Health Insurance Marketplace in Wisconsin

by Wisconsin Office of the
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Wisconsin typically ranks among the states with the highest level of health care coverage for its citizens. Over the last decade, about 4% to 5% of the state's population has been without coverage for the entire year. During this time, the commercial health insurance market has been declining (from 42% in 1998 to 26% in 2005), and government health care has been rising (from 22% in 1998 to 30% in 2005). Government programs cover about (a) 800,000 Wisconsin residents through Medicare, (b) 800,000 through Medicaid, and (c) 18,300 through the Health Insurance Risk Sharing Program. Health care costs in Wisconsin, particularly in the southeastern part of the state, are rising faster than in most areas of the country. These rising costs translate into higher health benefit costs, recently estimated to be $9,500 per covered employee. The Office of the Commissioner of Insurance regulates health insurers in Wisconsin.

Wisconsin's health care marketplace in 2005 reflected the traditionally high rate of health care coverage in the state. Wisconsin typically ranks among the states with the highest level of health care coverage for its citizens. The health insurance marketplace in Wisconsin can be divided into four categories: commercial (or private) insurance coverage, self-funded employer health plans, public coverage (Medicaid, BadgerCare, etc.), and the uninsured.

Wisconsin ranks among the states with the highest level of health care coverage.

Commercial Insurance Coverage. Commercial insurance coverage is health insurance that is purchased from a licensed insurance company either through an employer-sponsored group health plan or by an individual. Commercial insurance is regulated by the state through the Office of the Commissioner of Insurance.

In 2005, commercial insurance products covered approximately 1.5 million Wisconsin residents, or 26% of the market. Since 1998, when 42% of the marketplace was covered by commercial insurance, commercial insurance coverage has been declining. The majority of these enrollees (1.3 million) are in group health plans offered by employers, whereas a small portion (142,000) is enrolled in individual health insurance policies. Commercial insurance plans consist of health maintenance organizations (HMO), point of service plans (POS), preferred provider plans (PPP), and indemnity plans.

Group Health Insurance. Group health insurance is generally offered by employers. Group plans are separated by state law into large and small groups. Small groups are employers with two to 50 employees (no groups of one). An employer with more than 50 employees is considered a large group employer in state insurance law. There are approximately 200 insurers currently licensed to offer health insurance coverage in the state.

Small Employer Health Insurance. Wisconsin law establishes underwriting requirements that are unique to small employer policies. Without the benefit of a larger buying

pool, small employers can be subject to severe swings in insurance premiums from year to year if medical claims costs attributable to the group become large. For this reason, the law places limitations on the rates that insurers may charge small employers through the use of rate banding, which limits rate increases to no more than 30% from the midpoint of all small employers with similar case characteristics and benefit design characteristics. Additionally, rate increases attributable to case characteristics such as occupation, claims history, health status, and more are limited to 15%. Small employer insurers are required to automatically renew the group coverage each year as long as the insurer is in the small group health insurance market. Insurers marketing coverage to small employers are also required to make products available to all small employers who apply (also known as guaranteed issue). A much smaller subset of licensed insurers (approximately 45) write coverage in the small group market.

Individual Health Insurance Policies. Individual health insurance policies are sold to individuals who are self employed or otherwise not eligible for group health insurance coverage. Individual health insurance policies are similar in plan types to group policies, and include HMO, PPP and indemnity plans; however, they are individually underwritten based on the characteristics of the individual purchasing the policy such as age, medical history, and occupation. Insurers are not required to make individual health policies available to all who apply. Insurers may reject an applicant or exclude coverage of specific conditions based on the insurer's particular underwriting standards. Under state law, individual policies are guaranteed renewable; however, there are no limitations on premiums.

Self-Funded Employer Health Benefit Plans. Instead of offering health insurance coverage through a commercial insurance product, employers instead may choose to self-fund their health benefits, meaning they pay their employee's covered medical expenses as they occur. Most large employers fund their health insurance benefits this way. Employer self-funded health benefits cover the largest number of Wisconsin residents, over 2.2 million in 2005. Self-funded plans comprised 39% of the health insurance marketplace in 2005, up from 32% in 1998. Employers may contract with a third party, sometimes called a third party administrator and often an insurer, to administer these benefits. However, these arrangements are not considered insurance policies.

Government health care programs comprised 30% of Wisconsin's health care market in 2005, up from 22% in 1998.

Employer self-funded health care benefits are exempt from state regulation. The Employee Retirement Income Security Act of 1974 (ERISA) preempted states from regulating self-funded, employer health benefit plans. Because of this exemption, employers may design their benefit plans and need not comply with state insurance statutes, most notably solvency regulations, and coverage and benefit mandates.

Public Coverage. In 2005, government health care programs comprised 30% of Wisconsin's healthcare marketplace, up from 22% in 1998. These programs consist primarily of Medicare, Medicaid, and the Health Insurance Risk Sharing Program (HIRSP). Each serves a unique portion of Wisconsin's population, although there is some overlap among the programs.

Medicare. Medicare is the federal government health care program for seniors aged 65 and over and certain disabled individuals. Medicare consists of Part A (Hospitalization), Part B (Medical), and Part D (Prescription Drug Benefits). Over 800,000 Wisconsin residents were enrolled in Medicare in 2005.

Medicaid. Medicaid encompasses a number of federal/state health care programs for low-income residents and their dependents. In Wisconsin, Medicaid recipients can participate in programs such as BadgerCare, BadgerCare Plus, FamilyCare, Medical Assistance, and SeniorCare, the state's senior prescription drug program. Over 800,000 Wisconsin residents were enrolled in Medicaid programs in 2005.

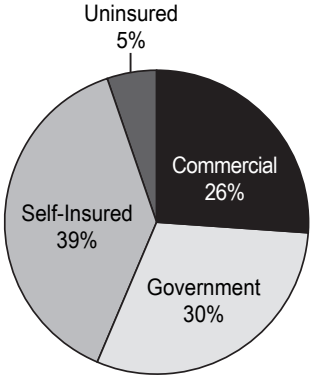
Health Insurance Risk Sharing Program (HIRSP). There are two criteria for eligibility for HIRSP. HIRSP enrollees can be generally high-risk individuals, with chronic health conditions, or with a past treatment for a major medical condition such as cancer. HIRSP enrollees do not have access to group insurance coverage and have been denied coverage in the individual health insurance market. Wisconsin also uses HIRSP to meet the federal Health Insurance Portability and Accountability Act (HIPAA) requirement for an insurer of last resort in the individual market. HIPAA eligibles are those who have lost employer-sponsored coverage and exhausted any continuation coverage for which they were eligible. HIRSP provided major medical coverage for approximately 18,300 enrollees at the end of 2005. On July 1, 2006, administration of the HIRSP program was transferred to an independent authority.

The Uninsured. The level of the uninsured has remained relatively stable over the last decade in Wisconsin. Approximately 4% to 5% of the state's population has been without coverage for the entire year.

Over the last decade, 4% to 5% of Wisconsin residents were uninsured for the entire year.

Figure 1 below summarizes the four categories of Wisconsin's health insurance marketplace in 2005.

Figure 1. The Wisconsin Health Insurance Marketplace in 2005



Regulation of Health Insurance in Wisconsin

Health insurers in Wisconsin are regulated by the Office of the Commissioner of Insurance.

Health insurers in Wisconsin are regulated by the Office of the Commissioner of Insurance (OCI). Insurers and insurance agents must be licensed before they are permitted to market an insurance product in the state. Insurers must meet certain financial standards to ensure they have the ability to pay claims when they are presented. Agents must demonstrate that they have the competence necessary to provide advice on complex insurance products. Insurance policies must be approved before use in the state, but insurers are generally permitted to establish premiums they believe to be necessary to cover anticipated expenses. In addition to Wisconsin insurance law, health insurers are also subject to compliance with HIPAA, which places conditions on the use of personal medical information and other privacy matters. HIPAA also establishes portability of health coverage and places restrictions on the use of pre-existing condition exclusions and the use of waiting periods in group health insurance policies.

Health Insurance Mandates. Health insurance policies sold in Wisconsin include mandated benefits. These are benefits that an insurer must include in certain types of health insurance policies. Mandates originate when it has been determined that requiring coverage for these benefits represents good public policy. Mandates can apply to group or individual coverage. There are two types of mandates. Provider mandates require that insurers cover health care received from specific types of providers, such as nursing homes. Benefit mandates require coverage of certain types of treatments or conditions such as newborn coverage or diabetes coverage.

There are currently 24 health insurance mandates in state insurance law. The most recently added health insurance mandate requires coverage for routine care costs in cancer clinical trials and became effective on November 1, 2006. Whenever a health insurance mandate is proposed in the state legislature, OCI is required to evaluate the proposal and prepare a report on the social and financial impact of any health insurance mandate contained in any proposed legislation affecting an insurance policy, plan, or contract. OCI is required to estimate current and potential utilization, current and potential patients affected and likely to seek treatment, the impact on the uninsured, and the impact on premiums.

Consumer Complaints. Consumers who are experiencing problems with insurers or agents can file a complaint with OCI. OCI typically receives between 8,000 to 9,000 complaints per year. Common complaints from consumers include claims handling and policyholder service. Over half of OCI's complaints are related to health insurance. Complaints help OCI assist Wisconsin's insurance consumers with their particular insurance problem, but also help OCI spot trends in the marketplace and allow the agency to focus resources to address emerging regulatory issues.

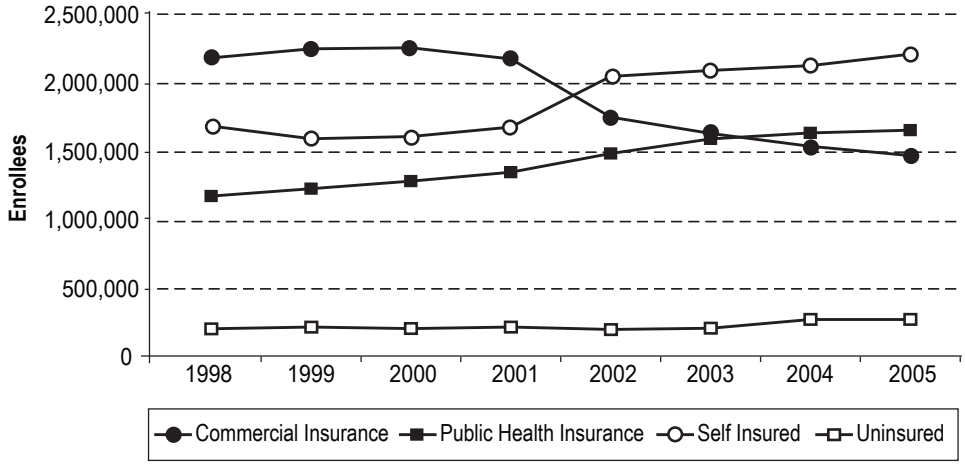
Grievance and Independent External Review. Health insurance policies are required to have an internal grievance procedure for individuals who are dissatisfied with the services they receive. If the dispute involves the denial of a claim because the insurer determined the treatment was not medically necessary or was experimental, the individual may additionally request that an independent

review organization (IRO) review the insurer's decision. In order to be certified to do independent reviews in Wisconsin, the IRO must demonstrate that it has procedures in place to ensure that it is unbiased and that its clinical peer reviewers are qualified and independent. The IRO has the authority to determine whether the treatment must be covered by the insurer.

Emerging Issues in the Health Insurance Marketplace

The commercial health insurance marketplace has been declining in recent years, whereas coverage through self-funded health plans and government health care have been on the rise. The level of the uninsured has remained about the same (see Figure 2). This poses a problem for state policymakers, because any solutions they try to develop to address cost and access to commercial health insurance affect a shrinking share of the entire health care marketplace. Self-funded health plans, Medicaid, and Medicare are not governed by state insurance law. While Medicaid is slightly less restricted, the state still must comply with federal rules governing Medicaid and must get federal waivers before attempting anything outside those rules.

Figure 2. Wisconsin Health Care Coverage



Source: DHFS, DOA, DHHS, OCI

Currently, certain areas of Wisconsin, noticeably the southeastern part of the State, are experiencing health care costs that are much higher than most other areas of the country. High health care costs translate into higher health insurance premiums for commercial insurance products. A recently published study from Mercer Health & Benefits has put Wisconsin's health benefit costs per employee at over $9,500 annually (including the cost of medical plans, dental plans, and employee premium contributions, but not employee deductibles, co-payments, or other out-of-pocket expenses). These figures vary from year to year depending upon which employers respond to the survey, but currently Wisconsin's premium costs are 26.5% higher than the national average and Wisconsin is the third highest state. The Mercer study also showed health care costs in Wisconsin are rising faster than in most other areas of the country.

Wisconsin's costs for health care and benefits are higher than most other parts of the country.

Recently, more employers have been switching their health benefit plans to consumer-driven health plans. Consumer-driven health plans are plans that encourage enrollees to become more informed health-care consumers through the use of health plans with high deductibles and co-payments along with wellness programs. Consumer-driven plans are usually tied to a Health Savings Account (HSA), which is a financial instrument that enables enrollees to deposit money into an account that may be later used to satisfy the deductibles for their health plan. Deposits into an HSA are deductible for federal income tax calculations.

Consolidation in the health insurance market presents problems for policymakers.

While not as pronounced here as in other states, consolidation in the health insurance marketplace presents additional problems for policymakers. Wisconsin has traditionally relied upon a competitive market to help keep premiums lower and encourage innovation by insurers. Both UnitedHealthcare and Anthem Wellpoint have acquired significant market share in Wisconsin since 2000.