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☞ Details: Hearing held in Madison, Wisconsin on September 27, 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)

Senate

Record of Committee Proceedings

Select Committee on Health Care Reform

The Committee will hear from the following invited speakers:

Laura Tobler, National Conference of State Legislatures
Health Care Cost Reform: State Activities

Cheryl DeMars , CEO, The Alliance
Employer Health Care Alliance Cooperative

Dr. Ralph Kalies, CEO, BidRx
Dr. Tom Kellenberger, VP Sales & Marketing, BidRx

Doug McIntosh, Digital Health Care

September 27, 2006 **PUBLIC HEARING HELD**

Present:	(4)	Senators Roessler, Darling, Olsen and Erpenbach.
Absent:	(1)	Senator Miller.

Appearances For
- None.

Appearances Against
- None.

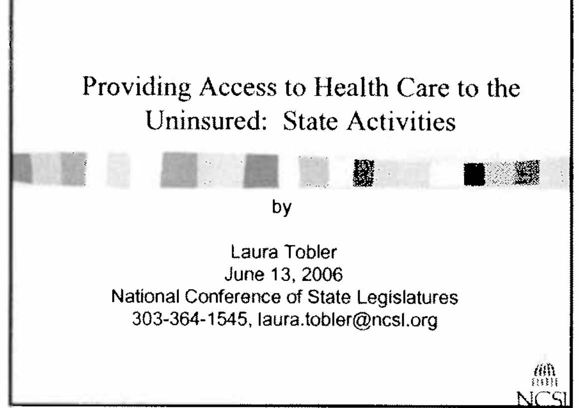
Appearances for Information Only
- Laura Tobler — National Conference of State Legislatures
- Ralph Kalies — Dr. , CEO, BidRx
- Tom Kellenberger — Dr., VP Sales and Marketing, BidRx
- Doug McIntosh — Digital Health Care

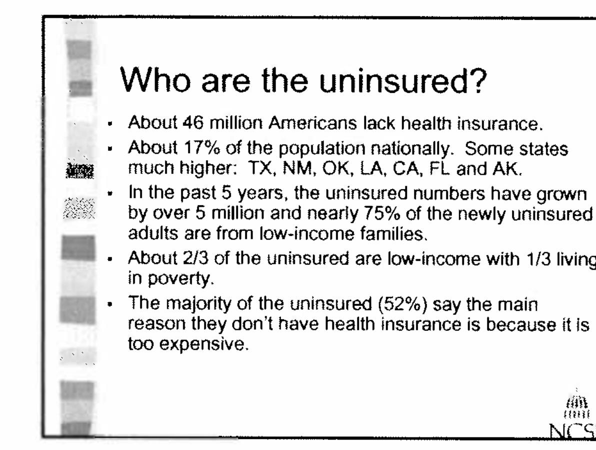
Registrations For
- None.

Registrations Against
- None.

Jennifer Stegall
Committee Clerk

FORWARD
E PLURIBUS UNUM


Providing Access to Health Care to the Uninsured: State Activities
by
Laura Tobler
June 13, 2006
National Conference of State Legislatures
303-364-1545, laura.tobler@ncsl.org
NCSL


Who are the uninsured?
• About 46 million Americans lack health insurance.
• About 17% of the population nationally. Some states much higher: TX, NM, OK, LA, CA, FL and AK.
• In the past 5 years, the uninsured numbers have grown by over 5 million and nearly 75% of the newly uninsured adults are from low-income families.
• About 2/3 of the uninsured are low-income with 1/3 living in poverty.
• The majority of the uninsured (52%) say the main reason they don't have health insurance is because it is too expensive.
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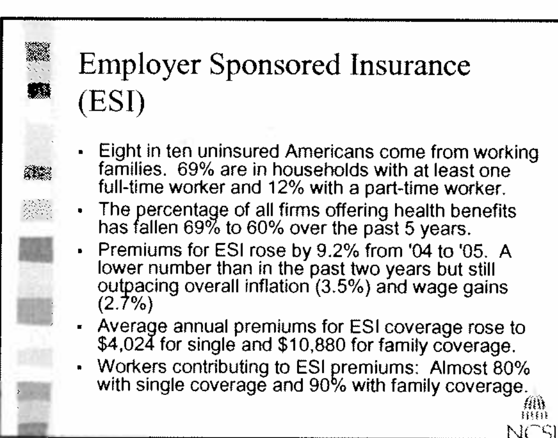
Employer Sponsored Insurance (ESI)
• Eight in ten uninsured Americans come from working families. 69% are in households with at least one full-time worker and 12% with a part-time worker.
• The percentage of all firms offering health benefits has fallen 69% to 60% over the past 5 years.
• Premiums for ESI rose by 9.2% from '04 to '05. A lower number than in the past two years but still outpacing overall inflation (3.5%) and wage gains (2.7%)
• Average annual premiums for ESI coverage rose to $4,024 for single and $10,880 for family coverage.
• Workers contributing to ESI premiums: Almost 80% with single coverage and 90% with family coverage.
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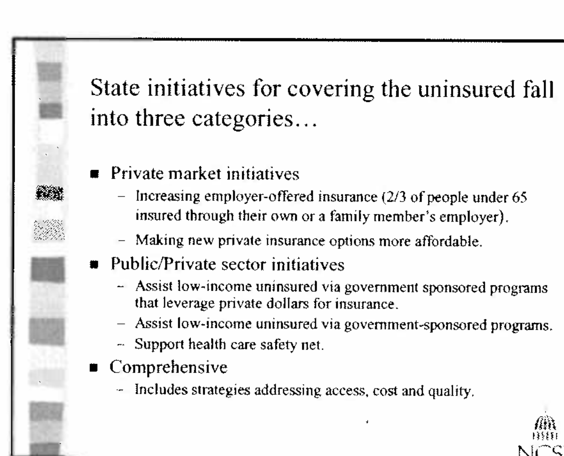
State initiatives for covering the uninsured fall into three categories…
■ Private market initiatives
– Increasing employer-offered insurance (2/3 of people under 65 insured through their own or a family member's employer).
– Making new private insurance options more affordable.
■ Public/Private sector initiatives
– Assist low-income uninsured via government sponsored programs that leverage private dollars for insurance.
– Assist low-income uninsured via government-sponsored programs.
– Support health care safety net.
■ Comprehensive
– Includes strategies addressing access, cost and quality.
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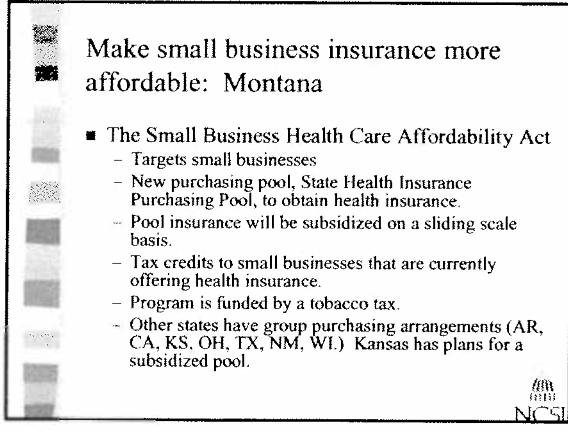
Make small business insurance more affordable: Montana
■ The Small Business Health Care Affordability Act
– Targets small businesses
– New purchasing pool, State Health Insurance Purchasing Pool, to obtain health insurance.
– Pool insurance will be subsidized on a sliding scale basis.
– Tax credits to small businesses that are currently offering health insurance.
– Program is funded by a tobacco tax.
– Other states have group purchasing arrangements (AR, CA, KS, OH, TX, NM, WI.) Kansas has plans for a subsidized pool.
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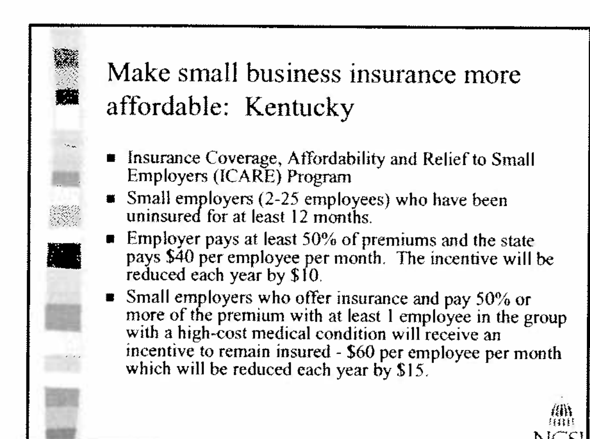
Make small business insurance more affordable: Kentucky
■ Insurance Coverage, Affordability and Relief to Small Employers (ICARE) Program
■ Small employers (2-25 employees) who have been uninsured for at least 12 months.
■ Employer pays at least 50% of premiums and the state pays $40 per employee per month. The incentive will be reduced each year by $10.
■ Small employers who offer insurance and pay 50% or more of the premium with at least 1 employee in the group with a high-cost medical condition will receive an incentive to remain insured - $60 per employee per month which will be reduced each year by $15.
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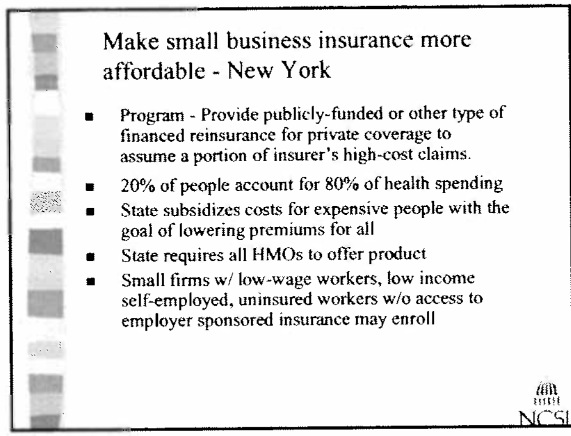
Make small business insurance more affordable - New York
Program - Provide publicly-funded or other type of financed reinsurance for private coverage to assume a portion of insurer's high-cost claims.
20% of people account for 80% of health spending
State subsidizes costs for expensive people with the goal of lowering premiums for all
State requires all HMOs to offer product
Small firms w/ low-wage workers, low income self-employed, uninsured workers w/o access to employer sponsored insurance may enroll
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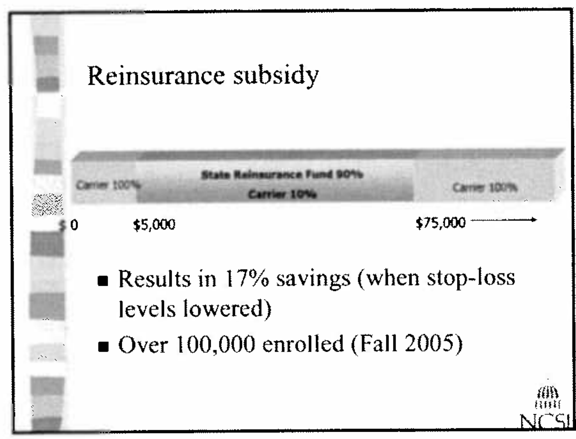
Reinsurance subsidy
Carrier 100%
State Reinsurance Fund 90%
Carrier 10%
Carrier 100%
$0
$5,000
$75,000
Results in 17% savings (when stop-loss levels lowered)
Over 100,000 enrolled (Fall 2005)
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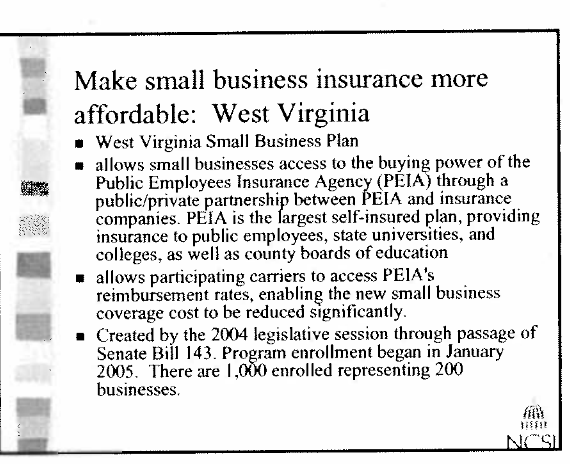
Make small business insurance more affordable: West Virginia
West Virginia Small Business Plan
allows small businesses access to the buying power of the Public Employees Insurance Agency (PEIA) through a public/private partnership between PEIA and insurance companies. PEIA is the largest self-insured plan, providing insurance to public employees, state universities, and colleges, as well as county boards of education
allows participating carriers to access PEIA's reimbursement rates, enabling the new small business coverage cost to be reduced significantly.
Created by the 2004 legislative session through passage of Senate Bill 143. Program enrollment began in January 2005. There are 1,000 enrolled representing 200 businesses.
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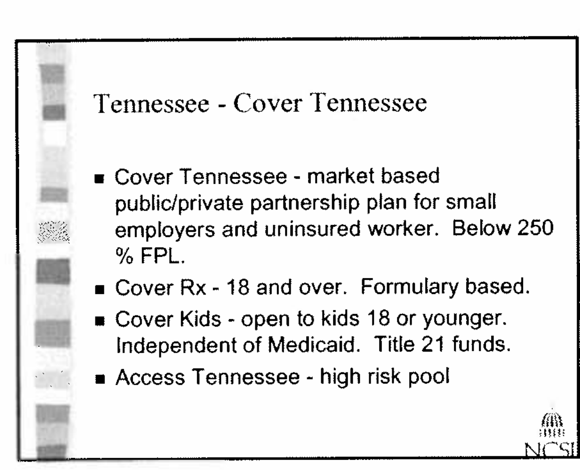
Tennessee - Cover Tennessee
Cover Tennessee - market based public/private partnership plan for small employers and uninsured worker. Below 250 % FPL.
Cover Rx - 18 and over. Formulary based.
Cover Kids - open to kids 18 or younger. Independent of Medicaid. Title 21 funds.
Access Tennessee - high risk pool
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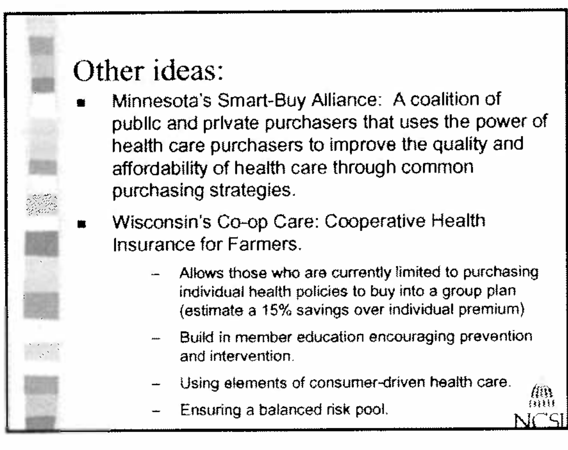
Other ideas:
Minnesota's Smart-Buy Alliance: A coalition of public and private purchasers that uses the power of health care purchasers to improve the quality and affordability of health care through common purchasing strategies.
Wisconsin's Co-op Care: Cooperative Health Insurance for Farmers.
– Allows those who are currently limited to purchasing individual health policies to buy into a group plan (estimate a 15% savings over individual premium)
– Build in member education encouraging prevention and intervention.
– Using elements of consumer-driven health care.
– Ensuring a balanced risk pool.
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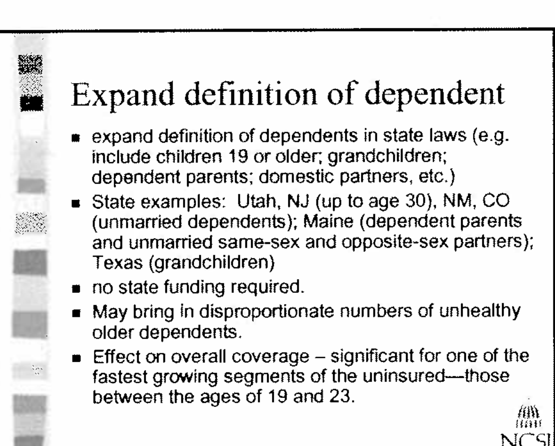
Expand definition of dependent
expand definition of dependents in state laws (e.g. include children 19 or older; grandchildren; dependent parents; domestic partners, etc.)
State examples: Utah, NJ (up to age 30), NM, CO (unmarried dependents); Maine (dependent parents and unmarried same-sex and opposite-sex partners); Texas (grandchildren)
no state funding required.
May bring in disproportionate numbers of unhealthy older dependents.
Effect on overall coverage – significant for one of the fastest growing segments of the uninsured—those between the ages of 19 and 23.
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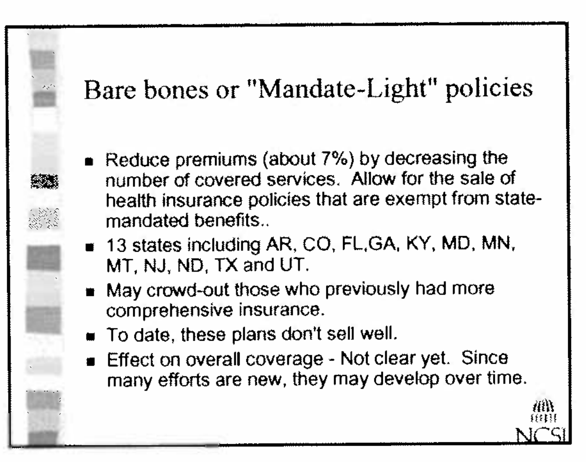
Bare bones or "Mandate-Light" policies
Reduce premiums (about 7%) by decreasing the number of covered services. Allow for the sale of health insurance policies that are exempt from state-mandated benefits..
13 states including AR, CO, FL,GA, KY, MD, MN, MT, NJ, ND, TX and UT.
May crowd-out those who previously had more comprehensive insurance.
To date, these plans don't sell well.
Effect on overall coverage - Not clear yet. Since many efforts are new, they may develop over time.
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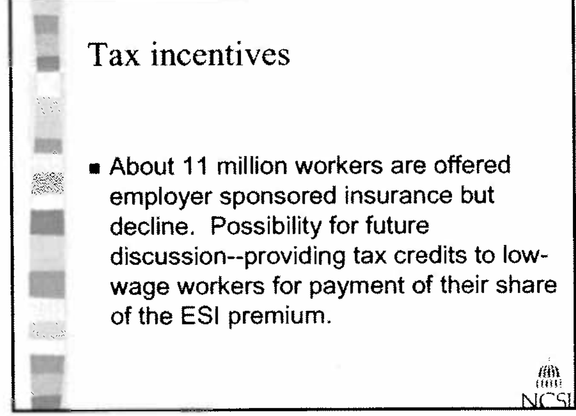
Tax incentives
About 11 million workers are offered employer sponsored insurance but decline. Possibility for future discussion--providing tax credits to low-wage workers for payment of their share of the ESI premium.
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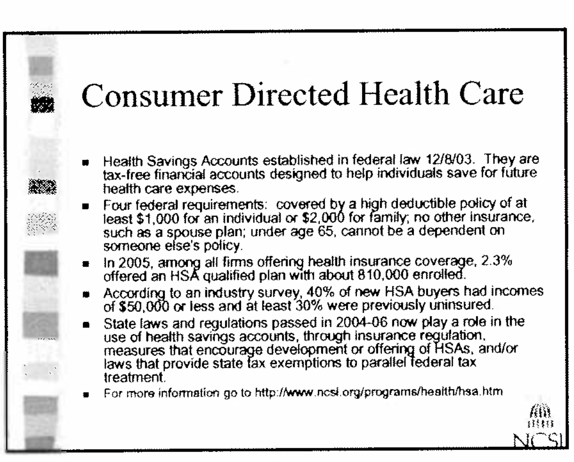
Consumer Directed Health Care
Health Savings Accounts established in federal law 12/8/03. They are tax-free financial accounts designed to help individuals save for future health care expenses.
Four federal requirements: covered by a high deductible policy of at least $1,000 for an individual or $2,000 for family; no other insurance, such as a spouse plan; under age 65, cannot be a dependent on someone else's policy.
In 2005, among all firms offering health insurance coverage, 2.3% offered an HSA qualified plan with about 810,000 enrolled.
According to an industry survey, 40% of new HSA buyers had incomes of $50,000 or less and at least 30% were previously uninsured.
State laws and regulations passed in 2004-06 now play a role in the use of health savings accounts, through insurance regulation, measures that encourage development or offering of HSAs, and/or laws that provide state tax exemptions to parallel federal tax treatment.
For more information go to http://www.ncsl.org/programs/health/hsa.htm
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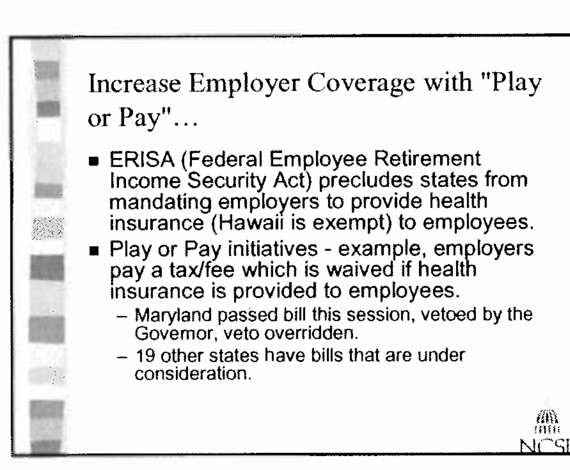
Increase Employer Coverage with "Play or Pay"…
ERISA (Federal Employee Retirement Income Security Act) precludes states from mandating employers to provide health insurance (Hawaii is exempt) to employees.
Play or Pay initiatives - example, employers pay a tax/fee which is waived if health insurance is provided to employees.
– Maryland passed bill this session, vetoed by the Governor, veto overridden.
– 19 other states have bills that are under consideration.
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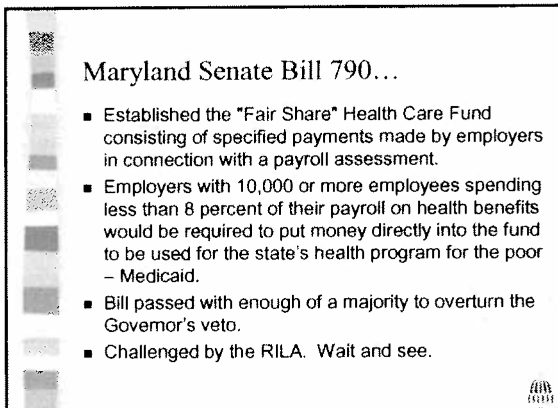
Maryland Senate Bill 790…
Established the "Fair Share" Health Care Fund consisting of specified payments made by employers in connection with a payroll assessment.
Employers with 10,000 or more employees spending less than 8 percent of their payroll on health benefits would be required to put money directly into the fund to be used for the state's health program for the poor – Medicaid.
Bill passed with enough of a majority to overturn the Governor's veto.
Challenged by the RILA. Wait and see.
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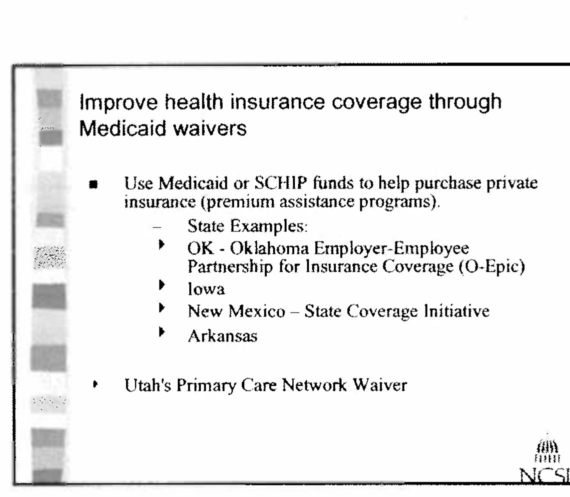
Improve health insurance coverage through Medicaid waivers
Use Medicaid or SCHIP funds to help purchase private insurance (premium assistance programs).
– State Examples:
OK - Oklahoma Employer-Employee Partnership for Insurance Coverage (O-Epic)
Iowa
New Mexico – State Coverage Initiative
Arkansas
Utah's Primary Care Network Waiver
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Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC)

- Aims to cover an additional 50,000 residents with incomes at or below 185 percent FPL.
- Funded by state general fund revenues generated by a tobacco tax, along with federal Medicaid matching funds and employer and employee contributions.
- The O-EPIC Premium Assistance Program will pay part of the health plan premiums for eligible employees working for qualified Oklahoma small businesses (with 25 or fewer employees). Participation in this program is voluntary. Enrollment began in Nov 2005.
- The O-EPIC Public Product Health Care Plan is designed as a safety net for people who cannot access private health coverage through their employer. This plan extends coverage to uninsured self-employed individuals, workers whose employers do not provide health coverage, workers who are not eligible to participate in their employer's health plan, sole proprietors not eligible for small group health coverage, and the unemployed who are currently seeking work. Enrollment began in spring 2006.

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New Mexico's State Coverage Initiative

- New health plan initiative providing low-cost basic health insurance through an employer based benefit program in conjunction with the state.
- Uninsured adults up to 200% federal poverty through employer-sponsored coverage.
- Financed through: employer contribution, employee contribution (based on income), Medicaid (match from unused SCHIP dollars).
- Benefits similar to basic commercial plan.

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Arkansas Safety Net Benefit Program

- Approved March 2006
- Increase health insurance coverage through a public/private partnership that will provide a "safety net" benefit package to approximately 50,000 uninsured individuals over 5 years.
- Targeted at businesses with fewer than 50 employees that have not offered health coverage in at least one year prior to enrollment.
- Funding comes from fees collected from employers, state tobacco settlement funds and federal Medicaid dollars.
- Will begin with a pilot in late 2006 for up to 25,000 participants. Second phase may go up to 80,000.

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Iowacares

- Signed by Governor in May 2005.
- Expansion. State plans to enroll up to 30,000 new eligibles each year.
- Cost sharing. Co-payments, premiums based on income.
- Incentives to make healthier lifestyle choices: no smoking and healthy body weights could lower premiums.
- Limited benefit. Providers are limited.
- Additional funding will come from state and local dollars currently used for health care at the participating health care providers. (IGT program)
- Program will be limited to the dollars appropriated.
- Addresses long-term care to place more emphasis on home and community-based care.

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Utah's Primary Care Network and Covered at Work (1115 waiver)

- provides ***primary/preventive care only*** to up to 25,000 new adults at or below 150 % FPL.
- Reduces benefits for some mandatory and optional Medicaid enrollees to help finance expansion.
- Enrollment fee and significant cost sharing.
- Folded state-only UMAP into Medicaid
- People are interested and enrollment continues to rise.
- Those not eligible for PCN because of ESI are eligible for a $50/month subsidy to pay for ESI.

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Support Direct Services Programs: Public Hospitals, Health Centers and others

- State Examples: MA, NJ and NY have bad debt and charity care pools for uncompensated care. 36 states support health centers. Many states have loan forgiveness programs for providers working in underserved areas.
- Presence of safety net providers improves both access to care and health outcomes. For example, communities with CHCs have lower infant mortality rates, lower rates of low-birth-weight babies, higher rates of women obtaining mammograms and pap smears, and higher rates of women receiving early prenatal care.
- Providing health insurance coverage may be more effective in ensuring access - ??
- Wouldn't be coverage but access. This strategy appears to have a positive impact on health outcomes. However, some studies suggest that providing health insurance coverage may be more effective.

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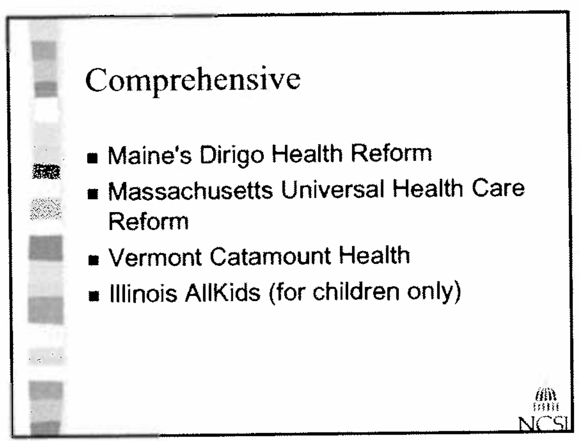
Comprehensive
Maine's Dirigo Health Reform
Massachusetts Universal Health Care Reform
Vermont Catamount Health
Illinois AllKids (for children only)
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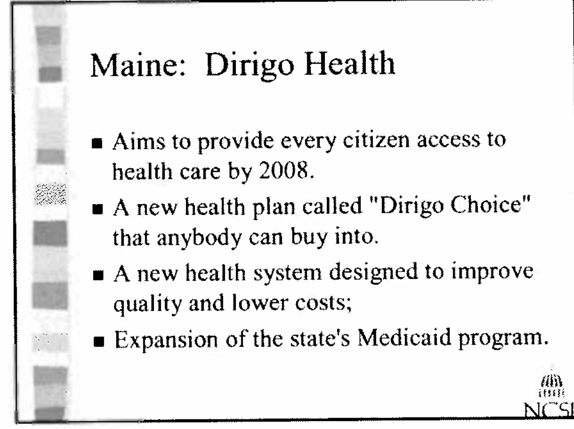
Maine: Dirigo Health
Aims to provide every citizen access to health care by 2008.
A new health plan called "Dirigo Choice" that anybody can buy into.
A new health system designed to improve quality and lower costs;
Expansion of the state's Medicaid program.
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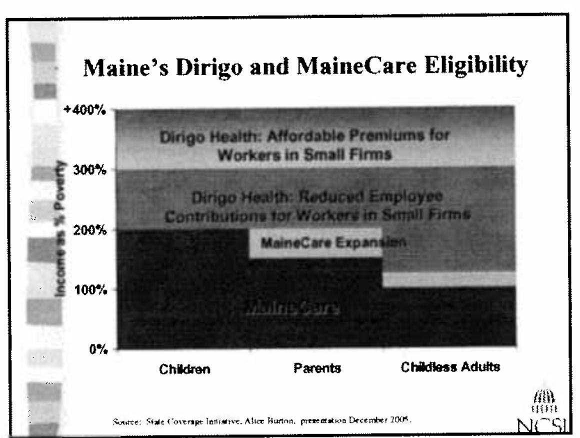
Maine's Dirigo and MaineCare Eligibility
Income as % Poverty
+400%
300%
200%
100%
0%
Dirigo Health: Affordable Premiums for Workers in Small Firms
Dirigo Health: Reduced Employee Contributions for Workers in Small Firms
MaineCare Expansion
Children
Parents
Childless Adults
Source: State Coverage Initiative, Alice Burton, presentation December 2005.
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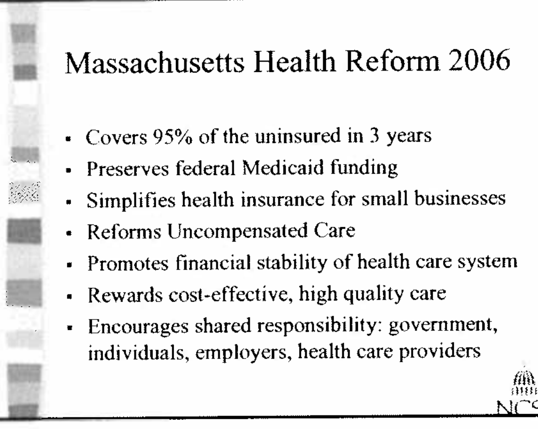
Massachusetts Health Reform 2006
Covers 95% of the uninsured in 3 years
Preserves federal Medicaid funding
Simplifies health insurance for small businesses
Reforms Uncompensated Care
Promotes financial stability of health care system
Rewards cost-effective, high quality care
Encourages shared responsibility: government, individuals, employers, health care providers
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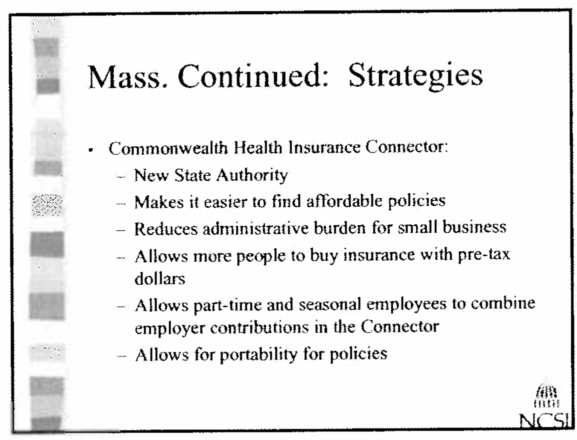
Mass. Continued: Strategies
Commonwealth Health Insurance Connector:
New State Authority
Makes it easier to find affordable policies
Reduces administrative burden for small business
Allows more people to buy insurance with pre-tax dollars
Allows part-time and seasonal employees to combine employer contributions in the Connector
Allows for portability for policies
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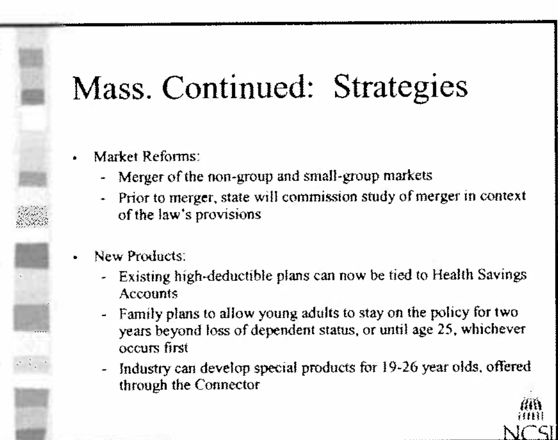
Mass. Continued: Strategies
Market Reforms:
Merger of the non-group and small-group markets
Prior to merger, state will commission study of merger in context of the law's provisions
New Products:
Existing high-deductible plans can now be tied to Health Savings Accounts
Family plans to allow young adults to stay on the policy for two years beyond loss of dependent status, or until age 25, whichever occurs first
Industry can develop special products for 19-26 year olds, offered through the Connector
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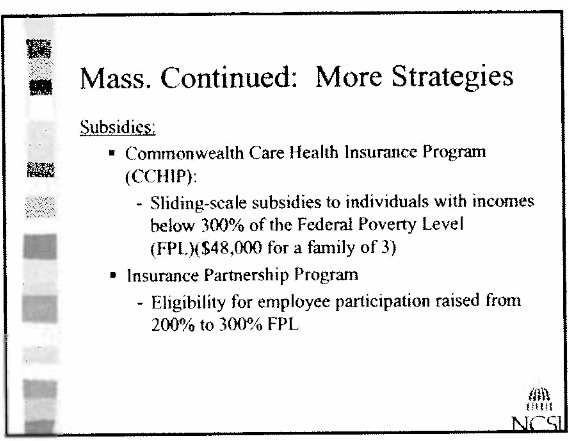
Mass. Continued: More Strategies
Subsidies:
Commonwealth Care Health Insurance Program (CCHIP):
- Sliding-scale subsidies to individuals with incomes below 300% of the Federal Poverty Level (FPL)($48,000 for a family of 3)
Insurance Partnership Program
- Eligibility for employee participation raised from 200% to 300% FPL
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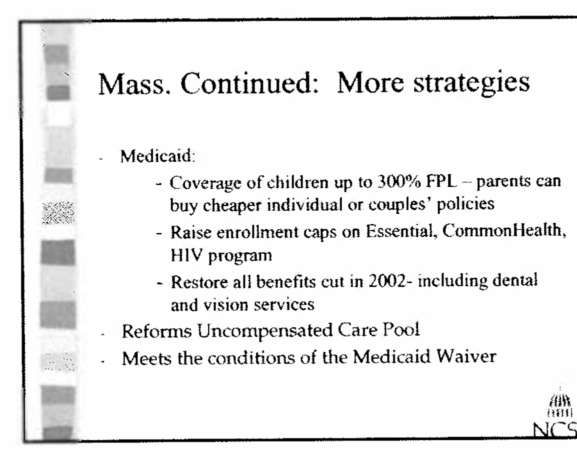
Mass. Continued: More strategies
Medicaid:
- Coverage of children up to 300% FPL – parents can buy cheaper individual or couples' policies
- Raise enrollment caps on Essential, CommonHealth, HIV program
- Restore all benefits cut in 2002- including dental and vision services
Reforms Uncompensated Care Pool
Meets the conditions of the Medicaid Waiver
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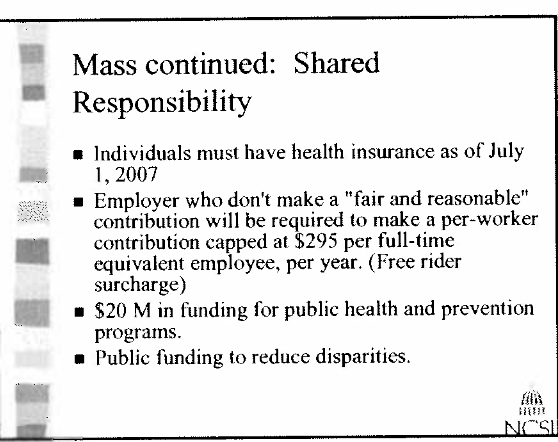
Mass continued: Shared Responsibility
Individuals must have health insurance as of July 1, 2007
Employer who don't make a "fair and reasonable" contribution will be required to make a per-worker contribution capped at $295 per full-time equivalent employee, per year. (Free rider surcharge)
$20 M in funding for public health and prevention programs.
Public funding to reduce disparities.
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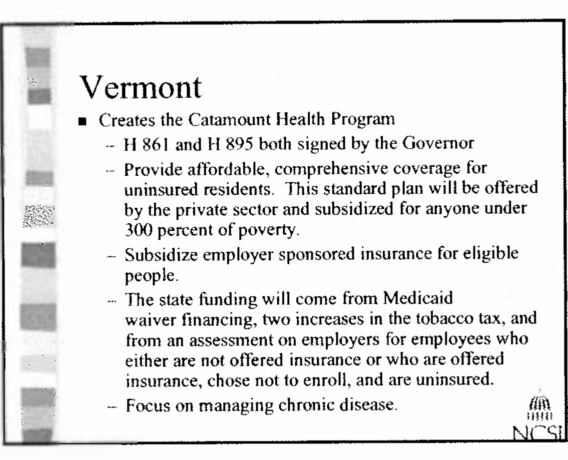
Vermont
Creates the Catamount Health Program
– H 861 and H 895 both signed by the Governor
– Provide affordable, comprehensive coverage for uninsured residents. This standard plan will be offered by the private sector and subsidized for anyone under 300 percent of poverty.
– Subsidize employer sponsored insurance for eligible people.
– The state funding will come from Medicaid waiver financing, two increases in the tobacco tax, and from an assessment on employers for employees who either are not offered insurance or who are offered insurance, chose not to enroll, and are uninsured.
– Focus on managing chronic disease.
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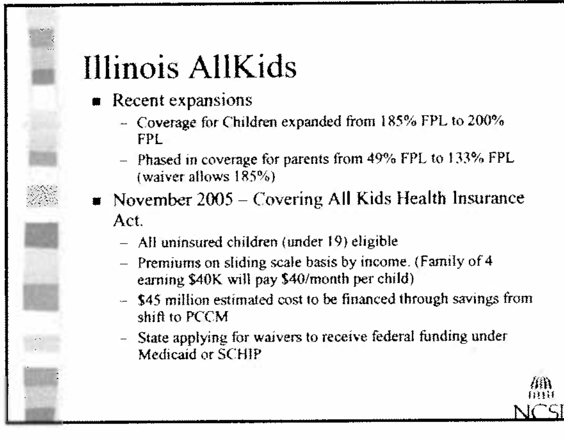
Illinois AllKids
Recent expansions
– Coverage for Children expanded from 185% FPL to 200% FPL
– Phased in coverage for parents from 49% FPL to 133% FPL (waiver allows 185%)
November 2005 – Covering All Kids Health Insurance Act.
– All uninsured children (under 19) eligible
– Premiums on sliding scale basis by income. (Family of 4 earning $40K will pay $40/month per child)
– $45 million estimated cost to be financed through savings from shift to PCCM
– State applying for waivers to receive federal funding under Medicaid or SCHIP
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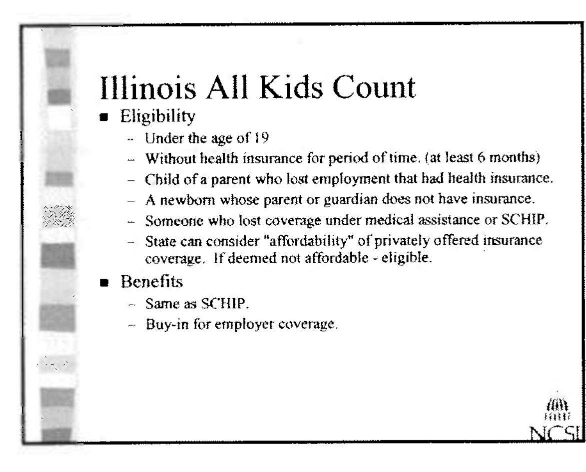
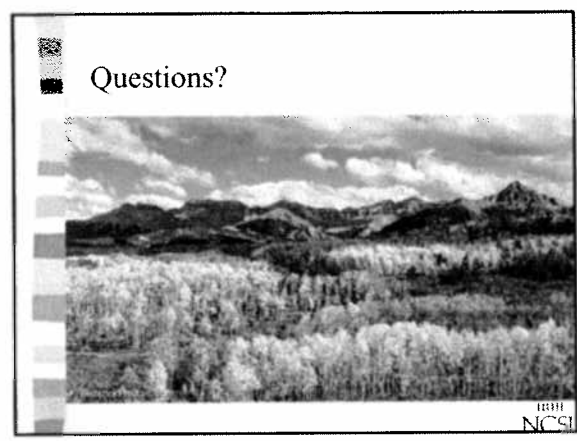

Illinois All Kids Count
Eligibility
– Under the age of 19
– Without health insurance for period of time. (at least 6 months)
– Child of a parent who lost employment that had health insurance.
– A newborn whose parent or guardian does not have insurance.
– Someone who lost coverage under medical assistance or SCHIP.
– State can consider "affordability" of privately offered insurance coverage. If deemed not affordable - eligible.
Benefits
– Same as SCHIP.
– Buy-in for employer coverage.
NCSL


Questions?
NCSL

FORWARD
E PLURIBUS UNUM

BidRx^{sm}

Patent Pending

Healthy Competition for Prescriptions

BidRx^{sm} Proposal

Background. The current prescription benefit paradigm is unsatisfactory for consumers and payers. Payers and consumers feel their costs rise, experience shrinking drug coverage, grudgingly adopt mandatory mail order for maintenance medications, and have no way to fight back except complain or seek their prescription drug needs from some foreign country. Payers experience double digit cost increases year after year with no end in sight despite promises that adding one more managed care tool will cure their pain: exclude this, add a formulary, add another co-payment tier, implement prior authorization, adopt step therapy, raise co-pays, etc. Every year a new tool surfaces yet costs continue to trend upwards at an unsustainable rate. At the same time, revenues and profits for prescription benefit managers and pharmaceutical companies continue to rise. It's apparent that managers' tools aren't working, but they continue to profit at the expense of payers and consumers. Here's the summary: broken paradigm; no options; rising costs; intense frustration.

BidRx^{sm} Marketplace. Here's the solution: new paradigm; new option; striking cost reductions; real satisfaction. At the core of the BidRx^{sm} marketplace is healthy competition through an electronic marketplace where consumers are linked to prescribers, pharmaceutical companies, pharmacies and benefit sponsors (employers, insurers, health plans, government, etc.) to find the best medicines and best services at the best prices. Pharmaceutical companies compete to offer the best medicines at the best prices and pharmacies compete to offer the best prescriptions and services at the best prices. All the ineffective tools used in the current paradigm to deliver complexity, mystery, and dependency, but not cost reduction, can be eliminated in favor of healthy competition and information so consumers and their health care providers make informed decisions in a real marketplace. BidRx^{sm} creates the same functional, understandable marketplace that consumers enjoy for other products and services they buy.

BidRx^{sm}

Healthy Competition for Prescriptions

- Imagine this: consumers and prescribers learn about similar prescription products, prices, effectiveness & safety before the prescription is written.
    - The result: prescribers choose more cost-effective therapies
    - The result: consumers & payers save money
- Imagine this: consumers learn about competing pharmacies, services that are meaningful, location, and prices before a pharmacy is chosen.
    - The result: consumers choose pharmacies that meet their needs
    - The result: consumers & payers get better service & save money
- Imagine this: consumers trust their prescribers and pharmacies to help them make the best decisions on their prescriptions and service needs, but it isn't blind trust; open transparent competition through BidRx^{sm} provides information that allows for trust with oversight
    - The result: consumers and providers learn together about options and value prior to making treatment & fulfillment decisions
    - The result: payers, consumers and providers save time and money

BidRx^{sm} contracts with employers, insurers, health plans, government, and other organizations to offer a new way to provide members access to prescription drugs. Companies sign a contract, select benefit designs for their employees (see examples on Exhibit 1), identify members that have the benefit design, and BidRx^{sm} handles the rest. Membership cards are produced and distributed to employees so they can begin using the BidRx^{sm} marketplace (www.BidRx.com) to get the best medicines and the best services at the best prices. A training tutorial on the website is all members need to get started.

BidRx^{sm}

Healthy Competition for Prescriptions

BidRx Proposal:

Employers that sign contracts with BidRx^{sm} through an umbrella agreement between the Employers and BidRx^{sm} are charged $3.00 per member per month for using all the benefits of the new competitive electronic marketplace (CEM^{tm}).

BidRx^{sm}

Healthy Competition for Prescriptions

Exhibit 1: Benefit Design Options

Plan A: 100% Co-Pay

Members get the benefits of the BidRx^{sm} marketplace including competition from pharmaceutical companies, coupons, list of similar drugs and discounted prices, links to information on effectiveness and safety, competition from pharmacies for the privilege to fill members' prescriptions, pharmacy coupons, required services, competitive prices, and coupons for related products and services sold in pharmacies. Members pay the total discounted cost for their prescriptions and services. Employer's cost for drugs is zero; employer's cost for membership fees on BidRx^{sm} is $3 per eligible member per month. Employees can save 50% or more on their prescription drug costs.

Plan B: $5 Employer contribution per prescription

Members get the benefits of the BidRx^{sm} marketplace including competition from pharmaceutical companies, coupons, list of similar drugs and discounted prices, links to information on effectiveness and safety, competition from pharmacies for the privilege to fill members' prescriptions, pharmacy coupons, required services, competitive prices, and coupons for related products and services sold in pharmacies. Employers pay up to $5 for each prescription and members pay the remainder of the total discounted cost for their prescriptions and services. Employer's cost for drugs is $5 for each prescription filled for eligible members through the BidRx^{sm} marketplace; employer's cost for membership fees on BidRx^{sm} is $3 per eligible member per month. Employees can save 50% or more on their prescription drug costs. A small, measured, and controlled contribution from employers can still be a powerful employee benefit.

Plan C: 50% Co-Insurance per prescription

Members get the benefits of the BidRx^{sm} marketplace including competition from pharmaceutical companies, coupons, list of similar drugs and discounted prices, links to information on effectiveness and safety, competition from pharmacies for the privilege to fill members' prescriptions, pharmacy coupons, required services, competitive prices, and coupons for related products and services sold in pharmacies. Employers pay 50% of the cost of each prescription and members

pay the remainder of the total discounted cost for their prescriptions and services. Employer's cost for drugs is 50% of the cost for each prescription filled for eligible members through the BidRx^sm marketplace; employer's cost for membership fees on BidRx^sm is $3 per eligible member per month. Employees and employers can save 50% or more on their prescription drug costs.

Plan D: Therapeutic Maximum per prescription

Members get the benefits of the BidRx^sm marketplace including competition from pharmaceutical companies, coupons, list of similar drugs and discounted prices, links to information on effectiveness and safety, competition from pharmacies for the privilege to fill members' prescriptions, pharmacy coupons, required services, competitive prices, and coupons for related products and services sold in pharmacies. Employers pay 100% of the lowest cost product in the report of similar products; if other product options are chosen, members pay the discounted cost for the chosen product minus the amount the employer would have paid for the lowest cost option. Employer's cost for drugs is 100% of the lowest cost product in a similar product report for each prescription filled for eligible members through the BidRx^sm marketplace; employer's cost for membership fees on BidRx^sm is $3 per eligible member per month. Savings of 50% or more can be guaranteed.

Plan X: Your Current Benefit Plan

Members get the benefits of the BidRx^sm marketplace including competition from pharmaceutical companies, coupons, list of similar drugs and discounted prices, links to information on effectiveness and safety, competition from pharmacies for the privilege to fill members' prescriptions, pharmacy coupons, required services, competitive prices, and coupons for related products and services sold in pharmacies. Employers and employees pay no more than they currently pay for prescriptions and have a great opportunity for paying lower costs when they and prescribers learn about drug prices and are motivated to choose more cost-effective products. Employer's cost for membership fees on BidRx^sm is $3 per eligible member per month.

BidRx^sm

Healthy Competition for Prescriptions

Company Summary:

BidRx, LLC, a Wisconsin-based limited liability Company, was formed in 2004. It is based in Oshkosh, Wisconsin and is led by a talented, experienced, and successful "been there, done that" management team with intensive and extensive knowledge of the pharmaceutical industry and existing prescription benefit paradigm.

Management Team:

DR. RALPH F. KALIES, JR. Dr. Kalies, age 54, is the founder of the Company and is its President and Chief Executive Officer. Dr. Kalies has proven success in founding and operating several healthcare companies. Her has served as Chief Executive Office of PBM-Plus, Inc., a pharmacy benefit management company and Continuous Quality, Inc., an outcomes risk and management company of which Dr. Kalies is the majority owner. Since 1975, Dr. Kalies has enjoyed a distinguished career in pharmacy. As a Fellow of the American Society of consultant Pharmacists ("ASCP"), a prestigious group of long-term care pharmacists, Dr. Kalies has served in a variety of capabilities, including serving as the President of ASCP in 1996-97. The author of many articles and a presenter at numerous pharmaceutical forums, including seminars and speaking engagements, he is one of the foremost experts in pharmacy practice and business.

Dr. Kalies earned a BS Pharmacy (1975) from the University of Wisconsin School of Pharmacy, a PhD (1984) from the University of Minnesota Graduate School of Pharmacy, and is one of 14 Kellogg Pharmaceutical Clinical Scientists trained there as a result of the recommendations made by the Millis Commission. He was a member of Phi Kappa Phi, Phi Eta Sigma, and Rho Chi honor societies.

RON JORDAN. Mr. Jordan, age 55, is the Company's Chief Operating Officer. Mr. Jordan is a seasoned executive, entrepreneur and pharmacy leader with over 30 years of experience in various business disciplines in the prescription industry. Recently, he was President of Healthation, LLC, a software development firm. Prior to that, Mr. Jordan was an officer for a health care product supply transformation firm, a hospice and pain management firm, a consulting group, and a Blue Cross organization. In 1998, Mr. Jordan was president of the American Pharmaceutical Association and continues to service AphA in a leadership role. While a trustee of the National Council of Prescription Drug Programs (NCPDP), Mr. Jordan was actively engaged in standard setting for the

flow of electronic information in the prescription industry. In his home state of Rhode Island, Mr. Jordan serves his University and the State government in leadership roles.

Mr. Jordan earned a BS Pharmacy at the University of Rhode Island, College of Pharmacy in 1976.

DR. THOMAS A KELLENBERGER. Dr. Kellenberger, age 60, serves as the Company's Executive Vice President – Sales & Marketing. Dr. Kellenberger has enjoyed a long career in pharmacy, both as a practitioner and educator, and for the past 26 years as a business executive in pharmacy benefit management. His work experience includes development of strategies that improve the use of drugs, programs that contain drug costs, and educational services for health care practitioners. Dr. Kellenberger led the design, implementation, operation and marketing of many management programs and services now used by PBMs. He has maintained significant, long-term relationships throughout the pharmacy benefit industry. Since 1999, Dr. Kellenberger has been an independent consultant to the PBM industry. Previously, he served in management positions at Medico, PCS, and the Minnesota Medicaid Agency.

Dr. Kellenberger earned a BS Pharmacy (1970) and Doctor of Pharmacy (1976), both from the University of Minnesota.

ANDREW R. JOHNSON. Mr. Johnson, age 74, is the Company's Vice-President – Pharmacy Registries. In this capacity, he will manage the Company's pharmacy recruitment function and pharmacy relationships. Mr. Johnson has over 30 years of experience owning and operating independent pharmacies. He developed and sold one of the first automated prescription drug claims processing systems in the U.S. and has continued to explore opportunities to enhance pharmacy claims adjudication. For the past 15 years, Mr. Johnson has contracted pharmacy networks, both local and national, for three of the largest PBMs. He has developed successful working relationships with contracting officers of all the major pharmacy chains and has immediate access to all who make contracting decisions for chain pharmacies and independents.

Mr. Johnson earned a BS Pharmacy degree at the University of Minnesota, College of Pharmacy (1954).

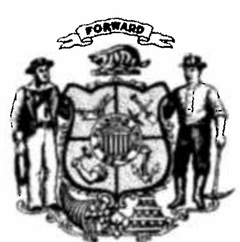
BidRx[sm]

Healthy Competition for Prescriptions

GREGORY D. BROWN. Mr. Brown, age 44, is the Company's Chief Financial Officer (CFO). He has had a significant career in accounting, finance, venture capital, and launch of start-up companies. Most recently, he has been responsible for internal finances and management of selected portfolio companies for a $160 million venture capital firm and represented the firm on the board of directors of seven companies on three continents. Mr. Brown has prior experience serving as COO, CFO and Treasurer of a service application software company, as CFO of a publicly traded healthcare service firm, and as CFO of a healthcare oriented venture capital firm.

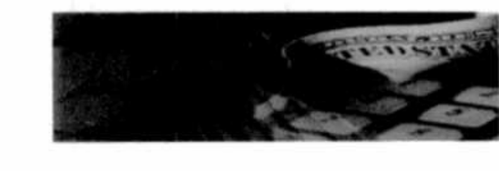
Mr. Brown earned a BBA in Accounting (1983) from the University of Iowa, graduating with high honors. He has also been a CPA.

WISCONSIN STATE LEGISLATURE


FORWARD

IMPACT OF COORDINATION OF BENEFITS ON WISCONSIN MEDICAID

Digital Healthcare, Inc.



Key Points

- Overview of Medicaid
- Impact of Third-Party Coverage
- Digital Healthcare's Private Sector Initiatives
- Summary of Audit Results of 26,000,000 Claims
  - Private Sector
  - Medicaid
- Our Offer to the State of Wisconsin

Statistics

- WISCONSIN (2004)
  - Private Insurance 3,502,800
  - Uninsured 170,900
  - Medicaid 177,900
  - Medicare 718,500

- Medicaid (2004)
  - Claims paid by Wisconsin $ 4,487,000,000

Medicaid

- Safety net for low income families, individuals and their children under age 19
- Coverage is based upon an Application
- The Medicaid Card functions as an "insurance card" for hospitals and other providers
- Medicaid is billed for services just as an insurance company is billed

How Medicaid Works

Medicaid

4,000 +
Carriers

That's Why There's COB

- COB = Coordination of Benefits
- Benefits = Insurance
- Issues for Medicaid
  - Is there insurance in effect?
  - If so, is there more than 1 company liable?
  - If so, which company has the primary obligation?

Conventional COB

- Based upon patient information
- Little or no independent verification
- No independent audit
- “Garbage in-garbage out”
- No metrics to allow for management of process

What’s our COB Program

- Electronic audit of insurance benefits
  - Prior to submission of claim for payment
  - Prior to submission of Medicaid claim
  - May also be performed retroactively
- Fully automated
- Does NOT require any software or IT modifications
- Carries proprietary private sector solution to the public sector

Our Pedigree

- National expert in COB analysis and capital recovery
- In COB business 10+ years
- Proprietary technology and software
- Recent experience
  - Audited 26,000,000 claims
  - Identified additional Payors for 20+% of Medicaid claims

Digital’s National Study

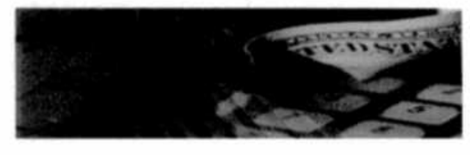
- Audited 26,000,000 claims
- Entities reviewed
  - Hospitals
  - State Employers
  - Group Health
  - Insurance Companies
  - Regional Health Plans
  - Medicaid

Selected Audit Results

		Audited	Exceptions	%	$Recovery
Hospital					
	Mo 1	2,890	539	18.65%	$ 7,823,585
	Mo 2	2,890	530	18.34%	$ 7,692,950
	Mo 3	2,891	516	17.85%	$ 7,489,740
		8,671	1,585	18.28%	$ 23,006,275
Hospital					
	Mo 1	3,578	556	15.54%	$ 8,070,340
	Mo 2	3,723	570	15.31%	$ 8,273,550
	Mo 3	3,880	582	15.00%	$ 8,447,730
		11,181	1,708	15.28%	$ 24,791,620
State					
	Mo 1	138,299	27,245	19.70%	$ 395,461,175
	Mo 2	137,770	24,523	17.80%	$ 355,951,345
	Mo 3	24,819	24,819	15.00%	$ 360,247,785
		300,888	76,587	17.50%	$ 1,111,660,305

More Audit Results

		Audited	Exceptions	%	$Recovery
Group Health					
	Mo 1	23,155	2,246	9.70%	$ 32,600,690
	Mo 2	21,469	2,104	9.80%	$ 30,539,560
	Mo 3	24,819	1,973	9.80%	$ 28,638,095
		69,443	6,323	9.77%	$ 91,778,345
National Carrier					
	Mo 1	1,509,824	163,061	10.80%	$ 2,366,830,415
	Mo 2	1,463,466	150,737	10.30%	$ 2,187,947,555
	Mo 3	24,819	140,745	9.90%	$ 2,042,913,675
		2,998,109	454,543	10.33%	$ 6,597,691,645
Regional Health Plan					
	Mo 1	196,557	29,916	15.22%	$ 434,230,740
	Mo 2	157,494	24,758	15.72%	$ 359,362,370
	Mo 3	24,819	24,588	15.99%	$ 356,894,820
		378,870	79,262	15.64%	$ 1,150,487,930



Medicaid Audited Results

		Audited	Exceptions	%	Potential Recovery
State 1					
	Mo 1	181,901	44,402	24.41%	$ 42,181,900
	Mo 2	189,773	45,944	24.21%	$ 43,646,800
	Mo 3	201,008	48,644	24.20%	$ 46,211,800
State 2					
	Mo 1	54,627	11,264	20.62%	$ 10,700,800
	Mo 2	57,023	11,741	20.59%	$ 11,153,950
	Mo 3	60,135	12,436	20.68%	$ 11,814,200
State 3					
	Mo 1	232,755	62,937	27.04%	$ 59,790,150
	Mo 2	225,185	60,800	27.00%	$ 57,760,000
	Mo 3	217,722	59,547	27.35%	$ 56,569,650
State 4					
	Mo 1	29,692	7,607	25.62%	$ 7,226,650
	Mo 2	31,640	7,910	25.00%	$ 7,514,500
	Mo 3	33,838	8,632	25.51%	$ 8,200,400
		1,515,299	381,864		$ 362,770,800

Our Conclusions

- Average Medicaid COB error rate of >20%
- Impact of Automated COB
  - Extend the assets of the Medicaid Trust
  - Fewer claims = lower claims administration cost
  - Strengthen defense against fraud & abuse

The Implications for Wisconsin

- 2004 — 177,900 Enrollees
- Potential Saving to Wisconsin $ 897 MM (at 20% claims avoided)
- Every 1% of Claims Avoided = $ 9.8 MM saved

Our Offer

- Assist in the fact finding process
- Audit – at no cost – 2005 Medicaid claims
- Interim reports during audit
- Executive Summary at end of audit
- Detailed written analysis of findings
- Independent audit of the process

Contact Information

- Doug McIntosh 440.478.0970
- doug.mcintosh@dhinc.biz

WINCONSIN SENATE
Select Committee
on
Health Care Reform

The Benefits to Medicaid
of
Pre-emptive Automated Coordination of Benefits

Presented by

Doug McIntosh
Director, Government Relations
Digital Healthcare, Inc.

September 27, 2006

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- Digital Healthcare Outline of Benchmarking Audit
- Digital Healthcare Wisconsin TPL Spreadsheet

Digital healthcare, Inc. Remarks

Good morning, Senator Roessler and Select Committee Members. My name is Doug McIntosh, Director of Government Relations at Digital Healthcare, Inc.

Thank you for inviting me to speak here this morning.

Third party liability

Two weeks ago, the National COB/TPL Conference shook the rafters in Orlando with the repeated call for better Cost Avoidance and TPL Recoveries. It is my company's pleasure to say that you have the means of responding to the challenge of that call with our automated pre-emptive coordination of benefits service.

Some Background

The 4000 healthcare payers in the United States have a serious health problem of their own. Secondary payers, and the 51 Medicaid Authorities among them, are especially vulnerable to it. Of course I'm referring to the fact that healthcare payers have no simple and sure way to determine if they should, in fact, pay the claims that come to them.

Every payer knows that he doesn't have the current census from the other 3,999 other payers, and is also aware that not having it results in shotgun billing by medical providers, making the problem worse.

Back in 1993, the Workgroup on EDI dreamed of the day when a centralized process would serve all payers equally by automatically routing a healthcare claim to its correct payers.

The inhibitors at that time were limited technology, authority to access the necessary information, and industry cooperation in sharing policyholder data.

The Extent of the Problem

In 2002, Digital Healthcare, Inc. conducted the first audited study of undiscovered additional coverage. We analyzed 20 million eligibility records from two hundred payer, corporate, government, and hospital entities. Six Medicaids were included in the study, averaging much higher undiscovered coverage than the 18% overall average.

The California Performance Review (excerpt attached) observes an incidence of undiscovered Other Health Coverage of 19% and a Washington State internal audit projected undiscovered OHC "well into double digits (from teleconference with State Auditor's official.)

Let's translate that to your concerns her in Wisconsin. Using a conservative figure of 15%, it could mean that the Wisconsin Medicaid Authority is paying claims amounting to some $728 Million. *If* this is true, that $728 Million is paid on behalf of insurers whose coverage doesn't surface in the TPL process.

The Solution

In 1995, the Office of Management and Budget asked the Senate Finance Committee to fix this problem: " ... we envision an online, up-front query system in which the primary and secondary payers will be determined at or before the time that care is provided, thus eliminating the need for after-the-fact attempts to match data across various data bases ..."

Eleven years ago, they were already looking for something to replace the after-the-fact TPL process.

They were calling for fully automated, *pre-emptive* COB, and it is now available.

Technology: Combine the fastest, most reliable and powerful computer system on the market with Internet speed and an innovative patent-pending business process that makes the vision of OMB and WEDI (real-time coordination of benefits with automatic ranking by primacy) a reality.

Authority: we have it in:

- HIPAA Sec. 1175's simplification provisions (see accompanying letter from co-author of Sec. 1175 affirming Digital Healthcare's service is consistent with the intent of Congress in)
- In DRA's Sec. 6035 mandate to coordinate benefits before bills go out (excerpt from bill attached)
- In the Federal Code's Section 1035 making it a criminal offense to interfere with the operation of a federally funded health plan
- Implied in New York State's law mandating pre-emptive coordination of benefits (excerpts of the law attached)

Cooperation: The insurance industry sees the merit in establishing such a cooperative process to resolve the vexing issues of coverage and primacy. Leading payers have shown their readiness to cooperate with Digital Healthcare's no-cost Medicaid audits by making coverage information available on 112 Million insureds. And that's just the leading edge, because other payers will follow.

Digital Healthcare is currently under contract to audit recent Medicaid claims in Kansas and Arkansas to benchmark the COB error rate in those states. Another nine states are reviewing our contract to conduct the audit, as well.

A brief outline of our benchmarking audit is attached.

If this is something Arkansas and Kansas want, shouldn't the good people of Wisconsin have it, too?

The Impact for Medicaid

You know that Wisconsin's Medicaid could be in the position of having to divert $728 Million or more from care to claims that properly belong to Medicare, Veteran Benefits, or other public and private health insurance programs. (Reference accompanying spreadsheet projecting possible savings)

Apply the same situation at the national level and it could mean over $50 Billion is beeing diverted from care to claims across the spectrum of federally supported programs. As taxpayers we feel that; and we feel the financial and social impact of so many of our fellow citizens' not getting the care they need.

So, where does all this bring us?

1. To the advantageous position of having a workable solution open to us,
2. To the enviable position of being able to lead the public sector health administration in adopting that solution, and
3. To the exciting position of choosing between making a safe decision to stay with a proven but flawed process that "everyone" accepts, or a courageous decision to break new ground and spend public money more carefully than ever before.

No one will receive a bill that they are not obligated to pay for

Sometimes such a critical choice can be daunting, but four compelling elements argue to earliest possible adoption of fully automated pre-emptive coordination of benefits:

1. Congressional support of Cost Avoidance over "Pay-and-Chase."
2. The sheer economic advantages of the Cost Avoidance approach.
3. The social need that must always be addressed.
4. The elimination of false claims as a concern for Medicaid providers.

All of this can be done with no loss of benefits to the Medicaid population.

False claims could be eliminated

My call to action this morning is simple:

I ask you to embrace this new technology to automate COB and to list it among your most urgent reform recommendations.

Doing so will be a bold step in Cost Avoidance, sharply cut administrative costs associated with Pay-and-Chase, reduce false claims, and correct an unintentional multi-billion dollar subsidy of the private healthcare payer sector.

Thank you, Senator Roessler and your Committee Members.

HHS27 Automate Identification of Other Health Coverage for Medi-Cal Beneficiaries

Summary

The process used to identify Other Health Coverage (OHC) for Medi-Cal beneficiaries is manual and paper intensive, causing huge backlogs and lost opportunities to avoid expenditures by the Medi-Cal program. In addition, the current process does not capture all OHC information for Medi-Cal beneficiaries. The state should automate this process to improve its accuracy and capture savings.

Background

The Medi-Cal program is California's version of the federal Medicaid program that provides health coverage to more than 6.5 million public assistance and low income beneficiaries. State law requires Medi-Cal applicants to provide information about their entitlement to OHC when they apply for Medi-Cal. Federal law requires Medi-Cal to be the payer of last resort; however, eligibility for OHC does not disqualify an individual for Medi-Cal. Providers must bill OHC or Medicare for services rendered before billing Medi-Cal. Medicare is the federal health insurance program offered to anyone over age 65 and individuals who are blind or disabled that meet certain federal rules. Medicare provides coverage for hospital inpatient services, some nursing home services and limited coverage of drugs. Medicare coverage of drugs will be expanded significantly beginning in 2004-2005.[1]

When a Medi-Cal beneficiary has OHC, typically they have medical coverage from commercial health plans, private health insurance, or other types of medical insurance. Some OHC covers all medical services or excludes certain services, such as drugs or obstetrics. Medi-Cal can only be billed for services that the OHC or Medicare will not pay for. Approximately 5 percent of the Medi-Cal population is eligible for commercial or private health plan coverage.[2] An additional 14 percent is eligible for Medicare. The average amount saved by Medi-Cal for every beneficiary identified with OHC is $117 per month.[3] With almost 20 percent of the Medi-Cal population having either Medicare or commercial health plan coverage, it is very important that the Department of Health Services (DHS) be accurate and timely in tracking this information to avoid Medi-Cal expenditures. However, the existing method used to identify OHC is slow and untimely, resulting in erroneously paid health service claims or premium payments to Medi-Cal managed care plans.

Manual process to report OHC

DHS records OHC information for Medi-Cal beneficiaries in the Medi-Cal Eligibility Data System (MEDS) via a manual process that was set up decades ago before the advent of current computer technology. MEDS is the database of Medi-Cal eligibility records maintained by DHS. County welfare departments process Medi-Cal applications and are required to complete a form that identifies any OHC. The form is sent to DHS and manually keyed into MEDS. When MEDS has an OHC indicator on the beneficiary record, claims from providers are rejected, thus avoiding significant expenditures for the Medi-Cal program. Providers are also able to access MEDS prior to rendering services, so they can identify beneficiary eligibility for OHC or Medicare to bill accordingly.

Automated reporting of OHC

In addition to people who apply for Medi-Cal in county welfare offices, other individuals eligible for federal supplemental security income or Medicare programs are also eligible for Medi-Cal. Medicare and OHC for these recipients are recorded in a database maintained by the federal Center for Medicare and Medicaid Services, which sends a monthly tape that reports recipient Medicare and OHC. DHS runs the monthly tape against MEDS to update eligibility records. DHS uses this electronic process to identify supplemental security income and Medicare beneficiaries whose claims should be billed to Medicare or OHC. Medi-Cal avoids expenditures of more than $4 billion annually due to Medicare eligibility. Only $80 million of the $4 billion in avoided expenditures is due to OHC. Currently, the bulk of cost avoidance savings is Medicare eligibility.[4]

A good comparison for automated reporting of OHC is the State of New York, which has a large Medicaid population of more than 4 million. New York's 58 counties record OHC when eligibility is processed at application. The state also contracts with Public Consulting Group to initiate billings and perform monthly data matches with over 100 carriers and Medicare.[5] This electronic updating of their Medicaid eligibility database results in a higher volume of eligibility file updates for OHC on a timelier basis. The state reports annual cost avoidance of $4 billion and recoveries of $60 to $70 million.[6]

Tom Sawyer
1298 North Howard St.
Akron, OH 44310

27 October 2004

Hon. Tommy Thompson
Secretary of Health and Human Services
200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Thompson:

I was a co-author with Congressman Hobson of the Administrative Simplification sections of the Health Insurance Portability and Accountability Act of 1996 (42 USC 1171-1176).

Earlier this year Congressman Hobson and I received information about anomalies in the enforcement of the Act. We advised Digital Healthcare to take up these issues with the officials at CMS, but in the attached letter you will see this was not successful.

Digital Healthcare offers to determine primacy of obligation among health plans by using the HIPAA-mandated eligibility e-commerce gateways of the payers, citing HIPAA 1173 and 1175.

No one wants a medical provider to bill the wrong payer, and no one wants the wrong plan to pay. The remedy is to find out which payer is primary, and the electronic eligibility inquiry is the means to accomplish that. Twenty years of Medicare and Medicaid history have shown that a pre-emptive, electronic eligibility process that exhausts the possibilities is essential to the fiscal integrity of those health plans.

The evidence strongly suggests that adoption of this proprietary method would substantially reduce the unintentional subsidy of the for-profit insurance market by Medicare and Medicaid, and thereby extend the assets of those plans for other purposes. This observation accords with the published opinions of OMB and GAO.

HIPAA casts a general public duty on health plans to respond to the required inquiries in standard data formats, and to do so without delay. Nothing in HIPAA permits a payer to condition his responses on prior business dealings, on the presence or absence of a 'trading partner agreement', on payer-specific data elements, or on any other restrictive condition.

I write to support Digital Healthcare's prayer for relief by adding every assurance I can that the remediation of these errors is both consistent with our original intent in Congress and, in my opinion, in the public interest.

Yours,

Tom Sawyer
Former Member of Congress

c.c.: Steven Ott
Secretary and General Counsel
Digital Healthcare, Inc.

From Deficit Reduction Act of 2005

(b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS DATA- Section 1902(a)(25) of such Act (42 U.S.C. 1396a(a)(25)) is amended--

(1) in subparagraph (G), by striking `and' at the end;

(2) in subparagraph (H), by adding `and' after the semicolon at the end; and

(3) by inserting after subparagraph (H), the following:

`(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to--

`(i) provide, with respect to individuals who are eligible for, or are provided, medical assistance under the State plan, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

`(ii) accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for an item or service for which payment has been made under the State plan;

`(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than 3 years after the date of the provision of such health care item or service; and

`(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if--

`(I) the claim is submitted by the State within the 3-year period beginning on the date on which the item or service was furnished; and

`(II) any action by the State to enforce its rights with respect to such claim is commenced within 6 years of the State's submission of such claim;'.

(c) EFFECTIVE DATE- Except as provided in section 6035(e), the amendments made by this section take effect on January 1, 2006.

New York Social Service Law (SOS) § 367-b(8). July 2006.

8. (a) For the purpose of orderly and timely implementation of the medical assistance payments and information system, the department is hereby authorized to enter into agreements with fiscal intermediaries or fiscal agents for the design, development, implementation, operation, processing, auditing and making of payments, subject to audits being conducted by the state in accordance with the terms of such agreements, for medical assistance claims under the system described by this section in any social services district. Such agreements shall specifically provide that the state shall have complete oversight responsibility for the fiscal intermediaries' or fiscal agents' performance and shall be solely responsible for establishing eligibility requirements for recipients, provider qualifications, rates of payment, investigation of suspected fraud and abuse, issuance of identification cards, establishing and maintaining recipient eligibility files, provider profiles, and conducting state audits of the fiscal intermediaries' or agents' at least once annually. The system described in this subdivision shall be operated by a fiscal intermediary or fiscal agent in accordance with this subdivision unless the department is otherwise authorized by a law enacted subsequent to the effective date of this subdivision to operate the system in another manner. In no event shall such intermediary or agent be a political subdivision of the state or any other governmental agency or entity. The department shall consult with the office of Medicaid inspector general regarding any activities undertaken by the fiscal intermediaries or fiscal agents regarding investigation of suspected fraud and abuse.

(b) The department of health, in consultation with the office of Medicaid inspector general, shall develop, test and implement new methods to strengthen the capability of the Medicaid payment information system to detect and control fraud and improve expenditure accountability, and is hereby authorized to enter into further agreements with fiscal and/or information technology agents for the development, testing and implementation of such new methods. Any such agreements shall be with agents which have demonstrated expertise in the areas addressed by the agreement. Such methods shall, at a minimum, address the following areas:

(1) Prepayment claims review. Develop, test and implement an automated claims review process which, prior to payment, shall subject medical assistance program services claims to review for proper coding and such other review as may be deemed necessary. Services subject to review shall be based on: the expected cost-effectiveness of reviewing such service; the capabilities of the automated system for conducting such a review; and the potential to implement such review with negligible effect on the turnaround of claims for provider payment or on recipient access to necessary services. Such initiative shall be designed to provide for the efficient and effective operation of the medical assistance program claims payment system by performing functions including, but not limited to, capturing coding errors, misjudgments, incorrect or multiple billing for the same service and possible excesses in billing or service use, whether intentional or unintentional.

(2) Coordination of benefits. Develop, test and implement an automated process to improve the coordination of benefits between the medical assistance program and other sources of coverage for medical assistance recipients. Such initiative shall initially examine the savings potential to the medical assistance program through retrospective review of claims paid which shall be completed not later than January thirty-dirst, two thousand seven. If, based upon such initial experience, the Medicaid inspector general deems the automated process to be capable of including or moving to a prospective review, with negligible effect on the turnaround of claims for provider payment or on recipient access to services, then the Medicaid inspector general in subsequent tests shall examine the savings potential through prospective, pre-claims payment review.

Wisconsin Medicaid
August, 2006

An audited study projects that **15% or more** of the claims paid by Wisconsin Medicaid could be primary elsewhere, **costing the state $728 Million yearly**.

Digital Healthcare can automate the Coordination of Benefits for Wisconsin Medicaid, enabling them to identify the health insurance coverage for every claim, without regard to size, against all other payers. That ensures Wisconsin Medicaid **will pay only the claims for which it is responsible**.

A **no-fee audit** is available to quantify undiscovered additional coverage for Medicaid recipients, and HIPAA provides for response to the electronic eligibility inquiries at the heart of this process.

Action:
This audit differs from existing TPL searches in the vastly greater number of payers queried, resulting in discovery of more coverage from distant or unlikely payers. **The audit's accuracy, and therefore its value, turns on the number of payers who respond.**

- Test claims against a broad base of payers to determine all coverage for each patient at the date of claim.
- Apply primacy rules if the audit discovers multiple payers.
- Report additional coverage to Wisconsin Medicaid and project the saving for Medicaid if those funds are recovered.
- Use audit results to evaluate adopting automated preemptive COB.

Historical Test Advantages to Wisconsin Medicaid:

- Incremental savings proven before full service implementation.
- Runs independently of present MMIS and TPL systems.

Advantages to Wisconsin Medicaid of Online Preemptive COB Service:

- Eliminates most TPL work, adjudication, pay and chase.
- Tests even the smallest claims, sharply reducing write-offs.
- Inhibits fraudulent claims.
- Enhances protection of plan funds.
- Requires no new software or hardware.
- Requires no additional staff people.

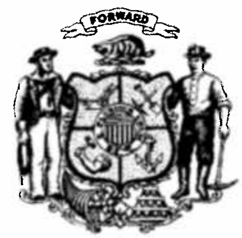
WISCONSIN

Projected Medicaid Savings
Using Preemptive Automated COB

Prepared By Digital Healthcare, Inc.

Wisconsin		
Automation of COB		
Impact on Wisconsin and CMS Medicaid Budgets		
	2004	**Authority**
Medicaid Insured Persons	608,920	1
Medicaid & SCHIP Assistance	$4,853,925,236	2
State Share	38.62%	3
Wisconsin Funded	$ 1,874,585,926	
FMAP(2003)	61.38%	3
Wisconsin Reported Other Health Coverage (OHC) Recoveries	$ 8,900,487	4
TPL %	0.18%	
DHI Comparision of Medicaid Programs		
State 1	24.4%	5
State 2	20.6%	5
State 3	27.1%	5
State 4	25.5%	5
Average Variance per DHI	24.40%	
Wisconsin TPL %	0.18%	
Average Variance Minus Wisconsin Recovery	24.22%	
Range of Recovery		
Per CMS	$8,900,487	
Potential Recovery per DHI- COB: Federal and State	$1,184,357,758	
Conservative Estimate at 15% Undiscovered OHC	$728,088,785	
Potential Recovery: State Only	$457,398,966	
Authority		
1. Kaiser Commission on Medicaid and the Uninsured		
2. CMS Form 64		
3. Federal Funds Information for States: FFIS		
4. 2001-02 CMS Reports 2003: Estimate		
5. National Coordination of Benefit Cost Aalysis		

WISCONSIN STATE LEGISLATURE



Marlia Moore:

DHFS does some of this already but has been looking at other co.'s to do more. The estimated 15% seems to be a little large given the state is doing some of this already.

DHFS contact: Ken Dybevik...267-7118

JS left Ken a message…

5/19/06

- EDS has MA contract
- Supplementing the work EDS is doing – Maximus & another company.
  In '04 were awarded revenue max contracts.

FORWARD
E PLURIBUS UNUM

DIGITAL HEALTHCARE, INC.
Enhanced Electronic Commerce

MAY 25 2006

May 22, 2006

Senator Carol Roessler
Wisconsin State Senate
Room 8 South
State Capitol
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Roessler:

It was a real pleasure to meet with you and Jennifer last week. I sincerely appreciate the focus you gave to discussing automated coordination of healthcare benefits, and the onward steps you initiated.

It was evident that you recognize the various advantages to using a pre-emptive, Internet-based method of identifying all the healthcare insurance a Medicaid recipient has. The dollars for Wisconsin could be substantial in administrative savings alone.

Your organizing next week's meeting was a clear indication of your enthusiasm and that was heartening. As we move forward introducing this to Wisconsin Medicaid and the other state agencies, I hope DHI can count on your continuing support. This will be particularly important when the inevitable resistance from the insurance community surfaces.

I look forward to seeing you again at next week's meeting.

Cordially,

Douglas S. McIntosh
Deputy Chief of Staff

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