Concept Paper
on the Development of

The Wisconsin Health Plan

A Collaboration of:
The Wisconsin Health Project
David Riemer and Lisa Ellinger

and

Rep. Curt Gielow (R-Mequon)
Rep. Jon Richards (D-Milwaukee)

June 2005

The Wisconsin Health Plan

Executive Summary
The Wisconsin Health Plan seeks to address Wisconsin's triple crisis in health care: the skyrocketing cost of health care, increasing numbers of uninsured, and the ever-present deficit in the state's Medicaid program.

Wisconsin-specific data show that employers now spend an average of **15%** of payroll for the health care premiums of their employees. Health care costs are rising **10-25%** per year, and the result is an adverse economic effect on wages, profits, job creation, and new investment in Wisconsin.

Wisconsin has been a national leader in having low rates of uninsured in our state. Yet, at some point over the course of the year, up to 500,000 Wisconsinites have no insurance coverage. Conservative estimates suggest that 6% of our population is not covered on any given day. Lack of insurance is a significant factor in premature death, unnecessary illness, and bankruptcy; and the trends in this area are getting worse, not better.

Wisconsin's Medicaid program is facing a structural deficit because costs and caseloads are rising much faster than state revenues. The state has relied on short-term fixes to get by thus far, but the ongoing structural deficit in this $4 billion program continues to undermine other state priorities.

The Wisconsin Health Plan provides a new way to pay for health care in Wisconsin. This proposal creates an effective purchasing pool and incorporates "consumer driven" incentives to promote health care quality and use market forces to drive down health care costs.

The proposal has three simple components:

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

The plan is structured in a way that would free up nearly $1 billion in the state's biennial budget. This revenue could be used to cut taxes or make needed investments. The details of the plan follow.

Participation: Who is Covered?
The Wisconsin Health Plan covers all Wisconsin residents less than 65 years of age, with a few exceptions. The plan does not cover any person who:

- has resided in Wisconsin less than six months (children with parents who have lived in Wisconsin for six months are covered);
- claims residency in another state or jurisdiction for Wisconsin income tax purposes;
- is an employee of the federal government;
- is eligible for Medicaid or BadgerCare (see more on this in the "**Merging Programs**" section below); or
- is institutionalized.

Benefit Structure: Health Insurance Purchasing Accounts
All eligible Wisconsin residents receive a "Premium Credit," which the participant uses to purchase health insurance from competing, qualifying health insurance plans. In addition, all adults (age 18-64) also receive a Health Savings Account (HSA), funded at $600 each year.

HSAs can be used to pay for a wide range of medical care. Extensive information on "qualifying" medical expenses is available at: http://www.health--savings--accounts.com/qualified-expenses.htm

Benefit Package: What is Covered?
The Premium Credit pays for a benefit package that covers medical care, hospital care, and prescription drugs. All participants receive a limited, evidence-based set of preventive care services with no cost sharing. The applicable deductibles, coinsurance, and out-of pocket maximums are listed below.

For Adults (age 18-64):

- an annual deductible of $1,200;
- co-insurance or co-pays for medical and hospital care (such as $25 for a doctors' visit or $35 for a visit to a specialist);
- co-insurance or co-pays for prescription drugs (such as $5 for generic drugs, $15 for "preferred" brand drugs, and $35 for non-preferred brand drugs);
- a $250 co-pay for non-emergency use of hospital emergency rooms;
- an annual out-of-pocket maximum of $2,000.

For Children (age 0-17):

- an annual deductible of $100;
- co-insurance or co-pays for medical and hospital care (such as $10 for a doctors' visit or $15 for a visit to a specialist);
- co-insurance or co-pays for prescription drugs (such as $5 for generic drugs, $15 for "preferred" brand drugs, and $35 for non-preferred brand drugs);
- a $250 co-pay for non-emergency use of hospital emergency rooms;
- an annual out-of-pocket maximum of $1,000.

Pre-existing conditions: Participants who move to Wisconsin after the inception of the program must provide evidence of health insurance coverage substantially similar to the health insurance provided by this program for the year prior to enrolling in the Wisconsin Health Plan. Those unable to do so will not receive coverage for pre-existing medical conditions.

Program Administration: The Health Insurance Purchasing Corporation (HIPCo)
The program is administered by the Health Insurance Purchasing Corporation of Wisconsin (HIPCo), a private corporation governed by a 9-person Board of Directors responsible for establishing and operating the health insurance purchasing program. Board members include two gubernatorial appointees and one representative from each of the following organizations:

- Wisconsin Manufacturers and Commerce
- Milwaukee Metropolitan Association of Commerce
- National Federation of Independent Business / Wisconsin
- Wisconsin AFL-CIO
- SEIU Wisconsin State Council
- Wisconsin Technology Council
- Wisconsin Farm Bureau

All major Board decisions require eight of nine votes. Board meetings are held in public, and subject to open meetings and open records law. The Board is required to submit annual reports to the Legislature, and the Legislative Audit Bureau is required to conduct a comprehensive audit at least every two years. The Board is responsible for choosing and overseeing an Executive Director and other staff, as well as approving all major contracts.

Participant Choice and Incentives: The Key to Controlling Health Care Costs
As mentioned above, all eligible Wisconsin residents receive a "Premium Credit," which they direct to the health care plan of their choice. Any insurer (for example, HMOs, PPOs, or indemnity carriers) licensed to sell health insurance in Wisconsin -- and that meets specified financial, coverage area, and disclosure standards -- is qualified to compete to provide insurance coverage. The competing insurer plans are placed into three "tiers" based on risk-adjusted cost and quality measures. Participants have a clear financial incentive to choose the health care plans that provide health insurance at the lowest cost and of the highest quality ("Tier 1"), because those

plans are available for the "value" of the Premium Credit, with no additional payment from the participant. Participants who opt for plans that provide higher-cost, lower-quality care ("Tier 2" or "Tier 3") are required to pay a portion of the premium to enroll.

This provides a powerful incentive to the insurers to be designated low-cost Tier 1 plans -- and for providers to be associated with those plans – thus controlling health care costs.

HIPCo is responsible for choosing an administrator to serve as the "trustee" of the Health Insurance Purchasing Accounts, to educate participants about how to use the accounts, and to transfer the Premium Credits to selected plans. The dollar value of the Premium Credit is adjusted to reflect age, gender, and other appropriate factors. In other words, plans are paid according to the "risk" of their enrolled population. HIPCo also retains a small portion of the Premium Credits to compensate health care plans that have incurred disproportionate risk. HIPCo may also retain a portion of the Premium Credits to directly provide the prescription drug coverage.

Financing the Program: The Employer Assessment
Any entity (or person) operating in Wisconsin that is required under federal law to file form "941" or schedule "SE" is required to pay the assessment that finances this program. The assessment is equal to the following percentage of Medicare wages as reported on these forms:

- 8% of the 1st $100,000 of Medicare wages
- 9% of the 2nd $100,000 of Medicare wages
- 10% of the 3rd $100,000 of Medicare wages
- 11% of the 4th $100,000 of Medicare wages
- 12% of all remaining Medicare wages

The assessment is collected by the Wisconsin Department of Revenue and can only be increased through an act of the state Legislature. If HIPCo determines that the assessment will not generate sufficient funds to pay for the health insurance benefits described above, it must present options to the Legislature to raise revenue and lower costs. If the Legislature does not act, HIPCo must reduce the HSA funding or other benefits. HIPCo also has the authority to direct any surplus revenues to a reserve fund, increase the HSA funding or other benefits, or recommend an assessment decrease to the Legislature.

Collective Bargaining Agreements: An employer with a collective bargaining agreement that provides for health insurance coverage and that is in effect upon the inception of this program is excluded from the assessment. The exemption applies to any employee who is covered by the agreement and lasts for the duration of the existing coverage. Those employees are not covered by this program until the collective bargaining agreement ends.

Special Assessment for Wisconsin Residents Working Out-of-State: Individuals whose earnings from Wisconsin employers are less than $10,000 annually if filing singly ($20,000 if married and filing jointly), but whose Adjusted Gross Income (AGI) is more than $20,000 if filing singly ($40,000 if married but filing jointly), will be subject to a special assessment. This is to account for the fact that those out-of-state employers cannot be assessed for the cost of this program, but their employees benefit as residents of Wisconsin. The assessment equals the lesser of:

- 10% of the difference between AGI and Wisconsin earnings, or
- $2,000 if filing singly or $4,000 if married and filing jointly.

This rule also applies to non-working residents with high income and low earnings who benefit from the program.

Merging Programs: Medicaid and BadgerCare
Under this proposal, the Department of Health and Family Services (DHFS) and HIPCo are required to jointly develop a plan to fold participants in the family portion of Medicaid and BadgerCare into this program. DHFS is required to seek a waiver from the U.S. Department of Health and Human Services to implement this merger which qualifies for an acceptable federal match for state health insurance expenditures for our low income population.