



COUNCIL DRAFT V.1

HEALTHY WISCONSIN COUNCIL
REPORT

DECEMBER 2006

I. EXECUTIVE SUMMARY

Governor Doyle created the Healthy Wisconsin Council in July, 2006, and charged it with developing an action plan to achieve the following:

- Reduce the uninsured rate in Wisconsin by 50 percent.
- Reduce health insurance premiums for individuals and small businesses by 30 percent.
- Strengthen the private insurance market in Wisconsin.
- Encourage more employers to offer comprehensive, affordable health coverage to their employees.
- Explore ways that other states have increased federal financial support for similar initiatives.
- Identify existing health insurance regulations and suggesting changes to help the Healthy Wisconsin program be successful.

The Council met eight times to explore the options available in establishing a reinsurance product. In brief, reinsurance is insurance for insurance companies and helps to offset the high cost of health care for individuals who suffer serious illness or injury. The Council examined models from states around the country, and identified available funding sources that will help to ensure the affordability of the Healthy Wisconsin product. The Council defined two challenges and developed two recommendations to address them. One recommendation addresses the challenge of rising premiums and stabilization of employer-sponsored health insurance market. The second recommendation addresses the challenge of uninsured, poor individuals. The Council proposes to implement both recommendations.

The Challenge of Reducing and Stabilizing Premiums in Employer-Sponsored Health Insurance

The number of residents covered by employer-sponsored insurance is decreasing. In 2001, 76 percent of Wisconsin's residents had their health insurance provided by their employers. That number dropped to 69 percent in 2004.

Health insurance costs in Wisconsin are high and growing. The total cost of employer sponsored health benefits in Wisconsin increased by 9.3 percent in 2006, to an average of \$9,516 for each employee. This is 26 percent more than the national average according to a survey by Mercer Health & Benefits LLC.

As a first priority, the Council examined the challenges for small employers. The small group (2-50 employees) health insurance market is weakening. In 2004, only 42 percent of small firms offered health insurance in Wisconsin. However, 96 percent of large firms offered health insurance. The Kaiser Family Foundation in its annual survey of health benefits found that firms with 3-24 workers experienced an 11.8 percent increase in premiums in 2005.

RECOMMENDATION #1

Create a Healthy Wisconsin Authority to Provide Reinsurance for Small Businesses and Co-ops

The proposal is designed to provide reinsurance for all small businesses and health care cooperatives in the state. The primary health insurance coverage will continue to be provided through the existing insurance market as it is done currently. The reinsurance program would pay a large portion of catastrophic claims above a specific attachment point or within a specific corridor. About 796,000 lives are covered under a small group market. Under this option, insurers would be required to pay a premium on each life they cover in their small group book of business. The state would subsidize the program. The Office of the Commissioner of Insurance (OCI) would ensure that the savings generated by the reinsurance program would be passed down to small businesses. Insurance companies would be largely unaffected as a result of the program and small businesses would continue to purchase insurance as they do now.

The Challenge of Reducing Wisconsin's Uninsured By At Least 50 percent

About 272,000 of Wisconsin residents between ages of 0 to 64 were uninsured for the entire year in 2004. Of those, 34,000 were between age 0-17, with the remaining 238,000 between 18 and 64. State and federal surveys indicate that the number of people insured through their employers is decreasing and the number of uninsured is increasing. It is important to note that 65 percent of the uninsured in Wisconsin are employed – an estimated 65,000 uninsured residents work for large employers (51 or more employees) and an estimated 92,000 uninsured residents work for small employers (50 employees or less, including self-employed). An estimated 81,000 uninsured residents are not working.

Many low-income individuals are uninsured because Medicaid does not cover childless adults under age 65. An estimated 61,000 childless adults (single adults and empty-nesters) have income below 200 percent of Federal Poverty Line (FPL) but do not qualify for Medicaid because they are not custodial parents or they do not have a disability. According to the 2006 federal poverty guidelines, 200 percent of FPL is \$19,600 annual income for a single person and \$26,400 for a family of two.

Health insurance affects access to health care as well as the financial well-being of families. According to the Kaiser Commission on Medicaid and Uninsured, over 40 percent of nonelderly uninsured adults have no regular source of health care, and coupled with a fear of high medical bills, many delay or forgo needed care. Delaying or forgoing needed primary care can lead to more serious illnesses and health problems. Lack of health coverage not only affects access to care and health status, but also job decisions and financial security.

RECOMENDATION #2

Develop a Medicaid Expansion Waiver to Cover Childless Uninsured Adults under 200 percent of the Federal Poverty Line

This proposal is an expansion of Medicaid to poor single adults who currently do not qualify for Medicaid. An estimated 61,000 people could qualify for the program, 23,000 of the poorest have incomes below 100 percent of the FPL and an additional 38,000 have incomes between 100 percent and 200 percent of the FPL. Some states have already received federal approval to expand Medicaid to childless adults. Reinsurance is not part of this proposal, but the program would directly lower the number of uninsured.

Cost and Impact for Both Recommendations

A subsidy is an important component of a successful reinsurance program to lower reinsurance premiums which will lead to lower rates. One option to fund a subsidy is to raise the cigarette tax. Currently, the cigarette tax in Wisconsin is \$0.77 per pack. Annual state revenues from the state cigarette tax are \$ 294.3 million (2005). It is estimated that a \$1 increase per pack of cigarettes would increase tax revenue by \$227.5 million (Campaign for Tobacco Free Kids provided this estimate during the public hearing). The subsidy used for reinsurance programs and Medicaid expansion would help uninsured residents to gain access to health care and would also help to stabilize and lower premium costs in the small group market. In result, more people would have health insurance. In addition to providing potential revenue for a subsidy, a cigarette tax increase is estimated to help decrease youth smoking by an estimated 16.7 percent.

II. BACKGROUND INFORMATION

Governor's Health Care Vision and Agenda

Governor Jim Doyle strongly believes that every Wisconsin resident has a right to health care and state government must do what it can to ensure that residents have access to high quality, affordable health care. No child in the state should ever be without health insurance.

The rising cost of health care is impeding the growth of the Wisconsin economy. Governor Doyle believes that state government must work with the private sector and other stakeholders to find ways to control costs. The Governor's health care agenda includes several complimentary initiatives related to broad goals to decrease the number of uninsured and to lower health insurance premiums.

- BadgerCare Plus is a policy solution to ensure that all of Wisconsin's children have access to health care. BadgerCare Plus will merge family Medicaid, BadgerCare, and Healthy Start programs to form a comprehensive health insurance program for low income children and families. In addition, Wisconsin will streamline eligibility, assist employees in purchasing quality, employer-sponsored coverage, and provide incentives for healthy behaviors. This proposal represents the most sweeping reform of the low-income, family portion of the Medicaid program in Wisconsin since its inception in 1967.
- Part of the Governor's affordability agenda is to reduce costs of health insurance premiums by leading the effort to leverage the power of health information technology. The power of health information technology can reduce medical errors, avoid costly duplicative testing, eliminate unnecessary hospitalizations, and provide a framework for using evidence based medicine in all settings. The E-Health board was created by an executive order last year and was charged with developing a road map for statewide use of health information technology.
- Affordable drugs are available for Wisconsin residents through programs such as Senior Care, BadgerRx, and the Canadian Drug Website. SeniorCare is Wisconsin's Prescription Drug Assistance Program for Wisconsin residents who are 65 years of age or older and who meet eligibility requirements. SeniorCare will expire by the end of June 2007 if a waiver extension is not approved by the federal government. BadgerRx provides a pooled purchasing power for buying prescription drugs. The program is available to government units, businesses, and individuals. The Governor's prescription drug website www.drugsavings.wi.gov helps save Wisconsin citizens thousands of dollars on prescriptions. Through the website, Wisconsin residents are able to purchase prescription drugs directly from Canadian pharmacies the state has visited and found to be safe, reputable, and reliable. Since unveiling the site, more than 415,000 people have visited it. The website includes three respected Canadian mail order pharmacies. Savings available through the website range from 33 percent for Lipitor to 52 percent for Celebrex.
- The health affordability agenda also include a full tax deduction for health insurance premiums for all Wisconsin citizens. Whatever people pay for their health insurance

premiums - whether they are self employed or get insurance through their employer - would not be taxed.

Healthy Wisconsin Executive Order

Though BadgerCare Plus, E-Health Board, Senior Care, and other programs address many of the health care cost and access problems, some problems remain unresolved.

In his State of the State address in January 2006, Governor Jim Doyle announced his plan to lower health care costs and pass along the savings to middle class families through the Healthy Wisconsin Initiative.

Governor Doyle created the Healthy Wisconsin Council in July, 2006, and charged it with developing an action plan that, in concert his other health care initiatives, will to achieve the following:

- Reduce the uninsured rate in Wisconsin by 50 percent.
- Reduce health insurance premiums for individuals and small businesses by 30 percent.
- Strengthen the private insurance market in Wisconsin.
- Encourage more employers to offer comprehensive, affordable health coverage to their employees.
- Explore ways that other states have increased federal financial support for similar initiatives.
- Identify existing health insurance regulations and suggesting changes to help the Healthy Wisconsin program be successful.

Governor Doyle appointed Dr. David Kindig, Professor Emeritus at the University of Wisconsin-Madison, and Michael Weiden, partner at Quarles & Brady, LLP to chair the Council. The Council consists of twenty members, representing a wide variety of interests, including two state Senators and one state Representative. A full list of committee members is included as Appendix 1 to this report.

Summary of Meetings

The Council met eight times to explore the options available in developing a reinsurance product, examined models from states around the country, and identified available funding sources that will help to ensure the affordability of the Healthy Wisconsin product.

Timeline and topics of meetings:

- **Introductory and Organizational Meeting**
July 31, 2006
Staff briefing about the goals of the Council, the Governor's Health Care agenda and the basics of reinsurance; meet the Council members and discuss future topics.
- **Defining the Target Population**
August 22, 2006

Present and discuss information regarding the uninsured population and trends in that population. Review trends in insurance rates for businesses and individuals.

- Mapping the Structure
September 6, 2006

Discuss what the Healthy Wisconsin reinsurance product and program might be, including: how it would be administered, the parameters of coverage, pertinent insurance rules and regulations, and how the savings translate into lower premiums for consumers.

- Mapping the Structure (Part 2)
September 26, 2006

Continue the discussion from the previous meeting concerning the structure of the Healthy Wisconsin reinsurance product.

- Exploring Funding Options
October 13, 2006

Discuss funding sources, including ways to leverage federal dollars, to support this effort.

- Participation in the Program
November 9, 2006

Discuss options for enrolling members in Healthy Wisconsin.

- Review Options/Recommendations
December 12, 2006

Review draft proposals based on the discussions at previous meetings; begin to assemble the Healthy Wisconsin proposal for submission to the Governor.

- Finalize Report
December 19, 2006

In addition to the Council's meetings, three public forums were held in Oshkosh, Eau Claire, and Waukesha. A public hearing on draft proposals was held in Madison on November 21, 2006.

III. DISCUSSION

The Healthy Wisconsin Council's discussions (and the name) started with the examination of the Healthy New York program, which is the most prominent example of a reinsurance program targeted at uninsured individuals and small businesses who currently do not offer insurance (described in detail in Appendix 3), and several other reinsurance programs in other states. The Council started exploring ways to develop several options to decrease the number of uninsured and to strengthen the private insurance market, as directed by the Governor.

A. The Challenge of Reducing and Stabilizing Premiums in Employer-Based Health Insurance

The number of residents covered by employer-sponsored insurance is decreasing. In 2001, 76 percent of Wisconsin's residents had their health insurance provided by their employers. That number dropped to 69 percent in 2004.¹ A recent report from the Kaiser Commission on Medicaid and the Uninsured indicates that this number continues to decline.²

Health insurance costs in Wisconsin are high and growing. The total cost of employer sponsored health benefits in Wisconsin increased by 9.3 percent in 2006, to an average of \$9,516 for each employee. This is 26 percent more than the national average according to a survey by Mercer Health & Benefits LLC.³

Employee premium contributions and out-of-pocket costs have been rising faster than wages, creating a growing "affordability gap" for employer-sponsored plans for low-income working families.⁴ In some cases, self-employed individuals, farm families, and employees of small firms without any health insurance plans may not be able to afford coverage for their children, even with incomes above 300 percent of FPL.

As a first priority, the Council examined the challenges for small employers. The small group (2-50 employees) health insurance market is weakening. Fewer and fewer small employers offer health insurance to their employees. In 2004, only 42 percent of small firms offered health insurance in Wisconsin.⁵ However, 96 percent of large firms offered health insurance. The Kaiser Family Foundation in its annual survey of health benefits⁶ found that firms with 3-24 workers experienced an 11.8 percent increase in premiums in 2005. That increase was 32 percent larger than what large firms (more than 200 workers) faced. As the table below indicates, most establishments in Wisconsin are small, but most of the workforce work for large employers.

Number of Establishments and Employees in Wisconsin, 2004

	Total	Employer Size	
		Small	Large
Establishments	132,800	78 %	22 %
Employees	2,532,400	30 %	70 %

Source: MEPS, Table II.A.1.a(2004) Percent of number of private-sector establishments by firm size and State: United States, 2004

Note: Small is defined as 50 or less employees, large as 51 or more.

¹ Census Bureau. *Current Population Survey*. Historical Health Insurance Tables (Table HI-6 Health Insurance Coverage Status and Type of Coverage by State – People under 65: 1987-2004). Accessed on April 20, 2006.

² Urban Institute and Kaiser Commission on Medicaid and Uninsured estimates based on the Census Bureau's March 2004 and 2005 Current Population Survey (CPS: Annual Social and Economic Supplements).

³ "Benefit tab 26 percent higher in state" Milwaukee Journal Sentinel, November 20, 2006, <http://www.jsonline.com/story/index.aspx?id=533357> accessed on November 21, 2006.

⁴ Kaiser Commission on Medicaid and Uninsured. www.kaiseredu.org/tutorials/uninsured/uninsured2006.ppt accessed on October 11, 2006.

⁵ Medical Expenditure Panel Survey (MEPS), Table II.A.2(2004) Percent of private-sector establishments that offer health insurance by firm size and State: United States, Wisconsin 2004

⁶ Kaiser/Health Research and Education Trust Survey of Employer-Sponsored Health Benefits, 2005.

An existing initiative to make health insurance more affordable to individuals, farmers, self-employed, and small businesses is that of Co-op Care, and the Council discussed the possibility of its integration into Healthy Wisconsin. The 2003 Wisconsin Act 101 allowed establishment of health benefit purchasing cooperatives in the state. The goal of Co-op Care - health purchasing cooperatives - is to form large groups of agricultural producers and businesses and, thereby, increase their buying power. The Wisconsin Federation of Cooperatives (WFC) helps to find funding and to establish such cooperatives. According to the WFC, Co-op Care's objective is to provide comprehensive coverage, rate stabilization, and consumerism in health care purchase decisions for participating members. Self-employed (including farmers) most often purchase health insurance in a non-group market because by definition they do not have a "group" to cover. A small group market in Wisconsin is defined as a group of at least two and up to 50. If Co-op Care would be included in the small group reinsurance market, many self-employed individuals (including farmers) could benefit from reinsurance if they joined a Co-op Care.

As a voluntary purchasing pool, Co-op Care faces two major challenges. One challenge is to avoid adverse selection. Since a pool is voluntary, people and businesses who need healthcare most will be the most willing participants in a pool, however, the pool may be too small to spread the risk of high medical expenses. Co-op Care hopes to overcome the adverse selection problem by requiring participating members to stay in the pool for at least three years and by creating and funding a stop loss fund which is proposed to pay 90 percent of health claims between \$30,000 and \$90,000. In effect, the stop loss fund will serve as a reinsurance program for this pool. The second challenge is to find insurance providers willing to provide coverage in the areas where cooperatives would be established. No partnerships between cooperatives and insurers have yet been formed although a number are under consideration. The benefits associated with eligibility for the reinsurance pool may be a needed catalyst to start forming Co-ops.

Building on the Healthy New York example, the Council considered the potential of a state reinsurance pool which could serve to reduce and stabilize premiums and indirectly reduce the number of uninsured by making insurance more affordable to small businesses and Co-ops. Reinsurance is most simply defined as "insurance for insurance companies." Just like individuals, insurance companies want to protect themselves against unforeseen and costly events. In fact, insurance companies base their livelihood on being able to assess risk. The more risk that an insurance company calculates, the more money it will demand to compensate for taking the risk, primarily through increasing premium rates. Small employers face higher premiums because they represent small groups and risk cannot be spread as widely as in large groups.

Reinsurance covers the extreme high cost of catastrophic medical procedures or higher than expected aggregate costs across an entire book of business. By removing some of the highest medical costs from the insurer, reinsurance programs reduce risk and lower both expenses for insurance companies and insurance premiums. Reinsurance can also help to stabilize premium rates, leading to smaller and more predictable annual increases in insurance premiums. In the market for health insurance, lower and more stable premiums make the purchase of insurance more viable for those whom the cost of coverage was previously too expensive. With less expensive policies, more businesses, especially small companies, can afford to offer their employees quality coverage. More families can afford

health insurance when costs are more predictable and premiums are lower. In this way, reinsurance can reduce the number of people without health insurance.⁷

In discussing reinsurance, the Council agreed on the following broad parameters:

- Any reinsurance program should be targeted at the small group market and should be based on employer-sponsored insurance. Depending on how a reinsurance program would be structured, crowd out has to be considered. Also, a program could start incrementally, perhaps with a pilot program to test impact.
- Learning from other states and existing programs in Wisconsin, the Council thought that participation must be mandatory or otherwise the program will not work. Council members wanted a program that could benefit employers who currently offer insurance, not just uninsured individuals.
- The program should be structured in a transparent way in terms of data and rates.
- The Council thought that a reinsurance program must be subsidized to achieve a meaningful reduction in premiums and impact the number of uninsured.

The Council discussed two options aimed at reducing premiums through a statewide reinsurance pool. The recommended option is to initially develop such a program for the more than 700,000 Wisconsin residents in the small group and Co-op category. Insurers cannot spread risk over a small group as widely as over a large group, and, therefore, charge higher premiums. If one employee gets sick, the whole group usually experiences sharp increases in premiums. One of the developed options would require insurance providers to put every covered life in a statewide reinsurance pool. The state would subsidize the program and would pay for high-cost claims within a corridor. The goal of a statewide pool is to stabilize the market and provide a competitive advantage to small businesses in Wisconsin, as it relates to access to and the cost of health insurance, as compared to other states. Another option would expand the reinsurance statewide to all businesses and individuals.

HEALTHY WISCONSIN COUNCIL RECOMMENDATION #1: Create a Healthy Wisconsin Authority to Provide Reinsurance for Small Businesses and Co-ops

The proposal is designed to provide reinsurance for all small businesses. The primary coverage would be provided through the existing insurance market as it is done currently. The existing standards and regulations would remain unchanged. The reinsurance program would pay a large portion of catastrophic claims above a specific attachment point or within a specific corridor. About 796,000 lives are covered under the small group market. Under this option, insurers would be required to pay a premium on each life covered under the

⁷ American Academy of Actuaries. (2005). "Medical Reinsurance: Considerations for Designing a Government Sponsored Program." & K. Swartz (2006) "Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do."

small group book of business. The state would subsidize the program. The Office of the Commissioner of Insurance (OCI) would ensure that all savings generated by the reinsurance program would be passed down to small businesses. OCI has existing authority to adjust rate bands within the small group market which might be an appropriate vehicle to ensure passing of savings. Insurance companies would be largely unaffected as a result of the program and small businesses would continue to purchase insurance as they do now.

Strengths of this Recommendation

- A small group reinsurance program would directly lower premiums due to creation of a statewide, mandatory reinsurance pool that is subsidized.
- The program addresses one of the most problematic sectors of the health insurance market – small groups.
- The program does not encourage crowd out of any existing insurance products; it may help stabilize the small group market.
- The program is relatively easy to administer. Small businesses would not be required to change their behavior.
- A balanced board of the reinsurance program would ensure that decisions are made based on mutual best interest of the board members.

Weaknesses of this Recommendation

- The source of the subsidy would need to be identified.
- Not all businesses would benefit under this program.
- The program does not directly address the uninsured problem.
- The size of the benefit to small businesses will vary based on the reinsurance pool's impact on premiums and the amount of subsidy.
- Individuals who are uninsured or not employed by small employers would not benefit from the program.

Composition of Healthy Wisconsin Authority

The Authority would be a quasi-government body with a board of directors created by state law, but would not be a state agency. The board of directors would have a balanced representation of interested parties.

Duties of the Healthy Wisconsin Authority

The Authority would be charged with implementing the Council's recommendation following the parameters set by the Council.

Design specifics of coverage. The Council recommends that the Authority design the specifics of reinsurance coverage. The Authority must decide which claims will be considered for reinsurance and between which attachment points will the reinsurance become effective.

Contract vendor for administration. The Council also recommends that the Authority contract with a vendor to administer the reinsurance program, including estimates for reinsurance premiums, claim pay-offs, customer service, and day-to-day administration. The Authority would be responsible for main policy decisions regarding expansion or changes to the program, and would set parameters under which the vendor would function.

Evaluation and Expansion. The Council recommends that the Authority evaluate implemented programs annually and make improvements/adjustments if the evaluation demonstrates problems or deficiencies. As part of the evaluation, the Authority is recommended to review the best practices that may impact the appropriate utilization of health care and disease management. A financial evaluation of the reinsurance fund must also be conducted annually. Once the evaluations are complete, the Council further proposes that the Authority explore possibilities whether and how a small group reinsurance pool could be expanded beyond the small group market to benefit more state residents, based on experience of the small group reinsurance pool.

The Small Employer Reinsurance Pool will cover all lives for which a small group health insurance coverage is bought. Insurers writing in the small group health insurance market will be mandated to put every covered life into this pool by paying a fee for each life underwritten in this category. The Authority will set the insurers' premiums, the co-insurance rate for claims in the corridor, and will administer the pool and pay for high cost claims. The Authority is charged to develop guidelines to define high-cost claims and attachment points. Individuals and small businesses would not have any contact with the Authority administering the pool.

Profit component is removed from the reinsurance pool, since the authority administering the pool will be a quasi-government body.

Reinsurance coverage will reduce volatility from risks incurred for random high cost cases. The statewide mandatory pool will eliminate adverse selection by requiring all lives covered under the small group market to be in the same pool. Reinsurance will reduce reserve levels required by the Office of the Commissioner of Insurance. The state subsidy will reduce insurers premiums for reinsurance coverage.

Health care cooperatives (Co-op Care) will also be mandated to participate in the statewide pool. For the reinsurance purpose the cooperatives will be treated like a small group, though other insurance regulations will remain as described under sec. 18 of the statutes.

The Council also discussed a second option which was that of a Statewide Catastrophic Pool for all employers in the state (Appendix 4). The Council did not believe that the state was ready to embark on such an ambitious program, but that it might be meritorious in the future. The Council recommends that the Authority consider expanding the small group statewide reinsurance pool to all residents after data and experience from the Small Group Pool have been evaluated, considering it as a pilot of this broader idea.

Costs and Impact (add actuarial data)

The impact of this program would be to stabilize the health insurance market and lower premiums by \$\$\$\$\$ for more than 700,000 individuals employed in small businesses and in Co-ops.

A subsidy is an important component of a successful reinsurance program to lower reinsurance premiums which will lead to lower rates. One option presented by Campaign for Tobacco Free Kids at the public hearing to fund a subsidy is to raise the cigarette tax. Currently, the cigarette tax in Wisconsin is \$0.77 per pack. Annual state cigarette tax revenue is \$ 294.3 million (2005). It is estimated that a \$1 increase per pack of cigarettes would increase tax revenue by \$227.5 million (Campaign for Tobacco Free Kids provided this estimate during the public hearing).

The subsidy used for reinsurance programs would help to stabilize the small group market. As a result, more people would have health insurance. In addition to providing potential revenue for a subsidy, a cigarette tax increase is estimated to help decrease youth smoking by about 16.7 percent.

B. The Challenge of Reducing Wisconsin's Uninsured By At Least 50 percent

About 272,000 of Wisconsin residents age 0 to 64 were uninsured for the entire year in 2004. Of those, 34,000 were between age 0 to 17, with the remaining 238,000 between 18 and 64. State and federal surveys indicate that the number of insured people through their employers is decreasing and the number of uninsured is increasing. It is important to note that 65 percent of uninsured in Wisconsin are employed – an estimated 65,000 uninsured residents work for large employers (51 or more employees) and an estimated 92,000 uninsured residents work for small employers (50 employees or less, including self-employed).

Many low-income individuals are uninsured because Medicaid primarily covers low income children, their parents, pregnant women, seniors, and people with disabilities. In Wisconsin parents and pregnant women are eligible for BadgerCare if their income is no more than 185 percent FPL (that is, a family of three does not earn more than \$30,710 per year). However, childless adults (single adults and empty-nesters) with the same incomes do not qualify for BadgerCare. A recent survey⁸ on the uninsured found that 57 percent of all uninsured people in the United States are childless adults (ages 19-64). Of course, some have high incomes and choose not to purchase health insurance, but about 40 percent of them earn below 300 percent FPL and are not eligible for publicly subsidized programs.

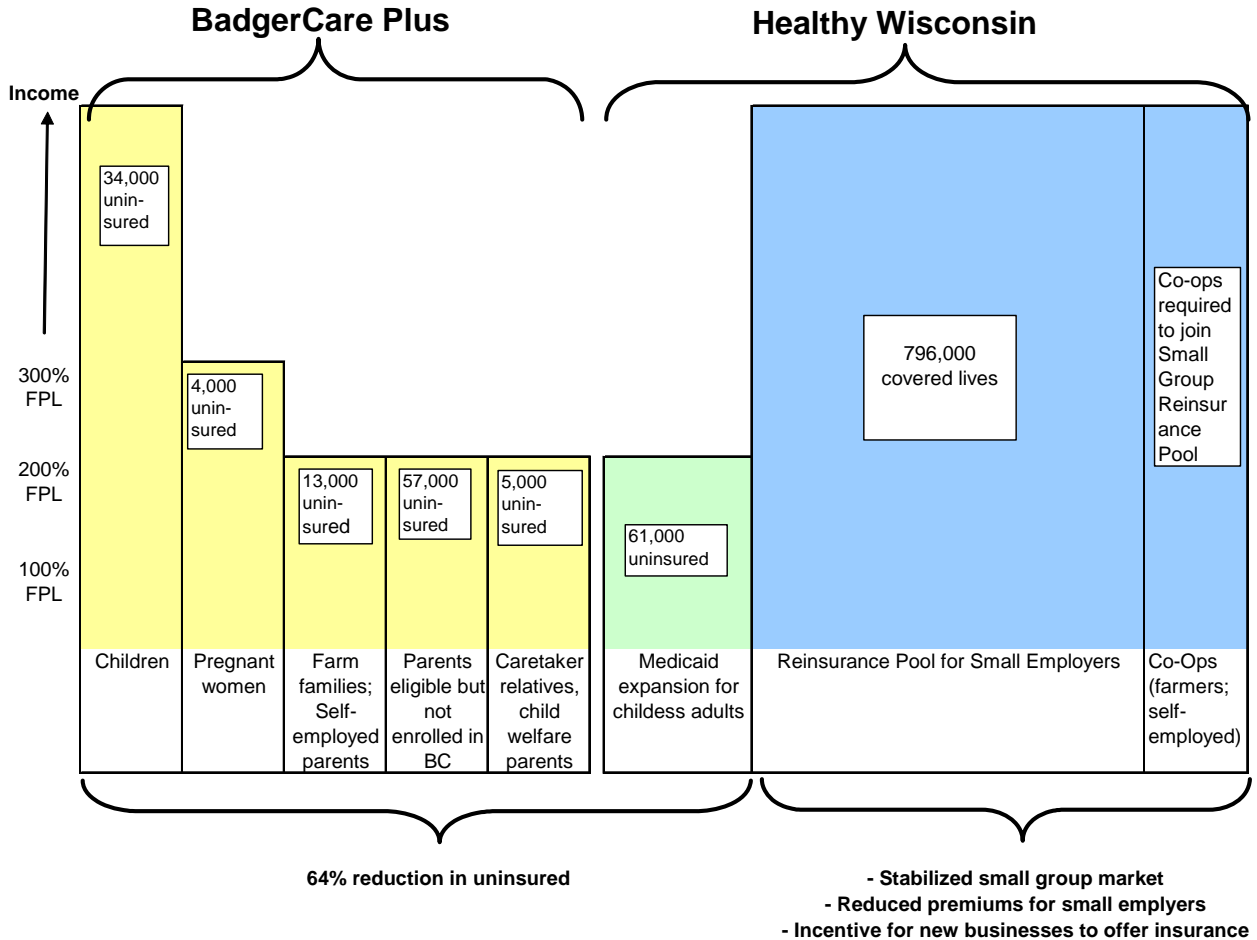
According to the analysis of the 2004 Wisconsin Health Insurance Coverage survey, young adults are more likely to be uninsured than other segments of the population. Residents of the City of Milwaukee and farmers also have higher uninsured rates. Concurrent with

⁸ L. Dubay, J. Holahan, A. Cook, "The Uninsured and the Affordability of Health Insurance Coverage," *Health Affairs* 26, no 1 (2007): w22-w30, published online November 30, 2006; 10.1377/hlthaff.26.1.w22.

national research on the uninsured, low income Wisconsin residents are also more likely to be uninsured.

Health insurance affects access to health care as well as the financial well-being of families. According to Kaiser Commission on Medicaid and the Uninsured, over 40 percent of nonelderly uninsured adults have no regular source of health care, and coupled with a fear of high medical bills, many delay or forgo needed care.⁹ Delaying or forgoing needed primary care can lead to more serious illnesses and health problems. Lack of health coverage not only affects access to care and health status, but also job decisions and financial security. Medical expenses by the uninsured have been shown to be an important contributor to U.S. bankruptcy filings.¹⁰ In addition, providers and hospitals face increasing demands for care by the uninsured for which there is little or no reimbursement. This places fiscal demands on these institutions and on government bodies and philanthropies that support them.

Figure 1. Healthy Wisconsin and BadgerCare Plus



⁹ Kaiser Commission on Medicaid and Uninsured report "The Uninsured and Their Access to Health Care" October 2006, www.kff.org, publication #1420-08.

¹⁰ D.U. Himmelstein, "Illness and Injury as Contributors to Bankruptcy," *Health Affairs* 24 (2005): w63-w73, published online February 2, 2005, 10.1377/hlaff.w5.63.

The Council discussed two options to reduce the number of uninsured in Wisconsin. The Council was aware that a companion proposal called BadgerCare Plus was also being concurrently developed. Of the 272,000 uninsured discussed above, BadgerCare Plus proposes to provide access to 38,000 of the children and 79,000 adults in several categories (see Figure 1). This leaves 159,000 remaining uninsured adults which the Council considered. In its deliberations, the Council concentrated on the uninsured who are not covered by any other program. Mainly, single poor adults or adults whose children no longer live with them and who have low incomes. These childless adults are most likely to be uninsured, have significant health problems, and they do not qualify for Medicaid.

Much of the early discussion focused on a Healthy New York-type program and product, which would utilize the reinsurance pool discussed above. In order for reinsurance to be possible, there has to be a primary insurance product as well. The Council explored assigning the Healthy Wisconsin Authority recommended above the responsibility of developing a new quasi-private primary product for uninsured low income individuals. This option is discussed in Appendix 5. However, since the implementation of Healthy New York in 2001, new flexibility in federal law allows federal Medicaid funding to be used for populations not previously eligible for Medicaid coverage and increases the affordability of such expansions by allowing more limited benefit plans with higher participant cost sharing. Because of the administrative complexity of developing a new product and since the Medicaid approach would leverage significant new federal dollars for the uninsured, the Council is recommending to cover uninsured through a Medicaid expansion.

HEALTHY WISCONSIN RECOMENDATION #2: Develop a Medicaid Expansion Waiver to Cover Childless Uninsured Adults under 200 percent of the Federal Poverty Level

This proposal is an expansion of Medicaid to poor single adults who currently do not qualify for Medicaid. An estimated 61,000 people could qualify for the program, 23,000 of the poorest under 100 percent of the FPL and an additional 38,000 between 100 percent and 200 percent of the FPL. Reinsurance is not part of this proposal, but the program would directly lower the number of uninsured.

Medicaid is a state and federally funded program that pays for medical services for low-income individuals. Medicaid primarily covers low-income families, seniors, and people with disabilities but generally does not cover non-elderly individuals who do not have custody of minor children and who do not meet federal disability standards. Medicaid expansions must be approved by the federal government. Some states have been able to obtain federal approval for Medicaid expansions to cover poor adults without children. With the design of the BadgerCare Plus, the Department of Health and Family Services studied crowd-out extensively. The BadgerCare Plus proposal has many crowd-out and premium assistance provisions aimed to help people keep private insurance if they have it. The same provisions would apply to a recommended Medicaid expansion.

The benefit design would be more limited than the current Medical Assistance package, but it must be carefully designed to incorporate the health benefits currently provided by the safety net programs, particularly mental health and alcohol and other drug abuse programs. There should be an emphasis on appropriate primary and preventive care and providing care in the most appropriate settings.

Currently, there are some state, county, and private programs that provide a health care safety net to poor individuals who are uninsured. With a federally-approved Medicaid expansion, these expenditures and uncompensated costs could be leveraged to match federal funds.

The Council recommends the Department of Health and Family Services design and implement the proposed Medicaid expansion. An advisory board could assist the Department designing the benefit package, cost sharing requirements, crowd-out and premium assistance provisions, and reviewing best practices for disease management and inappropriate use of emergency rooms. The Department could seek a federal waiver approval together with BadgerCare Plus.

Strengths

- The administration is the same as for the current Medicaid program.
- A new insurance product does not have to be designed, as was done in New York.
- Unlike Healthy New York, which was designed before the federal government expanded flexibility in Medicaid coverage, the program would leverage federal funding for uncompensated health care and/or expenses currently paid with state and county funds.
- The program would allow care to be better managed, emphasizing cost-effective primary and preventive care and reducing unnecessary and expensive emergency care.
- The proposal like Healthy New York would offer low-cost, comprehensive health care to a population that is unable to afford coverage without government assistance.
- Medicaid expansion would be targeted at the lowest income uninsured population that in many cases is unemployed because of health problems.

Weaknesses

- The federal approval process may be long and involved, delaying implementation.
- Medicaid expansion is limited to individuals with lower incomes.

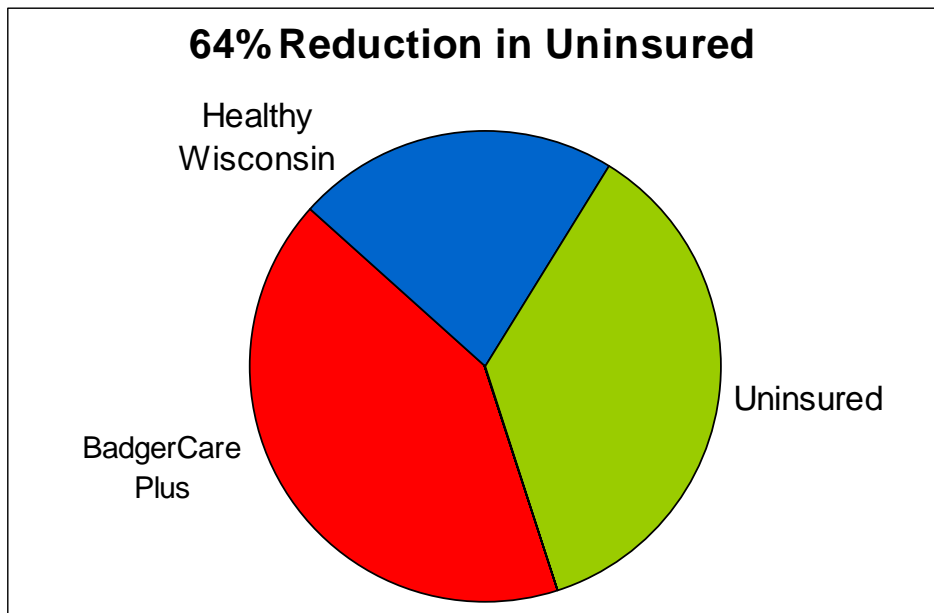
Costs and Impact (add actuarial data)

A state subsidy is required for the state match for a federal Medicaid expansion. One option to fund a subsidy is to raise the cigarette tax. Currently, the cigarette tax in Wisconsin is \$0.77 per pack. Annual state cigarette tax revenue is \$ 294.3 million (2005). It is estimated that a \$1 increase per pack of cigarettes would increase tax revenue by \$227.5 million (Campaign for Tobacco Free Kids provided this estimate during the public hearing).

The subsidy used for Medicaid expansion would help uninsured residents to gain access to health care and would decrease uncompensated care provided. In addition to providing potential revenue for a subsidy, a cigarette tax increase is estimated to help decrease youth smoking by about 16.7 percent.

The impact of Recommendation #2 would be to make health insurance available to an additional 61,000 childless adults in Wisconsin. Combined with BadgerCare Plus, the two proposals would result in a 64 percent reduction in the uninsured in the State, (see Figure 2) leaving only 98,000 or about 2 percent of residents without accessibility to health insurance for an entire year.

Figure 2. Reduction in Uninsured



Appendix 1 Council Members

Co-Chairs

Dr. David Kindig, Emeritus Professor of Population Health Sciences at the University of Wisconsin-Madison School of Medicine
Michael Weiden, Partner at Quarles & Brady, LLP

Council Members

Bob Bass, Board Vice-Chair, Wisconsin Federation of Cooperatives
Wayne Corey, Executive Director, Wisconsin Independent Businesses Inc.
Tim Cullen, Senior VP, Anthem BlueCross/Blue Shield
Jay Fulkerson, President, United HealthCare of Wisconsin
Representative Curt Gielow
Dr. Tito Izard, Chief Medical Officer, Milwaukee Health Services Inc.
Al Jacobs, Executive Director, WEA Trust
Mickey Judkins, Owner, Details
Senator Julie Lassa
David Newby, President, WI State AFL-CIO
Jim Riordan, CEO, WPS Insurance
Senator Carol Roessler
Dr. Rene Settle-Robinson, President, Cream City Medical Society
Kristine Seymour, Senior VP, Humana
Randy Smith, President, City Brewery
Mary Starmann-Harrison, CEO, SMSS Health Systems
Gail Sumi, Government Affairs Representative - AARP
John Torinus, CEO, Serigraph Printing
Gregory T. Troy, VP and Chief Human Resource Officer, Modine Manufacturing
Dan Velicer, Director of Global Benefits, Kohler Co.

Appendix 2 Meeting agendas and materials

Meeting materials are available at the Healthy Wisconsin website
<http://dhfs.wisconsin.gov/healthywisconsin/meeting.htm>

July 31, 2006 Meeting: [Agenda](#)

- [Healthy Wisconsin Introduction](#)
- [The Basics of Reinsurance](#)

August 22, 2006 Meeting: [Agenda](#)

- [Background on Insurance Trends](#)
- [Overview of State Reinsurance Programs](#)
- [Memo: Federal and State Reinsurance Programs](#)
- [Defining the Target Population](#)

- [Employee Retirement Income Security Act of 1974 \(ERISA\)](#)
- [Future Meeting Schedule](#)

September 6, 2006 Meeting: [Agenda](#)

- [Structure: Key Policy Questions](#)
- [Reinsurance Programs](#)
- [Complimentary State Programs](#)
- [Glossary of Terms](#)
- [Uninsured Population in Wisconsin](#)
- [Healthy Wisconsin Council Request Responses](#)

September 26, 2006 Meeting: [Agenda](#)

- [Potential Models: Key Policy Issues](#)
- [Potential Models: Target and Structure](#)
- [Mapping the Structure -- Part II](#)

October 13, 2006 Meeting: [Agenda](#)

- [Comparison of Benefit Packages](#)
- [Uninsured Population in Wisconsin](#)
- [Exploring Medicaid Reform & Funding](#)

November 9, 2006 Meeting: [Agenda](#)

- [Input on Concepts](#)
- [Table Comparing 4 Options](#)
- [Option 1](#)
- [Option 2](#)
- [Option 3](#)
- [Option 4](#)

**Appendix 3
Existing Reinsurance Programs**

Reinsurance pools for health insurance can alleviate the consistent problem of adverse selection that insurers experience and fear. There are several existing federal and state level programs with reinsurance components.

Other States

Healthy New York program is the most prominent example of an existing reinsurance program.¹¹ The program reimburses insurers for 90 percent of claims paid between \$5,000 and \$75,000 on one policy. Individuals and small business who employ a large share of

¹¹ Healthy New York website: <http://www.ins.state.ny.us/website2/hny/english/hny.htm>

low-wage workers are eligible for the program. All Health Management Organizations (HMOs) in New York state are required to offer Healthy New York product to eligible parties. The Healthy New York evaluators estimated that the program reduced premiums for individuals by over 50 percent and for small businesses up to 30 percent since 2001.

Currently more than 21 states operate some kind of reinsurance pool. Some states (Idaho and Massachusetts) have separate group and non-group pools. Connecticut and Arizona have non-subsidized pools. Other states either have brand new programs or are revamping old programs (New Mexico).

Wisconsin

Wisconsin also has several state-wide, successful reinsurance programs. The Unemployment Insurance System and Worker's Compensation Insurance involve employers and employees, while the Patient Compensation deals with the medical malpractice liability insurance market.

In 1932, Wisconsin became the first state in the nation to implement an unemployment insurance program. The program was designed to provide a temporary source of income, financed by employers, for workers who were laid off from their jobs. The maximum benefits are the lesser of 26 times the weekly benefit rate or 40 percent of total base period wages. Employers are required to make payments to the unemployment insurance reserve fund; the amount of payment reflects fluctuation in the level of employment. Wisconsin requires the following employers to participate in the program: all governmental units and Indian Tribes regardless of the number of people employed, non profit organizations if they employ at least 4 individuals, and for profit businesses if they pay wages of at least \$1,500 during a calendar quarter or if they employ at least 1 individual for at least 20 weeks.

Workers who experience job-related injuries or illnesses receive medical treatments and wage replacement through the Wisconsin Worker's Compensation Insurance program. Worker's Compensation is a form of insurance that is paid for in advance by employers which entitles employees to full medical coverage and part of their salary for job-related injuries and illnesses. Nearly all employees in Wisconsin are covered. The exceptions include domestic servants, some farm employees, volunteers, religious sect members, and federal government employees. Coverage for Workers Compensation purposes begins on the first day of work. Basic benefits may include: coverage of all reasonable and necessary medical costs, disability benefits, retraining, and if a death occurs, death benefits and burial expense up to specified limits. The coverage also applies to employers who are self-insured.

The Wisconsin Patient Compensation Fund was created in 1975 to provide excess medical malpractice insurance for Wisconsin health care providers. Health care providers are required to pay yearly assessments into the fund. The fund covers providers above \$1 million per occurrence or \$3 million in the annual aggregate. Providers must purchase their own insurance up to that amount. The fund provides compensation for claimants whose damages exceed the provider's liability insurance. As of 2005, there were almost 14,000 participants. Physicians comprised 84 percent of the fund participants, corporations 10

percent, and all other participants made up the remaining 6 percent. Pennsylvania and Kansas also have mandatory patient compensation funds.

Federal Government

The idea that the private market can operate more efficiently if the government takes over the responsibility for the worst case scenarios is not new. The flood loss insurance and the secondary mortgage insurance markets are prime examples.

Flood insurance was not available for homeowners and factory-owned property until the late 1970s. Insurers did not have an actuarial rate structure to adequately reflect risks of flood. For a private market in flood insurance to succeed, these risks had to be identified for all geographic areas. No private company or a group of companies could identify and map all regions that may be affected. Finally, the Army Corps of Engineers conducted hydrological studies to identify the nature and extent of the risk of flooding in various areas. Congress passed the National Flood Insurance Act in 1968 creating the National Flood Insurance Program (NFIP). After several restructures, the program brought in private insurers through what is called “write-your-own” program. Insurers sell and service the policies and the federal government bears all the risks. The insurers are permitted to keep about 32 percent of the premium for administrative and production costs. In 2003, 93 companies participated and about 4.4 million policies were written. Without federal government intervention, there might not be a private insurance company willing to sell flood insurance in many areas.

The federal government also plays an important role in the secondary mortgage market. By mid-1930s, the federal government started assisting working families, who did not have enough savings for a down payment, to obtain mortgages. Later, the government helped soldiers returning from the World War II to secure mortgage loans. The Federal Housing Administration (FHA) and the Home Owners Loan Corporation (HOLC) ran these mortgage programs. The FHA provided mortgage insurance to mortgage borrowers so mortgage investors would not fear borrowers defaulting in large numbers as happened during the Great Depression. The HOLC used government-backed bonds to purchase mortgages on which people had defaulted. The HOLC bought mortgages from banks and then reinstated them with new terms. In effect, such practice standardized mortgages to be longer terms (usually 20 years), fixed rates, and fully amortized over the life of the loan. The intent was to reduce borrowers’ desire to refinance mortgages and to provide security to lenders. Almost a decade later, the HOLC was replaced by the Federal National Mortgage Association (known as Fannie Mae), which changed its focus from defaulted mortgages to the secondary mortgage market. To provide finances for the secondary market, Congress authorized Fannie Mae to issue stock and bonds, which enabled Fannie Mae to borrow below the market rate. Existence of the secondary market allows lenders to pool mortgages, resell them, and, therefore, shift the risk of defaults. The government assumes the risk that high-risk mortgage borrowers might default on repaying their loans. By taking on this risk, the federal government has been widely credited for expanding home ownership.

Appendix 4
Recommendation #1 Expansion
Statewide reinsurance

This proposal is similar to Recommendation #1, but it would be a statewide program. The statewide catastrophic reinsurance program would pay a portion of catastrophic claims above a specific attachment point or within a specific corridor. Wisconsin residents age 18-64 would be required to pay premiums to the statewide reinsurance program. The state would subsidize the program.

Strengths

- The statewide reinsurance program would directly lower premiums due to creation of a statewide, mandatory catastrophic reinsurance pool that is subsidized.
- The program will provide coverage to those that experience catastrophic incidents and decreases the amount that insurance companies must charge for unknown risk.
- The program could help stabilize the insurance market.
- Businesses and insurers would not be required to modify their behavior; they would continue to purchase insurance as they do now.
- The program would be relative easy to administer.
- A balanced board of the reinsurance pool would ensure that decisions are made based on mutual best interest.

Weaknesses

- The source of subsidy would need to be identified.
- The program does not directly address the uninsured problem.
- Large insurers and some large employers already purchase or self-fund reinsurance.
- Insurers would need to be assured that they would not be worse off.
- The size of the benefit would depend on the level of program premiums and the amount of the subsidy.
- There is a challenge with ensuring that savings from re-insurance are passed on to large employers and their employees.

Appendix 5
Alternative to Recommendation #2:
Primary health care product + reinsurance for currently uninsured

The proposal would create a primary health care product with a reinsurance component and targets uninsured individuals working for small businesses. About 90,000 people are estimated to be eligible for this program. Insurers (insurance companies, HMOs, etc.) would be required to offer the primary product. Premiums would be set by insurers, but the state would subsidize the program through the payment of catastrophic claims.

Strengths

- The program directly lowers premiums due to creation of a basic primary insurance product that is subsidized.
- The program addresses one of the most problematic sectors of the health insurance market – low income individuals and small groups.
- The program provides an opportunity to pilot reinsurance concept without instituting problematic geographic restrictions. If successful, the program could be expanded.
- The program is relatively easy to administer. In Wisconsin, a small number of insurers write the majority of small group policies.
- Small businesses would not be required to modify their behavior. They would continue to purchase health insurance as they do now.

Weaknesses

- No federal funding.
- The source of the subsidy would need to be identified.
- Not all businesses would benefit under this approach.
- Crowd out needs to be prevented.
- The size of the benefit to small businesses would depend on the level of program premiums and the size of the subsidy. A limited decrease in premiums and/or no subsidy would have minimal impact.
- Uninsured individuals with the lowest incomes would still be unable to afford to purchase this product.
- The proposal requires the Authority to become involved with designing and managing a primary insurance product.