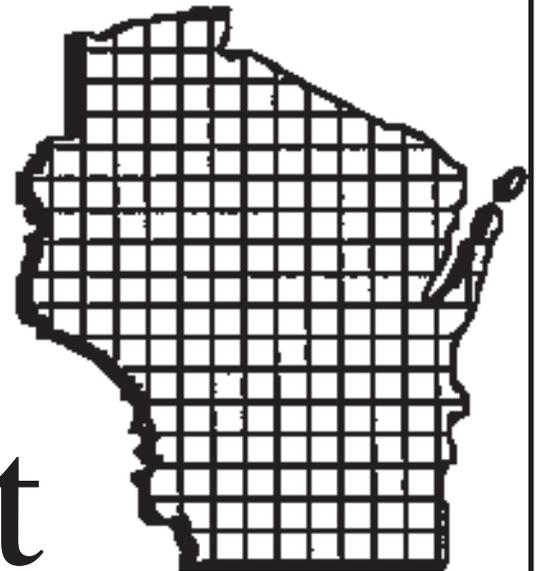


Wisconsin

Policy  
Research  
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R e p o r t



January 2007

Volume 20, Number 1

**An Evaluation of  
*The Wisconsin  
Health Plan***

## REPORT FROM THE SENIOR FELLOW:

At the top of the to-do list for the upcoming legislative session is fixing Wisconsin's health care system. Polls show the public expects action, and since Washington has reached gridlock on health care, there will be pressure on state government to find a workable solution. The Governor and Legislature will be looking for ideas they can turn into legislation.

High on radar for the Governor and the Legislature is the Wisconsin Health Plan (WHP), a bipartisan initiative that emerged in the last legislative session. How good is the plan? That is the question we commissioned labor economist Dr. M. Scott Niederjohn and UW-Milwaukee Professor Mark Schug to explore. Their review should give pause to those in the Capitol thinking that the WHP is a viable platform for health care reform in Wisconsin.

Schug and Niederjohn found that the well-intentioned plan would almost certainly grow into another expensive, entrenched government program. The plan will increase taxes while holding little prospect for reforming the system that is pricing health care beyond the reach of many citizens. In the rush to do something about health care, the Governor and the Legislature should look toward consumer-oriented solutions rather than creating another large tax-supported program. The authors did find a few positives in the plan including elements that encouraged individual responsibility and coverage that is more accessible for more Wisconsinites.

Their review found several flaws in the WHP, the most serious of which is that the cost of the plan has been significantly underestimated. Several states including Tennessee and Kentucky entered into health care programs only to discover huge cost overruns soon after enactment.

The WHP would be paid for via a 12 percent payroll tax according to the plan's authors. However, because the plan's costs are underestimated, the tax would more likely exceed 15 percent. While new statewide taxes are rarely advisable, they are especially bad when based on flawed data.

Run by a board appointed in Madison, the WHP includes few elements that would attack the factors that drive health care costs in Wisconsin up. Worse, the plan holds the prospect of denigrating the quality of health care in Wisconsin. If the price tag of the plan has been significantly underestimated, as the authors maintain, Wisconsin workers and employers will be facing escalating payroll taxes, a cut in health care quality, or both. In health care policy, the status quo might seem unacceptable, but this plan could make Wisconsin's already ailing health care system even sicker.



George Lightbourn

## WISCONSIN POLICY

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# AN EVALUATION OF "THE WISCONSIN HEALTH PLAN"

M. SCOTT NIEDERJOHN, PH.D.  
MARK C. SCHUG, PH.D.

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## EXECUTIVE SUMMARY

### Background

Health care problems — including limited access, increasing costs, and increasing utilization — loom large in Wisconsin and across the nation. Several states, notably Massachusetts, are experimenting with new health care policies. Wisconsin is not an exception. In June 2005, two Wisconsin legislators unveiled a new plan to address these issues in Wisconsin. It is called the Wisconsin Health Plan (WHP).

The market for health care is complex. It is marked by some peculiarities in demand and supply. On the demand side, for example, we find price inelasticity and third-party payers. On the supply side, we find barriers to entry for health care providers and high technology prices. Because of the peculiarities, the health care sector operates as an imperfect market. But the fundamental problem in health care is not the operation of an imperfect market system; it is the lack of a vibrant free-market system. Over time, reliance on third-party payment for health care costs has eroded the incentive for consumers and providers to economize.

### Policy Approaches

Wisconsin stands now at a crossroads in health care policy formulation. It faces two distinct options. Option one would establish policies that strengthen the role of command-and-control governance in the health care sector, expanding the role of government and moving the state along on a path that may eventually lead to state-operated health care of the sort we see in nations such as Canada, the United Kingdom, France, Japan, and Germany. Option two would establish policies that increase competition in the health care sector and shift responsibilities increasingly toward individual consumers.

We recommend option two. Wisconsin should strive to establish health care policies and practices that move the state toward a market-oriented solution.

### How to Choose?

In our analysis, we have been guided by four criteria.

1. Does the proposed health care policy improve accessibility and reduce the number of people without access to health care?
2. Does the proposed health care policy increase the role of individual consumers in making health care decisions?
3. Does the proposed health care policy increase price competition?
4. Does the proposed health care policy limit the role of government?

These criteria, we believe, are the ones that Wisconsin citizens and legislators also should apply in choosing between the two broad approaches now under consideration.

### The Wisconsin Health Plan

The WHP seeks to provide universal health insurance coverage for all Wisconsin residents. It would be funded by a new payroll tax. It would establish a system by which health insurance providers would bid to sell insurance plans to state residents. The program would be managed by a private, not-for-profit, unelected board without representation from health insurers or providers; this board, called the Health Insurance Purchasing Corporation (HIPCo), would categorize insurance plans in tiers based on price and quality. Plans placed in the first tier would not impose a monthly premium on the insured.

Each of the qualifying Tier I plans would provide insurance for basic preventative care, including dental coverage for children, without any cost-sharing requirement. For other services, the plans would require an annual

deductible of \$100 per child and \$1,200 per adult, as well as coinsurance requirements between 10 and 20 percent. The annual out-of-pocket maximum would be \$500 for children; \$2,000 for adults; and \$3,000 for families. Theoretically, employers would no longer offer health insurance coverage to their employees unless the employers chose to enhance the benefits offered by the WHP. The WHP would also provide \$500 toward the purchase of a Health Savings Account (HSA) that could be used to pay medical expenses and would be combined with a high-deductible health insurance plan.

The WHP would be funded through a payroll tax. Each Wisconsin employer would be required to pay a new payroll tax of up to 12 percent of the total Social Security payroll. All employees would be required to pay a flat tax of 2 percent of their Social Security wages. A special tax would be levied upon certain Wisconsin residents who work for out-of-state firms.

## Evaluating the WHP

The WHP has positive aspects. These include access to health insurance for most state residents and a shift of the responsibility for choosing a health care plan to the individual. Further, the combination of a high-deductible insurance plan and an HSA would be likely to have positive effects on individuals' health care choices.

Overall, however, the WHP presents a number of problems. The most troubling of which involves the plan's costs. The WHP mandates a one-size-fits-all health insurance plan without brakes and state government at the steering wheel. The WHP would create a new state entitlement to health care for Wisconsin citizens. Entitlement programs rarely stand still. Interest groups of all sorts would fight relentlessly to expand WHP coverage for their members. Actual costs of the WHP would dramatically exceed those projected by the plan's authors. Cost overruns will generate pressure for tax increases, or benefit and provider reimbursement cuts, to fund the plan.

This should not be surprising. Other state health care initiatives have underestimated their expenses, causing major problems for state governments. Examples include plans in Kentucky and Tennessee. Kentucky Kare cost overruns were responsible for serious fiscal problems in the public employee's insurance pool. With the exception of funding and governance, the WHP offers nothing new for the Wisconsin health care sector. Nothing in this plan impacts the delivery of health care; that is there is no mechanism to help remove waste and the redundancies that in turn lead to many of the dramatic cost increases we see today. A vibrant market solution will reform both the financing and delivery aspects of the health care sector in Wisconsin.

Other concerns about the WHP include:

- WHP reimbursement rates for health care providers are likely lower than what providers receive today. Inadequate reimbursement rates will adversely affect the quantity and quality of health care available in Wisconsin.
- The payroll tax needed to pay for the WHP would have negative secondary effects — for example, discouraging employers from creating high-paying jobs in the state.
- The WHP would not affect everyone equally. It would create winners and losers. It would provide health care coverage for most of Wisconsin residents who currently are uninsured. But most Wisconsin residents who currently have health care insurance would see a cut in their benefits under the WHP. Employees in the public sector, who frequently pay little or nothing for their health care benefits, would be adversely affected. Other losers would include firms that compete in tight labor markets, along with labor-intensive and high-wage industries.
- Because it would be funded by a new payroll tax, the WHP would almost certainly be under-funded in subsequent years as Wisconsin payrolls lag behind increases in health care costs.
- Under the WHP, all health care decisions in Wisconsin would be made by an unelected board lacking health care expertise. Concentration of power in the hands of a powerful board would hinder competition in the health care sector.

## Looking Toward Markets

Now is not the time to give up on consumer-oriented reforms in health care. A movement in that direction is underway at the state and national levels. The Wisconsin Health Information Organization, for example, is a consor-

tium of managed-care companies, employer groups, hospitals, and doctors striving to share information regarding health insurance claims and to find out which doctors and hospitals provide quality care at low costs. And the U.S. Congress approved legislation in 2006 to give every individual a chance to own his or her electronic medical record. This legislation helps to establish a nationwide health information network so that patients' medical information can travel with them no matter which doctors or hospitals they visit.

In 2005 Congress also considered legislation, introduced by Wisconsin Congressman Paul Ryan, to provide new incentives for uninsured persons to purchase health insurance. One proposal would allow individuals who are uninsured by their employers to purchase a high-deductible health insurance plan combined with an HSA and deduct the amount of the premium from his or her taxable income.

## Our Recommendations

**Recommendation 1.** Wisconsin should reject the broad policy approach represented by the WHP. Efforts to reform health care in the state should be guided by the consumer-driven, market-based movement in health care management already underway in the state and nationally.

If Wisconsin policy leaders are determined to approve a new health care policy along the lines of the WHP despite the shortcomings noted in this report, we then make the following additional recommendations.

**Recommendation 2.** An actuarial analysis of the WHP's costs should be conducted by a third-party consultant. Total costs of the plan should be calculated along with the payroll tax necessary to raise the revenue required to fund the plan. This analysis should include an identification of the winners and losers that would be created by the new payroll tax. Further, the analysis should investigate the discount rate that is currently offered by health care providers in the commercial market and determine what effect a change in this rate by the WHP would have on the quality and availability of health care in Wisconsin.

**Recommendation 3.** The WHP should include a strategy for eliminating the cost over-runs that are likely to occur in most years under the current policy proposal. The strategy would likely require a large contingency reserve. That reserve should be included in the projected costs of the plan.

**Recommendation 4.** The proposed organization of the HIPCo should be restructured. Wisconsin's citizens are unlikely to accept an unelected board, lacking in health care expertise, as the body responsible for serious health care decisions in the state.

## INTRODUCTION

Problems related to health care and the solutions needed to address them are being debated across the nation. Several proposals have come forward in Wisconsin and elsewhere suggesting ways to reduce health care costs, improve quality, and expand health insurance coverage.

Most discussions focus on three types of problems.

### Problems Related to Access

Nearly 46 million people or about 65 percent of the population in America lack health insurance, according to the U.S. Census Bureau. Estimates of the costs generated by this lack of coverage vary; however, most sources put the costs in the tens of billions of dollars. The U.S. Census Bureau also reports that from 2000 to 2004, the percentage of people under 65 who obtained insurance through their employer fell from 67.9 to 63.3 percent.

According to the Wisconsin Department of Health and Family Services Family Health Survey (2004),<sup>1</sup> employers provide most of the health care coverage in Wisconsin. In 2004, employer-sponsored insurance covered 76 percent of people aged 0-64. According to Wisconsin Manufacturers & Commerce,<sup>2</sup> nearly 95 percent of U.S. businesses with more than 50 employees offer health insurance. The Family Health Survey (2004) reports further that among Wisconsin adults aged 65 and older, 95 percent have Medicare coverage and 4 percent have Medicaid coverage.

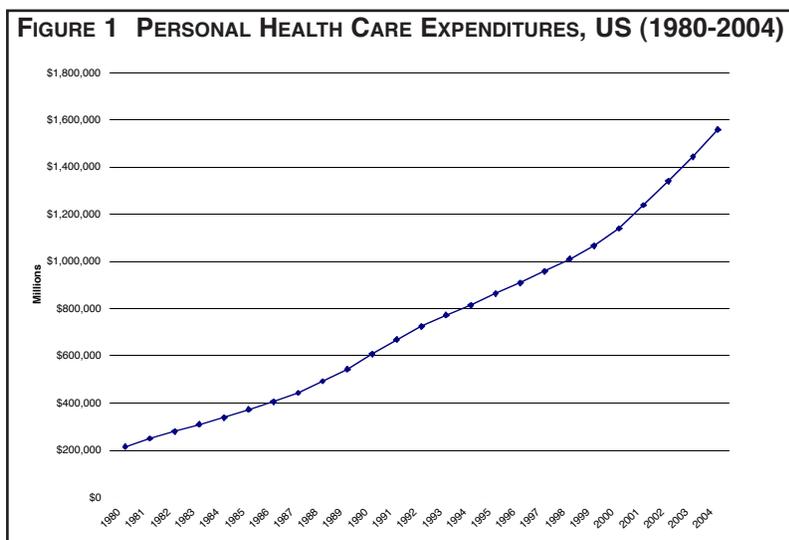
How many Wisconsin residents have health insurance coverage? Wisconsin's Family Health Survey<sup>3</sup> reports that in 2004, an estimated 4.8 million people in Wisconsin were insured for all 12 months; 270,000 were insured for part of the year; and 275,000 had no health insurance coverage at all during the year.

Directly or indirectly, states pick up much of the cost for the uninsured. Uninsured individuals obtain health care at state-subsidized clinics and hospital emergency rooms. States also bear the treatment costs for chronic illness among the uninsured. Moreover, having large numbers of people without good health care hurts the state's labor force. It erodes human capital and hampers Wisconsin's productivity.

Young people, those most likely to take on risks, are high on the list of the uninsured. A 2005 Commonwealth Fund report<sup>4</sup> found that there are 13.7 million young adults who lack health insurance in the United States, an increase of 2.5 million from 2000. According to the Commonwealth Fund, young adults between the ages of 19 and 29 represent the largest and fastest growing segment of the population without health insurance.

### Problems Related to Rising Costs

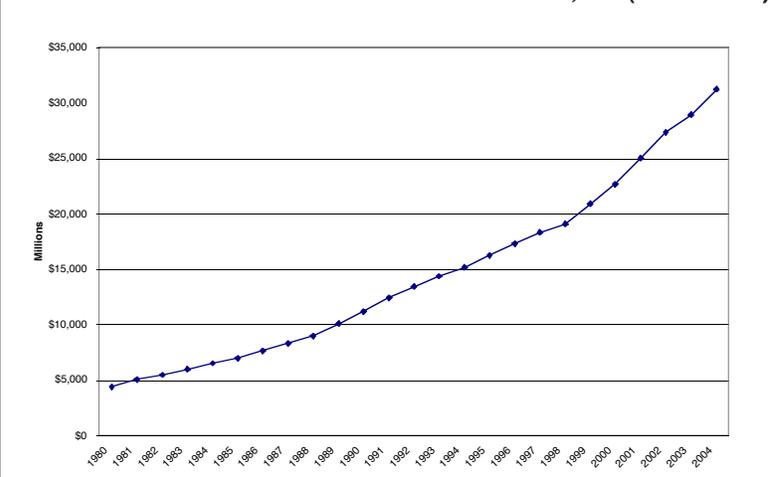
The costs of health care insurance have been increasing much faster than the rate of inflation. According to the Centers for Medicare and Medicaid Services of the U.S. Department of Health and Human Services,<sup>5</sup> personal health



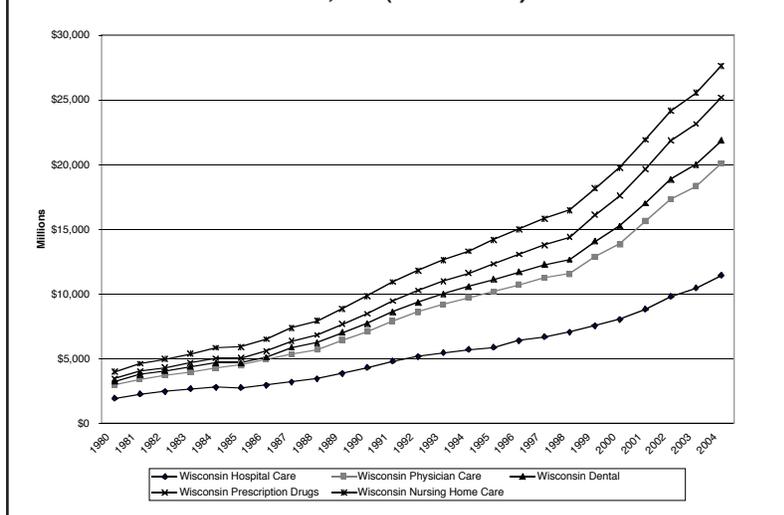
care spending increased by 7.9 percent in 2004, to \$1,560 billion. Figure 1 shows the increasing cost of U.S. personal health care expenditures from 1980 to 2004. Between 2000 and 2004, U.S. personal health care spending grew, on average, 8.2 percent per year. Health care spending is projected to have grown by 7.4 percent and surpass \$2 trillion in 2005. As a percentage of Gross Domestic Product (GDP), health care spending is expected to continue to grow, reaching 16.2 percent in 2005. By 2015, health care spending in the United States is projected to reach \$4.0 trillion and 20 percent of GDP.

Wisconsin has experienced a similar increase in health care costs. Figure 2 shows that personal health care spending in Wisconsin increased from 1980 to 2004. The total increase has been over 600 percent in the past 25 years. The average annual increase for Wisconsin from 1980 to 2004 is 8.5 percent — compared with 7.8 percent for the United States; 7.4 percent for Illinois; 7.1 percent for Michigan; 8.6 percent for Minnesota; and 7.1 percent for Indiana. Figure 3 shows that Wisconsin’s health care expenditures have increased across the board, in nursing-home care, prescription drugs, dental care, physician care, and hospital care.

**FIGURE 2 PERSONAL HEALTH CARE EXPENDITURES, WI (1980-2004)**



**FIGURE 3 PERSONAL HEALTH CARE EXPENDITURES BY MAJOR PROVIDER GROUP, WI (1980-2004)**



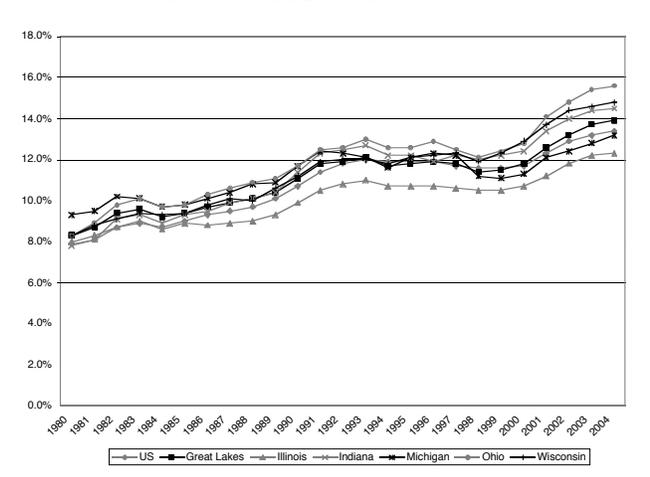
The amount of sacrifice that is made to pay for health care has been increasing in the nation, in Wisconsin and in nearby states. The proportion of total state income devoted to health care has been increasing at levels well above inflation. Figure 4 illustrates the change in the percent of Gross State Product (GSP) that is used for health care. In 1980 Wisconsin devoted 8.3 percent of GSP to personal health care expenditures compared to 7.9 percent GDP devoted to health care for the United States; 8.0 percent GSP for Illinois; 9.3 percent GSP for Michigan; 8.6 percent GSP for Minnesota; and 7.8 percent GSP for Indiana. By 2004, Wisconsin devoted 14.8 percent of GSP to personal

health care expenditures compared to 13.4 percent GDP devoted to health care for the United States; 12.3 percent GSP for Illinois; 13.2 percent GSP for Michigan; 13.8 percent GSP for Minnesota; and 14.5 percent GSP for Indiana.

**Problems Related to Demand**

Over the past 20 years, there has been a large increase in the number of diseases acknowledged and treated in the U.S. health care system. While this may be a good problem to have, it does contribute to increasing the cost of health care. People are living longer and thus are susceptible to ailments associated with increasing longevity, including Alzheimer’s disease, heart disease, and various

**FIGURE 4 TOTAL PERSONAL HEALTH CARE AS PERCENT OF GROSS STATE PRODUCT**



cancers. Our ability to diagnose and treat diseases has been improving, and new technologies — in imaging technology and prescription drugs, for example — have contributed to increased utilization of health care. In addition, some risk factors have increased. For example, obesity has doubled among adults in the past 20 years.

## STATE EXPERIMENTS

As we discovered in 1993 when the Clinton administration flirted with a national health care plan, health care policy is a controversial issue on the national stage. While some progress has been made at the national level — for example, in legislation to permit Health Savings Accounts — Congress remains bitterly divided. States currently seem to be taking the lead. Maryland passed legislation in 2006 called Maryland’s Fair Share Health Care Fund Act, also known as the Wal-Mart tax. It would have required companies with 10,000 or more employees to spend at least 8 percent of their payroll on health care or pay the state the difference. While this law was found to violate the Constitution’s Equal Protection Clause, it nonetheless shows how far some states are willing to go in efforts to solve the health care problem.

Better known, perhaps, than the health care experiment in Maryland is “Romney Care.” In 2006, Massachusetts passed a bill that made health insurance compulsory. The plan offers a mix of penalties and subsidies. It allows uninsured people earning less than the federal poverty level to obtain subsidized policies without premiums. They would make small payments for emergency room visits and other services. People earning between the poverty threshold and three times that amount would be able to buy subsidized policies, with premiums based on their ability to pay. The proposal would fine anyone who can afford to buy insurance, but does not. The idea is that the individual mandate spreads out the burden of covering the uninsured among ordinary citizens, government, and business.

Wisconsin is also debating a variety of health care initiatives. One, the subject of this study, is the Wisconsin Health Plan (WHP). The goal of the program is to provide everyone in Wisconsin with health care insurance.

## DEMAND, SUPPLY, AND THE MARKET FOR HEALTH CARE SERVICES

### Demand

Before turning to an in-depth analysis of the WHP, we’d like to discuss why problems in the health care sector seem so intractable. The fundamental problem is one we always face in cases that involve economic choices: health care is scarce. The resources devoted to the production of health care — the people, hospitals, prescription drugs, clinics, and technology — have potential, valuable uses in other sectors. What’s more, people desire more health care than can be provided with existing resources. As a result, we have to make choices about how, and to whom, health care is to be allocated.

The need to allocate scarce resources raises difficult problems. Most goods and services produced in our economy come from the private sector, and most people like it that way. Few Americans would want their condos, cars, or cantaloupes to be produced by the government. But when it comes to health care, people often think differently. To many, the allocation of medical care on the basis of price seems unethical. As a result, many nations with market economies (Canada, Japan, the United Kingdom, and nearly all the nations of Western Europe) have opted for socialized approaches to medical care.

In these countries, hospitals and clinics are operated by the government and paid for by taxes. Physicians, nurses, and other health care providers are government employees. Since tax revenues typically do not keep pace with the quantity of health care that people demand when it is provided for them at no direct cost, shortages frequently result. To deal with the shortages, governments develop rules and policies to allocate health care services. The consequence is that patients sometimes must wait in line for important medical procedures. A recent (2005) waiting-list survey<sup>6</sup> of Canada found, for example, that total waiting time in Canada between referral from a general practitioner and treatment averaged 17.7 weeks. The waiting time between referral by a general practitioner and consultation with a specialist was 8.3 weeks, and waiting time between specialist consultation and treatment was 9.4 weeks.

In the case of shortages and other problems in the health care sector, the laws of demand and supply help to explain what is going on. We should begin by acknowledging that health care is a normal good. This means that as

incomes rise, people demand more health care. Per capita income in the United States amounted to about \$41,800 in 2005. That level of per capita income, by itself, explains in good measure why Americans now demand more and better health care. Other factors, including price, are also relevant. If the price for health care were to fall to zero, the quantity demanded would soar, as it has elsewhere.

Demand for health care is also affected by the notion that it is a necessity. There are few good substitutes for medical care. Thus health care demand is inelastic. When prices increase for the latest cancer treatment or the newest diagnostic device, many people still want the treatment. They are made even more willing because they often do not bear all of the out-of-pocket costs.

Health care is regarded as a necessity. That fact may seem to be decisive, setting health care apart in a special category, but health care is not the only necessity about which consumers make choices. Food and housing are necessities, too, but most Americans don't turn to others to manage their purchase of food and housing. They don't ask their employers to pay their rent or buy their groceries. Instead, they decide what sort of housing they wish to have and what sort of food they wish to eat. The concept of necessity does not explain why health care should be different.

Demand for health care in the United States is bolstered by payment methods. American consumers of health care depend heavily on third-party payers. Most families have health insurance paid for, at least in part, by an employer. As a result, they do not feel the "bite," in direct costs, of the health care they consume. Vernon Smith, 2002 Nobel Laureate in Economics, describes it this way:

A is the customer. B is the service provider. B informs A what A should buy from B, and a third entity, C, pays for it from a common pool of funds. Stated this way, the problem has no known economic solution because there is no equilibrium. There is no automatic balance between willingness to pay by the consumer and willingness to accept by the producer that constrains and limits the choices of each.

Moreover, consumers of health care do not shop around for medical care as they do for other goods and services. The disinclination to shop is explained in part by widespread reliance on third-party payers. Why spend time shopping for a low price when somebody else is paying the bill? Also, health services often involve highly personal relationships between physicians and patients. As a result, health care consumers may prefer long-term relationships, regardless of prices, with their "regular" doctors.

Health insurance itself has a special status in the United States. About two-thirds of working adults have health insurance through group insurance programs offered by their employers. The insurance is part of their compensation packages. And it is a form of compensation that is not subject to federal taxation.

It hasn't always been this way. Before World War II, health insurance was an individual responsibility. During the war, although workers were in short supply, federal wage and price controls prevented companies from offering increased wages to attract workers. But employers could offer prospective employees "fringe benefits." One such benefit was health insurance. Employers began to offer health insurance coverage to their employees especially after the War Labor Board decided to exempt pension and insurance contributions from wage and price controls. In 1943, the Internal Revenue Service ruled that such benefits were not considered to be taxable income. This ruling was built into the IRS code in 1954.

Two additional factors influence demand for health care. First, our population is aging, and older people demand more health care than younger people. By 2030, over 20 percent of the population (about 70 million U.S. citizens) will be 65-years-old or older, and about 8.5 million will be older than 85. People older than 85 are in fact the fastest-growing age group in the United States. According to Medicare records, a large spike in the demand for health care occurs after the age of 70, for obvious reasons. They are the ones most likely to be disabled, to use multiple medications, and to need comprehensive, long-term care. Second, physicians themselves influence demand. Physicians are compensated on a fee-for-service basis. This provides an incentive for physicians to offer more services, especially when they know that the services they provide will generate little or no out-of-pocket expense to the patient. The threat of malpractice suits is also relevant. It provides an incentive for physicians to practice defensive medicine — for example, by ordering expensive tests even when they know that the tests are medically uncalled for.

## Supply

Like demand, the supply of health care is also influenced by several factors. One has to do with the supply of physicians. Medical education ordinarily requires four years of undergraduate college work, four years of medical

school, an internship, and perhaps three more years of training in a medical specialization. It is an expensive undertaking, and according to a recent article in the *New England Journal of Medicine*,<sup>8</sup> it has become increasingly expensive over the past 19 years. Medical school tuition in that time has increased by 317 percent at public schools and by 151 percent at private schools. Accompanying this increase has been an enormous increase in the average amount of student debt. Average debt in 1984 was \$22,000 for students in public schools and \$26,000 for students in private school. By 2004, the average debt had increased to \$105,000 and \$140,000, for public- and private-school students respectively. The high cost of medical education no doubt discourages some capable people from becoming physicians. Further, the number of seats for students in U.S. medical schools has not kept pace with the increase in population.

Another supply problem has to do with technology. Technology in health care works differently than it does in other sectors. In other sectors, when a technological breakthrough occurs and a new product comes to the market, the initial price is usually high. Hand-held calculators and desktop computers, for example, appeared in stores initially as relatively expensive products. In most sectors, however, market forces soon take over and work to reduce prices. High early prices attract additional producers. Competition increases. Production techniques improve. Supply increases. Prices come down.

In health care, new technologies often take years to develop, and they are subject to numerous regulations. Like other new products, they come onto the market initially at a high price. But we don't typically see market pressures bringing prices down as quickly in health care as they do in other sectors. Why not? The explanation has to do with the nature of health care where stakes are high. Consumers facing acute medical problems demand prompt access to the latest technology — the latest robot-assisted surgery, the least invasive treatment for a herniated disk, or the newest cancer treatment. They do not want to wait around for new producers to enter the market, increase competition, increase supply, and reduce prices. This preference by patients is made easier, of course, when someone else is paying for the treatment in question.

### **The Lack of a Vibrant Market**

Supply and demand analysis reveals peculiarities in the market for health care services in the United States. But the fundamental problem is not that health care is provided within a market system. It is that we try to provide health care outside the context of a vibrant, free-market system. Health care policies that shift costs heavily to third-parties have eroded the incentive for consumers and providers to economize. In the introduction of her book, Herzlinger (1997) writes:

Is the health care sector different from the other sectors of the economy? Are there no lessons at all to be learned from the manufacturing and service industries that turned themselves inside out to give the United States back its number-one competitiveness ranking? Do world-class firms like McDonalds that specialize in quick, courteous, consistent, low-cost service really have nothing that the health care sector can emulate? Is there really no role in the health care sector for brilliant entrepreneurs and technologies, like those who created the consumer-responsive Home Depot and the technology leader Microsoft?<sup>9</sup>

Herzlinger is a leader in the emerging national movement aimed at transforming our health care system into one that is controlled by consumer decisions. In a vibrant market, consumers weigh the price of a good or service against its quality. If the quality isn't provided at the right price, they walk away. Producers pay close attention to these decisions. They innovate to provide consumers with the quality they want at the price they are willing to pay. Providers who are successful remain in business and expand, while providers who are not successful are driven out.

Many examples show how market forces can work in health care. Herzlinger (1997)<sup>10</sup> points to changes made in the eyewear sector. Consumers wanted contact lenses that were easy to wear, easy to use, disposable, and inexpensive. Producers such as Johnson and Johnson responded by developing disposable contact lenses. These were a big hit with consumers, and Johnson and Johnson was highly rewarded in the marketplace. Other illustrations can be found in the eye glass industry and, more recently, in the market for Lasik eye surgery. The Lasik eye surgery market, a procedure not typically covered by insurance, has seen market forces work with falling prices and significant competition among physicians for new customers.

## WISCONSIN AT A CROSSROADS

Wisconsin stands now at a crossroads in health care policy formulation. It faces two distinct options. Option one would establish policies that strengthen the role of command-and-control governance in the health care sector, expanding the role of government and moving the state along on a path that may eventually lead to a state-operated health care system of the sort we see in nations such as Canada, the United Kingdom, France, Japan, and Germany. Experience in these countries shows that centralized decision making leads to poor health care, poor consumer service, and squandered resources. Option two would establish policies that increase competition in the health care sector and shift responsibilities increasingly toward individual consumers. Due to some peculiarities of the health care sector, it may never function as a perfect market. Few markets ever do. Nonetheless, health care can move much closer to being market-driven and avoid many of the problems associated with the socialized systems that operate in other countries.

If the people of Wisconsin favor option two — consumer-driven health care—what would they look for in reform proposals for the state? We suggest criteria built into the following questions.

**1. Does the proposed health care policy improve accessibility and reduce the number of people without health insurance?** Any reform for health care needs to propose ways to reduce the number of people in Wisconsin who are uninsured. Would the proposed reform, for example, reduce the cost of acquiring health insurance, thus providing an incentive for more people to obtain coverage?

**2. Does the proposed health care policy increase the role of individual consumers in making health care decisions?** Would the proposed reform, for example, reduce the role of third-party payers of health care expenses? Plans that shift responsibility for purchasing health insurance from employers to consumers would provide a step in this direction.

**3. Does the proposed health care policy increase price competition?** What incentives are provided to encourage new producers to enter the market? Allowing Americans to buy health insurance from vendors in any one of the 50 states would substantially increase price competition among insurance providers. Would the proposed policy open up opportunities of this sort?

**4. Does the health care policy limit the role of government?** Does the policy set the stage for a government-driven system, or will it lead to market-oriented solutions that will result in a stronger role for consumers and more innovation? Increased health care costs are often cited as a reason to increase the role of government in paying for those costs. Over time, however, governments responsible for health care costs will take steps to control those costs by increasing rules and regulations. The result will be less competition, poorer quality, and unhappy consumers.

## THE WISCONSIN HEALTH PLAN: A CLOSE LOOK AT ASSEMBLY BILL 1140

The WHP is a proposal that, if adopted, would dramatically change the funding and governance of health care services to most Wisconsin residents under the age of 65. In March 2006, Wisconsin state representatives Curt Gielow (R-Mequon) and Jon Richards (D-Milwaukee) formally introduced the WHP as Assembly Bill 1140<sup>11</sup> (AB 1140). We turn now to a description of the key features of this proposed legislation.

If adopted, the WHP would provide eligible state residents with a health insurance purchasing account. This account would be used to purchase health insurance from a set of competing health care plans. The purchasing account would cover the costs of the entire premium for any “Tier I” plan that individuals might select. Tier I plans are the plans that have the lowest risk-adjusted prices and that score well on several quality measures.<sup>12</sup> Enrollees may be required to contribute toward their premiums if they select a Tier II or Tier III policy. Eligible adults would also receive a Health Savings Account (HSA) funded at \$500 per year.

Each of the qualifying health care plans would provide for basic preventative care, including dental care for children, without any cost-sharing provisions. For other services the plans would require an annual deductible of \$100 per child and \$1,200 per adult, as well as coinsurance requirements between 10 and 20 percent. The annual out-of-pocket maximum would be \$500 for children; \$2,000 for adults; and \$3,000 for families. Theoretically, Wisconsin employers would no longer offer health insurance coverage to their employees unless they chose to enhance the ben-

efits offered by the WHP. For example, a private firm could contribute funds above the \$500 provided by the plan into their employees' accounts.

Most Wisconsin residents under the age of 65 would be entitled to receive the benefits described above. Exceptions would include persons that have resided in Wisconsin for less than six months, persons claiming residency in another state for income tax purposes, federal government employees, institutionalized persons, and persons eligible for Medical Assistance (MA) or BadgerCare. New Wisconsin residents would have to provide evidence of health insurance coverage similar to the WHP benefits for the year prior to enrolling in the WHP; otherwise they would not be eligible for coverage for preexisting medical conditions until they had lived in Wisconsin for two years.

Assembly Bill 1140 would establish a new state entity called the Health Insurance Purchasing Corporation (HIPCo). This new private, nonprofit corporation would be responsible for establishing and operating the new health insurance purchasing arrangement. The HIPCo would be managed by an appointed board consisting of two appointees from the Governor and representatives from each of the following organizations: Wisconsin Manufacturers and Commerce, the Milwaukee Metropolitan Chamber of Commerce, the National Federation of Independent Businesses (Wisconsin chapter), the Wisconsin American Federation of Labor and Congress of Industrial Organizations, the Service Employees International Union State Council, and the Wisconsin Farm Bureau. All major board decisions would require seven of eight votes.

Insurers licensed to sell health insurance in Wisconsin would be qualified to compete to provide policies under the WHP. Qualifying policies would have to meet standards developed by the HIPCo. The HIPCo would then place each of the suitable plans into one of the three tiers discussed above, based on price and quality.

## FUNDING THE PLAN

Assembly Bill 1140 included no mechanism for funding the WHP; however, the plan's authors do provide a funding plan on the web site for the project.<sup>13</sup> The plan is based on a payroll tax assessed on employers and employees. In addition, a special assessment would be levied upon employees covered by the plan who work for out-of-state firms.

Each employer required to file an employer's quarterly federal tax return (Form 941) or a self-employment (SE) tax form would be required to pay the new payroll tax. The tax would be graduated, based on the Social Security wages the employer pays. All employers would pay a tax equal to 3 percent of the first \$50,000 of Social Security wages. For each \$1,000 increment of additional Social Security wages, the tax would be increased by 0.02 percent until it reached 12 percent at \$500,000 of Social Security wages. A 12 percent tax would be applied to all firms with wages that exceed \$500,000.

All employees would be required to pay a flat tax of 2 percent of their Social Security wages. A special tax would be levied upon certain Wisconsin residents who work for out-of-state firms. All the tax rates would be established in state statutes; the Wisconsin Department of Revenue (DOR) would collect the taxes.

## THE WISCONSIN HEALTH PLAN: POSITIVES

Most importantly, the WHP would nearly eliminate the problem of the uninsured in Wisconsin. Barring a handful of exceptions, all Wisconsin residents would be covered by some form of health insurance if the WHP were adopted. Questions remain as to whether health care utilization would improve for low-income residents, given the substantial out-of-pocket costs associated with this plan. In respect to access for those who are now uninsured, however, the WHP does meet our first criterion for policy reform.

The WHP includes other positive features as well. It strives to shift responsibilities for choosing a health insurance plan to individual consumers. If that goal were realized, state policy would move in the direction of our second criterion for policy reform. How would the WHP shift responsibility toward individuals? It would allow all Wisconsin residents to receive a "premium credit" which residents then could use to purchase health insurance from a list of approved options. In this way, the plan is similar to the insurance plan currently used by State of Wisconsin employees. The advantage of this approach is that it allows consumers to make choices and brings some price competition into the sector, again meeting one of the criteria we set out. However, the choices envisioned in the WHP are

highly constrained. Participants could choose from a list of plans selected by a highly centralized authority, the Health Insurance Purchasing Corporation. Also, in using the premium credit, participants would be spending “other people’s money.” As Milton Friedman once wrote, “Nobody spends somebody else’s money as wisely as he spends his own.”<sup>14</sup> Nonetheless, this feature does shift more responsibilities to consumers than is currently the case.

The WHP also proposes that all adults will receive a Health Savings Account (HSA) funded at \$500 each year. HSAs are simple for consumers and businesses to understand. An HSA is a federally tax-favored savings account that is combined with a qualifying high-deductible health insurance plan. HSAs allow individuals to deposit tax-deductible funds into an account that they can then use to cover medical costs. Health care expenses that are paid for from an HSA account are, therefore, paid for with pre-tax dollars. The WHP would provide participants with an HSA deposit of \$500 per year. Like the “premium credit,” the HSA would provide an incentive for individual consumers to take more responsibility for their health care — even though they would once again be spending someone else’s money. Theoretically, consumers would economize when spending HSA money in order to stretch it out as far as possible.

## **THE WISCONSIN HEALTH PLAN: PROBLEMS**

While the WHP addresses some key problems in Wisconsin’s health care system, it also raises concerns that Wisconsin’s taxpayers and policy makers must consider. These concerns have to do with costs and how the plan would be funded; they also include philosophical questions about who should make important health care decisions for Wisconsin’s families. Perhaps the most troubling aspect of the WHP is that, as proposed to date, it appears to severely underestimate the costs of the new system. The proposed mechanism for funding the WHP is a new payroll tax. Our analysis suggests that revenue from this payroll tax will not be sufficient to keep pace with the expenditures required by the program. Revenue shortfalls would set the stage for a major increase in the role of government in the health care market. That turn of events would be a turn for the worse, according to our fourth criterion for policy reform, which calls for limiting the role of government. Over time, the WHP might also decrease competition in the health care market, putting it in a negative light according to our third criterion. The following sections elaborate these concerns.

### **Health Care Expenditures in Wisconsin**

The WHP rests on assumptions that require further analysis and scrutiny. Foremost among these is the set of assumptions according to which the costs of providing the WHP benefit are estimated. The projected total cost of the WHP is based upon an analysis done by the actuarial firm Reden & Anders, Ltd. (R&A). This firm used its national database of health care costs to estimate the total bill for providing WHP benefits to all Wisconsin residents under the age of 65,<sup>15</sup> with limited exceptions. R&A factored in all of the information likely to affect the costs in question, including: annual deductibles, co-payments, out-of-pocket maximums as specified by the WHP, in addition to the provider discounts for various medical services and utilization rates. R&A also adjusted their data upward by 3 percent to account for the amount that costs for Wisconsin medical services exceed national averages.

After completing their analysis, R&A concluded that \$11,024.9 million is the amount that participating insurers would pay for medical treatment of WHP participants, not including administration and profit. Once this number is adjusted downward by \$1,430.5 million to account for the under-65 Medical Assistance (MA) and BadgerCare population (not initially covered by this plan), the projected total cost to provide each WHP participant with a “premium credit” for their benefit would be \$9,594.4 million. Using this figure, the total cost of the WHP can be estimated.

This summary, provided by the Legislative Fiscal Bureau (LFB), is developed using the assumptions made by the WHP’s authors on the plan’s costs. Exhibit 1A shows that the largest cost associated with the WHP is, of course, the health benefit package provided to all Wisconsin residents under the age of 65. To calculate this number, the estimate by R&A discussed above for “premium credits” is added to the \$500 Health Savings Account (HSA) that would be provided to every Wisconsin resident under the age of 65 included in the plan. The WHP authors then add an estimate for the administration and profit costs for the insurers selected, as well as \$112.2 million to administer the benefits by the Health Insurance Purchasing Corporation (HIPCo). After accounting for the impact of MA and BadgerCare on the WHP, and adding in a \$23 million contingency reserve, a total price tag of \$12,668.9 million is estimated. It is this cost estimate that is then used to calculate the revenue required to fund this plan. The revenue would come via a payroll tax to be levied on Wisconsin employees and employers.

**EXHIBIT 1A THE COST OF THE WISCONSIN HEALTH PLAN (IN MILLIONS),  
ACCORDING TO THE WHP AUTHORS' ASSUMPTIONS<sup>16</sup>**

Premium Credits + Health Savings Accounts:	\$11,169.5
Administration and Profit:	834.3
HIPCo Administration:	112.2
<b>Subtotal Wisconsin Health Plan:</b>	<b>\$12,116.0</b>
State Costs of Providing Services to Certain MA Recipients	
(payments to MA Trust Fund):	\$523.0
State Cost of Eliminating BadgerCare Cost-Sharing Requirement:	\$6.9
<b>Total Costs Funded from Assessment Revenue:</b>	<b>\$12,645.9</b>
Contingency Reserve:	\$23.0
<b>Total:</b>	<b>\$12,668.9</b>

The LFB analysis of this plan raised concerns about the accuracy of the R&A estimate of the costs required to provide Wisconsinites with their “premium credits.” The LFB memo makes the point that accurate information on current health care expenditures is difficult to obtain. There is currently no accounting system for tracking Wisconsin-specific health care costs. This said, the LFB analysis does make use of one publicly-available data source for Wisconsin-specific information on personal health care expenditures. The Kaiser Family Foundation, relying on data from the federal Department of Health and Human Service’s Centers for Medicare and Medicaid Services (CMS), calculated a total expenditure of \$22.5 billion on health care in Wisconsin in 2000. The LFB analysts inflated this number to 2005 dollars using the average annual percentage growth (8.4 percent) in Wisconsin health care expenditures from 2000 to 2005; it then removed the portion of this expenditure associated with Medicare, Medicaid, and all persons over the age of 65. The result of this analysis is a 2005 estimate of total personal health care expenditures in Wisconsin for people under 65 years of age. The estimates come to \$21.5 billion, or \$8.7 billion more than estimated by the WHP.

In order to explore this issue of WHP costs further, we analyzed more recent data to try to get some estimates of total 2005 commercial health care expenditures in Wisconsin, for comparison with the WHP assumptions. Our purpose is not to estimate a new price for the WHP, rather we will examine the plausibility of the WHP assumptions to determine whether the initial cost estimates are too low. We analyzed three sources to see if there might be some consistency in their estimates: (1) data from the federal Department of Health and Human Service’s Centers for Medicare and Medicaid Services (CMS) (updated since the LFB estimate), (2) Wisconsin economic total data, and (3) hospital payment data. The assumptions and calculations for each of these totals can be seen in Appendix 1. It should be noted that each of these estimates are purged of the costs of providing benefits to those not covered in the WHP.<sup>17</sup> A summary of the results from our analysis is displayed in Table 1.

As shown in Column (2) of Table 1, all three approaches to estimating total health care expenditures in Wisconsin yield a fairly similar result. The smallest estimate was \$19.5 billion; the largest was \$21.5 billion; the average was \$20.2 billion. Before an accurate comparison can be made between these estimates and the costs assumed in the WHP, some adjustments need to be made for out-of-pocket costs.<sup>18</sup> Because the WHP requires significant cost sharing by the insured, and because the R&A study took this factor into account in estimating the WHP costs, Column (3) shows total health care expenditure data after the removal of typical out-of-pocket costs for health plans nationally. Once this is done, the average of the estimates on personal health care expenditures in Wisconsin for 2005 comes out to about \$16.3 billion. Even with this adjustment, the health care cost estimates exceed the WHP authors’ assumed cost for premium credits and HSAs by about \$4.3 billion.

This new estimate for total health care costs in Wisconsin can then be utilized to provide an estimate of the full cost of the WHP. Exhibit 1B does this by inserting the new costs of health care into Exhibit 1A, shown earlier, but not changing any of the other WHP assumptions about HIPCo administration, BadgerCare, or MA of the contingency reserve. Because our estimates of health care costs include profit and administrative costs for the insurers, they are not added into this calculation.

**TABLE 1: ESTIMATES OF TOTAL 2005 COMMERCIAL HEALTH CARE EXPENDITURES IN WISCONSIN COMPARED TO WHP ASSUMPTIONS**

(1) Method	(2) Total estimated Wisconsin health care expenditures (\$ in millions)	(3) Total estimated cost of WHP benefit using (2) (\$ in millions)	(4) Assumed cost of WHP benefit in current plan (\$ in millions)	(5) Difference between (3) and (4) (\$ in millions)
CMS Data	19,615	15,770	12,003.8	3,766.2
Economic Data	19,506	15,683	12,003.8	3,679.2
Hospital Payment Data	21,559	17,333	12,003.8	5,329.2
<b>Average</b>	<b>\$20,226.7</b>	<b>\$16,262</b>	<b>\$12,003.8</b>	<b>\$4,258.2</b>

Notes: (2) details for these calculations are presented in the Appendix. (3) This result is calculated by adjusting (2) to eliminate the out-of-pocket expenses. They are adjusted using Medical Expenditure Panel Survey data showing 19.6% of medical costs are paid out-of-pocket (4) from Legislative Fiscal Bureau memo dated December 22, 2005. This cost is determined by adding the premium credits cost, the HSA benefit cost, and the administrative and profit cost in order to make the WHP benefit comparable to the total health care expenditures data.

**EXHIBIT 1B USING THE AVERAGE COST OF TOTAL COMMERCIAL HEALTH INSURANCE EXPENDITURES IN 2005 FROM TABLE 1**

Premium Credits + Health Savings Accounts (1):	\$16,262.0
HIPCo Administration:	112.2
<b>Subtotal Wisconsin Health Plan:</b>	<b>\$16,374.2</b>
State Costs of Providing Services to Certain MA Recipients (payments to MA Trust Fund):	\$523.0
State Cost of Eliminating BadgerCare Cost-Sharing Requirement:	\$6.9
<b>Total Costs Funded from Assessment Revenue:</b>	<b>\$16,904.1</b>
Contingency Reserve:	\$23.0
<b>Total:</b>	<b>\$16,927.1</b>

Exhibits 1A and 1B reveal a substantial gap between the cost of providing the WHP benefit as assumed by the authors of the plan and the costs determined by using the best publicly available data on health care expenditures in Wisconsin. Table 1 summarizes these results, showing that the WHP estimate, according to the data we analyzed, is \$4,258.2 million too low. A cost estimate that is too low by this large amount would obviously lead in turn to a major under-estimate of the revenue needed to sustain the program.

As noted earlier, the WHP authors propose to fund their plan through a payroll tax on employers and employees. Employees would be assessed at 2 percent of their Social Security wages and net earnings from self-employment. Employers would pay an assessment equal to 3 percent of the first \$50,000 of total Social Security wages, adding 0.02 percent for each additional \$1,000 of Social Security wages until the assessment reaches 12 percent at \$500,000 of Social Security wages.<sup>19</sup> Applying this funding mechanism to the cost estimates of the WHP, the total payroll tax required to fund the plan can be calculated. We have made the calculation for both the WHP assumptions and the costs as determined upon reanalysis using publicly-available data. Results are displayed in Table 2. According to the WHP assumptions, a total payroll tax of 12.93 percent would be needed to fund the plan. Again, 2 percent of this would be assessed on employees and employers would pay an average tax of 10.93 percent. If costs of the WHP are updated according to currently available data, the payroll tax rate would need to rise to 17.31 percent — a rate that is 4.38 percent higher than the one originally assumed. In that case, an average tax of 15.31 percent would have to be assessed on employers, higher than what is planned under the current funding model discussed by the WHP authors.

**TABLE 2: A COMPARISON OF WHP COSTS ACCORDING TO TWO STARTING POINTS**

	(1) WHP Assumptions	(2) Using Total Wisconsin Commercial Health Expenditure Data	(3) Difference Between (1) and (2)
Cost of Plan (millions)	\$12,645.9	\$16,904.1	\$4,258.2
Tax on Payroll Required to Fund (*)	12.93%	17.31%	4.38%

(\*) This result is calculated by dividing the total cost of the WHP benefit — less \$60 million that would come from a special assessment on out-of-state employees and individuals with non-wage income — by \$97,320 million (the total payroll in Wisconsin in 2005 from the Department of Workforce Development). 2% of this tax would be paid by employees, while the rest would be paid by employers.

Given the paucity of Wisconsin-specific health care cost data available, this analysis should not be seen as a new estimate for the WHP's price. Rather, it is a relatively rough check, based on gross data, regarding whether the currently assumed WHP numbers are credible.

A discriminating reader at this point might ask why the two cost estimates are so different. There are two potential sources of variation. First, the WHP assumes a significant amount of out-of-pocket costs by the insured. The WHP plan proposes a very high deductible (\$1,200) and out-of-pocket maximum (\$2,000). These levels are probably higher than those found in typical health insurance plans held by Wisconsin residents today (this point will be investigated later in this report), suggesting that perhaps the national average estimate of 19.6 percent of health care costs being out-of-pocket is too low for comparison here. It should be noted that the WHP does include a \$500 HSA, making the actual deductible equivalent to \$700. While this may explain some of the difference, it is unlikely to account for the full amount.

A more significant source of disparity between the two estimates, however, is likely attributable to health care provider discount assumptions. Reden and Anders assumed that the WHP would pay providers the following discounts from billed charges.<sup>20</sup>

- Inpatient hospital services, 40 percent
- Outpatient hospital services, 45 percent
- Professional services (such as physician services), 45 percent
- Prescription drugs, 18 percent
- All other services, 40 percent

The LFB memo states that limited data are available on the reimbursement levels that providers currently receive. However, the Wisconsin Hospital Association's (WHA) 2005 fiscal survey shows that the typical discount for the commercial market for hospital services is around 23 percent.<sup>21</sup> This report shows that the Medicare market is more in line with the 40-45 percent rate. Anecdotal evidence suggests that this is also true in the other health care sectors, such as professional services. The 45 percent discount rate appears to be significantly higher than what is currently offered to commercial customers. Given the substantial decrease in health care provider compensation that would be provided under the WHP, it will be important to determine how this will impact Wisconsin providers. Will Wisconsin begin to lose physicians as they move to states that don't cap their earnings? Will Wisconsin be left to make do with less qualified health care providers? Will hospitals close? These questions need to be answered before moving forward on the WHP.

In summary, this analysis raises serious questions concerning the accuracy of the estimate of WHP costs.

- The cost of providing the WHP benefit, based on publicly available data, appears to be underestimated by almost \$4.3 billion per year.
- When the new estimate of plan costs is considered, the total payroll tax (employer and employee portions) required to sustain the WHP is likely to be more than 17 percent as opposed to the near 13 percent envisioned by the authors.
- The discrepancy in cost may be explained in part by out-of-pocket costs.

- A larger portion of the discrepancy is likely explained by the deeper-than-current discount levels the WHP authors assume for Wisconsin health care providers.

It is not surprising to find evidence that the WHP authors may have underestimated the costs of the plan. Other state health care initiatives have underestimated their expenses, causing major problems for state governments. Examples include plans in Kentucky and Tennessee. Kentucky Kare cost overruns were responsible for serious fiscal problems in the public employee's insurance pool. TennCare finances became so problematic that the state refused to pay providers even actuarially determined rates of payments.<sup>22</sup> A hard look needs to be taken at the Wisconsin Health Plan before proceeding to assure that Wisconsin taxpayers are not on the hook for major cost overruns.

### Spending on Health Insurance by Wisconsin Employers

WHP documents tout the fact that the state's employers currently spend an average of 15 percent of their payroll on employees' health care premiums. Given this fact, the authors argue, the WHP would be a good deal for Wisconsin firms, since the payroll tax needed to fund the new plan would top out at 12 percent for employers. Earlier in this report, we questioned the 12 percent payroll tax figure, arguing that if the real costs of providing the WHP are accounted for, the payroll tax on employers is likely to average over 15 percent. In either case, it is useful to try to ascertain what Wisconsin employers currently spend on health care as a percentage of payrolls in order to better evaluate the WHP.

It is difficult to find a good estimate for the percentage of payroll Wisconsin's employers spend on health care. Table 3 shows what appears to be a wide range of spending on health care by different types of Wisconsin employers. For example, government employers like the state of Wisconsin or Wisconsin public school districts appear to spend significantly more than private-sector firms. Data show that the state spends over 19 percent of payroll on health care, while Wisconsin public school districts spend an astounding 46 percent of wages on health care. For these two employers, it certainly appears that the WHP would save money on health care costs. (Of course, the WHP would also result in a drastic cut in benefits for employees in these sectors. This will be discussed in the next section.)

A survey of Wisconsin National Federation of Independent Business (NFIB) members found that those that offer health insurance to their employees spent, on average, 12.7 percent of wages on these benefits. A study by a Milwaukee-based benefit provider to small- to medium-size employers found that their average customer spent between 5 and 7 percent of their payroll on health benefits. Perhaps the most comprehensive study, cited in the Legislative Fiscal Bureau's memo on the WHP, found that the average health insurance premium as a percentage of all wages for private-sector Wisconsin firms was 11.8 percent. It should be noted that many Wisconsin employers, particularly small businesses, offer no health care benefits to their employees. For these employers, the WHP would represent a dramatic new cost of doing business in Wisconsin.

**TABLE 3: HEALTH CARE SPENDING IN WISCONSIN TODAY AS A PERCENTAGE OF PAYROLL**

	(1) State and Local Government	(2) Wisconsin Public Education	(3) Wisconsin Small Businesses	(4) Study by a Wisconsin Benefit Provider to Small- to Medium-Sized Businesses	(5) All Wisconsin Insuring Private- Sector Firms
<b>Health Insurance Premium as a Percentage of All Wages</b>	19.2%	46%	12.7%	5-7%	11.8%

(1) As stated by Wisconsin Health Plan authors in the Legislative Fiscal Bureau memo dated December 22, 2005. (2) 2002-2003 data from the Wisconsin Association of School Boards (WASB). (3) From a survey conducted of Wisconsin National Federation of Independent Business (NFIB) members. The estimate is based on a sample size of 115 responses. (4) From a study conducted by a Milwaukee-based benefit provider with customers averaging 23 employees. (5) This number is cited by the Legislative Fiscal Bureau memo issued on the Wisconsin Health Plan. It comes from Wisconsin-specific wage data from the Department of Workforce Development, U.S. Census Bureau data, and Medical Expenditure Panel Survey (MEPS) data.

In summary, the WHP would yield a savings in health care costs for government employers as they cut benefits for their employees. For most private-sector firms, the new payroll tax required to fund the plan would almost certainly exceed what they currently spend on health insurance. The next section of this report will analyze the effect of the WHP on the quality of health insurance coverage.

### Current Health Care Benefits in Wisconsin

As described earlier, the WHP would provide health care coverage for Wisconsin residents under age 65, with a few exceptions. Each eligible Wisconsin resident would own a health insurance purchasing account, and adults would be given a health savings account (HSA) funded at \$500 per year. The health insurance purchasing account would allow residents to purchase a benefit package including medical care, hospital care, prescription drugs, and a limited dental benefit. The benefits purchased by adults would have an annual deductible of \$1,200 and would require co-insurance for medical care, hospital care, emergency care, and prescription drugs. The annual out-of-pocket maximum costs for an individual would be \$2,000. For children, the annual deductible would be \$100 and the out-of-pocket maximum would be \$500.

Our previous cost analysis shows that once the full costs of the WHP are considered, the payroll tax necessary to fund the program is likely to be much higher than what Wisconsin firms currently spend on health care. Now we turn to a consideration of how the benefits to be provided by the WHP compare to what employers in the state currently offer their employees. Table 4 below displays a sample of the levels of health care benefits for single coverage, as measured by the annual deductible and out-of-pocket maximum, currently offered to Wisconsin residents by their employers. Column 1 shows the benefits that would be provided by the WHP. As noted above, the WHP would come with a \$1,200 deductible for adults; however, a \$500 HSA would also be provided, making the effective deductible \$700 for adults. The WHP benefits would also contain a \$2,000 out-of-pocket maximum.

**TABLE 4: COMPARISON OF WISCONSIN IN-NETWORK COST-SHARING PROVISIONS (SINGLE COVERAGE)**

	(1) Wisconsin Health Plan	(2) Average from 2005 MRA Study of Wisconsin Employers	(3) Average of 2006 Study of 500 Wisconsin Employers by Mortenson, Matzelle, Meldrum	(4) 2006 State of Wisconsin Standard Plan (1)	(5) Average Wisconsin Teacher's Union Plan (2)
<b>Annual Deductible</b>	\$1,200 (\$500 HSA provided)	\$300 - \$500	\$156 (public sector plans) \$298 (private-sector plans)	\$100	\$94.57
<b>Annual Out-of-Pocket Maximum</b>	\$2,000	\$1,100 - \$1,650	-	\$100	\$671.94

Notes: (1) From the Wisconsin Department of Employee Trust Funds (ETF) for the Tier I Plans. (2) From the Wisconsin Association of School Boards (WASB). The annual out-of-pocket maximum data are based on limited sample sizes.

Columns 2, 3, and 4 compare the WHP level of benefits to information offered by Wisconsin employers. Note that a 2005 study by the MRA of Wisconsin employers found that the average annual deductible in Wisconsin was between \$300 and \$500, and the average out-of-pocket maximum fell between \$1,100 and \$1,650.

Another study of 500 Wisconsin employers was conducted by the Mortenson, Matzelle, Meldrum firm in 2006. It focused on annual deductibles. It found that the average deductible in the state was \$156 for public-sector plans and \$298 for private-sector plans. To find a point of comparison, we also looked at benefit levels provided by the State of Wisconsin health plan, as administered by the Department of Employee Trust Funds (ETF). The benefits provided by the WHP are in many ways modeled after this plan. Column 4 shows that both the annual deductible and out-of-pocket maximum are \$100. Lastly, to get an idea of the level of benefits offered to employees represented by

unions, we analyzed data from the Wisconsin Association of School Boards (WASB) to determine the typical benefits offered to public school teachers in the state. Column 5 shows that the average annual deductible for such plans is \$94.57, with an annual out-of-pocket maximum under \$700.

The results of this limited, and somewhat anecdotal, study suggest that benefits to be provided under the WHP benefits would amount to a benefit cut for most employed Wisconsin residents. On the positive side, of course, the WHP would also provide these limited benefits to those currently without any insurance. Our analysis, however, leads to a number of questions that require further study:

- Because the WHP benefits would represent a benefit cut (and therefore essentially a cut in compensation) for most of Wisconsin's employed citizens, would Wisconsin firms be forced to offer further benefits (at an added expense) to employees in order to attract and retain them?
- The WHP benefits would represent a drastic cut in benefit levels for government and unionized employees. How might this plan affect the quality of employees electing to work in public education, for example? Many would argue that they have forgone pay raises in exchange for insurance benefits which would be taken away by this plan.

### **The Consequences of an Additional Tax on Payroll**

An old adage is that whatever you tax, you get less of it. This adage is worth bearing in mind as Wisconsin citizens consider how the state would pay for the WHP through a new payroll tax. Put simply, the proposed new payroll tax would create a *disincentive* for Wisconsin firms to increase their payrolls. Instead of fostering growth, a new payroll tax would give firms an incentive to hire fewer employees, to have them work fewer hours, to hold wages steady or to try to reduce them. It also would provide employers with an incentive to be more selective in hiring, seeking only highly productive employees. Altogether, the picture is one of undesirable outcomes.

Wisconsin has recently taken several steps to increase its attractiveness to business in order to bring new jobs and income to the state. But if Wisconsin chooses to purchase health care insurance for its citizens through the imposition of a new payroll tax, firms considering locating in this state will certainly take note of this new cost of doing business in Wisconsin. This will be the case particularly if the payroll tax leads to an increase in health care costs for most Wisconsin firms. The analysis we have presented thus far suggests that health care costs would go up for most Wisconsin private-sector employers under the WHP. Wisconsin employers are already concerned about possible increases in the Social Security tax and in unemployment taxes. Over and above these concerns, employers facing the WHP would see their costs increase when they hired new employees, when they engaged hourly employees to work more hours, and when they increased employees' compensation.

The graduated scale that has been proposed for the WHP payroll tax is also likely to have effects at the margin. Because the payroll tax rate increases at various income levels (similar to rates for personal income taxes), firms may have an incentive to keep their payrolls below a certain level and avoid paying the higher tax rate. Again, this would not be a positive development for Wisconsin jobs or incomes.

Against the background of several undesirable outcomes likely to be produced by a substantial new payroll tax, it is also worth bearing in mind who actually pays payroll taxes on businesses. Politicians often speak of imposing new taxes on business as if it were a benign act, since a large share of the tax burden would be transferred to a non-person — to a business. This is an ill-considered view. Business taxes like all other taxes are paid by individuals. A business, acting through its financial officer, writes the check for taxes owed to the government, but in doing so it merely collects the money it pays from someone else. Businesses can obtain money to pay taxes from only three sources: from its customers (in the form of higher prices), from its employees (in the form of reduced wages or benefits), or from its stockholders in the form of reduced dividends.

### **When the Tax Revenues Run Short**

It is unclear, as we have noted, what the payroll tax rate would have to be in order to fund the proposed WHP program of benefits. Regardless of the rate set initially, however, the WHP would almost certainly face revenue shortfalls before long. Information summarized in Table 5 supports this claim by reference to the average monthly premium for state employees in Dane County from 1998 to 2005. Because the WHP is, in many ways, modeled after the

health insurance plan administered by the Department of Employee Trust Funds for Wisconsin's state employees, Column (2) provides a reasonable estimate for the likely increases in costs of the WHP over time. Table 5 also shows data on total Wisconsin wages over this same time period. The columns most pertinent to our analysis are (3), the annual percentage increase in the premium for the Wisconsin state employee health plan, and (5), the annual percentage increase in Wisconsin's total wages. As the table shows, the health premiums rose, on average, by 9.63 percent per year from 1998 to 2005. Over this same time period, total Wisconsin wages rose, on average, by only 4.2 percent per year. More strikingly, Table 5 reveals that in every year analyzed, health care costs increased at a faster rate than wages. This suggests that any funding mechanism for health care that is based on a tax on payroll will almost certainly come up short every year. Exacerbating this problem is the fact that the WHP's proposed funding mechanism actually provides a substantial disincentive for Wisconsin firms to increase their payrolls.

**TABLE 5 TOTAL WAGES AND HEALTH CARE COSTS IN WISCONSIN, 1998-2005**

(1) Year	(2) Average Monthly Family Premium (State Plan HMO)	(3) % Increase (2)	(4) Total Wisconsin Wages (millions)	(5) % Increase (4)	(6) Consumer Price Index (CPI-W)	(7) % Increase (6)
1998	\$525.59	--	\$75,156	--	162.3	--
1999	571.26	8.7%	79,703	6.1%	165.4	1.9%
2000	616.90	8.0%	84,001	5.4%	170.8	3.3%
2001	700.58	13.6%	85,710	2.0%	176.6	3.4%
2002	787.15	12.4%	87,245	1.8%	178.9	1.3%
2003	865.55	10.0%	89,832	3.0%	183.3	2.5%
2004	957.88	10.7%	94,269	4.9%	187.6	2.3%
2005	996.45	4.0%	97,320	3.2%	193.2	3.0%
<b>AVERAGE</b>	<b>752.67</b>	<b>9.63%</b>	<b>86,655</b>	<b>4.2%</b>	<b>177.26</b>	<b>2.53%</b>

Notes: 2. Average premium of Dane County plans from Employee Trust Funds. 4. Wisconsin Department of Workforce Development. 6. CPI for urban wage earners and clerical workers (base period = 1982-1984) from the Bureau of Labor Statistics.

What will the options be for the WHP when the costs exceed the revenue? The WHP authors provide an answer to this question in a "Frequently Asked Questions" section of their web page.<sup>23</sup> "[The Health Insurance Purchasing Corporation] will be required to present options to the Legislature to raise revenue and lower costs." This coy answer to the question really means that there would be two alternatives:

- Increase revenue by raising the payroll tax on Wisconsin employees and employers, or
- Decrease costs by reducing benefits, decreasing the rate of reimbursement to health care providers, or rationing care.

None of these alternatives looks desirable, yet at least one of them would need to be implemented every year that the WHP is in existence, given the reality that payroll taxes set at a fixed rate cannot keep pace with rising health care costs. And given that the payroll tax is likely to be much higher at the outset than the level the plan's authors have estimated, and that the benefit levels provided by the plan are significantly lower than what most Wisconsin residents enjoy today, and that the WHP authors assume a reimbursement rate for Wisconsin health care providers at a rate well below what they currently charge in the commercial health insurance market, the options available when the plan runs short on funding all will be unpalatable.

## Creating Winners and Losers

If it were adopted and implemented, the WHP would bring about a dramatic shift away from current practice in Wisconsin's market for health care coverage. Whenever a large change is made in an important sector of the market, it is likely to affect different individuals in different ways, depending upon their circumstances. This is certainly the case with the WHP. The Legislative Fiscal Bureau analysis of the plan makes this point and suggests that the "winners" and "losers" we should expect to see from this policy shift should be more clearly identified.

Whether employers or employees would be better or worse off after the implementation of the WHP depends upon the costs and benefits provided by their current plans. Obviously, employees that have better coverage today than the coverage envisioned in the WHP would be worse off. Employers would benefit if the payroll tax they pay to fund the plan costs them less than the current costs of health care for their employees. That said, some employers, in industries with tight labor markets, might be forced to offer benefits above and beyond the WHP, adding costs above their payroll tax assessment. Earlier in this report, we presented data suggesting that the WHP would represent a cut in benefits to most of Wisconsin's employed citizens, and that the benefits would cost more than most employers currently pay. Identifying the winners and losers with anything like certainty requires a better understanding of the costs of the WHP and the current benefits afforded most Wisconsinites today. Bearing this in mind, we offer the following general thoughts about who is likely to win and who is likely to lose under the WHP.

### Likely Winners

- ***The uninsured.*** Estimates from the Wisconsin Department of Health and Family services suggest that 5 percent of Wisconsin's population had no insurance for health care during 2004.<sup>24</sup> Under the WHP, most of these Wisconsinites would gain at least limited health care benefits. It remains to be seen, however, exactly *how* beneficial the WHP would be for low-income, uninsured residents, given the dramatic cost-sharing provisions in the plan.
- ***Government.*** Government employers spend significantly more on health care benefits than employers in the private sector. Even at the higher payroll tax level we estimate, most would see a drop in their health insurance costs, as shown in Table 3.
- ***Employers with unionized workforces.*** Similarly, employers whose workers belong to strong labor unions tend to spend significantly more than other firms on health care benefits. The WHP might bring about a cut in health care costs for heavily unionized industries by severely cutting employee benefits.

### Likely Losers

- ***Most employees (especially public-sector employees).*** As shown in Table 4, most Wisconsin residents with health insurance would see a cut in their benefits under the WHP. Employees in the public sector, who frequently pay little or nothing for lucrative benefit levels, would be adversely affected.
- ***Private-sector employers.*** Table 3 shows that the typical Wisconsin private-sector employer would spend more for health care, via the new payroll tax, than they currently spend today. Many small businesses that currently don't offer health insurance would be adversely affected.
- ***Firms that operate in tight labor markets.*** These firms probably would have to pay not only the new payroll tax; they also would have to offer either a higher salary or benefits above and beyond the WHP in competition for qualified employees.
- ***Labor intensive/high wage industries.*** Because the WHP would be funded with a payroll tax, employers in firms that are labor intensive would be losers. Firms in high-paying industries also would pay heavily under the WHP. A major law firm or financial services firm, for example, would be likely to face steep increases in its health care costs. Other potential losers are indicated in Table 6, which shows data from the Wisconsin Department of Workforce Development on average annual wages by Wisconsin industry segments. This table shows that many industries Wisconsin currently seeks to attract would be strongly affected by the WHP payroll tax.

**TABLE 6: 2005 AVERAGE WAGES AND PAYROLL IN WISCONSIN INDUSTRIES**

Industry	Average Annual Wage	Total Wages
Financial Activities	\$46,267.00	\$7,291,908,993.00
Manufacturing	\$44,430.00	\$22,455,707,382.00
Information	\$43,439.00	\$2,237,725,065.00
Construction	\$42,891.00	\$5,561,460,805.00
Professional & Business Services	\$40,462.00	\$10,682,498,146.00
Public Administration	\$37,244.00	\$5,213,672,518.00
Education & Health Services	\$37,228.00	\$20,579,582,402.00
Trade, Transportation, Utilities	\$31,088.00	\$17,283,548,533.00
Natural Resources & Mining	\$27,765.00	\$590,764,898.00
Unclassified	\$27,296.00	\$396,725,624.00
Other Services	\$20,604.00	\$1,728,813,815.00
Leisure & Hospitality	\$12,468.00	\$3,298,042,465.00

Notes: From the Wisconsin Department of Workforce Development

- **Those firms that already work to control health care costs.** Many firms have made significant efforts to control their health care costs. The efforts might include wellness initiatives, a competitive bidding process, or educational programs for their employees. These firms would pay the new payroll tax like all other firms and receive no advantage for the independent efforts they put forth.
- **Health insurance agents/benefit consultants.** It is hard to imagine a role for health insurance agents or health benefit consultants if the WHP is adopted in its current form.
- **Wisconsin's Citizens.** If the WHP is adopted, the state of Wisconsin will assume responsibility for insuring all state residents through the HIPCo. It will take on the risks that come with handling rising health care costs and be saddled with responsibility for determining how to fund benefits for decades into the future. Much like Milwaukee County's requirement to pay pension benefits to retirees years into the future, the state of Wisconsin will be required to allocate tax revenue, or cut benefit levels, to pay for WHP for years to come.

### The Impact on Small Businesses and Entrepreneurs

How would the WHP affect Wisconsin's small businesses and entrepreneurs? This is an interesting question without a clear answer. On the one hand, an argument can be made that the WHP might increase entrepreneurship in the state. Under the WHP, more Wisconsin employees, with new business ideas, would be able to leave their current employers and start small businesses on their own since they would no longer be dependent on an employer for their family's health insurance. On the other hand, payroll taxes hit small businesses particularly hard. The WHP would represent another cost to doing business, one that might be steep enough to undo some new businesses, or to provide an incentive for the entrepreneur to locate in a neighboring state.

To obtain information about effects of this sort on Wisconsin's small business community, we conducted an online survey of more than 3,000 members of the Wisconsin chapter of the National Federation of Independent Business (NFIB) in the summer of 2006 (A copy of the survey is provided in the appendix of this document.). We received 319 completed surveys; however, the number of useable responses differed by question. About 68 percent of the responses came from firms with fewer than 10 employees. Another 15 percent came from firms employing between 10 and 25 employees. Only 3 percent came from firms employing 100 or more employees. The sector with the highest rate of returns was services, at 44 percent. Around 19 percent of the responses came from manufacturers, and 11 percent came from retailers. Almost 23 percent of our respondents chose "other" as their sector identification.

Questions on the survey ranged from specific inquiries into current health care benefits and costs to employers' feelings about the WHP. The results, summarized in Table 7, yield a number of interesting findings.

First, approximately 53 percent of the small businesses surveyed currently offer a group health insurance plan for their employees. This finding relates to the WHP in that it shows a large percentage of small businesses would take on a major new cost, in the form of the payroll tax, which they currently do not have. Second, in response to a question asking employers whether they offered a high deductible MSA/HSA/MRA plan to their employees, about a third of the employers said that they did. This finding suggests that certain consumer-driven solutions to high health care costs are becoming popular among small businesses. Third, as noted earlier, we asked the small businesses to tell us what percentage of their payroll they currently spend on health insurance, in order to compare this percentage with the payroll tax rate they would face under the WHP. The reported average was 12.7 percent of payroll — approximately the same rate as the one envisioned by the WHP authors, but significantly lower than the payroll tax we have estimated as necessary to fully fund the plan. It should be noted that for the average firm to report this level of spending on health insurance many, of course, spend much less while others spend more. This reinforces the idea that winners and losers will be created.

The last question in the survey described the WHP in a paragraph, including the proposed funding mechanism via a payroll tax, and asked NFIB members whether they would support such legislation in Wisconsin. Nearly 20 percent of the respondents said they would support such legislation. The largest numbers of respondents, over 50 percent of the total, were against the WHP. Interestingly, respondents from a large number of small businesses, almost 30 percent, said that they were undecided about the WHP. The results from this last question suggest a couple of salient points. First, there is little support currently among Wisconsin's small businesses for a health care policy shift to something like the WHP. But many small businesses remain undecided about the plan, perhaps indicating that health care has become such a prominent issue in their businesses that they are searching avidly for some solution to this problem.

**TABLE 7: RESULTS OF A SURVEY OF WISCONSIN NATIONAL FEDERATION OF INDEPENDENT BUSINESS (NFIB) MEMBERS**

Question	Number of Useable Responses	Response
Do you currently offer a group health insurance plan to your employees?	316	Yes = 52.5% No = 47.5%
Do you currently offer a high deductible plan with a health reimbursement account (i.e. MSA, HSA, MRA)?	166	Yes = 33.7% No = 66.3%
Approximately what percentage of your total payroll (total wages) in 2005 did you spend on health insurance premiums?	115	Average = 12.7%
Should legislation be enacted that would create a statewide health insurance purchasing pool funded by a tax on payroll (1)?	278	Yes = 19.8% No = 50.4% Undecided = 29.9%

(1) See the appendix for the description of the Wisconsin Health Plan used in this survey

### The Central Decision Making Authority

As mentioned earlier, the WHP calls for the establishment of a new private, nonprofit corporation called the Health Insurance Purchasing Corporation (HIPCo). This Board would be responsible for establishing and operating the new health insurance purchasing arrangement. The eight members of the HIPCo Board of Directors would be responsible for making health care decisions that would affect millions of Wisconsin citizens. In fact, this unelected board with no health care expertise would make major health care decisions for Wisconsin residents. They would decide what medical procedures are covered for all residents in the state.

This proposed concentration of decision making into one body has two serious disadvantages. First, it would hinder competition in the health care sector. Competition is driven by the decisions of many consumers. While millions of Wisconsin citizens would be able to choose their own health care plan under WHP, the alternatives would be determined by the HIPCo. This Board would make the call on the health care options accessible to Wisconsin citizens. It would become the final arbiter of health care in the state.

How would decisions made by the members of a centralized HIPCo Board differ from decisions made within a consumer-driven model? Herzlinger (2004)<sup>25</sup> argues that “when consumers drive health care, it will be better and cheaper.” She suggests that one reason average consumers can change a sector as vast as health care is that markets are not guided by the average consumer. Rather, they are guided by the marginal consumer. The marginal consumer is their last consumer. It is this last group of highly demanding consumers that seek large amounts of information, drive hard bargains, and make the final difference for the producer’s success. The WHP would place a vast amount of authority in the hands a few appointed officials rather than depending on the abilities of individual consumers to choose what is best for them.

Second, the WHP would create a new state entitlement to health care for Wisconsin citizens. Entitlement programs rarely stand still. Given an entitlement that is initially circumscribed, interest groups of all sorts will fight relentlessly to expand its scope of coverage for their members. The existence of the HIPCo would allow interest groups to concentrate their efforts on this group. The stakes would be high, the pressure intense.

The track record of Social Security and Medicare provide examples of what happens over time when new entitlements are created. Initially, the WHP would offer a basic set of coverage plans envisioned by the WHP authors. (This was also the case with Social Security in 1935; it began as a modest plan.) But, as time goes on, members of the HIPCo Board will be pressured to expand mandates to cover more and more procedures. Early on, coverage might be mandated for prescription drugs. Later, coverage will be mandated for hair transplants and cosmetic surgery.

### Now Is Not the Time to Give Up on Market Solutions

What most clearly distinguishes the purchase of health care from the purchase of hamburgers is that health care is regarded as a necessity. Its status as a necessity causes many people to regard health care as a basic right, an entitlement, the distribution of which should have nothing to do with prices and income. But the entitlement sector—Social Security, Medicare, Medicaid—is the one most marked by failure and an inability to contain costs.

Markets work well to provide us with most of the goods and services that we need and want. The health care sector should be no exception. But in the health care sector, insurers and employers hold sway. Herzlinger (2004) argues that the time has come to give consumers a chance. In a consumer-driven health care system, health insurers would act like automobile and life insurers who sell directly to the consumer. They would seek out all consumers, including the self-employed, and not only those employed in large organizations. Herzlinger (2004) asserts that putting consumers in charge would slow the trend toward increasing costs while also improving quality. A number of programs that promote consumer-driven health care are already in place in Wisconsin, and nationally, with a strong potential to profoundly affect the health insurance market, moving it closer to a consumer-dominated market system. Examples include the following:

- **Wisconsin Health Information Organization (WHIO):** This consortium includes managed-care companies, employer groups, hospitals, and doctors. The plan is to create the state's largest warehouse of information on how hospitals and doctors treat patients. The companies, which historically have not shared information, will pool their data, without patients' names, on health insurance claims. The plan is to mine through the health insurance claims to find out which doctors and hospitals consistently provide quality care at the lowest cost.
- **Wisconsin Collaborative for Healthcare Quality (WCHQ):**<sup>26</sup> This collaborative is working to promote the development and sharing of best practices among health care providers for the benefit of patients and communities.
- **Checkpoint:** A program developed by the Wisconsin Hospital Association<sup>27</sup> that reports information about quality improvement initiatives for the benefit of consumers, benefit designers, and hospitals.

National efforts are also underway. Wisconsin First District Congressman Paul Ryan has provided leadership at the national level. This year, for example, Congress approved legislation to give every individual a chance to own

his or her electronic medical record. This legislation helps to establish a nationwide health information network so that patients' medical information can travel with them, regardless of which doctor or hospital they visit. Moving to electronic-based medical records will also help reduce paperwork, lower administrative costs, and streamline the reporting of public information. These efforts will help to reduce the cost of health care.

In 2005 Congress considered legislation to provide new incentives for uninsured persons to purchase health care insurance. One provision would allow an individual who purchases a high-deductible health plan combined with an HSA, and does not receive health insurance through an employer (or any government program), to deduct from his or her taxable income the amount of the premium. Several other ideas have been proposed.

- ***Small business tax credit.*** Under this proposal, small businesses of up to 100 employees would receive a refundable tax credit for contributions they make to their employees' health savings accounts (up to \$200 for a contribution into an individual HSA, or \$500 for a family HSA.) In order to be eligible for the credit for contributions to HSAs, the employer must offer a group high-deductible health plan.
- ***Low-income tax credit for the purchase of health insurance.*** In order to help low-income people get coverage, this proposal calls for a subsidy of up to 90 percent of the cost of health insurance premiums — up to \$1,000 for an individual or up to \$3,000 for a family plan. This credit would be refundable, advanceable, and assignable — meaning the money would go straight to the insurer of the consumer's choice, to pay for his or her health care on a monthly basis.

With the exception of funding and governance, the WHP offers nothing new for the Wisconsin health care sector. Nothing in this plan impacts the delivery of health care; that is there is no mechanism to help remove waste and the redundancies that in turn lead to many of the dramatic cost increases we see today. A vibrant market solution will reform both the financing and delivery aspects of the health care sector in Wisconsin.

## CONCLUSIONS AND RECOMMENDATIONS

Early in this report we suggested four criteria to judge the adequacy of health care reform proposals. Our criteria included increasing health care coverage, shifting responsibilities to consumers, increasing price competition, and limiting the role of government. How does the WHP stack up?

First, the WHP would mandate that virtually all Wisconsin residents have access to health care, and that is a positive. The WHP through its "premium credits" and the \$500 contribution to individual HSAs would increase the role of individual consumers in making health care decisions. These two policies when combined with the establishment of the HIPCo may also result in some increase in price competition. The WHP gets a passing grade here.

But WHP as proposed to date is problematic in several respects, especially regarding undesirable side effects. The WHP calls for a massive increase in the role of state government in the health care market as all Wisconsin residents receive health care insurance as an entitlement paid for by a new payroll tax. The WHP mandates a one-size-fits-all health insurance plan without brakes and state government at the steering wheel. About this, our analysis suggests the following critical observations:

- The costs of the WHP will be much higher than the current authors' cost estimates. Thus the payroll tax rate will need to be much higher than the one initially proposed. The payroll tax will significantly increase the burden Wisconsin employers bear in paying for the health care of all state residents. Of course, the actual costs of the new payroll tax will be passed along to consumers, employees, stock holders or some combination of these sources of revenue.
- There is almost no chance that a payroll tax will keep pace with rising health care costs over time. As a result, a governing body will need to make decisions about increasing the payroll tax, cutting benefits, or reducing reimbursements to providers.
- The WHP will produce serious secondary effects. It will provide health care insurance for citizens who are currently uninsured — a commendable outcome. But the WHP will create losers as well as winners. Under the WHP, many Wisconsin residents will see a reduction in their health care benefits. Winners will include government employers; losers will be concentrated in Wisconsin's private-sector firms.

Speaking from this critical stance, we offer the following recommendations regarding the future of the WHP.

**Recommendation 1.** Wisconsin should reject the broad policy approach represented by the WHP. Efforts to reform health care in the state should be guided by the consumer-driven, market-based movement in health care management already underway in the state and nationally.

If Wisconsin policy leaders are determined to approve a new health care policy along the lines of the WHP despite the shortcomings noted in this report, we then make the following additional recommendations.

**Recommendation 2.** An actuarial analysis of the WHP's costs should be conducted by a third-party consultant. Total costs of the plan should be calculated along with the payroll tax necessary to raise the revenue required to fund the plan. This analysis should include an identification of the winners and losers that would be created by the new payroll tax. Further, the analysis should investigate the discount rate that is currently offered by health care providers in the commercial market and determine what effect a change in this rate by the WHP would have on the quality and availability of health care in Wisconsin.

**Recommendation 3.** The WHP should include a strategy for eliminating the cost over-runs that are likely to occur in most years. The strategy would likely require a large contingency reserve. That reserve should be included in the projected costs of the plan.

**Recommendation 4.** The proposed organization of the HIPCo should be restructured. Wisconsin's citizens are unlikely to accept an unelected board, lacking in expertise, as the body responsible for serious health care decisions in the state.

## APPENDIX 1

**TABLE 1 ESTIMATE OF TOTAL 2005 COMMERCIAL INSURANCE EXPENDITURES IN WISCONSIN USING CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) ( IN MILLIONS)**

2004 Wisconsin Personal Health Care Expenditures (PHCE)	\$31,231
LESS:	
2004 Wisconsin Medicare Personal Health Care Expenditures	\$4,895
2004 Wisconsin Medicaid Personal Health Care Expenditures	\$4,261
2004 Veterans Administration and Other	\$1,349
Benefits Not Included in Wisconsin Health Plan(1)	\$3,661
2004 Total	\$17,065
<b>2005 PHCE (add 8% average increase in PHCE since 2000)</b>	<b>\$18,430</b>
PLUS:	
Insurance Administrative Expenses (average for WI insurers)	\$1,185
<b>2005 Commercial Insurance Expenditures (2)</b>	<b>\$19,615</b>

Notes: (1) Includes nursing home, dental, and other services. The WHP will cover some limited dental care for children. (2) Personal Health Care Expenditures do not include insurance administrative expenses.

**TABLE 2 ESTIMATE OF 2005 COMMERCIAL INSURANCE EXPENDITURES IN WISCONSIN FROM WISCONSIN ECONOMIC TOTALS (IN MILLIONS)**

2005 Gross State Product (1)	\$217,537
Health Care Percentage of Total (16%) (2)	\$34,806
LESS:	
2005 Wisconsin Medicare Personal Health Care Expenditures (3)	\$5,287
2005 Wisconsin Medicaid Personal Health Care Expenditures (3)	\$4,602
2005 Veterans Administration and Other (3)	\$1,457
Benefits Not Included in Wisconsin Health Plan (3)	\$3,954
<b>2005 Total</b>	<b>\$19,506</b>

Notes: (1) This is an estimate by the U.S. Bureau of Economic Analysis. (2) Based on a U.S. average from Department of Commerce, Bureau of Economic Analysis. (3) The 2004 data were used and then increased by 8%, the average annual growth rate since 2000.

**TABLE 3 ESTIMATE OF 2005 COMMERCIAL INSURANCE EXPENDITURES IN WISCONSIN FROM TOTAL HOSPITAL PAYMENT DATA (IN MILLIONS)**

2005 Total Hospital Commercial Payments (1)	\$7,546
<b>2005 Estimated Commercial Expenditures (Assumes hospitals represent 35% of total commercial payments) (2)</b>	<b>\$21,559</b>

Notes: (1) From the Wisconsin Hospital Association Information Center, 2005 Hospital Fiscal Survey. (2) From the Centers for Medicare and Medicaid Services (CMS).

## Wisconsin Health Insurance Policy Survey

### Background Information:

Number of Employees	<input type="radio"/> < 10	<input type="radio"/> 11-25	<input type="radio"/> 26-50	<input type="radio"/> 51-100	<input type="radio"/> >100
Business Type	<input type="radio"/> Manufacturing	<input type="radio"/> Retail	<input type="radio"/> Service	<input type="radio"/> Technology	<input type="radio"/> Other

### Current Health Insurance Information:

1. Do you currently offer a group health insurance plan to your employees?

<input type="radio"/> Yes	<input type="radio"/> No
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2. Do you currently offer a high deductible plan with a health reimbursement account (i.e. MSA, HSA, MRA)?

<input type="radio"/> Yes	<input type="radio"/> No
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If you answered **No** to question 1 above, please skip to the **State Health Insurance Policy** section below. If you answered **Yes**, please continue to question 3 below.

3. Approximately what percentage of your total payroll (total wages) in 2005 did you spend on health insurance premiums (including your contribution to an MSA, HSA, MRA, etc.) ? \_\_\_\_\_

### State Health Insurance Policy:

A health insurance proposal has been introduced that would create a government-driven health purchasing pool funded with assessments on the payroll from employers, including the self-employed and farmers. The plan would cover all residents under 65 years of age, including part-time workers. The goals of the plan are to ease health care costs, provide coverage for the uninsured and solve the Medicaid deficit. Assessments would be based upon a percentage of Medicare wages from 3 percent of the first \$50,000 and gradually increasing to a maximum of 12 percent of payroll for any amount of \$500,000 and more. Participation in the plan would be mandatory, and participants could select from plans with varying levels of coverage, deductibles and co-pays. Insurance plans and benefits would be determined by a non-elected eight person board of directors.

Should legislation be enacted that would create a statewide health insurance purchasing pool funded by a tax on payroll as described above?

<input type="radio"/> Yes	<input type="radio"/> No
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## NOTES AND REFERENCES

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10. Herzlinger, Regina E. *Market-Driven Health Care*. Reading, MA: Addison-Wesley Publishing Company.
11. The Wisconsin Health Plan (WHP) will be summarized using information obtained from the web site of the Wisconsin Health Project: <http://www.wisconsinhealthproject.org/>, the actual Assembly Bill 1140 and the Legislative Fiscal Bureau memo on the Wisconsin Health Plan dated December 22, 2005.
12. The Wisconsin Health Plan Tier system would work in a very similar manner to the current health insurance plan for state employees run by the Department of Employee Trust Funds (ETF).
13. The web site for the Wisconsin Health Project is: <http://www.wisconsinhealthproject.org/>. The funding mechanism is also discussed in the Legislative Fiscal Bureau memo on the Wisconsin Health Plan dated December 22, 2005.
14. Quoted by Cogan, John F.; Hubbard, Glenn, R.; and Kessler, Daniel P. "Healthy, Wealthy and Wise" *The Wall Street Journal*, May 4, 2006.
15. More can be read about this analysis in the Legislative Fiscal Bureau memo on the Wisconsin Health Plan dated December 22, 2005.
16. This calculation is reproduced from a Legislative Fiscal Bureau (LFB) memo on the Wisconsin Health Plan dated December 22, 2005.
17. This includes payments to Medicare, Medicaid, or benefits not covered under the WHP like nursing home, dental, and other services.
18. The Legislative Fiscal Bureau memo did not make this adjustment to the total health care expenditure data that they cited; however, they did mention this as one potential source of difference between their result and the WHP assumptions.
19. The WHP would also collect revenue from a special assessment on Wisconsin residents working out-of-state.
20. This information is summarized from a Legislative Fiscal Bureau (LFB) memo on the Wisconsin Health Plan dated December 22, 2005.
21. 2005 Wisconsin Hospital Association (WHA) Fiscal Survey.
22. More information about the problems with TennCare can be found in a Tennessee Department of Finance and Administration audit dated June 30, 2003.
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26. More information is available from: <http://www.wchq.org/>.
27. For more information see: <http://www.wha.org/>.

## ABOUT THE INSTITUTE

The **Wisconsin Policy Research Institute** is a not-for-profit institute established to study public-policy issues affecting the state of Wisconsin.

Under the new federalism, government policy increasingly is made at the state and local levels. These public-policy decisions affect the life of every citizen in the state. Our goal is to provide nonpartisan research on key issues affecting Wisconsinites, so that their elected representatives can make informed decisions to improve the quality of life and future of the state.

Our major priority is to increase the accountability of Wisconsin's government. State and local governments must be responsive to the citizenry, both in terms of the programs they devise and the tax money they spend. Accountability should apply in every area to which the state devotes the public's funds.

The Institute's agenda encompasses the following issues: education, welfare and social services, criminal justice, taxes and spending, and economic development.

We believe that the views of the citizens of Wisconsin should guide the decisions of government officials. To help accomplish this, we also conduct regular public-opinion polls that are designed to inform public officials about how the citizenry views major statewide issues. These polls are disseminated through the media and are made available to the general public and the legislative and executive branches of state government. It is essential that elected officials remember that all of the programs they create and all of the money they spend comes from the citizens of Wisconsin and is made available through their taxes. Public policy should reflect the real needs and concerns of all of the citizens of the state and not those of specific special-interest groups.