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☞ Details: Department of Health and Family Services Update and Long Term Care. Hearing held in Madison, Wisconsin on October 17, 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

Department of Health and Family Services Update and Long Term Care

DEPARTMENT OF HEALTH AND FAMILY SERVICES UPDATE

Helene Nelson, Secretary
Department of Health and Family Services

Kevin Hayden, Administrator
Division of Health Care Financing
Department of Health and Family Services

ISSUES:

- Review of the DHFS 2007-09 budget items that relate to the Deficit Reduction Act.
- Update on Family Care and the Relocation Initiative.
- Explanation of the Department's Pay for Performance Initiative.
- Individual Cash Accounts.
- Explanation of Department efforts to ensure Medicaid is not paying for services third party payers should be covering.
- Efforts to maximize federal dollars.

LONG TERM CARE PARTNERSHIP PROGRAM

Peter Leonis, Intergovernmental Affairs Liaison
Centers for Medicare and Medicaid Services

Mary Ann Hack
Representative for Indiana's Long Term Care Partnership Insurance Program

Laura DeGolier and Jim Harbridge
National Association of Insurance and Financial Advisors

FAMILY CARE

Tom Frazier
Coalition of Wisconsin Aging Groups

Lynn Breedlove
Disability Rights Wisconsin

LONG TERM CARE REFORM AND NURSING HOME CARE

Bill Bruce, President
St. Joseph's Community Health Services
Hillsboro, WI

Mike Schafer, CEO
Spooner Health System

Tom Moore, Executive Director
Wisconsin Health Care Association

John Sauer, Executive Director
Wisconsin Association of Homes and Services for the Aging

Craig Thompson, Legislative Director
Wisconsin Counties Association

Karen Bullock, Chief Executive Officer
Community Health Partnership, Inc.
Representing the Wisconsin Partnership Program

Paul Soczynski, Chief Operating Officer
Community Care, Inc.
Representing the Wisconsin Partnership Program

October 17, 2006 **PUBLIC HEARING HELD**

Present: (5) Senators Roessler, Darling, Olsen, Erpenbach and Miller.
Absent: (0) None.

Appearances For
- None.

Appearances Against

- None.

Appearances for Information Only

- Helene Nelson — Secretary , Department of Health and Family Services
- Kevin Hayden — Department of Health and Family Services
- Peter Leonis — Centers for Medicare and Medicaid Services
- Laura DeGolier — National Association of Insurance and Financial Advisors
- Jim Harbridge — National Association of Insurance and Financial Advisors
- Tom Fraizer — Coalition of Wisconsin Aging Groups
- Lynn Breedlove — Disability Rights Wisconsin
- Bill Bruce, Hillsboro — President , St. Joseph's Community Health Services
- Mike Schafer — CEO, Spooner Health System
- Tom Moore — Wisconsin Health Care Association
- John Sauer — Wisconsin Association of Homes and Services for the Aging
- Craig Thompson — Wisconsin Counties Association
- Karen Bullock — CEO, Community Health Partnership, Inc.
- Paul Soczynski — CEO, Community Care, Inc.

Registrations For

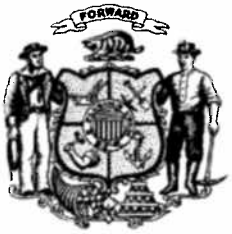
- None.

Registrations Against

- None.

Jennifer Stegall
Committee Clerk


WISCONSIN STATE LEGISLATURE


FORWARD

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, Maryland 21244-1850

Peter Lewis

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Center for Medicaid and State Operations

SMDL #06-019

JUL 27 2006

Dear State Medicaid Director:

This letter is one of a series that provides guidance on the implementation of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171. The legislation made a number of changes in the Medicaid rules on eligibility and benefits. This letter provides information for States regarding implementation of section 6021 of the DRA. Section 6021 amends section 1917(b) of the Social Security Act (the Act) to provide for Qualified State Long-Term Care (LTC) Insurance Partnership programs, and permits an exception to estate recovery provisions with respect to individuals who receive benefits under LTC insurance policies sold in States that implement a Partnership program. These changes are described briefly below and are discussed in detail in the enclosure to this letter.

Qualified Partnerships

A Qualified State LTC Insurance Partnership (Qualified Partnership) means an approved State plan amendment (SPA) that provides an exemption from estate recovery in an amount equal to the benefits paid by certain LTC insurance policies, where those benefits were disregarded in determining an individual's Medicaid eligibility. Policies must meet specific conditions and the State Insurance Commissioner, or appropriate State official, must certify that a policy meets those conditions, in order for the State to apply the exemption from estate recovery. The term "Qualified Partnership" refers to Partnership SPAs, other than those approved as of May 14, 1993. However, those States that had approved Partnership SPAs as of May 14, 1993, continue to be "Partnership States," as long as they have not relaxed the consumer protection standards that were applied under their State plans as of December 31, 2005.

Effective Dates

A State plan amendment that provides for a Qualified Partnership under section 1917(b)(1)(C)(iii) of the Act can specify that policies issued after a certain date will be subject to the amendment, as long as that date is not earlier than the first day of the first calendar quarter in which the SPA is submitted for approval.

I am enclosing a more detailed explanation of the above DRA provisions. If you have any questions about this letter, or the enclosure, please feel free to contact Gale Arden, Director, Disabled & Elderly Health Programs Group at (410)786-6810, or by e-mail at Gale.Arden@cms.hhs.gov. We look forward to working with you as you implement this legislation.

Sincerely,

Dennis G. Smith
Director

Enclosure

cc:

CMS Regional Administrators

CMS Associate Regional Administrators
for Medicaid and State Operations

Martha Roherty
Director, Health Policy Unit
American Public Human Services Association

Joy Wilson
Director, Health Committee
National Conference of State Legislatures

Matt Salo
Director of Health Legislation
National Governors Association

Jacalyn Bryan Carden
Director of Policy and Programs
Association of State and Territorial Health Officials

Christie Raniszewski Herrera
Director, Health and Human Services Task Force
American Legislative Exchange Council

Enclosure

Qualified Long-Term Care Partnerships Under the Deficit Reduction Act of 2005

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations

July 27, 2006

Enclosure Highlights—Section 6021

I. Expansion of State Long-Term Care Insurance Partnerships

II. Definition of "Qualified State Long-Term Care Insurance Partnership" and Requirements

A. Definition
B. Requirements

III. Grandfather Clause

IV. Effective Date

Appendix I Requirements for a Long-Term Care Insurance Policy under a Qualified Long-Term Care Insurance Partnership

Appendix II National Association of Insurance Commissioners Model Regulations

Appendix III National Association of Insurance Commissioners Model Act

Deficit Reduction Act of 2005

I. Expansion of State Long-Term Care (LTC) Partnership Program

Section 6021(a)(1)(A) of the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, expands State LTC Partnership programs, which encourage individuals to purchase LTC insurance. Prior to enactment of the DRA, States could use the authority of section 1902(r)(2) of the Social Security Act (the Act) to disregard benefits paid under an LTC policy when calculating income and resources for purposes of determining Medicaid eligibility. However, under section 1917(b) of the Act, only States that had State plan amendments approved as of May 14, 1993, could exempt the LTC insurance benefits from estate recovery.

The DRA amends section 1917(b)(1)(C)(ii) of the Act to permit other States to exempt LTC benefits from estate recovery, if the State has a State plan amendment (SPA) that provides for a qualified State LTC insurance partnership (Qualified Partnership). The DRA then adds section 1917(b)(1)(C)(iii) in order to define a "Qualified Partnership." States that had State plan amendments as of May 14, 1993, do not have to meet the new definition, but in order to continue to use an estate recovery exemption, those States must maintain consumer protections at least as stringent as those they had in effect as of December 31, 2005. We refer to both types of States as "Partnership States."

II. Definition of "Qualified State LTC Partnership" and Requirements

A. Definition

Section 6021(a)(1)(A) of the DRA adds several new clauses to section 1917(b)(1)(C) of the Act. The new clause (iii) defines the term "Qualified State LTC Partnership" to mean an approved SPA that provides for the disregard of resources, when determining estate recovery obligations, in an amount equal to the LTC insurance benefits paid to, or on behalf of, an individual who has received medical assistance. A policy that meets all of the requirements specified in a Qualified State LTC Partnership SPA is referred to as a "Partnership policy."

The insurance benefits upon which a disregard may be based include benefits paid as direct reimbursement of LTC expenses, as well as benefits paid on a per diem, or other periodic basis, for periods during which the individual received LTC services. The DRA does not require that benefits available under a Partnership policy be fully exhausted before the disregard of resources can be applied. Eligibility may be determined by applying the disregard based on the amount of benefits paid to, or on behalf of, the individual as of the month of application, even if additional benefits remain available under the terms of the policy. The amount that will be protected during estate recovery is the same amount that was disregarded in the eligibility determination.

It should be noted that while an approved Partnership SPA may enable an individual to become eligible for Medicaid by disregarding assets or resources under the authority of section 1902(r)(2) of the Act, the use of a qualified Partnership policy will not affect an individual's ineligibility for payment for nursing facility services, or other LTC services, when the individual's equity interest in home property exceeds the limits set forth in section 1917(f) of the Act, as amended by the DRA.

B. Requirements

The new clause (iii) also sets forth other requirements that must be met in order for a State plan amendment to meet the definition of a Qualified Partnership. These include the following:

1. The LTC insurance policy must meet several conditions, which are listed in Appendix I of this enclosure. These conditions include meeting the requirements of specific portions of the National Association of Insurance Commissioners' (NAIC) LTC Insurance Model Regulations and Model Act (see Appendices II and III).

   The Qualified Partnership SPA **must** provide that the State Insurance Commissioner, or other appropriate State authority, certify to the State Medicaid agency that the policy meets the specified requirements of the NAIC Model Regulations and Model Act. The State Medicaid agency may also accept certification from the same authority that the policy meets the Internal Revenue Code definition of a qualified LTC insurance policy, and that it includes the requisite inflation protections specified in Appendix I. If the State Medicaid agency accepts the certification of the Commissioner or other authority, it is not required to independently verify that policies meet these requirements. Changes in a Partnership policy after it is issued will not affect the applicability of the disregard of resources as long as the policy continues to meet all of the requirements referenced above.

   If an individual has an existing LTC insurance policy that does not qualify as a Partnership policy due to the issue date of the policy, and that policy is exchanged for another, the State Insurance Commissioner or other State authority must determine the issue date for the policy that is received in exchange. To be a qualified Partnership policy, the issue date must not be earlier than the effective date of the Qualified Partnership SPA.

2. The State Medicaid agency must provide information and technical assistance to the State insurance department regarding the Partnership and the relationship of LTC insurance policies to Medicaid. This information must be incorporated into the training of individuals who will sell LTC insurance policies in the State.

3. The State insurance department must provide assurance to the State Medicaid agency that anyone who sells a policy under the Partnership receives training and

demonstrates an understanding of Partnership policies and their relationship to public and private coverage of LTC.

4. The issuer of the policy must provide reports to the Secretary, in accordance with regulations to be developed by the Secretary, which include notice of when benefits are paid under the policy, the amount of those benefits, notice of termination of the policy, and any other information the Secretary determines is appropriate.

5. The State may not impose any requirement affecting the terms or benefits of a Partnership policy unless it imposes the same requirements on all LTC insurance policies.

III. "Grandfather" Clause

A State that had a LTC insurance Partnership SPA approved as of May 14, 1993, is considered to have satisfied the requirements in section II above if the Secretary determines that the SPA provides consumer protections no less stringent than those applied under its SPA as of December 31, 2005. Under this provision California, Connecticut, Indiana, Iowa, and New York would continue to be considered Partnership States.

IV. Effective Dates

A SPA that provides for a Qualified State LTC Insurance Partnership under the amended section 1917(b)(1)(C) of the Act may be effective for policies issued on or after a date specified in the SPA, but not earlier than the first day of the first calendar quarter in which the SPA is submitted.

The DRA requires the Secretary to develop standards regarding the portability of Partnership policies by January 1, 2007. These standards will address reciprocal treatment of policies among Partnership States. The Secretary is also required to develop regulations regarding reporting requirements for issuers of Partnership policies and related data sets. It is not necessary for States to wait for these standards and rules to be promulgated before submitting a Partnership SPA. A State may submit a Partnership SPA at any time after the effective date of the DRA.

Appendix I

Requirements for a Long-Term Care Insurance Policy under a Qualified Long-Term Care Insurance Partnership

In order for a State Plan Amendment to meet the definition of a "Qualified Partnership," allowing the State to disregard assets or resources equal to the amount paid on behalf of an individual, the long-term care insurance policy, including a group policy, must meet the following conditions:

1. The policy must cover a person who was a resident of the Qualified Partnership State when coverage first became effective. If a policy is exchanged for another, the residency rule applies to the issuance of the original policy.
2. The policy must meet the definition of a "qualified long-term care insurance policy" that is found in section 7702B(b) of the Internal Revenue Code of 1986.
3. The policy must not have been issued earlier than the effective date of the SPA.
4. The policy must meet specific requirements of the National Association of Insurance Commissioners (NAIC) Long Term Care Insurance Model Regulations and Model Act. These are listed in Appendices II and III.
5. The policy must include inflation protection as follows:
    - For purchasers under 61 years old, compound annual inflation protection;
    - For purchasers 61 to 76 years old, some level of inflation protection; or
    - For purchasers 76 years or older, inflation protection may be offered but is not required.

Appendix II

NAIC Model Regulations

The following is a list of the NAIC Model regulations that are referenced in Appendix I, item 4:

Model Regulations

1. Section 6A, with a certain exception, relating to guaranteed renewal or non-cancellability;
2. Section 6B of the Model Act, as it relates to 6A;
3. Section 6B, with certain exceptions, relating to prohibitions on limitations and exclusions;
4. Section 6C, relating to extension of benefits;
5. Section 6D, relating to continuation or conversion of coverage;
6. Section 6E, relating to discontinuance and replacement of policies;
7. Section 7, relating to unintentional lapse;
8. Section 8, with certain exceptions, relating to disclosure;
9. Section 9, relating to disclosure of rating practices to the consumer;
10. Section 11, relating to prohibitions against post-claims underwriting;
11. Section 12, relating to minimum standards;
12. Section 14, relating to application forms and replacement coverage;
13. Section 15, relating to reporting requirements;
14. Section 22, relating to filing requirements for marketing;
15. Section 23, with certain exceptions, relating to standards for marketing, with the exception of specific paragraphs;
16. Section 24, relating to suitability;
17. Section 25, relating to prohibition against pre-existing conditions and probationary periods in replacement policies or certificates;
18. Section 26, relating to contingent non-forfeiture benefits;
19. Section 29, relating to standard format outline of coverage; and
20. Section 30, relating to the requirement to deliver the NAIC publication ***"A Shopper's Guide to Long-Term Care Insurance"***.

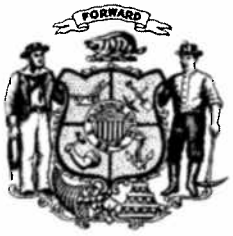
Appendix III

NAIC Model Act

The following is a list of the requirements of the NAIC Model Act that are referenced in Appendix I, item 4:

1. Section 6C, relating to pre-existing conditions;
2. Section 6D, relating to prior hospitalization;
3. Section 8, the provisions relating to contingent non-forfeiture benefits;
4. Section 6F, relating to right to return;
5. Section 6G, relating to outline of coverage;
6. Section 6H, relating to requirements for certificates under group plans;
7. Section 6J, relating to policy summary;
8. Section 6K, relating to monthly reports on accelerated death benefits; and
9. Section 7, relating to incontestability period.

WISCONSIN STATE LEGISLATURE



Carol-
Laura Tobler, NCSL, sent this asking if this is what you are looking for. I'm going to tell her yes - if you aren't happy with this, please let me know ASAP so we can get the message to Laura. It sounds like she'll be flying in tomorrow.
Thanks!
Jennifer

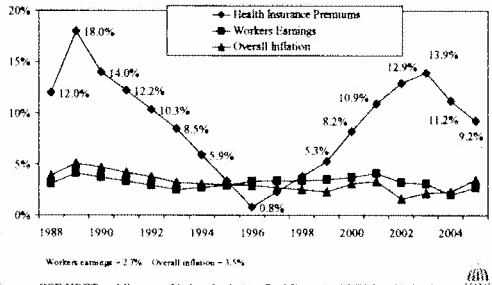
Health Care Reform: Addressing Health Care Costs

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

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



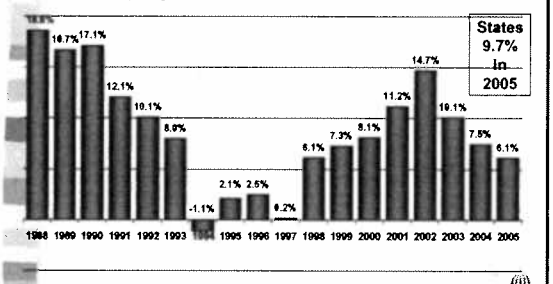
Source: KFF/HRET and Bureau of Labor Statistics; Paul Fronstin, EBRI for NCSL 4/06

NCSL

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

All employers

Paul Fronstin, EBRI for NCSL 4/06



NCSL

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

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

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

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.

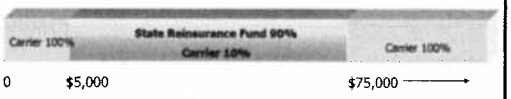
NCSL

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

NCSL

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

NCSL

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

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

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

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.

NCSL

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

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.

NCSL

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.

NCSL

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.

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.

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.

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.

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.

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

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%

*Based 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

NCSL

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"

NCSL

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

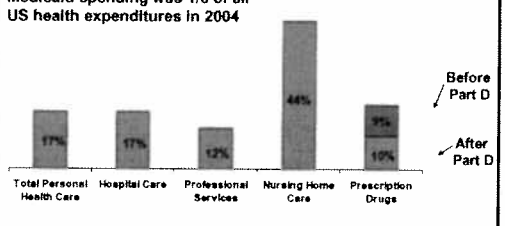
- Emphasis on personal responsibility
  - "Consumer choice" of plans
  - Increased premiums or cost sharing
  - Incentives for healthy behaviors
- Increased role of private marketplace
  - Increased control to plans to determine benefit packages
  - Encourage employer coverage through premium assistance
- 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

NCSL

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)

NCSL

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

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

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

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.

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)

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

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.

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

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

Idaho (Cont.)

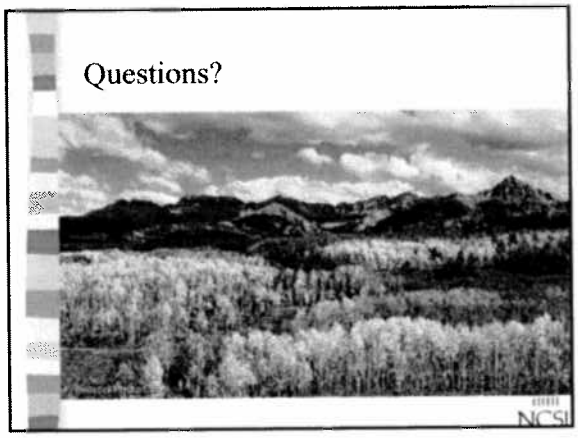
- Basic Benchmark Plan restrictions:
  - Long Term Care benefits excluded
  - Limits applied to mental health services
  - Some provider specialties restricted to diagnostic and evaluation services only
- Personal Health Accounts:
  - Individuals earn credits (complying with recommended preventive services) 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)

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

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


Questions?
NCSI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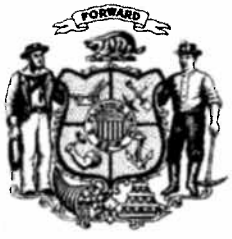

FORWARD

My name is Jim Harbridge and I'm here with Laura De Golier. We are with National Association of Insurance and Financial Advisors - Fond du Lac Association.

We're here to encourage you to implement a Partnership LTC Program in Wisconsin.

I've been working with families and their loved ones providing LTC Planning and selling LTC Insurance since 1990. Laura has been providing Insurance Services since 1979.

I've worked with various entities such as Mercury Marine, Fond du Lac County, Agnesian HealthCare, J.F. Ahern Company, Fond du Lac Regional Clinic to name a few.

The way I work with both Business's and individuals is thru education. This education is needed to dispel certain myths and fallacies concerning LTC. I often use 3rd party articles.

Does anyone here have an LTC Insurance policy or have they had a loved one who has needed LTC?

Our goal today is to educate you on reasons people buy LTC Insurance, myths and fallacies concerning LTC, the risk associated with needing LTC, and to give you information on the current Partnership Plans and their successes in the current States.

Why do people buy LTC Insurance?

- I would like to maintain my financial independence
- I don't want to be a burden on my family
- A LTC Plan would give me peace of mind
- I want to preserve my assets to leave an inheritance

- I want every opportunity to stay in my own home
- I want to be in control as long as possible
- I don't want to see all my assets used to pay for care in the last years of my life
- If I need a nursing home I want to be able to choose
- Asset Planning with 2nd marriages require LTC

What are the myths and fallacies concerning LTC?

- Is LTC about Nursing Homes only- only 18% of LTC is provided in Nursing Homes
- Who needs LTC- 40% is for care for people under the age of 65 yrs. (Example would be Christopher Reeves)
- What is the cost of LTC and are there certain high cost areas in this country-Nursing Homes $62,000 /$140,000 per year, Assisted Living $30,000 per year, Home Care $65,000/ $98,000 per year (Theses are average prices from 2002)
- Who pays for LTC- 42 % Medicaid, 15 % Medicare, 25 % Individuals, 12 % Private Insurance, 6 % Other
- Does Private Health Insurance or Medicare cover LTC Needs- skilled care only
- How long does Medicare pay- up to 100 days- the average number it pays is 23 days
- What does it take to qualify for Medicaid
- Does divesting your assets make any sense- lose control, costs basis, divorce, misuse of funds, etc

What are the risks associated with needing LTC does it make any sense to purchase LTC Insurance

- 1 in 1200 chance of losing everything in a house fire (but surely your home is covered)

- **1 in 240 chance of major auto accident (but you would not drive without auto insurance)**
- **50% chance that you will need some LTC at some point in your life (so doesn't it make sense that you should insure this greater risk)**
- **Check the obituaries in your local newspapers**

And now Laura will discuss the current partnership plans.

Formerly w CMS then Robert Wood Johnson.
Mark Meiners, PhD. George Mason

In summary, education is key! In my opinion, when you consider the various reasons that people purchase LTC Insurance

- **I would like to maintain my financial independence**
- **I don't want to be a burden on my family**
- **A LTC Plan would give me peace of mind**
- **I want to preserve my assets to leave an inheritance**
- **I want every opportunity to stay in my own home**
- **I want to be in control as long as possible**
- **I don't want to see all my assets used to pay for care in the last years of my life**
- **If I need a nursing home I want to be able to choose**

A partnership program fits in well with these motivating factors.

The needy will still need assistance.

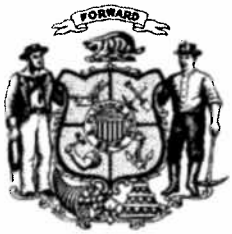
The wealthy will buy LTC or self-insure.

It's the middle class that this partnership program will work well with via education.

I urge you to grandfather all previously written LTC Insurance programs.

Thank-you


WISCONSIN STATE LEGISLATURE


FORWARD

Senate Select Committee on Health Care Reform – Nursing & Long Term Care Issues

Written Comments

I. My name is Bill Bruce and I represent St. Joseph's Community Health Services, Inc.; which includes a 25 bed critical access hospital located in Hillsboro, a 30 bed nursing home located in Hillsboro and 3 primary care clinics located in Elroy, Wonewoc and Hillsboro, Wisconsin. We serve approximately 18,000 people in this rural setting located about 45 miles west of the Dells.

II. Our nursing home has been serving this area since the mid 50's and served up to 65 local residents one year ago. However, with the loss due to ongoing occupancy of 80+% medical assistance residents we have been forced to cut the local access to about 30 beds. This is due to the fact that there is just not enough revenue to cover the cost of caring for medical assistance residents. For the fiscal year ending June 30, 2006 our audit firm reported that our total uncompensated community benefit was $1,400,000; with $700,000 being directly attributed to the operation of the nursing home. This resulted in a year end loss of $172,000. This is the most recent year. Prior years have much the same message. As a result our local Board of Directors was forced to make the very hard decision to close over 50% of the beds due to the dismal reimbursement from the medical assistance for our nursing home population.

III. Going forward our situation continues to look troubled. With our downsized population of thirty residents we are estimating the annual subsidy requirement for the nursing home will be $250,000. While this is felt to be sustainable today another year will see our costs continue to increase. Costs associated with energy, supplies and labor will continue to rise. Over the last few years we have seen this increase at an actual rate of approximately 5.5%. Assuming the nursing home reimbursement only continues to increase at its historical 1-2% levels our local Board will soon be forced to re-address the fiscal drain the nursing home has on our ability to provide needed local access to medical services for the employers and families in our area rely on.

If we are forced to close the remaining nursing home beds there will be significant hardship on local families. Many are two worker families; they will have to make a choice. Do they continue to work, and pay their way, and ship their loved one to a location far away or have one worker stay home, likely qualify for state low income benefits and care for their elderly. It is clear that our state leadership has an obligation to break this cycle before we are left with no infrastructure to care for the most needy in our society, the elderly who are truly without the means to pay their way privately.

IV. Many look to reform. There have been several ideas surface in our local area. They include:

a. Provide Financial Support for elderly to stay at home with loved ones.

The idea is to provide financial support to families truly in need to care for their loved ones in their homes. In this approach the financial condition of the entire family would be considered. This would solve the issue of asset divestiture that we commonly see being done throughout our society today.

b. Provide real cost reimbursement for those truly needy.

There will remain some in our society that do not have any living relatives or means of outside support under any circumstance. In many ways we are judged by how we treat our most vulnerable; the cost for the care of truly needy must be paid by society, not local employers, or underpaid local employees.

c. Re-visit qualification criteria.

I am told that nursing homes currently have more regulation than it takes to run a nuclear fueled electric generating plant. With this in mind, we must continue to re-visit the criteria it takes to qualify for nursing home care. All too often we see folks who skirt the true intent of our plans. With the common use, and promotion, of asset divestiture we are seeing ever increasing numbers qualify for Medical Assistance. It must be recognized that this benefit is not an entitlement, but rather a special benefit for the truly needy among us.

Thank you for your time to hear about our situation. As we move forward there is no doubt our local population will watch carefully to see how our state leadership handles this growing problem that must be faced today.

Questions...

Contact Information:

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bbruce@stjhealthcare.org


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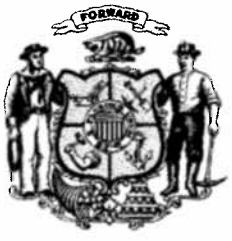

FORWARD

Testimony before the Senate Select Committee on Health Care Reform
October 17, 2006

By:
Michael D. Schafer, CEO/Administrator
Spooner Health System

Chairpersons Roessler, Darling and Committee Members:

Thank you for the opportunity to testify before this committee about a very important subject, long-term care. I have been a licensed nursing home administrator for 21 years, and have found the past few years to be the most challenging of my career. As we deal with an aging population, an aging workforce, and residents who are receiving care in the nursing home that used to be provided in hospitals, state government continues to attempt to balance the state budget at a great cost to our seniors and those providing their care.

I would like to start by telling you a little about Spooner Health System. We are a 25 bed Critical Access Hospital, a 90 bed Medicare certified nursing home, and a home health agency. We also own and sponsor a hospice agency with 4 other rural hospitals in Wisconsin and Michigan. We are one of two hospitals in our county, and one of two nursing homes. The other nursing home in our county recently downsized from 66 beds to 50 beds. Spooner Health System is a not for profit corporation and provides many services to our community that are not otherwise available. I will say more about that later.

Spooner Health System is governed by a Board of Directors consisting of members from the Spooner area. The residents of the Spooner area have been fortunate to have a Board of Directors that is committed to providing necessary health services,

even if the individual service loses money. And over the years we have offered many services such as hospice, chemotherapy, home health care, and nursing home services that are traditionally money losers. However, due to reimbursement issues, they are now going to be faced with the daunting task of deciding which services we can no longer offer, in order to be able to continue to provide other services to our area residents.

As a system, the hospital and nursing home share many of the same departments and services. Dietary, laundry, housekeeping, maintenance, laboratory and x-ray personnel to name a few provide services in both areas. We are truly an integrated system.

As you are well aware, for many years Medical Assistance reimbursement rates have not come close to keeping up with the increased costs of caring for our nursing home residents. To illustrate this point I would like to review the changing financial picture at Spooner Health System Nursing Home during our last fiscal year. Utilities and fuel increased by approximately 43%. Employee benefits increased by approximately 23%. This was driven by a 40+ % increase in our health insurance premiums. Overall our costs increased by nearly 16%, with over 1/3 of this increase caused by utilities and employee benefits alone.

To make matters worse we received virtually no increase in Medical Assistance reimbursement. During that year, 74% of our resident days were covered by Medical assistance. As a result we were forced to cost shift these expenses to our private pay nursing home residents, and to our hospital patients. This is a practice that can no longer continue. In our last fiscal year we were reimbursed by the state government nearly $1.1 million less than it cost us to provide the care to our residents covered by Medical

Assistance. This computes to a loss of $49 per day! By marking up our private pay rates and receiving somewhat better reimbursement for our Medicare residents we dropped the overall deficit in reimbursement to just over $700,000 or $22 per day.

There is one simple conclusion that can be drawn from looking at our nursing home financial data. Continuing to provide all of the services we currently provide will affect our ability to provide any services. So what are the options that we have?

The most obvious, and most painful will be to start systematically closing nursing home beds. It is the decision that will most directly and dramatically stop the losses incurred due to very inadequate reimbursement. But who will suffer from this decision? It will be those who most need our services. We have run at or near capacity for the past year, as has the other nursing home in our county. We have a waiting list of 62 people. All but 28 of those on the list would come into our nursing home today if the beds were available. The other 28 want to secure their place on the list due to the reputation our county has for difficulty in getting a nursing home bed. We have averaged 2.35 patients per month from our hospital that have been placed in nursing homes in other counties due to the lack of beds at our nursing home. This causes stress and hardships on these residents and their families who must now travel to see them.

Another option will be to discontinue providing other non-nursing home services to our area residents. We can consider dropping our financial support for hospice, which would leave no option for hospice services in much of our service area. We could do the same with home health care. We can also consider dropping our chemotherapy services, which would require patients to drive up to 80 miles for this service. These services are

all very valuable to our area residents, and all in danger of being discontinued if we hope to keep our nursing home services.

What other potential ramifications exist for Spooner Health System? The biggest is the financial affect the nursing home loss will have on our ability to provide our core hospital services to area residents. The largest area of concern is in the emergency services department. We are on a pace to see 6,000 emergency room visits this year, in an area that is designed to accommodate approximately 4500 visits. In addition to this we have numerous outpatient specialists who hold their clinics in this space, and perform other outpatient services here as well. We are in desperate need for additional space, and have a Facility Master Plan in place to address these needs. Mounting nursing home losses will affect our ability to undertake the capital project necessary to address the most critical service we offer.

I recognize that the state government is looking towards an expansion of Family Care to save money. It is my understanding that there are those that feel that many of the state residents who currently reside in nursing homes can more cost effectively be cared for in their homes with supportive services. I support the idea of allowing our seniors to live in the least restrictive environment. It is a goal we have every time we discharge a patient from our hospital. We also strive to discharge any nursing home resident to a less restrictive environment whenever it is safe to do so. However, we see very few of these types of residents in our nursing home. In fact in our last fiscal year 96.1% of our residents were classified as Skilled or Intensive Skilled.

The level of care that our residents require increases each year. We now regularly see residents who require tube feedings and intravenous fluids. We see an increasing

number of demented residents, and an increase in those with behavior issues. Providing care for these types of residents has become much more labor intensive. Yet we have seen a decrease in the number of falls that occur in our nursing home and a decrease in behaviors that affect other residents. We have accomplished this by providing excellent, high quality and compassionate care to our residents. It is the care our elderly deserve and will receive at Spooner Health System. And our ability to continue to provide quality care is in immediate jeopardy due to a badly broken payment system at the state level.

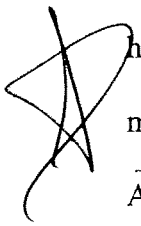
I have spent most of my time to this point talking about the affects inadequate reimbursement is having on our ability to provide services. I would like to switch gears for a moment, and talk about other effects it has on our community. Historically low reimbursement from government providers has forced health care providers to cost shift to other payers. It has created a "Hidden Tax" on all other purchasers of health care. This is most evidenced by the increase in health insurance premiums, which hits us as an employer as well. Individuals and small businesses in our area can no longer afford to provide health insurance for their employees. So these people end up either uninsured or on a program such as Badgercare. And the crisis worsens as once again providers get paid under their costs, for an increasing number of patients. So what does the state do to deal with this situation? They look at expanding programs such as Badgercare and sticking it to the other purchasers of health care even worse than we do now. It is a cycle that must end, and the state government needs to recognize this, and take the lead.

I just recently learned that DHFS has proposed a Badgercare Plus program in their budget. This would once again expand the number of people enrolled in a state program, for which healthcare providers are reimbursed at less than their costs. But that is not the

end of this story. This time DHFS proposes that higher co-payments be included in the plan. For instance those covered under Badgercare Plus would be required to pay a $75 co-pay for emergency room services. Does anyone at DHFS really believe people will pay this? We cannot collect the $3 co-pay that currently exists in the program. And we have difficulty collecting co-pays from commercial insurance as well. The $75 co-pay will become bad debt, and once again lessen reimbursement to the providers. This simply becomes another in a long line of reimbursement cuts for providers.

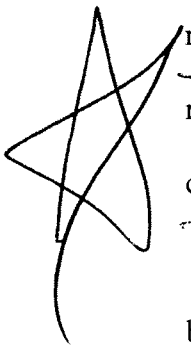
While I digressed from long-term care for a moment, I feel it was important, because at Spooner Health System all of our services are intertwined. This is true in most small communities. Decisions cannot be made keeping only one service in mind. I only wish it were that easy. But the reality we currently face is that inadequate nursing home reimbursement is creating a crisis at Spooner Health System. And talking with my colleagues around the state I recognize that this is statewide. We are being forced to pick and choose the services we offer, based on what we are getting paid, rather than where the greatest need is.

It should not be this way. Our seniors deserve better. They deserve access to high quality care in nursing homes. They do not deserve to be sent to nursing homes miles away from where they lived their entire lives to spend their final months or days. Are our seniors not worth the necessary investment needed to keep them close to home, receiving high quality and compassionate care?



In closing I would like to reiterate that Spooner Health System has some difficult choices to make. Ultimately we have to follow the ethical principal of Stewardship of Resources. We have to decide where both our human and financial resources are best

spent, to derive the greatest benefit possible. It saddens me to think that we may be closing needed nursing home beds, in order to continue to provide other services. It makes me angry that this situation is perpetuated by the fact that the state government has not lived up to the responsibility that they have taken to provide payment for long term care for our elderly who have no other payer source.



Thank you for allowing me the time to testify on this important matter. I would be happy to answer any questions you might have.