



Brief Summaries of the Major Health-Care Reform Proposals in Wisconsin

Please find below a summary of the major health-care reform proposals that are likely to receive attention in the 2007-08 legislative session. In reviewing the proposals, it may be useful to consider the list principles adopted by the WHA Board in October. WHA's Task Force on Access and Coverage came up with these principles to provide a tool for WHA staff to evaluate health-care reform proposals.

**WHA Access, Coverage and Cost Principles**

- 1) Wisconsin's health care system must provide affordable coverage for everyone's basic health care needs.
- 2) Initiatives must directly address the reality that current trends in health care costs and insurance premiums are not sustainable and are contributing to access and coverage challenges.
- 3) Each health care stakeholder has shared responsibilities:
  - Government must play a role in guaranteeing access to health care services for our most vulnerable populations, fully recognize the special costs of educating the health care workforce, promote transparency and adequately pay for health care services provided to patients covered by its programs.
  - Individuals must share directly in the financial responsibility for covering the costs of their health care needs and engaging in behaviors that maximize their health care status. In addition, individuals must be prudent buyers of health care services, availing themselves of available information to purchase health care based on demonstrated quality and efficiency.
  - Hospitals and physicians must deliver health care that is guided by the best clinical evidence or expert consensus and be willing to share best practices with their peers. They must be accountable for their costs and quality by embracing initiatives designed to measure, publicly report and improve performance.
  - Employers should offer a basic health care benefit to their employees. They should provide financial incentives for their employees to select the highest

quality, lowest cost providers in their region and participate in programs and behaviors that support wellness and prevention.

- Payers should provide meaningful incentives for providers to coordinate the delivery of health care services, especially to patients with chronic diseases and design plans that provide incentives for prevention services and promote healthy lifestyles.
- 4) Government oversight of access and coverage initiatives must be transparent and sheltered from short-term political processes.
- 5) Coverage and access are related issues but will require different strategies (e.g., Medicaid “covers” dental care but access to Medicaid dental services is unavailable in much of Wisconsin).
- 6) Initiatives should build upon and improve employer-based coverage and preserve pluralistic payment for health care services.
- 7) Initiatives must include fair and adequate provider payments, reward value (quality and cost efficiency), must be simple to administer, promote innovation, and stress prevention and wellness.
- 8) The rapid diffusion of information technology should be encouraged, coordinated and funded by providers, government, and payers as a way to improve quality, patient safety and cost efficiency.

## **1. Wisconsin Healthcare Plan (AFL-CIO Plan)**

**Principal Authors/Sponsors:** Senator Russ Decker (D-Weston) and Representative Terry Musser (R-Black River Falls)

**Eligible Population:** All residents under 65 who are not eligible for Medicare.

**Covered Services:** “All reasonable medical services and prescription drugs,” with specified exceptions.

**Administration:** 11-member Wisconsin Health Care Plan Board, attached to the Office of the Commissioner of Insurance (OCI).

**Funding:** Employer assessments. Cost projected at \$300 single/\$600 family. Understates current costs.

**Provider Reimbursement:** Board establishes payment rates, *which are prospectively reduced because they assume providers will reap huge administrative savings.* (In other words, even if the assumed huge administrative savings materialize, providers will not experience any net gain.)

Annual increases may not exceed medical inflation. Providers must accept Board's payment as payment in full, not counting any required cost-sharing.

**Role for Insurer(s)**: None, with the possible exception of serving as an administrator/claims-processing vendor. Board/state takes on all risk.

## **2. Wisconsin Health Security Act**

**Principal Authors/Sponsors**: Senator Mark Miller (D-Monona) and Representative Chuck Benedict (D-Beloit)

**Eligible Population**: All residents of Wisconsin.

**Covered Services**: Very few exceptions.

**Administration**: New state Department of Health Planning and Financing (DHPF), with six regional offices advised by six Regional Consumer Health Councils. DHPF would be overseen by 11-member Health Policy Board, which has broad authority to regulate health care delivery and payment.

**Funding**: Tax on employers based on total payroll, plus a graduated income tax on individuals. Possible redirection of current federal, state, local spending.

**Provider Reimbursement**: DHPF establishes provider payment rates. As a condition of participation, providers must accept reimbursement under the plan as payment in full (no balance-billing). *By design, the plan will decrease health care employment in Wisconsin. DHPF is required to arrange for job retraining or job placement services for health care providers and staff who lose jobs because of the program.*

**Role for Insurer(s)**: None, except perhaps as a claims-payment vendor. *By design, the plan will eliminate insurer jobs in Wisconsin. DHPF is required to arrange for job retraining or job placement services for employees of insurers who lose jobs because of the program.*

## **3. Wisconsin Health Plan**

**Principal Authors/Sponsors**: Representative Curt Gielow (R-Mequon) and Representative Jon Richards (D-Milwaukee). The Plan was developed in large part by David Riemer.

**Eligible Population**: All residents of Wisconsin, except those eligible for Medicare.

**Covered Services**: All current mandated benefits; H.S.A. model with \$1,200 deductible and a \$3,000 annual out-of-pocket limit. The state would deposit \$500 in each enrollee's H.S.A. account. All insurers would offer the same benefit plan, although they would be free to offer supplemental benefits as well.

**Administration:** New Health Insurance Purchasing Corporation (HIPCo) would collect revenues and pay premiums to insurers. Insurers would bid on business by county. The HIPCo would place each insurer in one of three “tiers” based on cost and quality. Participants could purchase coverage from a Tier 1 plan for no additional cost beyond the required assessment (see below). Tier 2 and Tier 3 plans would require progressively higher premium contributions from employees/employers.

**Funding:** Employers would pay up to 12 percent of payroll and employees would pay a flat two percent of wages to the HIPCo. The amount of money raised appears to be far short (by \$3 billion to \$5 billion) of current health care spending for the eligible population. The payroll assessment would require thousands of employers to pay more for a limited health plan than they are currently paying for a comprehensive plan.

**Provider Reimbursement:** Provider reimbursement is ostensibly a matter between the health plans and their contracted providers, but given the multi-billion-dollar gap between program revenues and current health care spending, reimbursement to providers is likely to be substantially below current levels.

**Role for Insurer(s):** Insurers would all have an opportunity to bid on delivering a single, state-approved benefit plan. They would also be free to separately market supplemental coverage. Given the funding shortfall, insurers would be highly incentivized to offer narrow provider networks, aggressively manage utilization, particularly of inpatient care and specialist services, and ratchet down provider reimbursement.

#### **4. Healthy Wisconsin**

**Principal Authors/Sponsors:** Recommendations of the Healthy Wisconsin Council, appointed by Governor Jim Doyle. The recommendations are expected to be included in the Governor’s 2007 – 09 biennial budget bill.

**Eligible Population:** Low-income insured, low-income uninsured, small businesses (2-50 employees) and their employees, participants in health insurance co-op plans.

**Covered Services:** For childless adults whose incomes are less than 200 percent of the Federal Poverty Level, an expansion of Medicaid eligibility, but more limited coverage that is supposed to parallel typical commercial insurance coverage. Some copayments and premium contributions would apply. For employees of small businesses who would not otherwise qualify for expanded Medicaid coverage, their coverage would be whatever their employer selected. Of the 800,000 persons employed by small businesses, about 100,000 of the lowest-income individuals would qualify for a subsidy of 25 percent of their premium. The entire small group market would be mandated into a reinsurance pool that would spread the cost of catastrophic claims among all participating insurers.

**Administration:** Creates a new quasi-governmental Reinsurance Authority charged with developing and implementing the reinsurance system and administering the subsidy program.

**Funding:** Recommends a \$1.00-per-pack increase in the cigarette tax, which will raise approximately \$300 million. \$100 million to be devoted to subsidies for the privately insured low-income groups of 2-10 employees and health insurance co-op members. The balance to be applied to Medicaid expansion and provider rate increases.

**Provider Reimbursement:** Provider reimbursement under commercial insurance products is unlikely to change. But the Council has recommended increasing Medicaid provider reimbursement rates.

**Role for Insurer(s):** Insurers would be forced to participate in a statewide reinsurance pool that would pay all or a portion of claims that exceed a specified threshold in a calendar year. They would pay premiums for the reinsurance coverage and build those costs into the premium rates they charge employer groups. In theory, this kind of reinsurance mechanism makes insurance premium rates more stable; however, actuarial analysis of the likely impact on premium rates is not yet complete.