☞ **05hr_SSC-HCR_Misc_pt38**

☞ 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)

Tom Korpady EXF

Aware of BidRx

Drug manufacturers give huge discounts within the classes of drugs they compete in. If the state puts the drugs on their formulary, it gets the discount. Nice thing too is that the pharmacists don't have to take a reduction in what they get paid for the drug.

Bid Rx Pharmaceuticals → generic Rexium - $130 per mo.
Generic - 19

Being mixed ins. co's. 120 Kick backs - 50
+ 3rd party administrators.

Neenah

Cartwright, 100th ~~neenee~~ sending her a letter letter

→ FYI

256-8348

① Glen Pollack

① Sept. 27

① BidRx

① John Carter

John Bergstrom

want 2 hear from her input.

Frank KB

★ Delora Newton, Dir. of Public Policy
P.O. Box 71
Madison 53701-0071


FORWARD
E PLURIBUS UNUM

Jennifer Stegall
Committee Clerk
Notes

9-27-06

Laura Tobler - ICSL
Power Pt - Health Care Reform: Addressing Health Care Costs
handout

- US Employer based market
- Used state examples of what they are doing to address H.C.
  Realizes this has limitations - what works in one place, may not work in another. But, may glean something from other states strategies, programs.

- Dirk Sweet = Mass. plan. Any ERISA challenge for the $295 fee per employer.
  Not yet. Seen more as a tax. Would likely know by now if there was going to be an ERISA challenge.

- most states looking @ incremental reform - filling the gaps vs. universal change.
- AZ passed tax credit for the insured.
- Trying to enable more people to be able to get into ins.
- focus on personal responsibility
- High cost comes down to over utilization.
- FI has included counselors to interact with system + help MA client choose product. Will have a HSA type product.

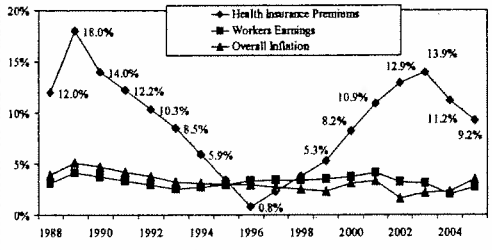
- Oregon has Pay for Performance model.

Health Care Reform: Addressing Health Care Costs

For the Senate Select Committee on Health Care
by

Laura Tobler
September 27, 2006
National Conference of State Legislatures
303-856-1545, laura.tobler@ncsl.org

Health Premiums Rising 3-5 Times Faster than Inflation and Wages, 1988-2005



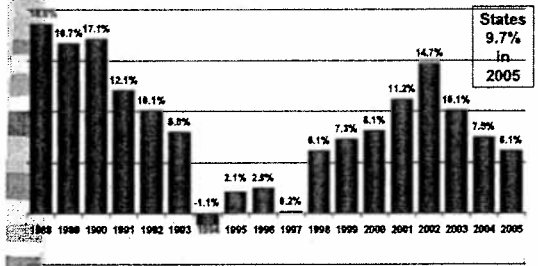
Workers earnings = 2.7% Overall inflation = 3.5%

*Source: KFF/HRET and Bureau of Labor Statistics; Paul Fronstin, EBRI for NCSL 4/06

Total health benefit cost increase slows for the third straight year – Good News?

All employers

Paul Fronstin, EBRI for NCSL 4/06



Health Care Reform: Addressing Health Care Costs

- Stabilize the insurance market/reduce the number of uninsured
- Focus more attention on preventive and primary care
- Focus more attention on appropriate care for chronic disease
- Promote personal responsibility
- Consumer-directed health care
- Address long-term care and quality

NCSL

More recent state initiatives for covering the uninsured fall into these categories…

- Making new insurance options more affordable
  - Increasing employer-offered insurance
  - Making new private insurance options more affordable.
  - Assist low-income uninsured via government sponsored programs
- Comprehensive
  - Includes strategies addressing access, cost and quality.
- Covering children

NCSL

Illinois

Massachusetts – address whole mkt – universal approach

Montana: Make small business insurance more affordable

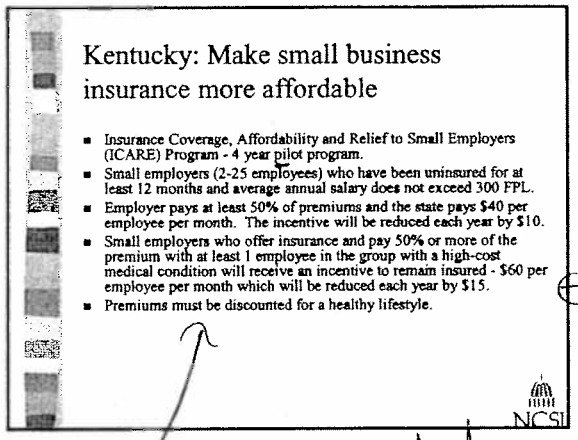
- The Small Business Health Care Affordability Act
  - Targets small businesses
  - New purchasing pool, State Health Insurance Purchasing Pool, to obtain health insurance.
  - Pool insurance will be subsidized on a sliding scale basis.
  - Tax credits to small businesses that are currently offering 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.

NCSL

State providing subsidy – paid for by inc. in cig tax

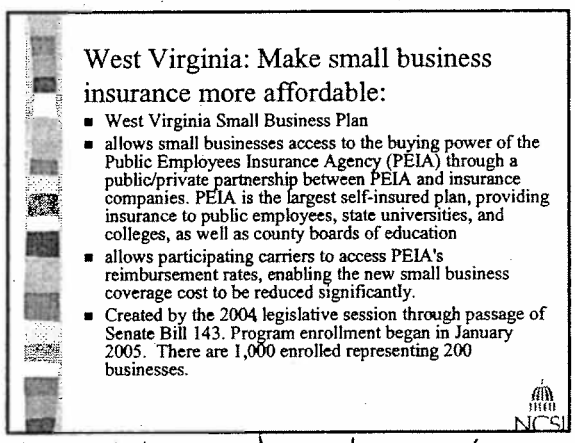
CR wants to know what the exact $1 amt. is.

Is subsidy enough to get people into the pool. New program. Have 1200 sm. employers enrolled. Too soon to know impact.



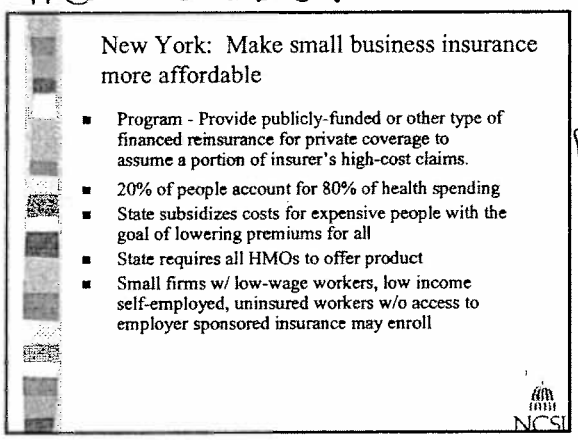
Pilot; funding from State's general fund.
Subsidy for payment of premiums.
State will offset rx. in premium;
Part of budget bill - new program.
Challenges not known yet.

not sure how implemented



Has been working for years to try to get sm. bus. mkt/ state ~~benefit~~ employee benefit plan. In the end - could not do. Risk to state budget would increase as risk of the small bus. changed.

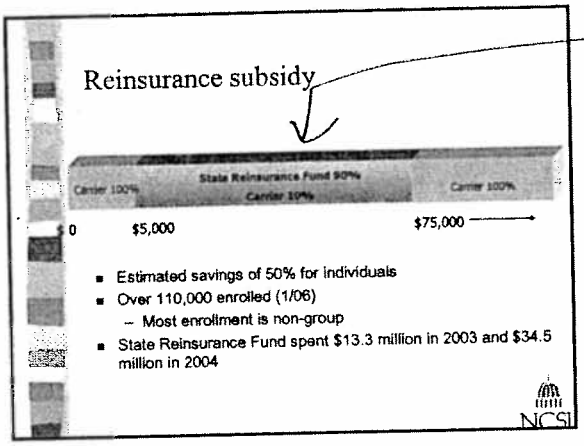
CW. Still costs about $30.00 a month. some still view this as too exp. for low income workers.



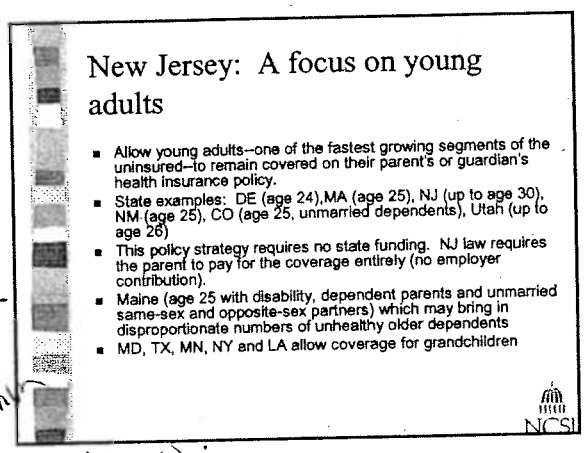
- States subsidized re-insurance - assesment on the industry helps support.
- Gen fund supports Re-insurance in NY
- More designed to stabalize the market.

Had low enrollment initially. Realized needed to work more w/ Brokers + advertise. After this - enrollment increased. $110,000 people enrolled in NY. High #.

Majority of enrollment is individuals. Still not getting sm. businesses into the market. Seems to be dynamic across the nation.

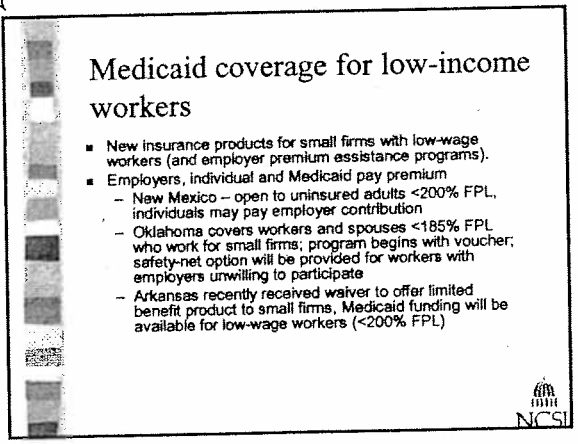


Subsidy pays for
In NY Re-ins. works.
Not the case in other states that have tried.
NY had tight regulation on its industry.
NY looked @ dynamics of the uninsured.



CO does req. paperwork req. for employer – due to this – causing implementation req.
* Make as easy as possible for your employers.

Req. no state funding.
New Jersey went up to age 30.
Parent pays 100% of the cost for that → not the employer.
Passed this Spring – they are working on it. No eval. data available yet. Worried about pulling young people out & small groups or indiv. mrkt.



Partnerships popular
- Other states that have created these as well.
- Oklahoma dev. prog. last yr. State, employer + employee pay. Enrollment began last fall.

(Slide – next page) →

AD - Assessment & amt. of State $ directed toward MA.
* Ans. more info. @ end of presentation.
* Major concern for states. Yes - it is a problem.

New fed. test funds

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.

NCSL

Created product that mimics the private market. Put out an RFP. Providers were @ the table when program created. Good enrollment - enrolling in phases.

unused CHIP $ funds program

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.

NCSL

Req. a 1115 waiver to change eligibity + way they do business.
Has had challenges in implementing. Gov. was leader in this, Gov. changed + not as int. in program. Legislature had big changes as well.

not actively marketing to sm. businesses. Most enrolled are individuals.

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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March - waiver approved

By 7/07 you have to have ins. or can't afford it. Req. employers to pay as well. $295 per employer per yr if the employer doesn't offer ins.

Depart on income tax form

(2) Created "the connector" — quasi gov. / run by board. Resp. for offering the subsidized product. Also determines affordability.

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

NCSL

Had to renegotiate their waiver. Risked losing $600 million if didn't.
2 components that are worth looking @:
(1) Created a shared responsibility program (next 3 yrs. 95% of people will be covered).
Has not been tried yet / not yet implemented

All employers have to offer cafeteria plan — the employee can purchase ins. from connector.

Focus on preventive and primary care: West Virginia

- HB 4021
- Establishes a clinic-based primary care services program for an undetermined prepaid fee (developing regulations now).
- West Virginia Health Care Authority will determine the eligibility of providers to obtain licenses to market and sell prepaid health services under such terms as may be established in guidelines developed by the Health Care Authority or the Insurance Commissioner
- Eight providers will be chosen.

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Pay fee - will be able to get care through clinic.
State has not written regs. yet.
Many states have talked about this idea.

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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- Implemented 3yrs ago.
- Quite a bit of cost sharing in program
- 21,000 people enrolled (close to cap).
- Specialty care + hospitalization not included.
- Primary, preventative + diagnostic care covered.

Focus More Attention on Chronic Disease: Vermont

- 2006 Health Care Affordability Act
  - H 861 and H 895 both signed by the Governor
  - Two major components:
    - Making health insurance affordable and accessible to the uninsured- Catamount Health Program.
    - Improving the delivery of health care.

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- Universal coverage model.
- ~~Medicaid waiver~~

Vermont: Catamount Health

- Everyone who is uninsured for 12 months or more will have access to - and help pay for- a comprehensive health insurance package.
- A standard plan (classic PPO 50% model) will be offered by the private sector and subsidized (sliding scale) for anyone under 300 percent of poverty.
- Subsidize employer sponsored insurance for eligible people.
- state funding 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. $365 per FTE who is uninsured.
- Focus on managing chronic disease.

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Vermont: Improving care delivery

- Focus on chronic disease management.
- Establish a system of chronic care management.
- Change provider reimbursement system to encourage excellence in chronic disease management.
- Waiving co-pays for patients who seek appropriate care.

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- Not mandatory
- Spending $ on chronic disease management.
- Incentivize providers
- Implementing pay for performance.

Asthma – If take meds – co-pay waived

Health Savings Account (HSA)

- Allows for tax-free accumulation of savings.
  - Tax free contribution; Tax free accumulation.
  - Tax free withdrawals for health care services, COBRA and Long Term Care Ins. premiums, retiree health premiums for Medicare-eligible retirees.
- Must have qualified "High Deductible health plan".
  - Self-only: Minimum $1,050 annual deductible, $5,250 Out-of-Pocket max
  - Family coverage: Minimum $2,100 deductible, $10,500 Out-of-Pocket max.
- Contributions
  - Self-only: limited to level of deductible up to $2,700 max.
  - Family coverage: limited to level of deductible up to $5,450 max.
- Catch-up contributions once age 55 of $1,000.
  - Phased-in by 2009.

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Health Reimbursement Arrangement (HRA)

- Employer provided account that allows for pre-tax reimbursement of medical expenses.
- Typically combined with a high-deductible health plan, but not required.
- Employee contributions not permitted.

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Health "Consumerism:" Potentials & Concerns

Potentials

- Lower costs
  - Reduction in use
  - Use of lower cost services
- Better engaged consumer
- More satisfied consumer
- Better health outcomes/more appropriate care
- Improve affordability

Concerns

- Low health literacy
  - Reduce necessary care
  - Induce demand for unnecessary care
- Lack of tools & resources to make decisions
- Impact on high cost users uncertain
- Crowd out of full coverage
- One-time savings

Paul Fronstin, EBRI for NCSL 4/06

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Consumer-directed health plans gain momentum: Percent employers offering

	2003	2004	2005	Likely to offer in 2006*	Likely to offer in 2007*
Large employers (500+)	1%	4%	5%	13%	17%
Jumbo employers (20,000+)	9%	12%	22%	29%	31%
State Gov't Employers			6%	22%	22%

*Selected 5 on a 5-point scale in which 1 = not at all likely and 5 = very likely. Inclusive employers that currently offer, 2007 figure includes employers likely to offer in 2006. Mercer Health & Benefits – NCSL, April 2006

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State Legislatures' Roles with HSAs

- Encourage wider use of federal HSAs.
- Create a state income tax exemption for deposits.
- Exempt from mandates that make high-deductible policies problematic.
- Require price transparency so consumers know costs of using their own $$.
- Regulate or restrict types of high deductible policies that can be offered or sold.
- Expand the types of financial institutions that can offer health savings accounts (credit unions, assoc.)
- Clean up older tax statutes affecting "Medical Savings Accounts"

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New laws on HSAs in many states

- States that conformed to federal Internal Revenue Code for HSA Purposes, 12/04: AZ, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, LA, MD, MI, MO, MT, NE, NM, NY, NC, ND, OH, OK, OR, RI *('04)*, SC, UT, VT VA, WV *(+ see below)* 30
- States that changed laws in 2005-06 to conform to federal IRS Code for HSAs: AR, FL, GA, IN, IA, KY, MA, MN, MS, NV, NJ, OK, PA, UT (effective dates vary) (15)
- States with HSAs for High Risk Pool plans: AL, AR ('05), CO, ID ('05), KY, LA, MD, MN, MO, NE, SD, WY (12)
- States with HSAs for state employees: AR ('04), FL ('05), KS ('06), OK ('05), SC ('05), SD ('04), UT ('06) (7)
- States that do not have state income tax: AK, FL, NH, SD, TN, TX, WA, WY (8)

NCSL's staff contact for consumer directed health care is Richard Cauchi at 303-856-1367 or dick.cauchi@ncsl.org

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Current State Medicaid Reform Initiatives

- Emphasis on personal responsibility
  - "Consumer choice" of plans
  - Increased premiums or cost sharing
  - Incentives for healthy behaviors
- Increased role of private marketplace
  - Increased control to plans to determine benefit packages
  - Encourage employer coverage through premium assistance
- Spending limits and predictability
  - Defined contribution approaches
  - Aggregate cap on federal funding
  - Strategies that preserve federal funding for health coverage
  - Increased use of managed care

Source: Kathy Gifford, presentation at NCSL's Fiscal Analysts Seminar, September 7, 2006.

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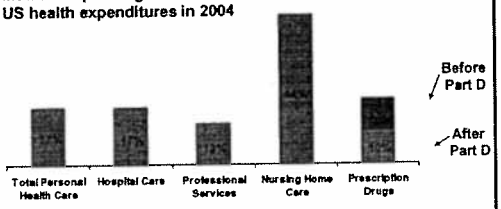
Retooling the MA program
- These are the 3 areas States are looking at.

Medicaid Pays a Sizable Share of U.S. Health Spending

Medicaid spending was 1/6 of all US health expenditures in 2004



SOURCE: Cynthia Smith, et.al., "National Health Spending In 2004," *Health Affairs*, January/February 2006. Based on National Health Care Expenditure Data for 2004, CMS, Office of the Actuary, 2006

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Florida Medicaid Modernization

- **"Customized" Benefit Options:** vary between plans
  - Must provide all mandatory and optional services required by plan enrollees, but ***may vary amount, duration and scope***
  - May cover non-traditional services
- **Lower Cost-Sharing:** plans may reduce (but not increase) cost-sharing requirements.
- **Risk-Adjusted Premiums**
- **ESI Opt-out:** beneficiary option to "opt out" of Medicaid to employer sponsored insurance.
- **Enhanced Benefit Accounts:** reward healthy behavior with credits of $125 per year to purchase health-related products and supplies
- **Initially, a two county pilot** (Broward, Duval)

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- Pilot program
- Quite controversial

For each individual - used to buy product.
The insurer is going to be able to det. scope, amt, & duration coverage offered in package -

CR + AD considering for use if person in smoking cessation program -

Vermont Global Commitment to Health

- **Global Cap:** $4.7 billion cap on total Medicaid expenditures over five years
  - All Medicaid enrollees except LTC and SCHIP
  - State at risk for enrollment and PMPM cost trends
- **State Agency as MCO:** state pays itself a "premium" for each enrollee
- **Flexible Financial Mechanism:** state may use savings to finance non-Medicaid health services for uninsured or underinsured
- **Flexibility to Reduce Coverage:** by reducing benefits, increasing cost sharing, limiting enrollment for optional and expansion populations within limits

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- Got good deal from CMS to run this program.
- All MA Clients will be managed by State Managed Care Organization.

Deficit Reduction Act

- Covering different population, sometimes higher income groups
- Increased cost-sharing
- Changing benefit designs
- Consumer Responsibility
- Role in expanding coverage to uninsured
- States are awaiting further interpretation of the law:
  - Many provisions require HHS Secretary to develop guidance
  - Guidance is needed where language is confusing or ambiguous

NCSL

DRA Premiums and Cost-Sharing Options

- Premiums/cost-sharing for new groups and types of services
  - **Premiums** permitted over 150% FPL
  - **Cost-sharing** permitted over 100% FPL
  - For current eligibles, children more likely than adults to be impacted because most states do not cover adults in the affected income ranges
- *But*, with limits and exemptions:
  - **Cost-sharing limit:** limited to **10%** of service cost under 150% FPL and **20%** over 150% FPL
  - **Family cap:** aggregate premiums and cost-sharing cannot exceed **5%** of family income
  - **Exempted populations:** mandatory kids, pregnant women, institutionalized persons, persons receiving hospice care and women with coverage due to Breast and Cervical Cancer
  - **Exempted services:** preventive services to kids, pregnancy services, hospice or institutional services, emergency services and family planning services
  - Impact limited (due to exemptions) mostly to non-institutionalized adults (who are not pregnant), optional children and expansion populations under waivers

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Kentucky

- Creates four benefit packages:
  - Global Choices (the "default" package for those not falling into another package)
  - Family Choices (children, including SCHIP)
  - Optimum Choices (persons with MR/DD needing LTC)
  - Comprehensive Choices (elderly and disabled in need of LTC)
- "Get Healthy" incentives – awarded for compliance with a disease management program.
  - Can be used for additional services (dental, vision, or nutritional or smoking cessation counseling)
- Establishes employer sponsored insurance as an alternative benefit package (benchmarked to state employee plan) – provides premium assistance to beneficiaries choosing this option

Source: HHS Press releases dated 5/3/2006.

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Changed MA program based on fed. def. Red. Act

Kentucky (cont.)

- New "soft" service limits (subject to PA override) vary by plan.
- New cost sharing requirements imposed on a wide array of services usually in nominal amounts except inpatient hospital ($50/Global Choices, $10 Comprehensive and Optimum Choices)
  - Annual Rx max = $225
  - Annual medical max = $225
  - Aggregate family cap = 5% of income
  - Children, pregnant women, institutionalized, hospice beneficiaries exempt
  - Enforceability permitted (allowing providers to deny service, for failure to meet the cost sharing requirement)

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Significant cost-sharing

West Virginia

- alternative benefit package for healthy adults and children providing an "enhanced" benefit for persons that sign and conform to a **"Medicaid Member Agreement"** and a scaled-back benefit for those who fail or don't sign.
- state and the HMO/medical home will track compliance for:
  - Screenings as directed by their health care provider
  - Adherence to health improvement programs as directed by their health care provider
  - Missed appointments
  - Medication compliance
- Noncompliant members will have benefits reduced (to the Basic Plan), subject to "good cause" and with the right to appeal

Source: HHS Press releases dated 5/3/2006.

NCSL

West Virginia Member Agreement

- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.
- I will use the hospital emergency room only for emergencies.

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West Virginia (Cont.)

- The "Basic" plan includes all mandatory and some optional services but is more limited than the current full WV benefit package (e.g., diabetes care and mental health care excluded)
- EPSDT is preserved
- "Healthy Rewards Accounts" planned:
  - Credits can cover copays for Rx/medical services
  - Balance at year-end can cover non-covered services
- Phase I in a 4-year Medicaid Redesign effort

NCSL

Basic Enhanced not traditionally opened.

for Healthy Children + Adults

Empower patients med. outcomes receiving screening adherence scheduled apts.

Idaho

- Creates Three Plans for three groups:
  - Basic Benchmark Plan for healthy children & adults
  - Enhanced Benchmark Plan for elderly and disabled (and for children and adults needing more services than Benchmark plan). Full range of services.
  - Coordinated Benchmark Plan for dual eligibles. Full range of services.
- Participation is voluntary New preventive services will be covered
  - Initial health risk assessment
  - Nutrition services
- EPSDT benefits preserved for all children

NCSL

Compliance in healthy outcomes.

Sign member agreements

Dist adhere - dropped to basic plan.

Pilot 3 Co's start.

Screening adherence to compliance make-keep appt?

Idaho (Cont.)

- Basic Benchmark Plan restrictions:
  - Long Term Care benefits excluded
  - Limits applied to mental health services
  - Some provider specialties restricted to diagnostic and evaluation services only
- Personal Health Accounts:
  - Individuals earn credits (complying with recommended preventive services) that can be used to purchase tobacco cessation and weight loss goods and services (e.g. nicotine replacement therapies, fitness program memberships and bicycle helmets)

NCSL

Initial Health Risk Assesment — ~~Expanded~~ directed physical.
State will B cert regs indicating what the assessment must cover.

DRA Health Opportunity Accounts

- Establishes a demonstration program in up to 10 states to allow high deductible medical service plans plus contributions to a Health Opportunity Account (HOA)
  - A state can apply alternative benefits for a group or groups of beneficiaries in one or more geographic areas of a state
  - The deductible may not exceed 110% of the HOA contribution
  - Groups precluded from participating: aged, blind and disabled, pregnant women, individuals receiving terminal care, long term care, or those eligible for Medicaid for less than three months

NCSL

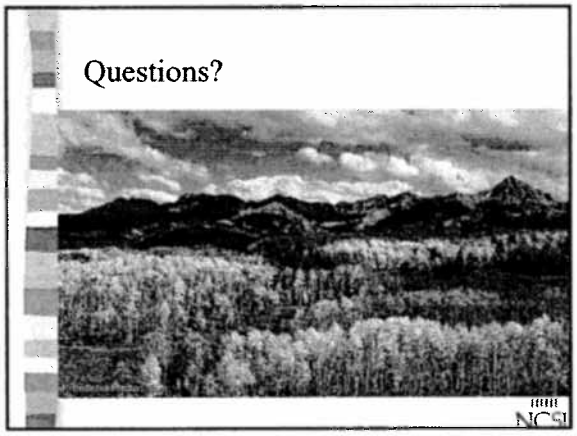
WI. apply?

Out 2nd - apps. due.
Feds will pick 10 states in new.

More resources:

- For NCSL's summary of the DRA go to http://www.ncsl.org/statefed/health/ReconDocs0206.htm
- For summaries of recent state Medicaid waivers and amendments go to http://www.ncsl.org/programs/health/1115waivers.htm
- For NCSL's web page on consumer directed health care go to http://www.ncsl.org/programs/health/hsa.htm
- For NCSL's web page on access to health care and the uninsured go to http://www.ncsl.org/programs/health/h-primary.htm

NCSL


Questions?
NCSU

JS Vacation Sheet 10-31 to Nov. 6

1. Can you please give me some feed back as to any current meetings scheduled with BidRx and also the current standing between BidRx and the State of Wisconsin? Carol asked me to stay in touch with you and she indicated that you would keep me informed.

Thank you,

Glen A. Pollack

Thomas Insurance Group
303 Pearl Avenue
P.O. Box 3387
Oshkosh, WI 54903-3387
Phone:920-235-6461
Fax:920-235-3186

MM responded to him regarding upcoming meetings. He wants to talk to you about BidRx and the State. 10-31

2. John Hogan called and requested talking points on SB 166. I faxed to him. MM 11-1

3. Rose from DWD Called

Re: You asked if there were any resources that DWD has for people that are receiving foodstamps.

There is no general assistance program; each community has there own things (i.e. Goodwill). A resource that you could recommend is JobService because they have other resources in those offices besides employment help.

267-7398—Rose's number…you don't need to call back unless you have questions (MW 11/2)


FORWARD
E PLURIBUS UNUM

Carol Roessler
Committee Chair
Notes

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.

- Ore
- Wash
- Cal
- OKlah
- Texas - carried
- mass
- Verm
- Conn
- Flor
- Miss.

September 27, 2006

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.

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.

Preempted automated

Florida created Counsellor help interact w/ system

help medicaid Risk adj. Premium. Counselors help move people into product.

ARIZONA - TAX - CREDIT FOR insurer

Health Care Reform: Addressing Health Care Costs

For the Senate Select Committee on Health Care
by

Laura Tobler
September 27, 2006
National Conference of State Legislatures
303-856-1545, laura.tobler@ncsl.org

NCSL

PLUGGING the GAP

not abolishing employer based market

help more people buy into private ins

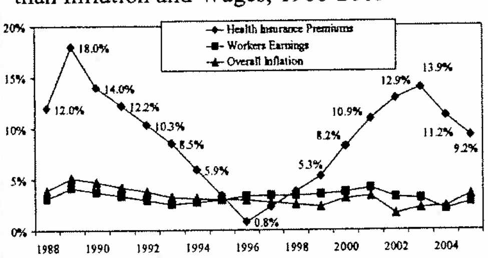
Personal responsibility for health.

* Appropriate care
* Evidence base medicine.

Pay for performance Oregon

Pharmacist

Health Premiums Rising 3-5 Times Faster than Inflation and Wages, 1988-2005



Source: KFF/HRET and Bureau of Labor Statistics; Paul Fronstin, EBRI for NCSL 4/06

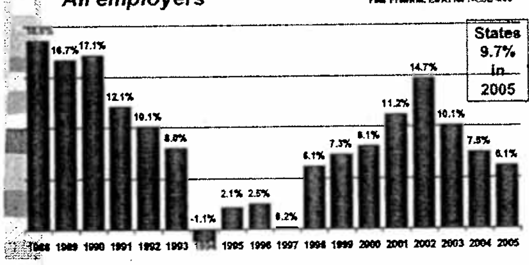
NCSL

14.7 to 6.1%

Total health benefit cost increase slows for the third straight year – Good News?

All employers

Paul Fronstin, EBRI for NCSL 4/06



NCSL

9.7%.

Plugging Gap those Targets low income workers + small bus.

Mass. Vermont tax all employers who not offering

Maryland Payroll tax doesn't give.

Health Care Reform: Addressing Health Care Costs

- Stabilize the insurance market/reduce the number of uninsured
- Focus more attention on preventive and primary care
- Focus more attention on appropriate care for chronic disease
- Promote personal responsibility
- Consumer-directed health care
- Address long-term care and quality

Donna Bakken,

NCSL

More recent state initiatives for covering the uninsured fall into these categories…

- Making new insurance options more affordable
  - Increasing employer-offered insurance
  - Making new private insurance options more affordable.
  - Assist low-income uninsured via government sponsored programs
- Comprehensive
  - Includes strategies addressing access, cost and quality. — MASSACHUSETTS, VERMONT, MAINE
- Covering children — universal HC for kids →

NCSL

States, subsidizing, whats w[illegible]

Employers paying less
Sign # employers dropping
Employer based market
here in US.

Montana: Make small business insurance more affordable

- 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.

NCSL

Subsidy

Not reduced price of product
emp must be 20-25%
2 to 10 employees.
reduce premiums this amount

BUY in - to pool add new tobacco tax.
Subsidized Purchasing Pools

marketed Waiting less.

1200 Small Business

Kentucky: Make small business insurance more affordable

- Insurance Coverage, Affordability and Relief to Small Employers (ICARE) Program - 4 year pilot program.
- Small employers (2-25 employees) who have been uninsured for at least 12 months and average annual salary does not exceed 300 FPL.
- 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.
- Premiums must be discounted for a healthy lifestyle.

NCSL

General Fund Subsidy for payment of Premium
State pays $40. per mo
- $10 next yr. Subsidy
Subsidy for Small business
offer. offset increase in premium
Incentives for choosing healthier behavior.

West Virginia: Make small business insurance more affordable:

- 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.

NCSL

Partnered w/ BCBS wked w/ Providers. ↓ Premium by 20% about $300 per mo coverage. 1000 enrolled.

Assessment. Halpsecond Costs
Subsidy draws. in to market.

New York: Make small business insurance more affordable

- 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

no enrollment

NCSL

Reinsurance - Assessment on Industry

NY - Equity Regulated
REI. Small % people take up large amt Spending.
Marketing important.

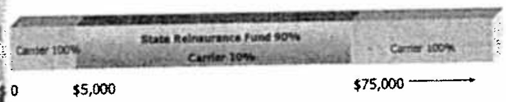
Onehole Carriers in ny individuals Perplexed

Carrier 5,000 to 75,000 — Carrier 100%

subsidized

Individuals can buy
Of Small businesses
Can buy — small businesses. not enrollees.

Reinsurance subsidy



- Estimated savings of 50% for individuals
- Over 110,000 enrolled (1/06)
  - Most enrollment is non-group
- State Reinsurance Fund spent $13.3 million in 2003 and $34.5 million in 2004

NCSL

New Jersey: A focus on young adults

- Allow young adults--one of the fastest growing segments of the uninsured--to remain covered on their parent's or guardian's health insurance policy.
- State examples: DE (age 24), MA (age 25), NJ (up to age 30), NM (age 25), CO (age 25, unmarried dependents), Utah (up to age 26)
- This policy strategy requires no state funding. NJ law requires the parent to pay for the coverage entirely (no employer contribution).
- Maine (age 25 with disability, dependent parents and unmarried same-sex and opposite-sex partners) which may bring in disproportionate numbers of unhealthy older dependents
- MD, TX, MN, NY and LA allow coverage for grandchildren

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Parent guardian w/ a group.
Parent Pays premium
Concern these folks out ...
each ind. 102% pay

Medicaid coverage for low-income workers

- New insurance products for small firms with low-wage workers (and employer premium assistance programs).
- Employers, individual and Medicaid pay premium
  - New Mexico – open to uninsured adults <200% FPL, individuals may pay employer contribution
  - Oklahoma covers workers and spouses <185% FPL who work for small firms; program begins with voucher; safety-net option will be provided for workers with employers unwilling to participate
  - Arkansas recently received waiver to offer limited benefit product to small firms, Medicaid funding will be available for low-wage workers (<200% FPL)

NCSL

Expand medicaid
Partnership
Employer/
EPIC - 50,000 people
Employer/Employee/State pays
Premium Assistance Program - helps buy into - check to buy in
Product goes ... individual
Buying into Private
90 state ≥ some decrease

mimics private market
Providers help create program.

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 tobacco tax.

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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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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Shared Responsibility
95% Coverage next 3 yrs
Gov. Subsidize
Req. individuals have ins. prove have ins. prove can't afford.
Req employers to pay as well.
Participate in ins — no pay $295 per employee per year
initial 8% payroll uninsured
Free Rider surcharge

Focus on ~~preventive and primary~~ care: West Virginia

- HB 4021
- Establishes a clinic-based primary care services program for an ~~undetermined~~ prepaid fee (developing regulations now).
- West Virginia Health Care Authority will determine the eligibility of providers to obtain licenses to market and sell prepaid health services under such terms as may be established in guidelines developed by the Health Care Authority or the Insurance Commissioner
- Eight providers will be chosen.

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Primary + preventative care through a fee.

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

- 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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a lot of cost sharing
close to cap
Covered at Work
$50 ck to buy employer

Connector
Market place for insurance

Focus More Attention on Chronic Disease: Vermont

- 2006 Health Care Affordability Act
  - H 861 and H 895 both signed by the Governor
  - Two major components:
    - Making health insurance affordable and accessible to the uninsured- Catamount Health Program.
    - Improving the delivery of health care.

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Changing chronic illness. Waiving Co pays — leaders in Quality measures.

Vermont: Catamount Health

- Everyone who is uninsured for 12 months or more will have access to - and help pay for- a comprehensive health insurance package.
- A standard plan (classic PPO 50% model) will be offered by the private sector and subsidized (sliding scale) for anyone under 300 percent of poverty.
- Subsidize employer sponsored insurance for eligible people.
- state funding 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. $365 per FTE who is uninsured.
- Focus on managing chronic disease.

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Vermont: Improving care delivery

- ~~Focus on chronic disease management.~~
- Establish a system of chronic care management.
- Change provider reimbursement system to encourage excellence in chronic disease management.
- ~~Waiving co-pays~~ for patients who seek appropriate care.

NCSL

Public Subsidized Product —

Investing for State Run MC program —

Subsidized product over incentivizing Providers to focus on chronic mgmt & pay for performance

Co Pays Waived for Private Pays

Health Savings Account (HSA)

- Allows for tax-free accumulation of savings.
  - Tax free contribution; Tax free accumulation.
  - Tax free withdrawals for health care services, COBRA and Long Term Care Ins. premiums, retiree health premiums for Medicare-eligible retirees.
- Must have qualified "High Deductible health plan".
  - Self-only: Minimum $1,050 annual deductible, $5,250 Out-of-Pocket max
  - Family coverage: Minimum $2,100 deductible, $10,500 Out-of-Pocket max.
- Contributions
  - Self-only: limited to level of deductible up to $2,700 max.
  - Family coverage: limited to level of deductible up to $5,450 max.
- Catch-up contributions once age 55 of $1,000.
  - Phased-in by 2009.

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Cost Choice

Health Reimbursement Arrangement (HRA)

- Employer provided account that allows for pre-tax reimbursement of medical expenses.
- Typically combined with a high-deductible health plan, but not required.
- Employee contributions not permitted.

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Health "Consumerism:" Potentials & Concerns

Potentials

- Lower costs
  - Reduction in use
  - Use of lower cost services
- Better engaged consumer
- More satisfied consumer
- Better health outcomes/more appropriate care
- Improve affordability

Concerns

- Low health literacy
  - Reduce necessary care
  - Induce demand for unnecessary care
- Lack of tools & resources to make decisions
- Impact on high cost users uncertain
- Crowd out of full coverage
- One-time savings

Paul Fronstin, EBRI for NCSL 4/06

NCSL

2 cost increase choices engage people discussion

INCREASE EDUCATION to Consumers on How to PROPERLY CHOOSE

50,000 income ceiling

Previously UNINSURED 2500 UN Insured before NOT Pay cost Starts

Consumer-directed health plans gain momentum: Percent employers offering

	2003	2004	2005	Likely to offer in 2006*	Likely to offer in 2007*
Large employers (500+)	1%	4%	5%	13%	17%
Jumbo employers (20,000+)	9%	12%	22%	29%	31%
State Gov't Employers			6%	22%	22%

*Selected 5 on a 5-point scale in which 1 = not at all likely and 5 = very likely. Includes employers that currently offer. 2007 includes employers likely to offer in 2006. Mercer Health & Benefits – NCSL, April 2006

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State Legislatures' Roles with HSAs

- Encourage wider use of federal HSAs.
- Create a state income tax exemption for deposits.
- Exempt from mandates that make high-deductible policies problematic.
- Require price transparency so consumers know costs of using their own $$.
- Regulate or restrict types of high deductible policies that can be offered or sold.
- Expand the types of financial institutions that can offer health savings accounts (credit unions, assoc.)
- Clean up older tax statutes affecting "Medical Savings Accounts"

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New laws on HSAs in many states

- States that conformed to federal Internal Revenue Code for HSA Purposes, 12/04: AZ, CO, CT, DE, GA, HI, ID, IL, IN, IA, KS, LA, MD, MI, MO, MT, NE, NM, NY, NC, ND, OH, OK, OR, RI *('04)*, SC, UT, VT VA, WV *(+ see below)* 30
- States that changed laws in 2005-06 to conform to federal IRS Code for HSAs: AR, FL, GA, IN, IA, KY, MA, MN, MS, NV, NJ, OK, PA, UT (effective dates vary) (15)
- States with HSAs for High Risk Pool plans: AL, AR ('05), CO, ID ('05), KY, LA, MD, MN, MO, NE, SD, WY (12)
- States with HSAs for state employees: AR ('04), FL ('05), KS ('06), OK ('05), SC ('05), SD ('04), UT ('06) (7)
- States that do not have state income tax: AK, FL, NH, SD, TN, TX, WA, WY (8)

NCSL's staff contact for consumer directed health care is Richard Cauchi at 303-856-1367 or dick.cauchi@ncsl.org

NCSL

Current State Medicaid Reform Initiatives

- Emphasis on personal responsiblity
  - "Consumer choice" of plans
  - Increased premiums or cost sharing
  - Incentives for healthy behaviors
- increased role of private marketplace
  - Increased control to plans to determine benefit packages
  - Encourage employer coverage through premium assistance
- Spending limits and predictability
  - Defined contribution approaches
  - Aggregate cap on federal funding
  - Strategies that preserve federal funding for health coverage
  - Increased use of managed care

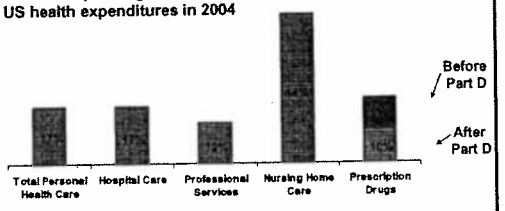
Source: Kathy Gifford, presentation at NCSL's Fiscal Analysts Seminar, September 7, 2006.

NCSL

Personal Responsibility
Private

Medicaid Pays a Sizable Share of U.S. Health Spending

Medicaid spending was 1/6 of all US health expenditures in 2004



SOURCE: Cynthia Smith, et.al., "National Health Spending in 2004," *Health Affairs*, January/February 2006. Based on National Health Care Expenditure Data for 2004, CMS, Office of the Actuary, 2006

NCSL

Florida Medicaid Modernization

- **"Customized" Benefit Options:** vary between plans
  - Must provide all mandatory and optional services required by plan enrollees, but ***may vary amount, duration and scope***
  - May cover non-traditional services
- **Lower Cost-Sharing:** plans may reduce (but not increase) cost-sharing requirements.
- **Risk-Adjusted Premiums**
- **ESI Opt-out:** beneficiary option to "opt out" of Medicaid to employer sponsored insurance.
- **Enhanced Benefit Accounts:** reward healthy behavior with credits of $125 per year to purchase health-related products and supplies.
- **Initially, a two county pilot** (Broward, Duval)

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For individuals to buy Product
Answer: create product that
medicaid person buys

Reward for healthy behavior.
ie smoking cessation

Vermont Global Commitment to Health

- **Global Cap:** $4.7 billion cap on total Medicaid expenditures over five years
  - All Medicaid enrollees except LTC and SCHIP
  - State at risk for enrollment and PMPM cost trends
- **State Agency as MCO:** state pays itself a "premium" for each enrollee
- **Flexible Financial Mechanism:** state may use savings to finance non-Medicaid health services for uninsured or underinsured
- **Flexibility to Reduce Coverage:** by reducing benefits, increasing cost sharing, limiting enrollment for optional and expansion populations within limits

NCSL

State Run Managed Care Organizations

Deficit Reduction Act

- Covering different population, sometimes higher income groups
- Increased cost-sharing
- Changing benefit designs
- Consumer Responsibility
- Role in expanding coverage to uninsured
- States are awaiting further interpretation of the law:
  - Many provisions require HHS Secretary to develop guidance
  - Guidance is needed where language is confusing or ambiguous

NCSL

DRA Premiums and Cost-Sharing Options

- Premiums/cost-sharing for new groups and types of services
  - **Premiums** permitted over 150% FPL
  - **Cost-sharing** permitted over 100% FPL
  - For current eligibles, children more likely than adults to be impacted because most states do not cover adults in the affected income ranges
- *But,* with limits and exemptions:
  - **Cost-sharing limit:** limited to **10%** of service cost under 150% FPL and **20%** over 150% FPL
  - **Family cap:** aggregate premiums and cost-sharing cannot exceed **5%** of family income
  - **Exempted populations:** mandatory kids, pregnant women, institutionalized persons, persons receiving hospice care and women with coverage due to Breast and Cervical Cancer
  - **Exempted services:** preventive services to kids, pregnancy services, hospice or institutional services, emergency services and family planning services
  - Impact limited (due to exemptions) mostly to non-institutionalized adults (who are not pregnant), optional children and expansion populations under waivers

NCSL

Kentucky

- Creates four benefit packages:
  - Global Choices (the "default" package for those not falling into another package)
  - Family Choices (children, including SCHIP)
  - Optimum Choices (persons with MR/DD needing LTC)
  - Comprehensive Choices (elderly and disabled in need of LTC)
- "Get Healthy" incentives – awarded for compliance with a disease management program.
  - Can be used for additional services (dental, vision, or nutritional or smoking cessation counseling)
- Establishes employer sponsored insurance as an alternative benefit package (benchmarked to state employee plan) – provides premium assistance to beneficiaries choosing this option

Source: HHS Press releases dated 5/3/2006.

NCSL

1st State for dual groups

Complying w/ disease

Kentucky (cont.)

- New "soft" service limits (subject to PA override) vary by plan.
- New cost sharing requirements imposed on a wide array of services usually in nominal amounts except inpatient hospital ($50/Global Choices, $10 Comprehensive and Optimum Choices)
  - Annual Rx max = $225
  - Annual medical max = $225
  - Aggregate family cap = 5% of income
  - Children, pregnant women, institutionalized, hospice beneficiaries exempt
  - Enforceability permitted (allowing providers to deny service for failure to meet the cost sharing requirement)

NCSL

West Virginia

- alternative benefit package for healthy adults and children providing an "enhanced" benefit for persons that sign and conform to a **"Medicaid Member Agreement"** and a scaled-back benefit for those who fail or don't sign.
- state and the HMO/medical home will track compliance for:
  - Screenings as directed by their health care provider
  - Adherence to health improvement programs as directed by their health care provider
  - Missed appointments
  - Medication compliance
- Noncompliant members will have benefits reduced (to the Basic Plan), subject to "good cause" and with the right to appeal

Source: HHS Press releases dated 5/3/2006.

NCSL

Alt. benefit for healt

West Virginia Member Agreement

- I will do my best to stay healthy. I will go to health improvement programs as directed by my medical home.
- I will read the booklets and papers my medical home gives me. If I have questions about them, I will ask for help.
- I will go to my medical home when I am sick.
- I will take my children to their medical home when they are sick.
- I will go to my medical home for check-ups.
- I will take my children to their medical home for check-ups.
- I will take the medicines my health care provider prescribes for me.
- I will show up on time when I have my appointments.
- I will bring my children to their appointments on time.
- I will call the medical home to let them know if I cannot keep my appointments or those for my children.
- I will let my medical home know when there has been a change in my address or phone number for myself or my children.
- I will use the hospital emergency room only for emergencies.

NCSL

West Virginia (Cont.)

- The "Basic" plan includes all mandatory and some optional services but is more limited than the current full WV benefit package (e.g., diabetes care and mental health care excluded)
- EPSDT is preserved
- "Healthy Rewards Accounts" planned:
  - Credits can cover copays for Rx/medical services
  - Balance at year-end can cover non-covered services
- Phase I in a 4-year Medicaid Redesign effort

NCSL

Idaho

- Creates Three Plans for three groups:
  - Basic Benchmark Plan for healthy children & adults
  - Enhanced Benchmark Plan for elderly and disabled (and for children and adults needing more services than Benchmark plan). Full range of services.
  - Coordinated Benchmark Plan for dual eligibles. Full range of services.
- Participation is voluntary New preventive services will be covered
  - Initial health risk assessment
  - Nutrition services
- EPSDT benefits preserved for all children

NCSL

Idaho (Cont.)

- Basic Benchmark Plan restrictions:
  - Long Term Care benefits excluded
  - Limits applied to mental health services
  - Some provider specialties restricted to diagnostic and evaluation services only
- Personal Health Accounts:
  - Individuals earn credits (complying with recommended preventive services) that can be used to purchase tobacco cessation and weight loss goods and services (e.g. nicotine replacement therapies, fitness program memberships and bicycle helmets)

NCSL

DRA Health Opportunity Accounts

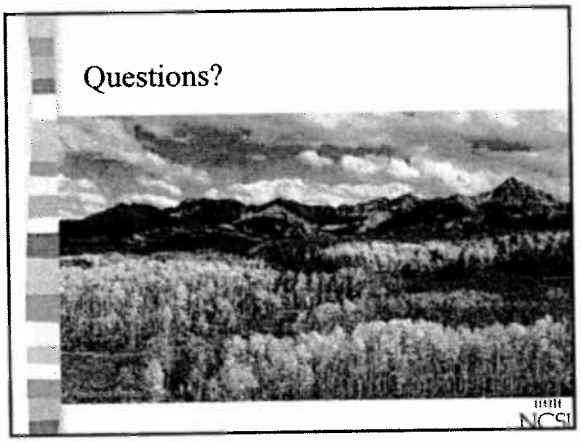
- Establishes a demonstration program in up to 10 states to allow high deductible medical service plans plus contributions to a Health Opportunity Account (HOA)
  - A state can apply alternative benefits for a group or groups of beneficiaries in one or more geographic areas of a state
  - The deductible may not exceed 110% of the HOA contribution
  - Groups precluded from participating: aged, blind and disabled, pregnant women, individuals receiving terminal care, long term care, or those eligible for Medicaid for less than three months

NCSL

More resources:

- For NCSL's summary of the DRA go to http://www.ncsl.org/statefed/health/ReconDocs0206.htm
- For summaries of recent state Medicaid waivers and amendments go to http://www.ncsl.org/programs/health/1115waivers.htm
- For NCSL's web page on consumer directed health care go to http://www.ncsl.org/programs/health/hsa.htm
- For NCSL's web page on access to health care and the uninsured go to http://www.ncsl.org/programs/health/h-primary.htm

NCSL


Questions?
NCSI


FORWARD
E PLURIBUS UNUM

5-30-06

330 SW

- Can do on pre-emptive basis
- Can query every payer in US + can assemble info + send back.
- 270 - eligibility requirement
  271 - payer
- Want to bring tech. to the public sector.
- est. State paying claims that privately funded should be paying — 15% of the time.
  - Mandy - how get to that #? what claims data?
  - Asked @ 260 mill claims
    Mandy - where from.
  - Major Clearinghouse who signed agreement to provide info.
  - At least 6 large states - this is where data is from.
  - Both commercial + public claims.

★ - Mandy - 15% sounds high for state MA claims. Sounds like a preposperous #.

★ - PHFS - Mandy - happens but small # of circumstances.

Proposal
Retrospective study of claims data in US. This would give them a #. Help to benchmark from a

different perspective. No charge to the State for this.

Arkansas + Kansas have signed on - DHI will do "audit" ... look at retrospective claims.

- Benefits to MA would be that there would be no cost in identifying where claims should be paid.

Moody - what payers are participating with you?
Ans: cooperation w/ Aetna + other regional payers.
As early states come on board - will wait longer than later states. Ready for pushback from insurers.
Moody - Insurers can just decline to participate.
Ans - HIPAA says you shall cooperate -
However - HIPAA

- 2 ways to get info:
① Query every payer or
② They can upload eligibility info. to their servers (on reg. basis)

- Get pd. by plan sponsors + providers
  - MA free for 1st cycle
  - After that - nominal cost

- DHS currently does pay avoidance.
Some pay + chase - DHI thinks can eliminate

- Many services where there are no private plan co-pay — LTC etc. Probably over 1/2 of MA.

★ - DHFS - cost to state:
for audit ↗
① provide data
② analyze results to see if state agrees.

DHFS

★ - what do we avoid paying now? 100's of millions.
★ - Have contract w/ top people and they are not finding much. Contingency based contracts.
- 1st recovery from current vendor — $5,000.
- For managed care — HFS takes $ in det. reimb. rates and it is up to them to look/get $.

- If 1% left on table - if this is what we aren't getting - could look like 45 mill. to state.

- Charlie — how long does audit take.
Ans — about 90 days.

Next Step —
Send technical needs — what do you need to do the retrospective analysis.
★ DHS indicates payers that should be paying — and rd. state $ pay for.
★ State reso. to an act. R

- Has security on data that is more strict than HIPAA stds.
- Have had some folks misuse data - trying to hijack data + do it themselves. Now being sued - likely to face jail time.
- Can't say system is absolutely air tight.
- Mady will contact Arkansas
- Some states have considered leg. to penalize ins. co.'s who aren't paying claims. These penalties are higher than HIPAA's penalty.
- Would have to mandate providers to submit claims to DHI, rather than state.
- Pre-existing bill contracts exist; hosp. checks w/ insurers + state.
- Other businesses can find cov. (who should pay). but - not provided in real time.
- IO eligibility providers that compete to verify claims etc.
- Need to evaluate what will we save based on what already saving — to det. Hmo contracts. Rates.

70% of $ is not in capitation – Nursing home care
LTC
(Community based waiver

Providers not providing service

In play - maybe $750 million

audit 1

~~Where do we start~~

mandate it with the payers

9? states looking @ (can't name in public)

2 states participating in

Don't think would be infringing on any other contracts

~~Contract other~~

Hewlett packard hosting software

Pre-emptive / comprehensive > coordination of benefits

CC -
next steps

- FIB. DHFS > find out what doing - how get started
- Coach Rose

Hoping to get less support.

Next week -

* 3pm Tues
* Wed 31st am

June

- Wed 6/7 afternoon

DIGITAL HEALTHCARE, INC.
ENHANCED ELECTRONIC COMMERCE
PO Box 25275
Cleveland, OH 44125

Wisconsin Medicaid
May 17, 2006

Digital Healthcare, Inc. is a privately held company that streamlines processing health insurance claims as Congress calls for in the simplification provisions of HIPAA. The Company offers a business process that automates the determination of all an individual's healthcare coverage, and ranking it in order of payment.

An audited study by the Company projects that **15% or more of the claims paid by Medicaid could be primary elsewhere.** In the case of Wisconsin, that could be costing the state $726 Million a year.

Digital Healthcare can automate the Coordination of Benefits for Wisconsin Medicaid, enabling them to test 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.**

Action:
State of Wisconsin Medicaid engages Digital Healthcare to benchmark double coverage by testing historical claims data. (Test fees waived for Medicaid.)

- Digital Healthcare tests claims against a base of payers to determine all coverage for each patient at the date of claim.
- Digital Healthcare applies NAIC rules to determine primacy for each payer discovered.
- Digital Healthcare reports additional coverage to Wisconsin Medicaid and projects the saving for Medicaid.
- Wisconsin Medicaid continues to provide monthly claims data until findings inspire confidence in deploying Digital Healthcare's online pre-emptive coordination of benefits service.

Advantages to Wisconsin Medicaid of Historical Test:

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

Advantages to Wisconsin Medicaid of Online Preemptive Service:

- Eliminates most TPL work, adjudication, pay and chase.
- Tests even the smallest claims, sharply reducing write-offs.
- Inhibits fraudulent claims.
- Requires no new software, hardware, or staff.
- Minimal interface requirements with existing processes.
- *Available to Medicaid at no cost for initial contract.*

Kansas has initial working with them.

• 7 other state> interested.

• no cost audit

• Good - benchmark who states are

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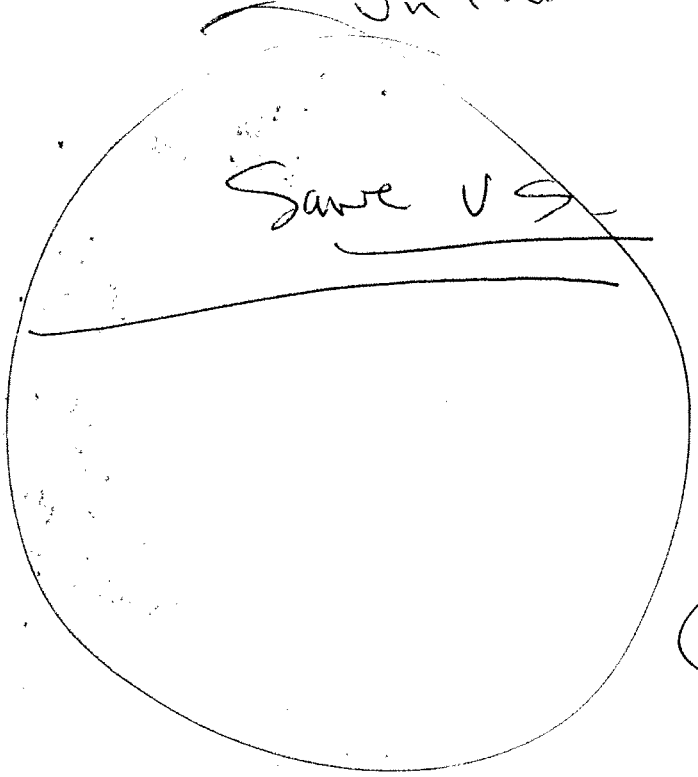
— suspend licenses
— reasons for them
to cooperate.
— unintended subsidy



BidRx℠: The New Marketplace for Prescriptions

September 27, 2006

PATENT-PENDING

Current Paradigm

- Prescription drug sales have increased nearly 13% per year in the previous decade (CMS, Office of the Actuary) with no end in sight
  - Consumers, & payers search for solutions to control unsustainable cost increases; offered solutions are not successful
  - Current market solutions restrict access and choice and shift costs to consumers & providers; participants are dissatisfied
- The current marketplace is inefficient, costing billions per year
- Not a functioning Marketplace
  - Product options are unknown
  - Prices of options are unknown
  - No differentiation among available providers
- No real choices for payers: Only option to one PBM is another PBM using same tools and techniques as above

PATENT-PENDING

- Cost pharmacist avg $ 3.00 to file paperwork to be paid by insurer.
- not enough info. to make choices.
- Need info to make choice (current paradigm doesn't differ

Registration free for any consumer

The New Marketplace

- A real, functional marketplace with relevant, timely, and actionable information
  - Therapy options are known @ point-of-decision
  - Price & value of options are known @ point-of-decision
  - Real differentiation among available products & providers
- Prescription drug costs for payers & consumers can decrease by over 50%; cost reduction, not transfer
- The new marketplace is efficient, saving billions of dollars in unnecessary costs
- A new choice for payers & consumers: an open, transparent, competitive electronic marketplace (CEM) for prescriptions.

PATENT-PENDING

The Bid_{Rx}^{sm} Marketplace

Thank you

BidRx.com: your Rx marketplace

PATENT-PENDING

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PATENT-PENDING

The Bid_{Rx}^{sm} Marketplace

Thank you

BidRx.com: your Rx marketplace

PATENT-PENDING

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Charles Morgan	LFB	266-3847
Lee Vang	Leg Council	
Laura Rose	"	266-9791
[illegible]		