

AFFORDABLE HEALTH CARE FORUM -- APRIL 6 2006 -- EDGEWOOD COLLEGE

Hosts: Progressive Dane and the Edgewood College Human Issues Program

Co-Sponsors: The Democratic Party of Dane County, the Four Lakes Green Party, the League of Women Voters, the South Central Federation of Labor, and the UW-Madison Center for Patient Partnerships

Summary of Plans*

	Wisconsin Health Care for All ("Provide or Pay" Plan) www.wisconsinhealthcareforall.org	Wisconsin Health Security Act (Coalition for Wisconsin Health - Single-payer Plan) www.wisconsinhealth.org/wiplan.html	Wisconsin Health Care Plan (AFL-CIO Plan) www.wisaficio.org	Wisconsin Health Plan (Wisconsin Health Project) www.wisconsinhealthproject.org/plan/index.htm
How would the plan be authorized?	Local ordinance. This plan is proposed for the City of Madison, but other cities or neighboring municipalities could join this plan or enact a similar one.	State law (currently introduced by Sen. Mark Millder (D-Monona) and others as SB388 and by Rep. Charles Benedict (D-Beloit) and others as AB807)	State law	State law (currently introduced by Rep. Curt Gielow (R-Mequon) and Rep. Jon Richards (D-Milwaukee), as AB1140). This bill does not include the financing mechanism)
Who would be covered?	All city residents who are not already covered by an employer plan, or by a government plan such as Badgercare, Medicare, Medicaid, or Seniorcare, would be required to have this coverage.	All Wisconsin residents regardless of age, including those currently covered by Medicare or another government program.	All employees of Wisconsin employers, and their dependents. Unemployed, self-employed, and early retirees could buy in at cost.	Most Wisconsin residents under age 65 (Badgercare and Medicaid clients are intended to be phased in at a future date). A 6-month waiting period applies to new residents.
What kind of policy would be provided?	You would have comprehensive coverage for medically necessary services, including preventive services, in-patient and out-patient treatment, and prescription drugs.	You would be able to receive all medical services necessary for maintaining health or for diagnosis or treatment or rehabilitation following an injury, disability or disease, including prescription drugs and long term care, without premiums or co-pays.	The plan would provide comprehensive coverage including all medically necessary services (including drug and alcohol treatment and mental health parity) and prescription drugs.	The plan would offer basic preventative services at no out-of-pocket cost. Adults would receive a comprehensive high-deductible policy for other services, plus a \$500/year Health Savings Account to help meet the deductibles. Children would have a very low deductible (\$100) and out-of-pocket maximum (\$500).
How does the funding work?	The administrator would collect premiums and employer fees and pay claims. If revenues were insufficient to pay all claims, benefits and/or premiums and fees would have to be adjusted.	Employer and employee taxes, federal funds, and other revenues now spent on health care, would be funneled into a Health Care Trust Fund. The Department of Health Planning and Finance would negotiate with providers for payment rates for services and prescription drugs; hospitals would be granted a global annual budget. Providers would be paid from the Trust Fund. No individual billing would be permitted.	The administrator would collect employer fees and pay claims. Individuals help to fund the plan through co-pays and deductibles.	The Department of Revenue would collect employer and employee fees and transmit them to the private Health Insurance Purchasing Corporation. The Corporation, through its administrator, would pay premiums to the insurance companies selected by participants. Individuals would pay co-pays and deductibles. The insurance companies would bear the risk for providing care in return for premiums. However, if premium revenues proved to be insufficient, benefits and/or assessments would have to be adjusted.

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Who would decide what the insurance covers?	The city would design the specifics of the plan.	The proposed legislation specifically requires that all necessary services be covered. The Health Policy Board, with the recommendations of the six regional health councils, will decide the necessary coverage, i.e. there is public direction and accountability.	A Labor-Management Commission established by law, within broad parameters setting minimum requirements established in legislation.	A private, non-profit Health Insurance Purchasing Corporation consisting of representatives from business, labor, a farm organization, and two gubernatorial appointees would provide overall leadership. Insurance companies could propose policies designed to meet requirements.
Who would administer the policy?	An administrator—probably an existing insurance company—will be selected by the city.	A state agency, the Department of Health Planning and Finance, under the direction of the Health Policy Board, would oversee the plan.	An administrator—probably an existing insurance company—will be selected by the Labor-Management Commission to pay re-imburements for services, cost of prescription drugs, etc.	You select your insurance company from among those that apply and are accepted by the Health Insurance Purchasing Corporation.
Would I be able to choose my own doctor?	Yes.	Yes. Doctors would be allowed to practice independently or within provider groups as they do now. You could seek treatment from any provider. The plan would pay the provider for services rendered.	You are free to choose your primary care provider. There would be an additional copay for specialists you visit without referral by your primary care provider.	Yes, within the network (if any) offered by the insurance company you select.
What would the insurance cost me?	You would pay a premium based on a sliding scale. People who earn less than 350% of the federal poverty level would pay no more than 3% of income for single coverage or 6% for family coverage. People with higher incomes would pay the full cost of the premium as actuarially determined. This should be less than an individual private or employer-provided policy would cost. The plan could, but is not required to, charge co-pays and deductibles.	No premiums or co-pays would be charged and no billing for services would be allowed. All residents would pay a health care tax. 95% of families would pay less than they do now for health care.	Employees would pay a co-pay for certain services and prescription drugs, plus an annual deductible, estimated at \$300 for single and \$600 for family coverage.	-Each employee would pay 2% of his/her social security wages. -Individuals would select one of the competing insurance policies. All policies would offer the same benefit package, but would be classified as Tier 1, 2, or 3 based on efficiency and quality. Tier 1 policies would be available at no additional charge. Tier 2 and 3 policies would require some premium to be paid by the individual. -Each insured would pay deductibles and co-pays capped at \$500 for children, \$2,000 for single adults or \$3,000 for families. -Each adult would receive a \$500 Health Savings Account which could be used to cover the first \$500 in deductibles and co-pays.

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What would my employer pay?	Employers who do not offer health insurance at least as good as the city plan would be charged a service fee of 4.5% - 8% of wages. This money would help to fund the plan. Employers who already offer a comparable health plan would not be affected	Employers would pay a health care tax, designed to raise the same revenue that is now spent by employers on health care but with the total spread among all employers.	All Wisconsin employers would pay a monthly per-employee assessment, estimated to be less than \$300 per month (based on 2003 costs)	Each employer would pay a percentage of its total social security wages: 3% if wages are \$50,000 or less, increasing to up to 12% for wages up to \$500,000 or more.
What if my employer already provides a better policy?	You would not be affected if you have adequate coverage through an employer.	Existing plans would be replaced by the single payer plan. You (or your employer) could purchase extra insurance to cover any services not included in the single payer plan, such as some cosmetic surgery.	Existing plans would be replaced by the new plan. Your employer can provide additional benefits over and above the new plan benefits, deductibles, or co-pays.	Employers can choose to keep the old plan, but they would have a strong economic incentive to adopt the new plan. Your employer can provide additional benefits over and above the basic plan to bring the total package back to the previous level.
Would the plan require more taxes?	No, the plan is designed to be self-supporting.	It would require new taxes, but these are designed to be less than the amount individuals and businesses now spend on premiums, deductibles, and co-pays.	No. Potentially, state government could choose to fund the cost of coverage for those not included through employment or buy-in. However, this cost is estimated to be less than our current spending for Medicaid.	No, the employer and employee assessments and the employee's co-pays and deductibles are intended to cover all plan costs.
Would the plan save money? How?	Currently, medical services provided to the uninsured drive up the costs charged to the insured. This plan would reduce such cost-shifting. Premiums and employer fees would be less than most individuals and employers now pay for health insurance, and more people would be covered.	The plan would save money by eliminating the excessive overhead in our current inefficient system of multiple payers and investor profits. That overhead is about 31% of total health care costs and would be diminished to 16% by the savings in our plan. There would be regional planning for technical equipment, hospital building, etc.	The plan would substantially reduce administrative costs by providing standard benefits and co-pays, eliminating the need for eligibility screening, and negotiating lower prices for prescription drugs. It would also reduce catastrophic costs by providing better preventive care.	Competing policies would strive for better quality and efficiency in order to become Tier 1 policies. The relatively high deductibles and co-pays would encourage consumers to shop carefully for medical services. In addition, the state would save \$500 million per year that it now spends on "family" Medicaid and Badgercare. This sum would be paid from Wisconsin Health Plan assessments instead.

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How would the plan affect Insurance companies?	No immediate effect, since existing plans would not be changed.	They could offer policies to cover cosmetic surgery, and other non-essential services, but would otherwise not cover health insurance.	They could offer policies to cover supplemental benefits and Medigap policies, and could complete to provide administrative services to the new plan, but their role would be substantially reduced.	Insurance companies would continue to offer policies but the variety of policies would be reduced since most Wisconsin residents under age 65 would have a uniform benefits package. Companies could offer supplemental policies and Medigap policies. They would have incentives to make their providers and administrative services more efficient.
How would the plan affect hospitals?	No immediate effect. The plan could negotiate discounts for hospital services for its enrollees as insurance companies do now.	Hospitals would receive a negotiated annual operating budget and a separate capital budget. There will be regional planning to assure availability of needed hospital services and to prevent duplication of these services	No immediate effect. The plan could negotiate discounts for hospital services for its enrollees as insurance companies do now.	No immediate effect. Insurance companies would continue to negotiate discounts for hospital services for their enrollees as they do now.

*Prepared by Progressive Dane. The presenters are not responsible for this information.