits, such as inpatient hospital care, but the plans would have flexibility to decide how much of such a benefit to offer (i.e.; how many days of inpatient care would be covered).[21] In fact, the ability of the plans

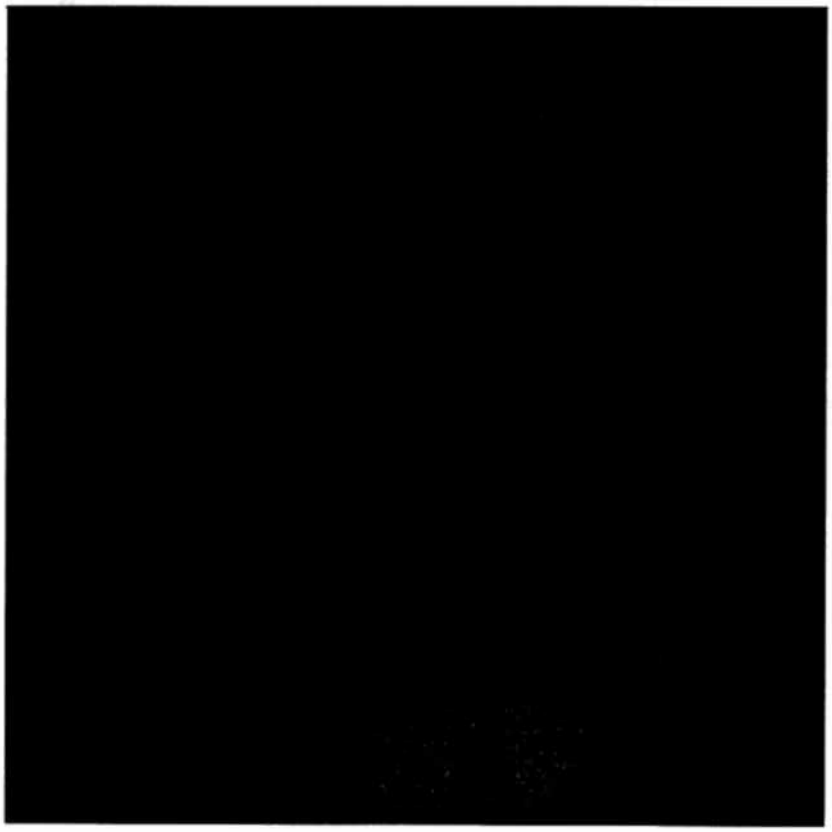
17 Letter from U.S. Secretary of Health and Human Services, Michael O. Leavitt to Governor Bush, April 1, 2005. Available at www.empoweredcare.com/docs/cms_medicaid_letter.pdf

18 For information on timelines from formal submission of Section 1115 waivers, see Table 1 in *Section 1115 Waivers at a Glance: Summary of Recent Medicaid and SCHIP Waiver Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) April 2003.

19 Section 3 of SB 838, p. 72 lines 3-7.

20 See March 14th *Empowered Care* proposal and Winter Park Health Foundation brief "Issues to Consider."

21 This is technically referred to as the "amount, duration and scope" of benefits.



to determine the benefits that Medicaid beneficiaries will receive is one of the unprecedented features of the governor's plan.

SB 838 does little to shed light on the structure and scope of the benefits package, but creates opportunities for the Legislature to continue to monitor this issue closely. It establishes that the demonstrations must ensure access to "medically necessary services" and that AHCA must develop and recommend a system that delivers all the current mandatory and optional services currently provided under Florida's Medicaid program, but it is silent on the question of the "amount, duration and scope" of benefits. Rather, SB 838 requires that the agency develop and recommend a data-based system to monitor the "utilization and quality of health care services" to establish whether or not beneficiaries enrolled in the demonstrations receive medically-necessary services.[22] In addition, as described below, SB 838 requires the state to provide analyses of anticipated benefit designs under three different fiscal models.

What did the Legislature say about how Medicaid will be funded?

SB 838 makes clear the intent of the pilot is to "stabilize Medicaid expenditures under the pilot program as compared with Medicaid expenditures in the pilot area for the 3 years before implementation."[23] Again, instead of establishing any specific requirements with respect to the financing structure, SB 838 requires AHCA to provide the Legislature with more information. In particular, SB 838 requires analysis which describes the effect on capitation rates and what benefits will be offered in the pilot program under three different budget scenarios for a prospective five-year period. These scenarios include: a) limiting the growth rate in Medicaid to the growth rate in general revenue (See Text Box on right), b) linking Medicaid's growth to increases in Medicaid's per-person costs and c) using Medicaid's current financing structure for a previous year (state fiscal year 02-03 to 03-04).[24]

AHCA has not provided any specific budget projections for the state's proposal. However, recent information clearly indicates that the state wishes to restrict the rate of growth in Medicaid funding by linking Medicaid's growth rate to the growth rate in state revenues.[25] This would fundamentally alter the financing structure of the Medicaid program in a way that has not occurred anywhere in the country.[26] Currently, Medicaid funding increases or decreases reflect changes in health care costs and changes in enrollment, as well as state choices about provider reimbursement, drug pricing methodologies, optional services and optional beneficiaries.[27] Under the current Medicaid structure, states have flexibility to control costs by changing provider reimbursement or clamping down on prescription drug expenditures, for example, but the state must cover medically necessary expenditures incurred by any eligible Medicaid beneficiary. If, for example, a recession occurs, Medicaid enrollment and expenditures are likely to go up as more children whose parents lose their jobs become eligible. If a recession occurred, however, state general revenue would likely go down.

Under the current reform proposal, the nature of this financing system would fundamentally change. If expenditures were linked to the growth of state revenue, overall spending levels would no longer be determined by changes in enrollment or changes in health care costs. In a recession, for example, enrollment in Medicaid would likely increase as unemployment rose, state revenues would likely slow down, and total state revenues could even shrink. As described in the box below, this would likely lead to considerable funding shortfalls for Medicaid, if Medicaid funding was tied to the growth in state revenues.

22 Section 409.91211(3)(p)
23 Section 409.91211 (2)(b)
24 Section 409.91211 (3)(x)
25 The state says "annual increases will allow a reasonable rate of growth commensurate with the growth in state revenue." *Frequently Asked Reform Questions* on the state's Empowered Care website. Available at www.empoweredcare.com/faqMedRef.aspx
26 The Governor of Tennessee has proposed a similar concept for Tennessee's Medicaid program known as TennCare.
27 For more information on how federal financing of Medicaid operates with and without Section 1115 waivers, see "What Could a Waive to Restructure Medicaid Mean for Florida?"

What are the legislative guidelines regarding managed care protections?

The state has sought to allow entities that wish to participate to be exempt from current state licensing and other requirements.[28] SB 838 permits AHCA to develop a new credentialing system with certain requirements for entities that wish to participate, but requires that applicable licensing laws must prevail. This means that for example, an HMO wishing to participate in the new system would have to meet state solvency laws, but a provider-sponsored network that sought to take on risk would be exempt.

28 See for example "Bush Plan May Boost No-Bid HMOs" *The Tallahassee Democrat* March 27, 2005.

SB 838 requires that AHCA's new credentialing system address certain issues such as the establishment of a grievance system for both consumers and providers, restrictions on marketing practices the plans may engage in, and the establishment of certain requirements with respect to consumer choice counseling.

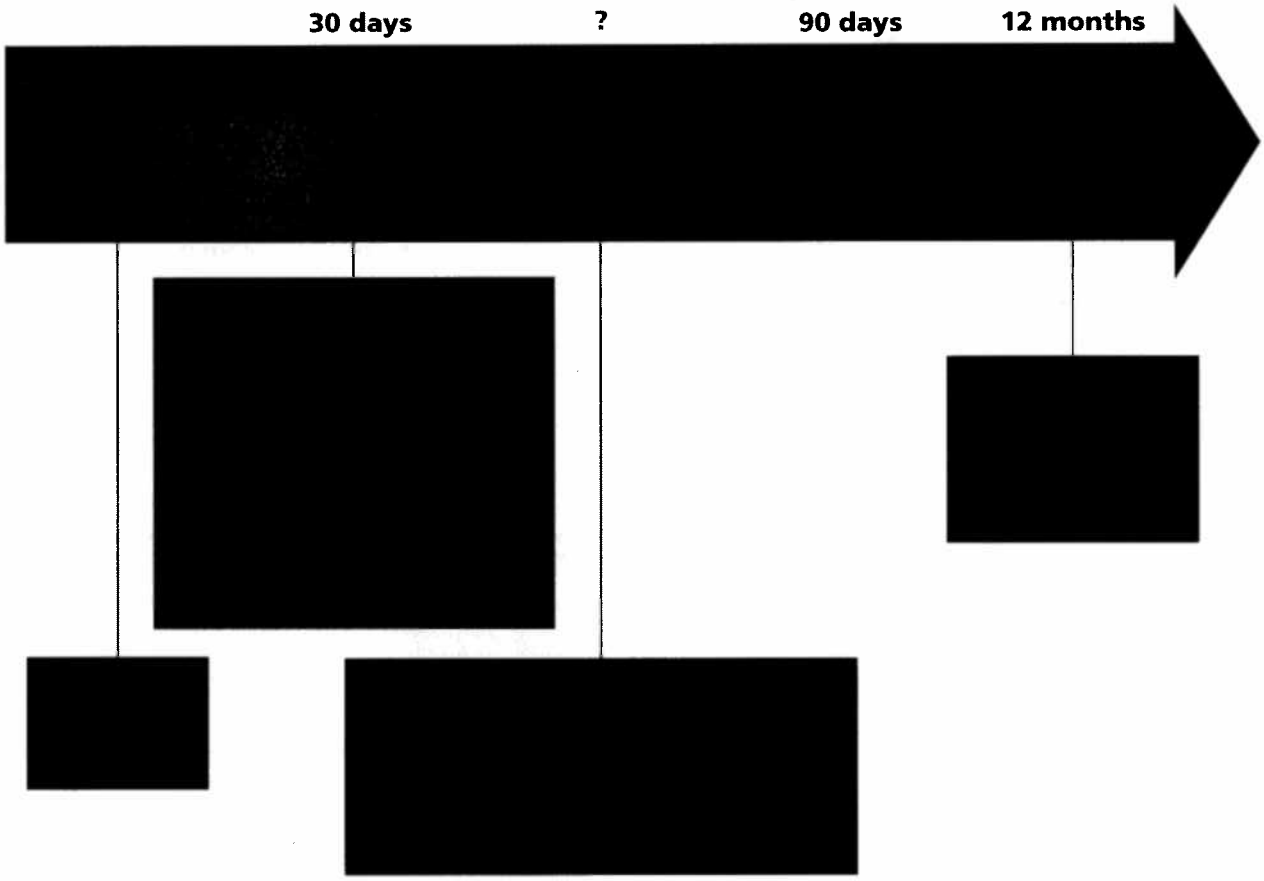
In addition, SB 838 establishes certain procedures for enrollment and assignment to plans in instances where beneficiaries do not choose a plan, as well as procedures for beneficiaries wishing to disenroll from a plan. **Figure 5** provides an overview of the process as specified in SB 838.

Premium subsidy for private insurance or "Opt-out": SB 838 authorizes AHCA to request federal waivers to eliminate Medicaid cost-sharing protections and benefits requirements to allow the state to offer families a premium subsidy for the purchase of employer-sponsored insurance. This is a program that would operate separately from the Medicaid managed care pilot, and would likely be similar in structure to Illinois' KidCare Rebate program which is currently operating under a federal Section 1115 waiver.[29] Because the program is voluntary for families, CMS is likely to permit a waiver of federal cost-sharing and benefits requirements.[30]

29 For a quick overview of Illinois' waiver see *Factsheet on Illinois Section 1115 Waiver* (Kaiser Commission on Medicaid and the Uninsured) August 2003, available at www.kff.org/medicaid/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=14357

30 See Alker J. *Serving Low-Income Families Through Premium Assistance: A Look at Recent State Activity* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured) October 2003.

Figure 5: Proposed Enrollment Process for Medicaid Beneficiaries



What does SB 838 say about the role of safety-net providers in the new system?

Health care providers that serve a large number of Medicaid beneficiaries, such as public and children's hospitals, community health centers, county clinics and others, have much at stake in any major restructuring of the Medicaid delivery system. These providers receive a large share of their funding through Medicaid, and also provide essential services to the uninsured in their communities. SB 838 includes a few provisions which recognize the importance of this funding stream for certain safety-net providers. First, the bill makes clear that the waiver authority granted is "contingent upon federal approval to preserve the upper-payment limit funding mechanism for hospitals."[31] The upper-payment limit (known as "UPL") allows hospitals to receive certain payments in excess of their per-beneficiary cost, up to an established limit.[32] States' UPL arrangements have recently come under increased scrutiny by the federal government.

In addition SB 838 requires that "to the extent possible" the pilot programs authorized by the bill include any "federally qualified health center, federally qualified rural health clinic, county health department, or other federally state or locally funded entity that serves the geographic areas within the boundaries of the pilot program that requests to participate."[33]

31 Section 409.91211(1)

32 For more on UPL and related financing arrangements, see the fact sheet on *Medicaid Financing Issues: Intergovernmental Transfers and Fiscal Integrity* (Washington, DC: Kaiser Commission on Medicaid) February 2005.

33 Section 409.91211(3)(h)

Conclusion

Medicaid is the cornerstone of the nation's health care safety-net. Begun in 1965, Medicaid now provides health and long-term care services to more than 2.1 million low-income families and elderly and disabled individuals in Florida. Medicaid's responsibilities are far-reaching – it is a health insurance program for low-income adults and children, a comprehensive source of medical and long-term care coverage for people with disabilities, and a supplement to Medicare for the elderly, providing assistance with prescription drugs, long-term care, Medicare premiums and other cost-sharing obligations.

The Medicaid Reform Act signed into law by Florida Gov. Jeb Bush June 3, 2005 enables the state to submit a "Section 1115" Medicaid Waiver proposal to the federal government. The process and the legislation offers the public multiple opportunities to provide input and comment on proposed reforms.

Given the scope and unprecedented nature of the proposals, and the number of Florida residents who depend on Medicaid for vital medical services and long-term care, it is critical that the public be aware of and capitalize on these opportunities. It will be important for Florida residents to examine the details of the state's Section 1115 Medicaid Reform Waiver proposal, as well as the various analyses required by SB 838, to fully understand the impact of proposed changes.

UNDERSTANDING FLORIDA'S MEDICAID REFORM LEGISLATION

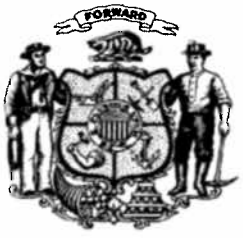
Fourth in a series of educational briefs on issues impacting Florida's families – Florida's Health at Risk. Published by the Winter Park Health Foundation.

Co-author
Joan Alker
Health Policy Institute
Georgetown University
2233 Wisconsin Avenue NW, Suite 525
Washington, DC 20007
202-687-0880
jca25@georgetown.edu
ccf.georgetown.edu

Co-author
Lisa Portelli
Winter Park Health Foundation
1870 Aloma Avenue, Suite 200
Winter Park, FL 32789
407-644-2300
lportelli@wphf.org
www.wphf.org

WINTER PARK HEALTH FOUNDATION

WISCONSIN STATE LEGISLATURE



WEAC owning co & TRUST HQH ins. better way of doing that.

Unsured problem still ....
90% period.

Reward Providers adopting best practice + Q measures
add reimb rates

build state of ~~art~~ system
differential reimbursement rates.

Wisconsin Health Care Partnership Plan

A Labor/Management Partnership Solution to our Health Care Crisis

Health Care That Works for Wisconsin

2 people wking ea pay.

If. you work ~~to~~ mandatory

Both Assuming wrap into overall

✓ dun

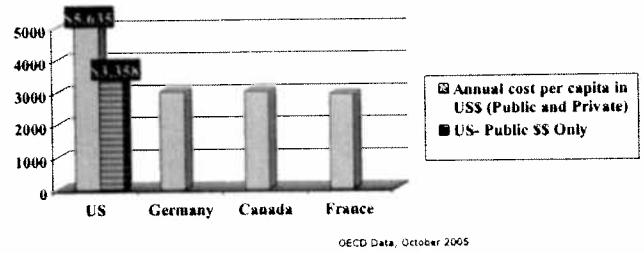
Other proposal = % of salary
this 1 is on set fee
Subsidies small business + low wage -

Basic plan waiver to bring all into plan

A Sick Healthcare System

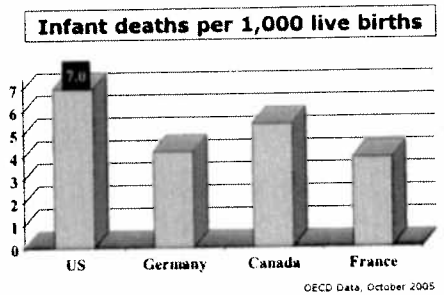
- The Problem
  - Our Patchwork, Fragmented Health Care System Has Failed Us:
    - Health Insurance Employer Premiums are Skyrocketing.
    - Health Insurance Employee Premiums, Co-Pays, and Deductibles are Skyrocketing.
    - Thousands of People Nationwide are Losing their Coverage *Each Day.*
    - The Rest of Us Are Only One Paycheck Away from Being Uninsured.
    - Among Industrialized Nations, the U.S. ranks only 24th in Overall Level of Health. (WHO World Health Report 2000)

We pay more for health care than countries with unified plans



OECD Data, October 2005

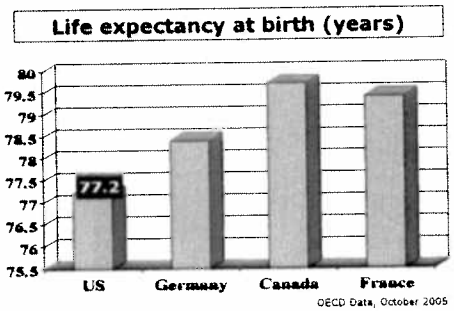
But we're not as healthy



Wisconsin Health Care Partnership Plan

Wisconsin Health Care Partnership Plan

America ranks low in life expectancy after birth



Wisconsin Health Care Partnership Plan

Wisconsin Health Care Partnership Plan

1 out of 6 Americans have no health insurance

The High Cost of Wisconsin's Uninsured

The Insured Must Absorb Costs of the Uninsured

- Over 546,000 Wisconsin Residents (over 10%) were uninsured for at least part of 2004[1].
- For every uninsured person in Wisconsin, **$910** of unpaid medical bills per year is ultimately shifted to higher premium costs for those with insurance[2].

1. *"Wisconsin Health Insurance Coverage 2004," Wisconsin DHFS. September 2005.*
2. *"Paying a Premium: The Increased Cost of Care for the Uninsured," Families USA. July 2005.*

The High Cost of Health Care

Expensive Health Care in Wisconsin Costs Us Good Jobs

- Wisconsin has the second highest cost for health care in the United States.
- The cost of health insurance has become a "key site location factor" for businesses[1].

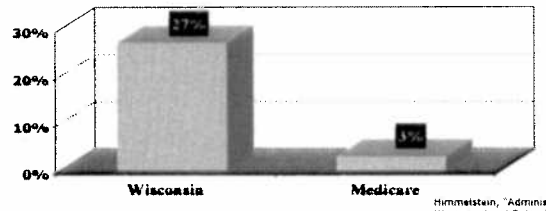
1. *"Health Care Expenses Are a Key Site Location Factor," Expansion Management, February 14 2005*

Cost

Why do we pay so much for healthcare?

ADMINISTRATIVE WASTE

Percent of Total Health Expenditures Spent on Administrative Overhead



Himmelstein, "Administrative Waste in the U.S. Health Care System in 2003"

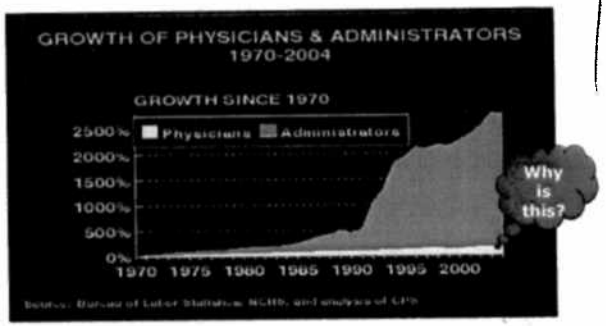
Cost (Continued)

- Figuring out who owes who what in every single health care encounter
  - Costs to insurance companies/HMO's, Hospitals, and Doctors or Clinics.
- Determining "Cost Experience" for every single insured group
  - Experience-rating
- Negotiating discounts

✓ Not one of these expenses gives us actual health care or adds value to our health care system.

✓ Each of these costs is a "tax" we pay because of the way we have structured access to our health care system.

More Administrators than Physicians



Cost (Continued)

The Vicious, Upward Spiral of Cost-Shifting

As the cost of insurance goes up...

- Employers cut health benefits
- Which leads to more uninsured and underinsured
- Who seek uncompensated care in the ER
- And the cost for their care is shifted to payers – people with health insurance and their employers

Wisconsin Health Care Partnership Plan

- _____
_____
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Wisconsin Health Care Partnership Plan

Cost (Continued)

Cost Shifting Between Firms

Firms that don't offer health insurance shift their costs to firms that do. This is particularly unfair to businesses that offer health insurance.

In fact, **80 percent** of the **uninsured** in Wisconsin live in a household that includes a full-time worker.

"The Uninsured: A Primer" The Kaiser Foundation, November 2004

This leads to higher health costs for everyone

Wisconsin Health Care Partnership Plan

- _____
_____
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Wisconsin Health Care Partnership Plan

80% w/o insurance.

Cost (Continued)

- But can't we cut the cost of health insurance if we all become better "consumers" of health care and "shop" for better quality at a lower price (as in so-called "consumer-driven" plans)?
  - Improving the quality of health care should be integrated into any serious health care reform plan (improves health and reduces costs)
  - "Shopping" for lower priced health care will do little over the long run to reduce costs – and won't increase access to quality care
  - Besides, 70% of the total cost of health care in the U.S. is incurred by only 15% of the population, particularly those with multiple acute conditions. "Better shopping" will do little to reduce their overall cost of care

So, what's the solution?

Wisconsin Health Care Partnership Plan

(WHCPP)

SB 698

Co-Sponsored by Democratic Senator Russ Decker and Republican Representative Terry Musser

NOT a universal Plan — All workers & all their dependents — Link to employment — early retirees buy in at costs

Wisconsin Health Care Partnership Plan

A Unified System of Comprehensive Affordable Care

- Builds on our tradition of employer-based access to health care.
- A practical proposal that can break the political logjam on Health Care Reform.
- Cuts costs dramatically for both employers and employees.

Wisconsin Health Care Partnership Plan

Wisconsin Health Care Partnership Plan

Who would be covered by the WHCPP?

- All workers and their dependents, private and public sector, in Wisconsin
- Anyone not covered by the WHCPP, Medicare, or Medicaid could buy into the WHCPP at cost (In a separate community rated pool)
  - Self-Employed
  - Family Farmers
  - Retired not yet eligible for Medicare
  - Others not covered through employment

Wisconsin Health Care Partnership Plan

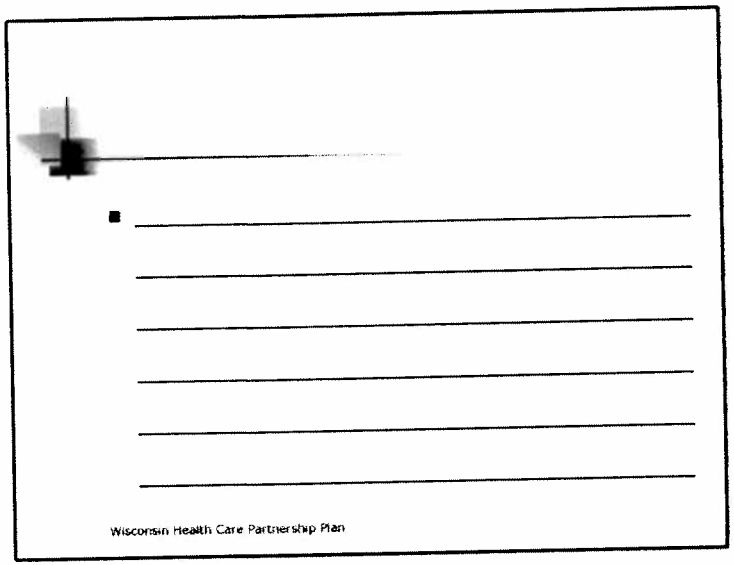
Wisconsin Health Care Partnership Plan

All medically necessary care

What benefits will be included in the WHCPP?

- All medically necessary care and prescription drugs, including:
  - Physician Services
  - Hospital Costs
  - Wellness and Prevention Programs
  - Mental Health Parity
  - Drug and Alcohol Abuse Treatment Programs
  - Rewards to Doctors and Hospitals for adopting highest quality standards
- WHCPP will not initially include dental, vision, and long-term care benefits.

Wisconsin Health Care Partnership Plan

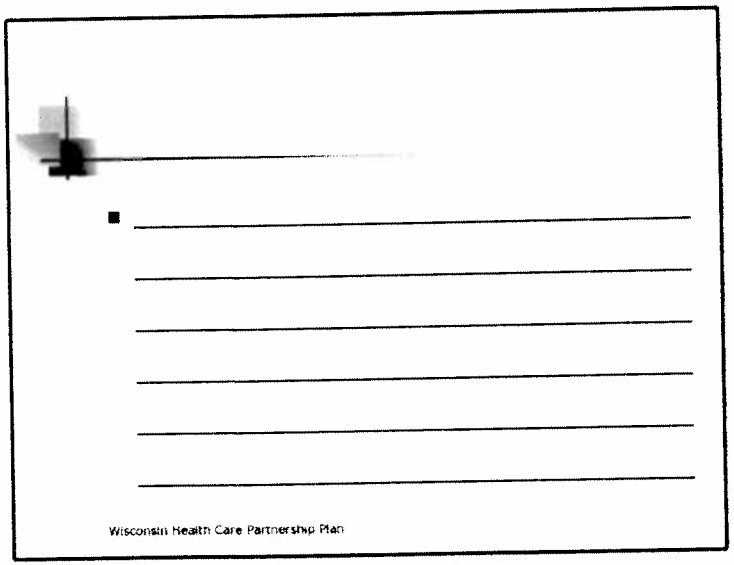


Wisconsin Health Care Partnership Plan

Sounds good...

But how much will it cost...
and how are we going to pay for it??

Wisconsin Health Care Partnership Plan



Wisconsin Health Care Partnership Plan

How would the WHCPP be financed?

- The cost of the WHCPP is split between employers and employees
- Basic principles of cost sharing between employers and employees:
  - Fairness
  - Keep it simple! The simpler the payment system, the more we'll save on unnecessary administrative costs

How would the WHCPP be financed? (Continued)

- The employee fair share is paid in deductibles and co-pays

How would the WHCPP be financed? (Continued)

- Employee Co-pays and deductibles
  - $300 individual yearly deductible / $600 family yearly deductible
  - $15 per office visit
  - Prescription Drug Co-pays:
    - $15 Generic Drugs
    - $20 Brand Name Drugs

How would the WHCPP be financed? (Continued)

- Employer Share: Flat monthly fee per worker, paid into central fund (as it would w/ WHCPP plan)

Payroll tax

How would the WHCPP be financed? (Continued)

- Employer monthly fee:
  - Estimated at less than $300 per month (2003 costs)
  - Includes 50% reduction in fee paid by employers for part-time workers and low-wage workers in small businesses

10 or fewer

How would the WHCPP be administered?

- Legislation would establish a Labor-Management Oversight Commission
  - Determine details of the Plan
  - Put out bids for administration (Payments to Doctors and Hospitals)
  - Determine fee schedule
  - Modify Plan, fees and charges as necessary
- Labor-Management Oversight Commission (similar to our nationally-recognized Workers Compensation Advisory Council) would work with doctors, hospitals and health care experts to develop a quality-driven state-of-the-art Health Care Plan
- The Plan would be required to incorporate incentives for doctors, hospitals and clinics to adopt professionally recognized "best practice" quality measures

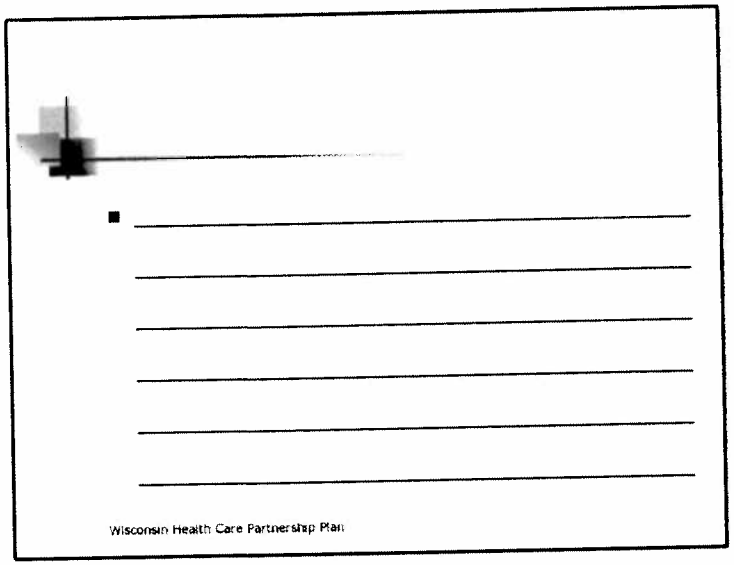
LABOR + MGMT oversight committee.
WBS UC WKC.

Medical Experts Federal Rep.

Advantages of the Wisconsin Health Care Partnership Plan

- Streamlined administration
- Single risk pool
- Bulk-buying power, to reduce cost of prescription drugs
- Public accountability and high quality health care delivery
- Dramatic reduction in number of uninsured: Wisconsin's uninsured population would be cut from 650,000 to less than 85,000

Wisconsin Health Care Partnership Plan

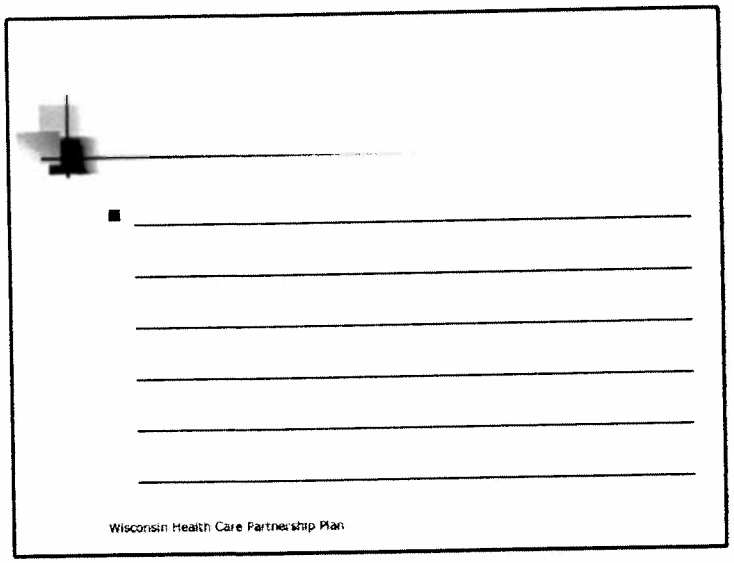


Wisconsin Health Care Partnership Plan

Sources of reduced costs for employers

- Administrative Savings from standardized, unified plan
- Elimination of unnecessary bureaucratic insurance costs
- Reduced delayed care and costly Emergency Room visits for the uninsured – costs that currently are shifted to the insured and their employers
- Reduced costs for prescription drugs
- Cost of health care for workers and their families shared equally among all employers

Wisconsin Health Care Partnership Plan



Wisconsin Health Care Partnership Plan

So What would the WHCPP mean for my health care?

- Affordable, Comprehensive, Quality Health Care
- Choice of Doctor
- Not Dependent on Where You Work
- Predictable, Reliable Coverage
- Public Accountability for our Health Care System

Wisconsin Health Care Partnership Plan

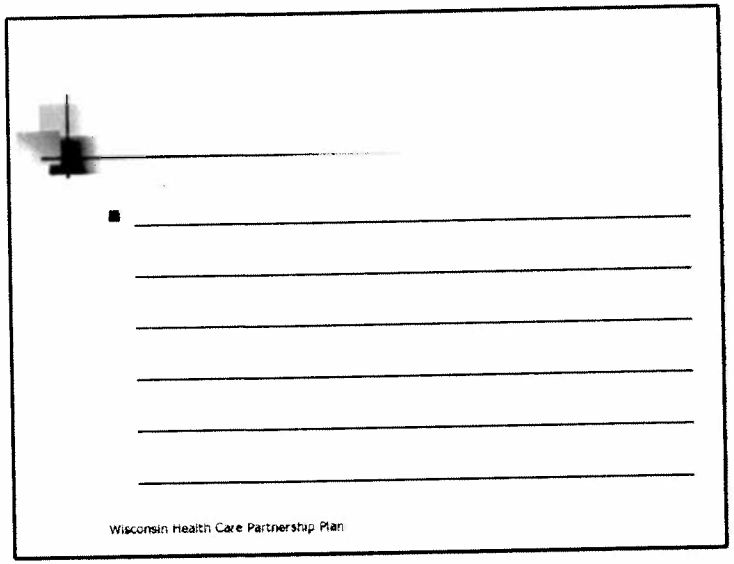
A Practical, Affordable, Achievable Solution to our Health Care Crisis

Wisconsin Health Care Partnership Plan

Health Care That Works for Wisconsin

For additional information:

- **Contact Senator Russ Decker (D-29)**
  - Phone: (608) 266-2502
  - Fax: (608) 267-9027
  - Email: sen.decker@legis.state.wi.us
- **Contact Representative Terry Musser (R-92)**
  - Phone: (608) 266-7461
  - Fax: (608) 282-3692
  - Email: rep.musser@legis.state.wi.us




FORWARD
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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

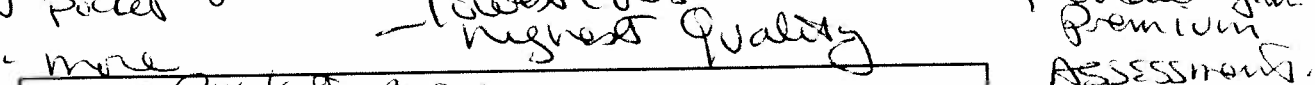
Health Insurance Purchasing Accounts

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 all health care plans

Preventive care

No 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

No more cost sharing

THE WISCONSIN HEALTH PLAN – AB 1140

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

– Build in higher healthy Generation

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.

B 12-15 BB
ANNUALLY
Payroll
~~Tax~~ Assess
new
Shared
between
employer
+ employee

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

www.wisconsinhealthplan.org

DRiemerMil@yahoo.com

lisa_ellinger@yahoo.com

trying to eliminate cost shifting — spouse, emergency room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The Wisconsin Health Care Partnership Plan

A LABOR-MANAGEMENT PARTNERSHIP SOLUTION TO OUR HEALTH CARE CRISIS

Structure: The Wisconsin Health Care Partnership Plan will cover all private- and public-sector employees and their dependents in the state. Self-employed workers, farmers and early retirees could purchase the same insurance at cost through a separate community-rated pool.

Coverage: The Plan will provide all medically necessary care, including mental health treatment and prescription drugs, with no exclusions for pre-existing conditions. There will be no maximum coverage limits, and individuals will have their choice of providers.

Financing: Costs will be split between employers and employees in a fair manner that keeps administrative costs to a minimum. Employers in both the private and public sectors will pay a flat fee per employee per month. Employees will be responsible for deductibles and co-pays.

Oversight: A Labor-Management Commission will:

- Develop the details of the Plan, within parameters set by legislation;
- Solicit bids to administer the Plan;
- Set fair reimbursement rates for hospitals and medical providers, - with incentives to adopt generally accepted best practice and quality measures;
- Adjust employer-paid monthly assessments and employee co-pays and deductibles as needed; and
- Make changes in Plan benefits and financing as needed.

SB 698 is co-sponsored by State Senator Russ Decker (D) and State Representative Terry Musser (R).


FORWARD

Marcie Malszycki
Committee Clerk
Notes

Senate Committee on Health Care Reform
7-26-06

Rep. Gielow, Rep. Richards, Joe Leann, Lisa Ellinger (testimony):

Lisa Ellinger and Joe Leann

The proposal we are here to talk about today, we needed a proposal that was bi partisan. This proposal is the product of this. This is intended to be a compromised proposal.

Health insurance is in a crisis mode. Mix between business and labor. If we don't all pull together we won't find a solution.

JL: The people who most need health care will join the pool and those who don't won't join. This new model requires mandatory participation. Funded health savings accounts. Increases efficiency. Private sector management. Consumer choice of plans and providers. Wellness and lifestyle encouragement. Disease management solution.

Mandated coverage is controversial. Our plan suggests phase out corporate income tax, increase earned income tax credit for low income families. Would provide insurance for those who could other wise not get it. Would be great for economic development in this state. Encourage life style changes.

People in this state are going to need to want this and legislators need to be brave to do this.

Q & A:

JE: Should there be or is there any profit sharing scenario?

JL: I see what you mean but with the private sector, where a private sector team of people will place people into tiers. I don't think we dip into the providers…

Very difficult to try to assess the profits or the providers. Controlling cost is better through disease management, reduce over use, wellness.

JE: Profit sharing model could work. What about after all research and development done, what about making them non-profit?

JL: Profit is a key word in heath care. We've been a leader in long term care reform. There are a lot of non-profits that are making profits. We want providers to make a decent living…encourage excellence.

JE: If we are dealing with tax breaks to the providers, I don't trust that the savings will be passed onto the consumer.

LE: Want to get the provider to work more efficiently with competition.

JE: I don't think we should be limited...there should be profit sharing. But if I am staying healthy, I should get money back.

JL: The overall cost of this thing is what is going to make this work. There are some models out there where we know what the profits should be.

CR: Was there a vote taken, a unanimous decision?

JL: We did not take a vote. I don't know what would happen if we did take a vote. It has to be mandatory with private sector management. I would say there is unanimous support for the plan but not that they are going to take a vote to show that support. Ultimately, very few policy makers can go out there saying we are going to mandate! Unless the people in this state say we need to do something. The push has to come from the constituencies. There needs to be some courageous policy makers. We haven't enforced that kind of vote.

CR: I can tell you in my district, I am not hearing that this is where they would like us to go. I am wondering why they are so quiet. Would this in any way put us in a situation where people would cross borders.

JL: we discussed that. You can't just come in here and immediately buy in. You have to be a resident. The demographers are telling us that we need workers too! We need to be a magnet for business expansion and workers.

AD: 3 comments. there isn't enough detail as in numbers...some say it is a cost shift. If you make that shift, tax incentive.

JL: most large business are paying 12-20% for health care. Would save large businesses money.
Most large business that provide comprehensive health plan would save money, but not a lot. Generally this plan, is not costing big businesses.

Rep. Gielow and Richards:

Assembly Bill 1140 (power point presentation) and statistic sheets.

It's clear that something is going on that we need to address (see stats sheet).

AB 1140 had one significant piece that was not in the bill which made it not serious...the financing piece.

This is a work in progress...no simple solution. It is going to take time. The objective is to keep the people at the table talking. This is a coalition of the frustrated.

This is a 70% solution. If you can support this 70%, it could work.

Market based solution: first criticism I got was it is universal health care. It is not. It puts all 4.6 million WI residents into the same purchasing pool.

Key elements: on page 2.

Need to be a WI resident. Here longer than 6 months.

This does not include the MA population but that is the goal down the road. Would need waiver.

HSA: Every adult would get $500 annually for health services. They would get a premium credit or a "voucher". Used to buy or pay for a tier 1 plan that you would choose. Tier 1 is the lowest cost plan with high quality.

Private Heath Ins Purchasing Corp should have a board that is not apart of the government. Page 4

As state employees, the tier system is what we have.

Incentive for Tier 1: avoid extra premium cost, insurers want to offer tier 1 plan, providers want to be in tier 1 plans, can only be a tier 1 by lowering cost. (page 4)

Incentive 2 Choose appropriate care: preventative care, HSA's, deductibles, co-insurance, encourage shopping for the best price.

Incentive 3: Maintain a health life style.
$12-15 billion to get health care on a standard plan. One way is the payroll assessment. That is how SS is paid for.

This is still a work in progress. We have been around the state for a year and a half. We continue to have meetings with many.

Q &A:

CR: When are the meetings? Could we get a roster?

CG: 8-16-06 State medical society. It is open for people to attend. We need an unbiased person to consult on this.

JR: We have been running those numbers. The next round of studies, I could share with you.

CR: yes, please provide that to us. From the start, I have been and remain open to an assessment. I am not opposed to that consideration. My point is we are surprised sometimes. I want to know who was against those things

LO: We have to be careful to realize that this is a work in progress. We don't want someone to bomb this before we get to the end product. We have to make sure that remain vigilant. Be an advocate for this. We know how hard it is to provide health insurance for our employees.

CR: We have silos now...separate things...we need to bring things together.

David Newby and Terry Musser Testimony: SB 698

Musser: Number 1 issue in this state. We have competing plans. I see this not as competing plans. People are waiting to see what is out there. We have to get the ideas out there and we need to force people to take a position on this. Needs to be mandatory. Leaders need to step up from the interest groups. The fear is not knowing what he health insurance will cost you next year.

Newby and Mike Rayome: Power Point

It is true that we initiated the process. We have consulted with many different groups. Partnership between labor and management. Broad support for the plan itself. It did initiate in AFL-CIO. Most in not all of an increase went to pay for health care.

We are putting more per capita into our health care than any other country. We are not getting the health care outcomes that other countries are.

46 million Americans have not heath insurance at all.

In 2004, 546,000 WI residents were uninsured for at least part of the year. Costs are being shifted. Page 3

Administrative Costs: high (page 4). We need to reduce administrative costs.

Every time a policy is written, underwriting must occur so they know how much to charge to make some money.

Graph on the increase on the number of MD's. page 5. Increase of administrators. We wonder why there is an increase.

Wanted to keep as much private involvement as possible. Labor management oversight Committee...worked for workers comp could work for this. Page 12

Advantages: streamline administration, bulk buying power, public accountability (page 13)

Even thought this is not a universal plan, it gets us very ,very close.

For individuals: this plan would give them affordable health care, choice of a MD, not dependent on where you work, predictable, public accountability. (page 14)

This is not a final product. The final detail is left for the labor management commission.

Build quality and preventative care into the plan.

Q & A:

CR: Define state of art practices and rewards for this? Do you have a sate of the art system that you are recommending on how we lay that into the system?

DN: Makes more sense to build those quality measures than put all the burden on the individuals.

CR: Where is the model for this?

DN: Differential reimbursement rate. Reward quality by having higher reimbursement rate. We are open to all kinds of ideas.

CR: Very appreciative of DN going to an employee that I have a close relationship with. He has met with a lot of people I have asked him to.

Next questions: What about some of the other union groups, WEAC?

DN: Yes we have. We have had discussions with WEAC. The trust was set up to provide quality insurance for teachers in the state. If there was a better way to do that they would not let anything stand in the way.

CR: What about buying into the state plan? What about opening that to local governments, to employers in WI?

DN: Personally, the problem is that you don't necessarily reduce the uninsured. Still cost shifting. You are not eliminating those administrative costs either.

CR: But they would be far less right?

DN: Yes, it would cut cost but would it do enough to solve our problem.

***Dick we want more information on this!!**

DN: There were about 650,000 people that did not have health insurance. With out plan, it would have cut that number down to a manageable level.

CR: The fastest growing un-insured is 18-24 years old. The point is what are we going to do about those folks who are choosing to pay for other things besides insurance?

Musser: Erp brought up a good point. If I knew I was going to live this long, I would have taken better care of myself. That is why this should be mandatory. That would stop the "cherry picking"

CR: why do you think there would be "cherry picking"? what if it was mandatory and we opened up the state plan?

DN: Cost

LO: Who is covered?

DN: all employees and dependents

LO: This goes on a flat fee, so if I am paying 14% per employee but if I am paying under your plan it is still the same. Why did you stick with a fixed number?

DN: That was a rough cut. Part of the problem with the percentage of wages, you are rewarding lower wage at the expense of higher wage. How ever you do it, there is no perfect way to do it.

LO: Seems like you designed the plan to say this how much we are going to kick in and how have to find the insurance to match it?

DN: Covers all medically necessary care. MD services, Rx, hospitalization, all the way down the line. For those that are employed, are plan would be the main plan and MA secondary.

LO: Do you have to be in this plan if you are self employed?

DN: No

AD: Cost shifting and over utilization?

DN: over utilization is a minor problem.

CR: There has to be education for consumers. Education is going to have to be a large part of what we expect.

Mike Rayome

$5000-$600,000 per month for health care.

This is a plan that has a lot of merit to it. Haven't talked to anyone who doesn't support this plan. Teachers asking for them to come and speak to their union.

The simplistic of if is taking out the administrative fees. That makes this plan really work.

CR: have you looked at the other plan.

Rayome: yes. Talking away property tax and substituting another tax...seemed like a shift. This plan lays out the playing field for all.

CR: So you looked at the other but didn't study it as you did this one? No
What you really didn't like was the corporate tax decrease and the cost shifting.

Rayome: spreads the risk in the program.

LO: Looking at this $300 in '03 and $500 now, not that big of increase. Are you concerned about the cost increasing?

Rayome: would still take us a long time to get to where we are now.

LO: If you pay SS taxes you can be part of this plan? Have you looked at this?

DN: not sure

Senator Miller, Dr. Farley and Art Taggart (coalition of WI Health)

SB 388

Dr. Farley: This is a family value kind of issue. Have seen enormous problems without insurance.

Days before Medicare was active...there was political movement to cover the elderly and poor because they were the highest to cover.

Cost is up and access and benefits are down.

Solution is a state wide, publicly funded plan.

Jails are the largest mental health institution. Infant mortality is the highest here than in any other country. If you look at Milwaukee, the number of deaths in the first year of life 19.3. Mostly due to lack of prenatal care among other things.

Spending on per capita for health is greater in this country.

Speaks about the administrative increase same as in the previous presentation. 31% administrative costs.

Tax payers are paying 60% or health care bills. Individuals only pay 20%.

How do we know we can do this? All other industrialized nations are doing this. We have great hospitals, research, professionals…

Those who vote in this county are the wealthy, not those that would or could gain the most from this plan.

We are headed towards a terrible storm unless we do something now. Medicare is a disaster for all. Elderly are going to have to pay more and more.

Senator Miller:

We are paying for a Cadillac system but that is not what we have.

Need to take a comprehensive reform. Need to find a compromised solution. We are not proposing a compromise.

We are proposing a plan that would include all WI residents.

It would effectively eliminate the inefficiencies associated with private insurance underwriting.

Eliminate the HIRSP program, the need for the program.

How do we accomplish this: page 2 there are 8 points.

All WI residents are a part of the plan. Dental, vision, Rx, mental health, everything is covered.

Surcharges can not be used.

Quality, efficiency, cost containment and regional responsiveness would be accomplished by mechanisms created.

Representative Benedict:

This would lay the ground work for a single payer plan. This will deliver better, more comprehensive health care. Currently have a mosaic of plans from federal and state dollars.

From a MD standpoint, my opinion that the practice of medicine will be improved with this plan.

Art Taggert:

Did not provide written testimony.

What do you want for the people in your district? It isn't fair for some to have great health insurance, assistance from the government, and others completely without.

Q & A:

AD: how to pay for this?

Miller: Through payroll tax and public monies

JE: This is a matter of changing the mind set. You are trying to get to that. It should be available no matter what. Can we take the money we have now and cover people?

Miller: We can cover people for the same amount or less.

JE: Move at federal level to ban advertisement for Rx's?

DR: Move among concerned individuals to push for a ban.

JE: Do you think that there should be after paying for everything, should there be a profit in health care period?

DR: The way our bill goes, there wouldn't be any 3rd party profit. DR has to get paid.

JE: Not saying that but there is a large chunk on money left over.

DR: There needs to be regional planning. How do we need to give adequate health care to everyone.

JE: Should there be any advertising at all for doc, rx, hospitals?

DR: Not from my point of view there should not be. Advertising adds to the system loss.

LO: We either have too much or not enough. Too much is very expensive and so is not enough. How do we figure out how much is too much or too little? I am concerned that we are saying that over supply of health care is a bad thing and it's expensive. What is worse?

Miller: I believe that it is important to have resiliency in the system. We have to be able to redirect health care with in the state where it is needed.

DR: Many places where people have to travel far...not a good distribution of doctors. Lets get everyone covered and then work on these other issues. Education is important to the public.

J.P. Wieske: (booklet provided)

jpwieske@cahi.org

Who are the uninsured: 79% were employed full or part time.

Target solutions: solutions should be targeted to specific populations. There is no one solution to everyone's problem.

Average age of person who bought insurance, 52. this was in other sates not WI. Average age in WI is 32 which show that WI is more affordable.

WI Health Plan: Government run health care! They decide premiums, eligibility, ...recipe for disaster. Use HSA model but doesn't meet federal requirements. Eliminates consumer choice by forcing individuals to choose from only one plan design. Does nothing to solve the issue of underlying medical cost.

Lessons learned from other states regarding the WI Health Plan. Employer mandates, not sure if it is legal. Struck down in MA.

Health Care Partnership Plan: No plan design details. No cost estimates. He has studied Medicare administrative costs. Actually much higher than reported. This plan ignores the fundamental issue: who is uninsured and why?

WI SB 388: Government run insurance plan.

In a government unsubsidized program, people would rather not join.

Public-Private Partnership: Montana and Oklahoma

Mandate-Lite Ins Plans: Lower cost benefit plan

Heath savings accounts: 30% were previously uninsured, successful targeting of small businesses. State tax deductibility helps protect employees.

High Risk Pools: 32 states have them including WI. Targets individuals who are uninsurable.

List Billing: WI has passed a weak bill. Allows indiv. to purchase an indiv insurance plan through pay roll deductions.

Underwriting: targets the young by making insurance more affordable. Creates healthier pool this leads to affordable insurance.

www.tonikhealth.com
Successful in targeting invincible, unique plan designs: high deductible, 4 dr visits, limited drug coverage, includes dental and vision.

Right start Plan: HSA qualified.

Limited Benefit Plan: get a certain amount of coverage.

www.cahi.org to download publications

Q & A:

CR: Clear, the proposals that came before…showing the rise in administrative costs and also in addition they offered a different way of payment.

JP: When I started the largest department was the claims department. Has gone down from then.

CR: Where is the answer to the problems we have identified? Cost?

JP: First step is to determine what the problem is that you want to solve. There are different solutions to different problems. Do you want to solve the coverage issue for all? We need to look piece by piece.

Subsidized plan, tax incentive, low cost benefit plan

CR: We need to make a difference and do more in WI. If you can give us anymore about solutions to the identified problems.

JP: There are small solutions in the booklet.

CR: If you could identify the small detailed solutions, you ID-ing them would be helpful.

JP: Some of these things can not be moved.

LO: When insurance rates are increasing, the ability to choose and have many plans can't happen, we may have to choose a few plans hat are best for the majority.

JP: HSA plan design is easier to understand. CA has been able to attract invicables into health plans.

LO: I can't afford to insure myself or anyone else.

JP: There are a certain number of hospitals that charge more to the uninsured.

LO: There are a lot of people that can't pay. There is charity care and uncollectible. That is different. Then the money comes from those who can pay. If I can get something for nothing, I will do until I realize I may need it.

JP: I don't know. I am not sure we are going to be able to get everyone. There will always be people that will want to choose something else.

CR: Please tell us ideas on how to get those to pay who are not insured by choice. To me in is about personal responsibility.

AD: The problem with the previous plans, not looking at the underlying cost. Where would I go to find who gets what?

JP: He could get that for us.

AD: Some say SE WI has highest care of health care in the Nation. You said another city.

JP: Health insurance premiums and health insurance cost.

Miller: Your headquarters in DC? What is the annual budget?

JP: Very low. Only 7 staffers.