Coalition for Sensible Health Care Solutions
September, 2007

All Wisconsinites deserve a health care system that delivers both world-class care and financial security. They deserve a system that is accessible, affordable and fair. Wisconsinites deserve a system that boosts the state's economy, attracts new businesses and strengthens existing enterprises. At the same time, all Wisconsinites share in the responsibility to be better stewards of their own health. We can only do so much as a single state; but what we *can* do, we *should* do.

The Coalition for Sensible Health Care Solutions is made up of four major agent associations in Wisconsin, representing health insurance counselors, agents, brokers and other professionals. The four associations include the Independent Insurance Agents of Wisconsin (IIAW), the National Association of Insurance and Financial Advisors - Wisconsin (NAIFA), the Professional Insurance Agents of Wisconsin (PIA) and the Wisconsin Association of Health Underwriters (WAHU). We occupy a unique place in the health care coverage system, working to connect Wisconsinites with the best possible coverage from health insurance providers. We see firsthand what's working and what's not. We educate consumers on their health care coverage choices, help them select the most appropriate plans for their specific needs and serve as their advocate if problems arise.

As Wisconsinites and as insurance professionals, we want a stronger, more effective health care coverage system. We applaud governmental leaders and others who have put forward comprehensive reform proposals – even when we disagree with their suggested solutions. This document provides a yardstick against which these solutions can be measured and offers a reform package we believe is a "sensible solution" for the health care challenges facing Wisconsin.

Requirements of Reform
As the Governor and State lawmakers move forward in efforts to reform Wisconsin's health care system, the Coalition is putting forward its "*Sensible Health Care Solutions*" package of reforms and principles that we strongly believe should be used as guidelines for any and all reform proposals.

► We believe reform must address and reduce skyrocketing medical care costs.

► We believe any reform package must ensure that all Wisconsinites have access to basic health care coverage.

►We believe reform must neither bankrupt families nor the state.

►We believe reform must provide the state's diverse population with equally diverse health care coverage choices.

►We believe reform must promote ongoing and long-term innovation and experimentation that enables the state's health care system to adapt over time to the evolving needs of its citizens.

►We believe reform must provide consumers access to meaningful information and expert advice and counseling from licensed and trained professionals.

The Six Indicators of a Sensible Health Care Solutions plan are:

1. Affordability
    - Can the state afford the plan?
    - Can the people of Wisconsin afford the plan?
2. Universal Participation
    - Does it offer every Wisconsinite access to basic affordable health care coverage?
3. Health Care Cost Containment
    - Does it address the cost of health care?
4. Consumer Choice
    - Does it empower Wisconsinites to find and choose the health care coverage that best fits their unique needs?
5. Evolving Needs
    - Does it enable health care coverage to evolve with changes to the state's population, their needs and expectations?
6. Insuring Freedom
    - Does it guarantee that health care and the coverage for such care can be purchased in the private market?

Proper Identification and Understanding of the Problem

The failure of any reform plan will most likely be the failure to understand the problem the plan is addressing. While Wisconsin has done a tremendous job in assuring access to insurance, the fact is that true accessibility to health care and health care coverage is dependent upon whether it is affordable.

According to the Centers for Medicaid and Medicare Services (CMS), 12 cents out of every insurance dollar goes towards the administrative costs of insurance (all insurance company expenses, profits, premium taxes, reserves, etc).[1]

This estimate by CMS if further evidenced in a study highlighted in the New England Journal of Medicine that reviewed the costs of health care administration in the United States and Canada. In that study, it found that the overhead of private insurers in the United States was 11.7%, nearly identical to the 12% estimate by CMS. [2] With 12 cents going to pay for administration costs, this means the vast majority of insurance premiums (88 cents out of every insurance dollar) are going directly to pay for health care services.

Since 2000, health care inflation averaged 12% each year, compared to increases in the Consumer Price Index at 2.7% for this same time period and US Household Income at 3.7%. [3] The problem any reform plan must address is the cost of health care services. There are a myriad of reasons for the high cost of health care, but health care and economic experts have clearly identified one underlying problem – the absence of any real health care consumers.

Wisconsinites are consistently using health care services more often with less concern for the actual cost of the services provided. This of course has added to the dramatic increase in the cost of the insurance programs that directly pay for these services. In 1960, 48 percent of health care expenses were directly paid by the patient. By 2003 the percentage had fallen to 13 percent with third party payers paying the remaining 87 percent of a participant's medical care expenses.[4]

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[1] Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group

[2] New England Journal of Medicine, Costs of Health Care Administration in the United States and Canada, Department of Medicine, Cambridge Hospital and Harvard Medical School, Cambridge, Mass.

[3] 2005 study by Hewitt Associates, LLC

[4] Blue Cross, Blue Shield of Minnesota, AwareCare premium rates, April 1, 2006 - May 31, 2007

In a report prepared by PricewaterhouseCoopers on behalf of America's Health Insurance Plans entitled *The Factors Fueling Rising Healthcare Costs 2006*, "higher utilization of services accounted for 43 percent of the increase, fueled by factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles."

Goals of a Sensible Health Care Solution
While much of our reform is geared toward the number one goal of controlling health care costs, we also believe we can make improvements to the insurance that finances health care.

These reforms will address separately, or in combination, the following items:

■Access to Health Care
■Access to Health Insurance
■Health Care Affordability
■Health Insurance Affordability

It is important to understand that any successful reform plan requires the effort of the private market and of government. We see the role of government as a supporting one – working with the private market to help it get control over the cost of health care. In some instances we see government using sticks or carrots to help the market control health care costs. In other instances we see government simply getting out of the way to let the market work.

The Coalition's Sensible Health Care Solutions Plan:

1. Returning to the Fundamental Principal of Insurance – Protection against large catastrophic loses.

Issues Addressed – Access to Health Care, Access to Health Insurance, Health Care Affordability, Health Insurance Affordability

Consumer Directed Health Care names continue to evolve but the design and premise of the plans are the same – *a design that has traditional cost sharing arrangements with insureds.*

Insurance is a simple concept. It is "a policy that indemnifies an insured from catastrophic loss against known perils." If insurance is to work, it must follow this concept and these new plans attempt to do just that. Typical insurance policies should provide protection against catastrophic financial loss. A doctor visit or a prescription should not be paid 100% by a third party payer or insurance policy nor does the $25.00 office co-pay represent the cost of that visit. Instead, if you develop cancer, you should be protected from a $100,000 hospital bill or a $75,000 physician bill. Insurance providers have found that simply cost shifting to the insured is not the answer, unless it engages the end user by providing choice information and consequences. These plans use the typical comprehensive major medical design up front through the use of a deductible. After the deductible, then the insurance policy is financially responsible, all the way up to the contract maximums which normally provide millions of dollars of financial protection. This is, by its very definition, comprehensive and catastrophic health care coverage.

With insureds now responsible for their initial cost of basic health care services, there is now a sense of concern over the cost and quality of services being purchased. As with any industry, when the consumer becomes concerned with cost and quality, so will the producer of that product or service. In the case of the health care industry, as consumers return to the market, providers will now be focused on the cost and quality of health care services they provide**.** If the business decisions of providers had to follow free market processes, it would control the over One Billion

dollars of new healthcare facility construction currently in Southeastern Wisconsin; and might prevent healthcare providers from building new hospitals in communities that have only 50% bed occupancy. While the private market is making strides, government can promote change in several areas.

Introduce Comprehensive Major Medical Insurance Plans into the Public Sector
Government has a direct role in helping move the market to true insurance policies as it relates to public sector health plans. With the private market moving toward consumer driven health care, it is important that the public market follow suit. A high deductible plan featuring an HSA should be priced following the Employee Trust Fund (ETF) process for government employees currently in place for both price and quality. This plan, offered by any carrier, should be offered to all state employees, municipalities and any other eligible ETF group.

HSA Tax Deductibility
Health Savings Accounts (HSA) are just one of the many plans that are true insurance policies that provide for the expectation of cost sharing combined with the security of catastrophic coverage. A comprehensive, catastrophic health insurance policy is purchased and because these policies are less expensive than typical first dollar health plans, the savings is put into an account where the policy holder can then use that money to help pay for the health care costs they are responsible for (this is the employee's cost sharing arrangement). These accounts are tax deductible on federal taxes, but Wisconsin is just about the only state that doesn't provide the same treatment relative to state taxes.

Health Insurance Premium Tax Deductibility
For the most part, the private market has done a good job of ensuring that the portion of the premium paid by employees is tax deductible to the employee. Roughly 50% of all employers have implemented a Section 125 plan. This section of the IRS Code allows employees to use before tax dollars to purchase certain health care related items, including premiums.

The State too has done a good job in trying to make premiums deductible for those who are not covered by a group plan. In Act 25 (the 2005-07 Budget), the State increased from 50% to 100% the amount of health insurance premiums that are deductible for employees whose employer doesn't pay anything toward health insurance. It also created a deduction (phased-in over time, to 100% in 2009) for people who aren't employed and don't have self-employment income. The Governor included a provision in his budget that would make health insurance premiums for all employees covered under their group plan tax deductible. In addition, there are legislative proposals being considered that would essentially do the same thing. While we support the Governor's budget provision and the legislative proposals that attempt to make these premium contributions tax deductible, we believe expanding Section 125 plans would be more valuable to Wisconsin consumers, as through a Section 125 plan, <u>both state and federal taxes are deductible</u>. Unfortunately, the Governor's and other legislative proposals would only allow state taxes to be deductible. We believe the State should provide private sector employers with tax incentives to implement Section 125 plans.

2. Covering the Uninsured – Moving Beyond Medicaid

<u>Issues Addressed</u> – Access to Health Care, Access to Health Insurance, Health Care Affordability, Health Insurance Affordability

Understanding who the uninsured are in Wisconsin is extremely important in coming up with a solution to provide them coverage. Responsible health care reform must recognize that the uninsured are as diverse as the state's overall population. They face different circumstances and challenges and they need health care coverage that addresses those differing needs.

In 2002 in Wisconsin:

- 409,000 residents were uninsured at any given point during that year
- 153,000 residents actually qualified for government programs but did not enroll
- 131,000 had incomes of over $50,000
- 51,000 were uninsured for a short time as they were either in between jobs or recent college graduates
- There were actually 73,000 long term uninsured residents in Wisconsin

In 2005 in Wisconsin:

- 272,000 Wisconsin residents between the ages of 0 to 64 were uninsured for the entire year
- Adults were by far the largest group of uninsured representing 238,000, while 34,000 children were uninsured during this same time
- Of the 238,000 adults, 65,000 worked for large employers (51 or more employees)
- 92,000 worked for small employers (50 employees or less)[5]
    - According to the Kaiser Family Foundation in its annual survey of health benefits, 96 percent of large firms offer health insurance

While the US Census Bureau admittingly has reported higher than actual uninsured numbers since 1995, according to even their latest study on the uninsured:

- 38% of the uninsured had household incomes of over $50,000 (with nearly 20% of all uninsured having incomes over $75,000)
- 40% of the uninsured are between the ages of 18 and 34

According to a study published last year by researchers at the Johns Hopkins Bloomberg School of Public Health and the Urban Institute

- 74% of uninsured children are eligible for some government health program but have not been signed up[7]

It would seem that some 62,000 uninsured have been offered coverage through their employer, but declined. For all 272,000 residents, there are specific reasons why they went uncovered – financial reasons, access to Medicaid, young and invincible to name a few. Recent reforms attempt to solve the problem of this group of uninsured by expanding Medicaid and by requiring residents to purchase coverage if they can afford to (Individual Mandate). We believe mandating coverage is problematic and we offer a solution[8] that provides Wisconsinites with the freedom to choose what's best for them.

Insufficient Provider Reimbursements

With Medicaid reimbursements rates at roughly 40 cents on the dollar, providers must cost shift this shortfall to the private sector. Each time rates go up in the private sector, more people become uninsured. An expansion of Medicaid and BadgerCare simply exacerbates the problem of cost shifting to the private sector, and therefore increases the uninsured population.
This leads to:

[5] Healthy Wisconsin Council Report, December, 2006

[8] please see WAHU's white paper on Individual Mandate

Private Sector Crowd Out
When an individual has the opportunity to either enroll in BadgerCare or remain covered in the private sector, they will likely choose BadgerCare as there is little or no cost sharing arrangement in BadgerCare and there is also no requirement to contribute any portion of the BadgerCare premium. This is known as private sector crowd out by requiring no cost sharing arrangements with these recipients. This leads to the rising cost of health care. In addition, since the private market is moving to Consumer Directed Healthcare when the working poor no longer remain poor, it creates an unrealistic expectation of what health care coverage is supposed to be.

There are literally thousands of Wisconsin workers who have chosen to be covered in our Medicaid system, instead of employer sponsored health coverage, where employers financially contribute to the cost of the premium. The state is literally subsidizing millions of dollars that might otherwise be paid for by employers willing to contribute to their employees' health insurance.

Bureaucracy and Confusing to Enrollees
In a review of our current Medicaid and BadgerCare programs, it was determined that there were thousands of uninsured who actually qualified for these programs but never signed up for them. It was determined that part of the problem was that it was difficult and confusing for individuals to enroll and even more difficult to find someone to help determine if they qualified and what their options were.

Our solution is an alternative to the existing system for the legislature to consider for appropriate portions of the Medicaid and BadgerCare populations. This solution would be a three pronged approach:

Create Health Coverage Accounts for Appropriate Portions of the Medicaid and Badger Care Populations
While the goal of BadgerCare is to help the working poor afford health care coverage until they no longer need the help, government should look to work with private employers who offer their employees health coverage to access the plan. For the majority of Medicaid and BadgerCare eligibles, the state should create Health Coverage Accounts (HCA) which are individual accounts for the recipients of Medicaid and BadgerCare. The purpose of these accounts is to help Medicaid and BadgerCare recipients afford basic health care coverage.

Private Market Coverage Using HCA's for Appropriate Portions of the Medicaid and Badger Care Populations
If Medicaid and BadgerCare recipients could purchase their health care coverage through the private market, it would completely eliminate Private Market Crowd Out, Insufficient Provider Reimbursements (thereby eliminating cost shifting to the private sector) and would offer these recipients the same health care afforded those in the private sector.

We believe in the goal of helping those who cannot afford coverage with the financial assistance to purchase such coverage. However, we do not believe it is beneficial for these individuals to be shielded from the realities and experiences of our health care and health care coverage marketplace.

We suggest that the State should submit a waiver request to the Department of Health and Human Services so that existing and future Medicaid matching dollars from the federal government could be used to fund a recipient's HCA and allow these individuals to use their HCA to purchase health care coverage in the private market. In addition, these funds could also be used to pay any health

care related expenses that might not be covered by the private market plan the recipient purchases due to any deductibles or other cost sharing arrangements of the plan.

For those that are working and are offered coverage through their employer, these funds could be used for the employee's portion of their premium contribution to an employer sponsored plan. For those not eligible for an employer sponsored health insurance plan, the dollars in the HCA could be used to purchase an individual health insurance policy from the private market.

In addition, the state could set up a cost sharing arrangement with these recipients that is based upon family income. A sliding scale should be implemented that helps finance health care coverage for those at certain percentages of the federal poverty level. In order to do this, the Office of Commissioner of Insurance (OCI) should report to the state each year on the average premium of the lowest high deductible health plan allowed by the federal government for the purchase of an HSA. This average premium would then be used to determine the amount of financial help that recipients could receive in their HCA. For those under the federal poverty level, 120% of the average premium would be provided to the recipient's HCA. This could be used to purchase a high deductible plan, leaving additional dollars in their HCA to help fund some of the deductible, or to purchase a plan with less out of pocket expenses requiring higher premiums than those found in HSA plans.

Funding for Premium

Household Income	Percent of Average Premium Subsidized
Under 100% of FPL	120%
101-125% of FPL	110%
126-150% of FPL	100%
151-175% of FPL	90%
176-200% of FPL	70%

Public/Private Partnership for Appropriate Portions of the Medicaid and Badger Care Populations

Someone who is currently uninsured will determine what programs they qualify for and which plan is best for them using the same resources the private sector uses to make such decisions - an insurance advisor.

A Public/Private Partnership should be implemented between the State and Coalition association members. The Coalition would be responsible for training insurance agents in this new program and would make available the list of insurance advisors who have agreed to help this population of people find coverage in the private market. The advisor would be in the field, a face the recipient could see and talk to, rather than a state worker on the telephone. The advisor would help the individual determine what options were best suited for them.

If using the HCA in the employer sponsored plan made sense, then the agent would complete the necessary paper work on behalf of the recipient so the money in their HCA could be sent to the employer's insurance company. If the recipient had no option of an employer plan, then the agent would find the best coverage available for that specific individual in the private market, filling out the necessary paper work to have the HCA dollars be sent to the insurer of choice. Based on the funding discussed above, in some instances there would be enough money in the HCA account to pay the full monthly cost of the premium and in other instances; additional contributions might have to be made by the recipient. However, those decisions of cost and value would be made by the recipient with advice from the advisor, rather than a one size fits all approach that currently exists.

3. Expand Wellness Programs

Issues Addressed – Access to Health Care, Health Care Affordability, Health Insurance Affordability

Some of the key drivers in the increased cost of health care are unhealthy behavioral and lifestyle choices. Research shows that behavior is the most significant determinant of health status,[9] with as much as 50 percent of health care costs attributable to individual behaviors such as smoking, alcohol abuse and obesity.

According to the National Center for Health Statistics, 30 percent of adults (more than 60 million Americans) are obese and the problem is worsening. Obesity has risen by 10 percent in the past decade and the trend can now be observed among American children.[10] Other sources show that smoking is responsible for approximately 7 percent of total U.S. health care costs.[11] These behaviors lead to many serious chronic health conditions such as cancer, diabetes, heart and cardiovascular disease and consumers are seeking medical solutions for these lifestyle issues rather than practicing wellness behavior.

It is imperative all insurance plans include incentives for wellness. All Wisconsin citizens need to take responsibility for their lifestyle choices that negatively impact their health.

Remove Employer Barriers to Offering Financial Incentives
We need to create a safe-harbor for those well-meaning employers that take action to promote wellness and health activities among their employees from non-intentional discrimination by adopting regulatory changes which adopt bona fide wellness plans under recent federal Department of Labor regulations. We should encourage this behavior by employers the same way we encourage safety features such as fire sprinklers through commercial and residential real estate insurance policies. State and federal policymakers should adopt rating changes which would permit those employers who are implementing and operating wellness plans to receive premium savings for wellness plan adoption.

Encourage Wellness Plans for Private Sector Employers
We believe lawmakers should do everything possible to enable employers to provide benefit incentives and premium flexibility through legal protections and tax breaks to enable them to implement smoking, drug, alcohol and wellness programs to encourage healthy lifestyles of employees and their families.

Implement Wellness Plans for All State Employees
As the state's largest employer, the state should implement a wellness plan for all state employees and municipal employees insured through the current ETF program; including health screening for all existing employees and all new hires. There are a myriad of wellness vendors operating in the state and we should use the same bid process in finding competitive health insurance plans to find competitive wellness vendors.

Implement Wellness Plans for Medicaid Recipients
In addition to the Medicaid reforms described earlier, the state should implement a wellness plan for all Medicaid recipients including pre-screening for all existing recipients and all new recipients on an ongoing basis.

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[9] Mercer Management Journal 18; Centers for Disease Control and Prevention
[10] Employee Benefit News, "Employers tackle obesity." Centers for Disease Control & Prevention; January 2006
[11] Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report.* July 8, 1994

4. Health Information Technology

Issues Addressed – Health Care Affordability, Health Insurance Affordability

We must expand both the patient safety and cost effectiveness that health information technology provides. We need to make improvements to health information technology systems. It is estimated that improvements to IT can reduce health care costs up to 20 percent each year by saving time and reducing duplication.[12]

The Coalition is highly supportive of health IT initiatives as a way to lead to higher-quality care for American consumers by reducing errors and improving patient satisfaction. Advances in health IT will enable true collaboration between doctors and patients as consumers make more informed choices and doctors become more involved in their care. In the long run, it will also provide better information to track public health problems and advance clinical research.

Expand Health IT
The Governor and our legislature recognize the value in expanding health IT. We support the Governor's budget provision that would expand health IT in Wisconsin. In addition we support legislative proposals that provide tax incentives to encourage health IT expansion.

5. Health Care Transparency

Issues Addressed – Access to Health Care, Health Care Affordability, Health Insurance Affordability

Medical care is perhaps the only service American consumers regularly purchase without having any upfront knowledge of the actual price. Americans are very accustomed to "shopping" for the best price on goods and services. For health care to operate in the private sector, like any other industry, it must provide comparable information for consumers. When provided with the right incentives, health care patients will become savvy consumers determining what they perceive is value.

An example is the advancement of Lasik eye surgery. With typically no coverage provided for surgery to correct eye sight, this industry has not only provided advancements in technology for the service and a significant reduction in the cost of treatment, but it provides complete transparency in both cost and quality because consumers demand it.

Require DHFS to Make Data Public
Both the Department of Health and Family Services (DHFS) and the Department of Employee Trust Funds (ETF) are participating in a Public/Private Partnership relative to health care transparency. Both departments participate in the Wisconsin Health Information Organization (WHIO), which will use claims experience to track the episodes of care of patients to determine comparable cost and quality data on the providers of care. We believe DHFS should be required to make the results of this data publicly available on their website to the benefit of all Wisconsin consumers.

Move the Private Market Where Necessary
We applaud Wisconsin hospitals and their state association for their efforts to make cost and quality data available for Wisconsin consumers. While we believe there is room for improvement and advancements, this private market effort should be given the opportunity to implement those

[12] Similar to Health Wisconsin

improvements. In this instance, we urge the state to step out of the way and allow this effort to continue.

However, where a segment of the market fails to respond to consumer demand and the need for such transparency, we believe the State needs to play a role in moving the market in the right direction. Particularly, physicians have been slow to provide meaningful and easily accessible data to consumers. The State should set timelines to achieve reasonable benchmarks for the physician community to implement true transparency.

Eliminate Non-Disclosure Provisions ("Gag Clauses")
While knowing what a physician or hospital will charge for any given service, it is equally important to know what each health plan has negotiated with that physician or hospital, as many plans receive discounts in those charges. With the insured having the responsibility of cost sharing provisions, knowing what their health plan negotiated is essential.

A common contractual provision found in network provider agreements, known as a non-disclosure or gag clause, prohibits health plans and providers from disclosing the contractual discounts to the public. There is a new effort to remove these non-disclosure or gag clauses from the industry. However, to the extent that the market does not respond and allow such negotiated fees to be made available to the consumers, we believe the State should help move the market to provide this information. The State can and should demand (and if necessary regulate) from any insurance plan purchased on behalf of their public sector employees to disclose the negotiated fee with the providers the plan contracts with.

6. Expand Long Term Care Coverage

Issues Addressed – Access to Health Care, Access to Health Care Coverage

End of life services, such as long term care, make up a large part of our overall spending on health care. For many, the only alternative is to apply for Medicaid in order to afford nursing home care. However, in order to do that, you need to spend down nearly all of your assets to be eligible. This is neither economically advantageous for the patient and their family, nor does it solve the problem of obtaining coverage for such care.

Long Term Care Partnership Program
Long-Term Care Partnership programs are a public-private partnership combining private long-term care insurance (LTCi) with Medicaid. Under LTCi Partnership Programs, the state provides an incentive for consumers to purchase a *specially designated type of long term care insurance* in the private market. This special policy pays first when the insured needs long term care.
If and when the individual exhausts the benefits under the policy, the individual may become eligible for Medicaid benefits while retaining a portion of his/her assets above the amounts usually allowed by Medicaid. This is the incentive to purchase the insurance in the first instance. The amount of assets preserved is established by the program and is dependent on the amount of insurance purchased. This program has worked in the states that have implemented LTCi because many claimants never deplete their policy benefits and even if they do, they are Medicaid recipients for a much shorter period of time, saving tax payer dollars. The Coalition believes Wisconsin should implement an LTCi Partnership Program.

7. Insurance/Market Reforms

Issues Addressed – Access to Health Care, Access to Health Care Coverage, Health Insurance Affordability

Insurance market reforms do not necessarily reduce health care costs, but they can make health care coverage more accessible and more affordable.

List Bill
Opening up access to health care coverage is a key component in reducing the number of uninsured. Many small employers do not offer group insurance to their employees, as they simply cannot afford to contribute to the premium. In addition, most employers have seasonal or part time employees who are not eligible for the employer's group insurance plan. List Bill is a change in state law that would allow a small employer to use payroll deduction to pay for health insurance premiums for an employee who has purchased an individual health insurance policy. The small employer may not pay for or contribute to any part of the premium because the employee is the owner of the policy. The employer merely facilitates the payment. Currently, about 30 states allow List Bill including Illinois, Iowa, Indiana, Michigan and Ohio.

Claims Data Disclosure
The ability to purchase affordable health insurance is dependent upon the ability to receive accurate and competitive proposals from all health insurance plans. The ability for a health plan to offer an accurate and competitive health care plan is dependent upon certain data used to generate the proposal.

While we have laws and regulations that require the disclosure of general claims data to be provided upon the request of the employer, we need to expand the requirement to include shock loss claims (these are claims that are in excess of a certain dollar amount).

Working Together for Sensible Health Care Solutions
Wisconsin's health care system works for the vast majority of its citizens. Yet we can do better. Improvement will require strong leadership, a thorough debate of all proposals and ultimately, compromises and decisions. The Coalition pledges full participation in the coming debate.

Ultimately we believe the time is right for a solution which provides the opportunity for basic health care coverage to all Wisconsinites without risking their financial health or that of the state. We believe this can be accomplished without limiting the people's ability to choose the health plan which best fits their needs and assures them continued access to the services of independent – and state-licensed – counselors and advocates. The Coalition's Sensible Health Care Solutions describes a comprehensive approach to meeting this challenge and a yardstick for evaluating other proposals. We look forward to working with all interested parties in achieving our common goal: a world-class health care system for all Wisconsinites.