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June 14, 2005

Mr. David Riemer
Project Director
Wisconsin Health Project
2821 N. 4th Street, Suite 211
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RE: An Interim Report on the Wisconsin Health Project

Dear Mr. Riemer:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

David J. Ward

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

The Wisconsin Health Project

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

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

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

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

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

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

Ms. Ellinger has a B.S. in Journalism and Political Science from UW-Madison and a Masters Degree from the UW-Madison LaFollette School of Public Affairs.

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Bi-partisan Team Unveils the "Wisconsin Health Plan"

Reps. Curt Gielow and Jon Richards Propose Plan to Lower Health Care Costs and Expand Access

Madison – Today, Rep. Curt Gielow (R-Mequon) and Rep. Jon Richards (D-Milwaukee) announced a health care reform initiative which seeks to address Wisconsin's "triple crisis" in health care: the skyrocketing cost of health care, increasing numbers of uninsured, and the ever-present deficit in the state's Medicaid program. If adopted, the plan could free up nearly $1 billion in state revenues over the biennium for tax cuts and other needed investments.

David Riemer, Director of the Wisconsin Health Project, outlined the details of the reform proposal before the Assembly Medicaid Reform Committee this morning.

"The Medicaid program is suffering from a mammoth, recurring structural deficit because costs and caseloads are rising much faster than state revenues," said Rep. Gielow, chair of the Assembly Medicaid Reform Committee. "The state has relied on short-term fixes to get by thus far, but the severity of the situation continues to undermine our other state priorities. This proposal aims to relieve pressures on the state budget stemming from the Medicaid and BadgerCare programs."

"Each year, up to 500,000 Wisconsinites have no insurance coverage and the number is increasing," said Rep. Richards. "Wisconsin has historically been a national leader in this area, but one-half million uninsured residents is simply unacceptable. Under this proposal, all Wisconsinites under age 65 will be covered."

Wisconsin employers now spend an average of **15%** of payroll for the health care premiums of their employees. "Wisconsin employers are experiencing double-digit percent increases in the cost of health care each year," said Gielow. "The result is an adverse economic effect on wages, profits, job creation, and new investment in Wisconsin."

"This proposal replicates the successful experience the state employment system has had in controlling its health care costs," said Richards. "Our plan will allow all state residents to buy health insurance as we do in the state employee plan."

The "Wisconsin Health Plan" proposes a new way to pay for health care in Wisconsin. The new proposal has three simple components:

- All Wisconsin employers pay a **fair assessment**;
- All Wisconsin residents (under age 65) own a **Health Insurance Purchasing Account;**
- All participants have an **annual choice** of health care plans and providers.

Through the creation of an effective purchasing pool and "consumer driven" incentives, the proposal aims to promote health care quality and use market forces to drive down health care costs. The details of the plan are outlined in the attached "Concept Paper."

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Op-ed on The Wisconsin Health Plan
By Rep. Curt Gielow and Rep. Jon Richards
June 17, 2005

For more information contact:
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This week we announced a bipartisan health care reform initiative which seeks to address Wisconsin's "triple crisis" in health care: the skyrocketing cost of health care, increasing numbers of uninsured, and the ever-present deficit in the state's Medicaid program. If adopted, the plan would eliminate nearly $500 million in state spending every year. This money could used for tax cuts or other needed investments.

To describe the situation as a "crisis" may seem extreme to some. But in our opinion, the situation has reached that level.

We introduced the Wisconsin Health Plan because we wanted to encourage a genuine, thoughtful public debate about how we should address the health care crisis in our state. In our role as legislators, we have heard from all sides of the problem that the current system is not working, and is not sustainable.

Labor unions tell us that health care costs are so out of control that it is impossible for them to negotiate for salary increases.

Employers tell us that they cannot afford to maintain benefits, cannot afford to add employees or expand their businesses, and cannot compete in the world market due to the never-ending increases in their employees' health insurance premiums.

Small businesses who want to provide health insurance either cannot afford it, or are hit harder than most by these costs. Their minimal negotiating power makes it difficult to find a "deal" on health care, and they are always one sick employee or one accident away from having their coverage cancelled.

The self-employed and farmers are much in the same boat; telling us that they are either "uninsurable," or only have access to coverage that is unaffordable.

Local government and school boards are seeing the same increases as every other employer, and the cost of providing that coverage gets passed along to all of us in higher taxes.

Each year, up to 500,000 (one half million) Wisconsinites have no insurance coverage and the number is increasing. Costs and caseloads are rising in the state's Medicaid program as well. The recurring structural deficit in that program is undermining our other state priorities and will only get worse if we do nothing.

The basic aim of our plan is to allow **all** state residents to buy health insurance the same way we do as state legislators. The "Wisconsin Health Plan" has three simple components:

- All Wisconsin employers pay a **fair assessment** -- an assessment with statutory caps on the amount paid, which will be a cap on their health care costs;
- All Wisconsin residents (under age 65) own a **Health Insurance Purchasing Account;**
- All participants have an **annual choice** of private health care plans and providers.

Much of our proposal is based on the state employee plan, because that program has been so successful in controlling its health care costs at a time when nobody else seems to have found a good solution to the problem.

By creating this large purchasing pool, and using "consumer driven" incentives to encourage people to use their coverage wisely and appropriately, the proposal aims to promote health care quality and use market forces to drive down health care costs. Coverage under the plan would be completely portable for participants.

Finally, a word about what this plan is not. This is not socialized medicine. The virtue of this plan is that it leaves in place our first-rate system of health care providers. Participants would be able to choose coverage from a menu of care providers -- including their current physician -- who are already operating in the state. This preserves consumer choice and preserves competition in the medical service industry -- things socialized medicine can never do.

As we said earlier in this column, we brought this plan forward to initiate a discussion about what government should or should not do to address the issue. We consider our proposal a starting point; it is not written in stone.

Finding reasonable solutions to such a complex problem is going to require patience, open mindedness, and a willingness to move forward in the spirit of compromise. We invite our colleagues, business and labor leaders, the insurance industry, health care providers, and the people of Wisconsin to join us on our quest to find a solution.

A brief but detailed description of the plan is available at: www.wisconsinhealthplan.org