

Wisconsin Family Impact Seminars
and
Evidence-Based Health Policy Project

**Affordable Strategies to Cover the Uninsured:
Policy Approaches from Other States**



UNIVERSITY OF WISCONSIN
Population Health Institute
Translating Research into Policy and Practice

UW
Extension

Affordable Strategies to Cover the Uninsured: Policy Approaches from Other States

First Edition

Wisconsin Family Impact Seminars

*A collaborative of the Center for Excellence in Family Studies
in the UW School of Human Ecology and UW-Extension*

and

Evidence-Based Health Policy Project

*A collaborative of the UW Population Health Institute and
La Follette School of Public Affairs*

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Purpose and Presenters

In 1993, Wisconsin became one of the first states to sponsor Family Impact Seminars modeled after the seminar series for federal policymakers. The Seminars are designed to connect research and state policy, and bring a family perspective to policymaking. Family Impact Seminars analyze the consequences that an issue, policy, or program may have for families. Because of the success of the Wisconsin Family Impact Seminars, Wisconsin is now helping 20 states conduct their own seminars through the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension.

The Family Impact Seminars are a series of seminars, discussion sessions, briefing reports, and newsletters that provide up-to-date, solution-oriented research on current issues for state legislators and their aides, Governor's office staff, legislative service agency personnel, and state agency representatives. The Seminars present objective, nonpartisan research and do not lobby for particular policies. Seminar participants discuss policy options and identify common ground where it exists.

"Affordable Strategies to Cover the Uninsured: Policy Approaches from Other States" is the 24th Wisconsin Family Impact Seminar. For information on other Wisconsin Family Impact Seminars topics or on Seminars in other states, please visit our website at www.familyimpactseminars.org.

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Executive Summary

Wisconsin citizens ranked health care as one of the state's top two issues in a recent UW poll. For CEOs and business owners in northeastern Wisconsin, health insurance tied as the top challenge they face. Despite public and private efforts to expand insurance coverage, Wisconsin's uninsured rate—4% to 5% of residents—has not changed over the last decade. However, Census data reveals a shift in insurance providers. Between 2000 and 2005, employer coverage fell from 79% to 71% for Wisconsin residents under age 65, while Medicaid coverage rose from 8% to 13%. This report covers what policies other states are using to bring people into coverage, and how to avoid a legal challenge under federal ERISA law.

The first chapter was written by **Patricia A. Butler**, a leading consultant on ERISA. Because voluntary approaches have not reversed the trend of declining employer health insurance, states have begun to consider more mandatory approaches. However, legislating employer financing of health care access initiatives runs the risk of a legal challenge under federal ERISA law. ERISA clearly prohibits states from requiring private employers or unions to offer coverage. Yet policymakers should be able to overcome ERISA challenges by drafting laws that (a) rely on traditional state authority, (b) avoid direct references to ERISA health plans, and (c) minimize impacts for multi-state employers desiring uniform national plans. For example, mandating individual coverage, as Massachusetts did, raises no ERISA problems. ERISA should not preempt a well-designed pay or play law that offers dollar-for-dollar credit for employer health care spending. States should be able to require employers to establish Section 125 cafeteria plans, as long as the law does not specify what type of health coverage should be offered.

Next, **Rick Curtis**, President of the Institute for Health Policy Solutions, discusses Massachusetts' bipartisan health care reform legislation that has recently garnered national attention. Other states, especially those with similar demographic and financial characteristics, could consider three promising elements of the Massachusetts plan. First, a health insurance exchange, or pool, allows uninsured individuals to purchase quality, affordable health insurance products and creates administrative efficiencies for employers. Second, because voluntary pools have little effect on health insurance costs or coverage rates, Massachusetts mandated that individuals have insurance. Mandating individual coverage assures that the exchange covers both healthy and unhealthy individuals, thereby avoiding the problem of attracting too many high-risk and high-cost individuals. Mandatory approaches also reduce cost shifting, minimize employer crowd out, and limit insurers cherry-picking the best risks. Third, by mandating that employers set up (but not necessarily contribute to) Section 125 cafeteria plans for all employees, workers will receive a significant federal tax subsidy at no cost to the state. Employers stand to benefit as well because FICA taxes are reduced.

According to **Randall R. Bovbjerg** of the Urban Institute, policymakers are asking whether publicly funding reinsurance is a useful way to expand primary coverage

and reduce the number of uninsured, particularly for small employers. Reinsurance reimburses primary insurers for cumulative claims that exceed established thresholds during a year. The main goal is to reduce premiums and encourage enrollment by subsidizing high-cost claims. Reinsurance may also help spread risk more broadly, protect the solvency of insurers, and reduce variation in premiums from year to year. Arizona and New York have both used reinsurance, although their approaches differ. Relatively modest state subsidies and other changes have helped make health insurance more affordable, and have enrolled some people who were previously uninsured. Careful implementation is important to (a) maximize the impact of public dollars and (b) maintain incentives for insurers to control the cost of large medical claims that reinsurance covers.

In the fourth chapter, **Wisconsin Office of the Commissioner of Insurance staff** explain that 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.

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What Can We Learn About Federal ERISA Law from Maryland's Court Decision?

by Patricia A. Butler, JD & DrPH
Independent Health Policy Analyst

Patricia A. Butler

Because voluntary approaches have not reversed the trend of declining employer health insurance, states have begun to consider more mandatory approaches. However, legislating employer financing of health care access initiatives runs the risk of a legal challenge under federal ERISA law. ERISA clearly prohibits states from requiring private employers or unions to offer coverage. Yet policymakers should be able to overcome ERISA challenges by drafting laws that (a) rely on traditional state authority, (b) avoid direct references to ERISA health plans, and (c) minimize impacts for multi-state employers desiring uniform national plans. For example, mandating individual coverage, as Massachusetts did, raises no ERISA problems. ERISA should not preempt a well-designed pay or play law that offers dollar-for-dollar credit for employer health care spending. States should be able to require employers to establish Section 125 cafeteria plans, as long as the law does not specify what type of health coverage should be offered.

Health insurance premiums are increasing four times faster than earnings for the average American worker.¹ Each year, more families are unable to afford health insurance and still pay the rent. At the same time, there has been a widespread decline in employer-sponsored insurance, particularly among small employers. In response, many states have encouraged employers to voluntarily offer health insurance to their employees and contribute to the cost of health benefits. Because these voluntary approaches have not reversed the trend of declining health insurance, some states have begun to consider more mandatory approaches. However, these mandatory programs run the risk of a legal challenge under ERISA, the 1974 federal Employee Retirement Income Security Act.

To comply with ERISA, state policymakers must carefully design health care access initiatives that involve employer contributions. In that spirit, this chapter provides background on the federal ERISA law, explains why state policymakers are concerned, and describes what states can and cannot do in designing access legislation under ERISA. I also discuss which strategies policymakers might consider, how they might finance access initiatives, and what the ERISA implications are of approaches used in Maryland and Massachusetts.

What is ERISA?

In 1974, Congress enacted ERISA, the Employee Retirement Income Security Act, primarily to remedy fraud and mismanagement of private employer pension plans. In addition to regulating pension plans, ERISA also applies to other employee benefits including health coverage. When the law was passed, one main concern

Health care access initiatives involving employer contributions run the risk of a legal challenge under federal ERISA law.

of Congress was encouraging employers to offer health insurance without being subject to varying state laws.

ERISA does apply to both insured and self-insured plans offered by private sector employers and/or unions. However, it does not apply to churches or to public employer health benefits.

Why are State Policymakers Concerned About ERISA?

State policymakers are concerned about ERISA for several reasons, three which are covered here. First, federal law usually preempts or supersedes only state laws that are in direct conflict with federal law. However, ERISA has a broad preemption clause that supersedes state law related to employee health benefit plans, even when there is no conflict with federal law.

Second, ERISA is interpreted, not by the Department of Labor, but instead by the courts. The problem with allowing courts to interpret the law is that policymakers do not know what is allowed or disallowed until cases have been filed and the courts have decided. Third, ERISA affects what strategies states can use to include employer financing in access initiatives, although vast grey areas exist regarding what states can and cannot do.

What States Cannot Do Under ERISA

ERISA prohibits states from requiring private employers or unions to offer health coverage.

ERISA clearly prohibits states from requiring private employers or unions to offer health coverage. The one exception to this is Hawaii. Just before ERISA passed in 1974, Hawaii mandated employers to provide health coverage to full-time employees. In 1983, Hawaii was granted an explicit exemption that does not apply to any other state.

To identify what states cannot do under ERISA, the Supreme Court set out a series of basic tests to provide guidance for lower courts. For 20 years, these tests were interpreted broadly, but recently the courts have narrowed the scope in ways that are more favorable to states wanting to expand health care coverage. State laws must, however, still pass the following tests:

- (1) Does state law refer to ERISA plans either explicitly or implicitly?
- (2) Does state law have a connection to ERISA plans by affecting its benefits, structure, or administration? Does it regulate areas ERISA addresses or impose substantial costs on plans?

If the answer to any of these questions is yes, the law will likely be preempted.

What States Can Do Under ERISA

States are prohibited from directly regulating employee health plans. However, the most important exception to ERISA is the “savings clause,” which allows states to regulate the insurers who provide employee health plans. Thus, the state has some influence over insured employee health plans, but not self-insured plans.

Using the savings clause, states can mandate:

- benefits requirements of health plans (e.g., mental health),
- provider coverage (plans that offer a service such as acupuncture are required to include some acupuncturists to provide that service),
- any willing provider (e.g., the use of managed care plans), and
- external review laws (allowing health plan enrollees to appeal to an outside medical expert when denied coverage under a plan's internal appeals process).

For states interested in expanding coverage, the 1995 *Traveler's Insurance* case is important. This decision upheld a New York rate setting law that made commercial insurance pay higher costs than Blue Cross plans. The 24% hospital surcharge imposed on plans other than Blue Cross made choosing Blue Cross more attractive. However, the court reasoned that it did not violate ERISA because it did not bind plan administrators to a particular choice of benefits or plans. The court also ruled that Congress did not mean to undermine the state role in traditional areas of state authority such as hospital rate setting and health care cost containment.

What this means for state policy initiatives is that states cannot directly regulate how ERISA plans are designed or administered, but states can raise the costs of these plans as long as the cost increases are not substantial. Moreover, policymakers can design plans in ways that are consistent with traditional lines of state authority.

What are the ERISA Implications of State Health Care Access Initiatives?

This section describes the potential ERISA implications of several initiatives that states could try, and that Maryland and Massachusetts have tried.

Maryland's Fair Share Act. The Maryland legislature passed this law in early 2006. If for-profit employers of 10,000 or more workers did not spend at least 8% of payroll on health insurance costs, they were required to pay the difference into a state Medicaid fund. The standard for non-profit employers was 6%. This law ended up affecting only Wal-Mart because of its size and limited health care spending.

In July 2006, a federal district court ruled that ERISA preempts this state law. In *RILA vs. Fielder*, the court held that the purpose and impact of the law required Wal-Mart to expand its ERISA health plan. Moreover, this law was found to interfere with uniform national administration of Wal-Mart's health plans in other states. The judge did suggest he might have ruled differently if state laws, like the 2006 Massachusetts law, addressed health care issues more comprehensively with only incidental effects on ERISA health plans.

On appeal, Maryland has argued that Supreme Court precedent does not prohibit laws that merely raise the cost of plans. What the law does is to mandate spending, which is different from mandating employers to maintain ERISA plans.

If this decision is not reversed upon appeal, it will be difficult for states to enact spending requirements like Maryland did. States should avoid laws that target only a small number of employers and that appear to mandate health benefits. Taxes

States should avoid laws that target only a few employers and that appear to mandate health benefits.

on employers for employees who use public programs might survive an ERISA challenge if they are assessed without regard to whether employees are covered under an employer-sponsored plan.

Pay or play laws could comply with ERISA depending on how they are designed.

Pay or Play Plans. Pay or play plans could comply with ERISA depending upon how they are designed. States should be able to create a public health plan financed by taxing employers (not plans); employers offering coverage would then be allowed a dollar-for-dollar credit for spending on employee health care. In essence, the state is creating a public health coverage program that allows a credit for employers that help the state provide health coverage.

The classic example was a 1988 Massachusetts law. For companies with more than five employees, employers were taxed on 12% of the payroll for full-time workers up to \$14,000 (indexed to health care costs); a dollar-for-dollar credit was granted for employee expenses for health care coverage. This tax was one source of funding for a universal health care access program in the state. The law was challenged in court on ERISA grounds, but was repealed before a court ruling.

This approach should withstand an ERISA preemption challenge because: (a) it does not interfere with the choices of the ERISA health plan administrators—they can either offer coverage or pay an assessment, and (b) taxing is a traditional area of state authority. A pay or play law could most easily overcome a preemption challenge if it:

- does not refer to ERISA plans.
- is neutral about whether employers pay or offer coverage (not a disguised mandate)
- applies to any health care spending (not only to more traditional health insurance or formal health plans)
- is not conditioned on whether an employer’s plan meets certain benefits or requirements, and
- does not require employers to pay for employees to qualify for coverage under the public program.

Massachusetts 2006 Health Care Access Bill. In 2006, Massachusetts passed an individual health care mandate. This law requires all state residents who can afford it to buy health care coverage or face substantial penalties. The law creates the Connector, a quasi-governmental organization to link individuals and firms with approved insurance products. The thrust of this bill is on individuals, but it requires employers with more than 10 employees to:

- establish IRS Section 125 plans allowing workers to purchase health insurance with pre-tax funds,
- pay a “free-rider surcharge” of between 10% and 100% of the cost of their employees’ uncompensated care if the employer does not create a Section 125 plan,
- pay the state a “fair share” assessment up to \$295 per full-time equivalent per year if they do not contribute a “fair and reasonable”

amount toward employee health insurance; this was interpreted in recent regulations to require employers to pay at least one-third of the employee's premium if at least one-quarter of employees are not enrolled in the employer's plan, and

- report to the state if a Section 125 plan is offered, whether employees decline the employer's health plan, and other information needed to implement the free-rider surcharge.

The Section 125 plans, also known as cafeteria plans, allow employees to pay for health coverage and other specified benefits with pre-tax wages. Employers can also exclude these contributions from the wages on which they pay FICA and unemployment taxes. The Department of Labor (DOL) does not consider these plans an employer-sponsored benefit under ERISA, so they are not considered ERISA plans. If the courts agree with DOL, a law requiring employers to establish Section 125 plans should not be preempted. Nor should plans that employees purchase through the Connector or on their own be considered ERISA plans.

The free-rider surcharge applies if employers do not establish a Section 125 plan. The purpose of the surcharge is to finance uncompensated care—a long-recognized state responsibility. Theoretically, the fair share assignment might raise preemption concerns because it attempts to affect ERISA plan structure (i.e., by waiving the assessment only if the employer pays a given share of the premium). However, the state could argue that \$295 per full-time employee is so insubstantial that it is not likely to have much of an impact. Practically, the law was supported by much of the business community, so it is unclear whether any employers will challenge it. The reporting requirements are minimal and should not bring a preemption challenge.

Premium Assistance Programs. Some states use Medicaid or SCHIP funding to assist low-wage workers in paying the employee share of employer health care; these premium subsidies should not be an ERISA problem. However, the biggest challenge in operating premium assistance programs is that states cannot require employers to provide information on their health care coverage. States often work with individuals to get the information they need to determine if premium assistance is cost effective.

This is one of the most likely areas in which the federal ERISA law could be amended. Federal law already requires employers to provide information to child support enforcement authorities. Similar language could be used to require employers to provide the information needed for operating premium assistance programs.

Single-Payer Plans. Universal publicly administered programs like single-payer systems can raise ERISA problems. Such plans may create incentives for employers to terminate or modify health plans, thereby influencing the structure of ERISA plans. ERISA preemptions become more complicated if a universal public program is financed by an employer payroll tax. Conceivably, multi-state employers might feel they are being forced to pay twice—their own health coverage costs as well as the payroll tax. For this reason, a single-payer plan funded by income tax (or an employee-only payroll tax) might be easier to defend from an ERISA challenge than an employer-paid payroll tax.

For financing universal public health programs, an employee payroll tax is easier to defend than an employer payroll tax.

States could defend tax-financed, single-payer plans on the grounds that it is hard to imagine the 1974 Congress intended to preempt such programs. Also, states could argue that financing health care is a long-standing state power. To date, no court has decided a case on a neutral financing scheme that eliminates the need for employer-sponsored coverage.

How Can States Raise Money for Access Initiatives Under ERISA?

In tight budget times, policymakers are asking how to raise money for health care access initiatives that can withstand an ERISA challenge.

- Taxes imposed on employer- or union-sponsored plans probably will face an ERISA challenge.
- Taxing insurers or health care providers should not be preempted, even if this increases the costs of ERISA plans.
- Taxes on employers, if they are allowed a dollar-for-dollar credit for spending on employee health care, are not likely to face an ERISA challenge.
- Payroll taxes on employees (not employers) to support universal, publicly-financed health programs ought to be okay; however, a state would need to successfully argue that Congress did not intend to preempt a public program, even if it does eliminate the need for employer-sponsored health plans.

Conclusion

Mandating individual coverage, as Massachusetts did, raises no ERISA problems.

Mandating individual coverage, as Massachusetts just did, raises no ERISA problems, even if employees enroll in employer coverage. ERISA should not be an issue in purely voluntary employer incentives such as health coverage tax credits or premium assistance subsidies for lower-wage workers enrolling in employer-sponsored plans.

Imposing mandatory requirements can raise ERISA concerns. Yet states should be able to tax employers to finance comprehensive public health care coverage if (a) the tax for employers whose employees use public programs is assessed without regard to whether employees are covered under an employer-sponsored plan, and (b) the program has only incidental effects on ERISA health plans. ERISA should not preempt a well-designed pay or play law that offers a dollar-for-dollar credit for employer health care spending, because it would not interfere with ERISA plan administrators' choices. States should also be able to require employers to establish Section 125 cafeteria plans, as long as the law does not specify what type of health coverage should be offered.

Unfortunately a large grey area exists in ERISA preemption. Policymakers will know for sure only when the Supreme Court decides a case. However, states should be able to overcome ERISA challenges by drafting laws that (a) rely on traditional state authority, (b) avoid direct references to ERISA plans, and (c) minimize impacts for multi-state employers desiring uniform national plans.

Maryland's court decision makes some laws difficult to defend from ERISA preemption challenges. Other financing approaches stand a better chance and are worth pursuing.

Patricia Butler, JD, DrPH, has a law degree from UC Berkeley and a doctorate in health policy from the University of Michigan's School of Public Health. She is a self-employed policy analyst on issues of health care financing, delivery, and regulation. Over the last 22 years, she has worked with 14 states on health care access issues. She has also served as a consultant to state legislative and executive branch officials, associations representing state government, and foundations including the Henry J. Kaiser Family Foundation, the National Academy for State Health Policy, and the National Governors Association. She has written over 60 publications with the most recent ones focusing on ERISA implications for state health policy and consumer rights.

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¹Kaiser Family Foundation and Health Research and Educational Trust (2004). *Employer health benefits: 2004 annual survey*. Washington, DC: Kaiser Family Foundation. Retrieved October 15, 2004 from <http://www.kff.org/insurance/7148/index.cfm>

This chapter is excerpted from a November 2006 paper written for AcademyHealth and the National Academy for State Health Policy by Patricia A. Butler, “*ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland “Fair Share Act” Court Decision*” (<http://www.statecoverage.net/SCINASHP.pdf>) and a March 2005 Cyber Seminar presentation for the Robert Wood Johnson Foundation’s State Coverage Initiative Program and the National Academy for State Health Policy by Patricia A. Butler, “*ERISA’s Implications for State Health Care Access Initiatives*” (<http://www.statecoverage.net/cyberseminar/index.htm>).

Promising Elements of the Massachusetts Approach: A Health Insurance Pool, Individual Mandates, and Federal Tax Subsidies

by Rick Curtis
President
Institute for Health Policy Solutions

Massachusetts has garnered national attention recently for its bipartisan health care reform legislation. Other states, especially those with similar demographic and financial characteristics, could consider three promising elements of the Massachusetts plan. First, a health insurance exchange, or pool, allows uninsured individuals to purchase quality, affordable health insurance products and creates administrative efficiencies for employers. Second, because voluntary pools have little effect on health insurance costs or coverage rates, Massachusetts mandated that individuals have insurance. Mandating individual coverage assures that the exchange covers both healthy and unhealthy individuals, thereby avoiding the problem of attracting too many high-risk and high-cost individuals. Mandatory approaches also reduce cost shifting, minimize employer crowd out, and limit insurers cherry-picking the best risks. Third, by mandating that employers set up (but not necessarily contribute to) Section 125 cafeteria plans for all employees, workers will receive a significant federal tax subsidy at no cost to the state. Employers stand to benefit as well because FICA taxes are reduced.

In the absence of federal legislation, several states, including Maryland, Maine, Illinois, and Massachusetts, have taken action to extend coverage to their uninsured. Perhaps the state that has received the most attention is Massachusetts, which passed its bipartisan health care reform plan in April 2006 with an implementation date of July 1, 2007. The aspect of this legislation that has been of particular interest to policymakers is its mandate that all individuals have coverage. The intent is to move Massachusetts close to universal coverage of its residents.

Key aspects of the Massachusetts approach may be used by Wisconsin and other states to cover the uninsured. Some states, like California and Montana, have vastly different demographics and economic constraints, which makes importing the Massachusetts model more difficult. Other states, like Minnesota and Wisconsin, have more similar characteristics, which may make it easier to adapt components of the Massachusetts approach to their state. This chapter describes the Massachusetts model and explains its most promising elements. The chapter concludes by explaining how states can adapt the Massachusetts model, illustrated with three alternative models recently developed and analyzed for California.

Key aspects of the Massachusetts approach could be used by other states to cover the uninsured.

What are the Main Components of the Massachusetts Plan?

Everyone must have health insurance. Individuals are required to have health insurance. This mandate will be enforced through income tax penalties; however,

those individuals for whom insurance coverage is not “affordable” will not be penalized. Within three years, 95% of the uninsured are expected to be covered.

The Massachusetts plan merges the individual and small business market, which is expected to reduce premiums costs for individuals by 24%.

The Commonwealth Health Insurance Connector Authority will act as a health insurance exchange, or pool, to manage key aspects of the plan. The Massachusetts legislation more generally merges the individual and small business insurance markets, which is expected to reduce premium costs for individuals by 24%.¹ Low-income individuals will have access to subsidized coverage through the Connector, which will also offer coverage to individuals and to employees of participating small businesses with 50 or fewer workers. It will “connect” them to private health insurance products that are certified as affordable and high quality.

Under this system of mandated insurance, the Connector can assure that workers not eligible for employer coverage can readily obtain a choice of affordable plans and tax shelter their premium payments through their employer, while minimizing the administrative burden on their employer. The Connector will (a) work with employers to enroll eligible workers, (b) collect workers’ health care payroll deductions (and any employer contributions) from employers, and (c) coordinate with private health plans to distribute enrollment information and premium payments.

Most employers are required to play a role. Employers with more than 10 full time equivalent (FTE) employees must establish a Section 125 plan (“cafeteria plan”) to allow workers to have their health insurance premiums deducted on a pre-tax basis. Employers who simply set up Section 125 plans but contribute nothing to their worker’s health premiums, or fail to contribute a “fair and reasonable” amount, must also pay a “Fair Share Contribution” of up to \$295 per worker per year.² If no employer plan is offered, the worker’s full premium payment can be made on a pre-tax basis. Employees who work part year or more than one job will be able to pool all of their own contributions, as well as any employer contributions, toward the purchase of insurance.

Low-income people will receive premium subsidies. The Connector manages a subsidized insurance program called the Commonwealth Care Health Insurance Program. People below 300% of the poverty line and who are ineligible for MassHealth (Medicaid) qualify for coverage in the Program. Premiums will be based on income and people below 100% of the poverty line will pay nothing toward premiums. The Program is open only to those individuals whose employer does not offer and contribute towards a health plan.

Low-income workers whose employer offers them coverage are not eligible for subsidies from the Connector, but the state does subsidize such workers’ premiums if they qualify for Medicaid/SCHIP or the expanded “Insurance Partnership” program (for small businesses under 50 employees). Such workers generally cannot bypass their employer plan and purchase insurance directly from the Connector. However, the statute provides the Connector Board with potential authority to waive the restriction, but only if the employer forwards its contribution to the Connector. It is unclear whether and how this waiver authority might be used to extend coverage to these low-income workers.

Can Other States Adopt the Massachusetts Model?

Massachusetts enjoys some advantages over other states in developing this type of health insurance reform. It has a small low-income population, a high percentage of workers with employer coverage, a low percentage of those with employer coverage who have low incomes, and a relatively large uncompensated care pool they can use to fund the program. These demographic and financial factors translate into a plan that comes with an “almost free” price tag. Realistically, other states will probably not be able replicate the model without increasing overall spending. To determine if Wisconsin could adapt some of the elements of the Massachusetts model with relatively modest increases in spending, policymakers could ask the following questions:

- How many Wisconsin citizens are low-income uninsured and would therefore need insurance subsidies?
- What is the risk of employer “crowd out?”
 - o How many workers are low-income but still have employer-sponsored insurance?
 - o How many workers are employed in low-wage firms?

Massachusetts and Wisconsin have some similarities in these respects, especially compared to the U.S. average. Both have below the U.S. average of nonelderly who are low income (below 300% of the poverty line). While the U.S. average is 46.7%, Massachusetts has just 35.9% whereas Wisconsin has 42.0%.³ This suggests that both Massachusetts and Wisconsin would experience lower subsidy costs to cover the low-income population than other states like California, where 48.9% residents are low income.

One concern other states may have with the Massachusetts approach is how employers will respond to subsidies, particularly if it causes “crowd out” of employer-sponsored coverage. Crowd out occurs when some employers elect to discontinue coverage for lower-wage workers who are likely to qualify for premium subsidies in the absence of an employer contribution. In Massachusetts, 43.5% of the low-income population (under 300% of the poverty line) has employer-sponsored insurance, which is lower than Wisconsin (49.9%) and higher than the U.S. average (42.6%). Because Wisconsin has more modest-income workers covered by employers, there is potentially more exposure to employer crowd out than in Massachusetts.

Another way to assess potential crowd out is to look at the number of workers who have employer-sponsored coverage and work for low-wage firms. In Massachusetts, 10.3% of workers are in this situation, compared to the U.S. average of 17.0% and the Wisconsin average of 12.2%.⁴ Wisconsin and Massachusetts are similar in this respect, although Wisconsin has a slightly higher risk of crowd out using these criteria.

One concern with the Massachusetts approach is whether subsidies will cause “crowd out” of employer-sponsored coverage.

Which Elements of the Massachusetts Plan are Promising for Health Insurance Reform?

States eyeing the Massachusetts model for possible policy approaches will find three promising elements to consider: a health insurance exchange or choice pool offering subsidized coverage for low income individuals, mandatory participation in insurance coverage, and access to federal tax benefits. Individually, these three elements will not cover a substantial number of uninsured. Taken together, these three elements create an effective public policy that brings people into coverage in ways that are both accessible and affordable. Importantly, a plan with these three elements assigns shared responsibility for coverage to individuals, employers, and government. (It is assumed that that these elements operate in an environment in which low-income individuals and families receive premium subsidies.)

Health Insurance Exchanges (Or Choice Pools). Many states see the relative success of large employer groups and try to replicate this “natural” insurance group through voluntary health insurance purchasing pools for individuals and/or small employers. But the end result typically is adverse selection and ultimately ineffective pools. Without needed safeguards, individuals who participate in such pools are too often high cost and cannot get coverage elsewhere. Small employers, by definition, do not have a large population and are more likely to have a disproportionate share of low-risk or high-risk workers. If an employer or pool has a disproportionate share of unhealthy people, over time the pool’s rates increase due to its higher costs. Eventually, the healthy, low-risk people find cheaper rates elsewhere in the market and the pool “sinks.”

Research shows that voluntary, unsubsidized insurance pools have little or no effect on health insurance costs or coverage rates

Health insurance pools, or exchanges, are not a magic bullet. For an exchange to be effective, it must reproduce the efficiency and effectiveness of natural pools formed by large employer groups. To do this, individuals must have a compelling reason to join the pool; for example, the exchange could be the exclusive coverage venue for anyone without employer coverage, or subsidized coverage could be made available only through the pool. Research shows that voluntary, unsubsidized insurance pools have little or no effect on health insurance costs or coverage rates.⁵ These are the very problems the pools are supposed to address.

Individual Mandates. A mandate that all individuals have insurance prevents systemic adverse selection by ensuring that both healthy and unhealthy individuals who do not have employer-sponsored coverage participate in the pool. These individuals include part-time or temporary workers, the self-employed, or workers at small businesses that do not offer insurance. In addition to avoiding adverse selection problems, mandatory approaches reduce cost shifting, prevent employer crowd out, and avoid insurers cherry-picking the best risks.

Voluntary insurance pools ultimately encourage cost shifts from private employers to state coffers. Research shows that subsidies need to be very high to induce the uninsured to voluntarily purchase coverage.⁶ In fact, the premium that modest-income uninsured people are willing to pay is much lower than what many other people at the same income level are paying for employer-sponsored coverage. With such high subsidies available, low-income workers will, when possible, seek out

employers that will pay them higher wages instead of offer them health insurance. It's a win-win situation for them, as they can then obtain state-subsidized coverage, often at a lower cost than their previous employee contributions. Over time, however, the state picks up the tab for more and more individuals who might have otherwise obtained coverage under employer plans.

Mandatory approaches alone or in conjunction with a health insurance pool are not a panacea. This is particularly true if the approach provides premium subsidies in an either/or way to workers: (1) if the employer does not offer a health plan, workers receive subsidies, and (2) if the employer does offer a plan, workers do not receive subsidies, regardless of how much the employee has to pay for the premium. In Massachusetts, the only workers covered by employer plans who will still receive subsidies will be those eligible for the pre-existing Mass Health (Medicaid) programs, or those whose employers join the pre-existing Insurance Partnership.

Under these types of mandatory approaches, employers, being rational actors in a competitive market, will slowly shift to not offering coverage ("crowd out"). Employers can then offer higher wages to their employees knowing their workers have access to subsidized health insurance. Even employers who wish to continue coverage may be compelled to drop coverage to compete with other firms that do not offer insurance.

Federal Tax Subsidies. An important feature of the Massachusetts plan is that it links the purchasing pool to employers. Employers with more than 10 workers will be required to offer a Section 125 "cafeteria plan" that allows all its workers to purchase health care with pre-tax dollars. These plans must be set up *even if the employer chooses not to offer a health plan or does not contribute to the plan if one is offered*. Plans set up only to tax-shelter employer contributions are called Premium Only Plans.

These plans must also be set up for workers who do not qualify for the employer's health plan, such as temporary or part-time workers. If the employer does not offer a plan, the workers' contributions are forwarded to the health insurance pool. There, workers can use the pre-tax contribution to purchase insurance through the pool and subsidies can be easily applied to the premium due.

By mandating Section 125 plans for all workers, the state can ensure that people receive a significant federal tax subsidy at no cost to the state. Using Section 125 plans, workers are able to shelter some of their income from FICA (Social Security and Medicare) taxes and federal income taxes. Employers, too, benefit from these savings because their FICA taxes are reduced as well. As a result, workers get a boost in their income and the state pays that much less in subsidies.

Some argue that those with low incomes have a low federal tax rate and therefore would not see significant savings. This is true for parents under about 125% of the poverty line and childless adults under about 85% of poverty. But most states are considering reforms to cover the uninsured for those under 200%, 250%, or even 300% of poverty. At these income levels, workers will garner tax savings that are not insignificant.

By mandating Section 125 plans for all workers, the state can ensure that people receive a significant federal tax subsidy at no cost to the state.

What are Some Ways States Can Use the Massachusetts Model?

There are difficult issues that state policymakers need to address when considering the Massachusetts model. Three alternative variations were developed for California,⁷ a state that has a much higher percent of low-wage workers, a higher lower-income population, and no funds to shuffle around to finance health care reform. Some of the differences between the three plans and the Massachusetts plan are presented below to illustrate possible policy options for Wisconsin.

	Plan 1 Basic Individual Mandate	Plan 2 "Pay-or-Play Plus"	Plan 3 "All-Consumer Choice Exchange"
Employer contribution level required	None, current contribution levels assumed.	5% of Social Security wages is required for part-time workers and at least that much must be spent for full-time workers.	Health insurance funded primarily by mandatory payroll-based fee paid by employers and workers. The percent of Social Security wages that is sufficient to fund a mainstream benefit plan to all full-time workers and their dependents will be determined. Employers would pay 80% of the fee and workers would pay 20%. Low-income workers pay on a sliding scale.
Contribution of families with employer coverage	Workers contribute to their employer plan, but low-income people will receive premium assistance to offset some or all of the costs.		Employers would pay 80% of the fee and workers would pay 20%. Low-income workers pay on a sliding scale.
Benefits	Medi-Cal and Healthy Families maintained. Others under 250% FPL will get comprehensive coverage through the Exchange or through employer coverage. Higher-income people must have \$5,000-deductible coverage, or better, to meet mandate.		Full-time workers and dependents get, at minimum, what average employer-plans currently offer ("mainstream benefits"). Others, see plans 1 and 2.

Unlike Massachusetts, the three alternative models analyzed for California assumed the following:

- The upper income limit for premium subsidies was set at 250% of the poverty level, instead of 300%. *Reason:* To align with California's relatively lower income distribution, health insurance premiums, and state revenue base.
- All employers, not just those with more than 10 workers, would be required to set up Section 125 plans for their workers. Employers must also cooperate with the health insurance exchange/pool for enrollment of workers and transmittal of workers' tax-sheltered contributions. *Reason:* To harness significant federal tax savings for *all* workers to reduce their net health care costs, while decreasing public subsidy costs and extending individual choice of health plans. Payroll deduction is the most efficient, reliable, and easy way to make and obtain worker health insurance contributions. Tax benefits should be available to all workers, no matter what size firm they work for.
- Low-income people with employer coverage would still be required to participate in that coverage, like Massachusetts. Premium assistance

Under the three California proposals, all employers would be required to set up Section 125 plans for their workers.

(subsidies) would be based solely on income, however, rather than whether the worker qualifies for Medicaid, SCHIP or an Insurance Partnership-like program. This would allow more workers to receive subsidies. *Benefit:* To create equity between workers whose employers offer coverage and those whose do not. It seems unfair that workers without employer coverage might be better off because they are always eligible to access subsidized health plans through the health insurance exchange, whereas other workers are bound to their employer plan. Without this provision, workers would have incentives to select employers who do not offer plans and some low-wage employers might have an incentive to drop their coverage. Such “crowd-out” could greatly increase state costs over time.

- The state pays the same proportion of the worker’s premium for employer coverage as it would pay for the premium coverage through the health insurance exchange. *Reason:* To encourage employers to continue contributing by assuring that their contributions benefit their own workers. The state also benefits because subsidy costs in this scenario would not increase as much as they would if all low-income workers were enrolled in public coverage through the pool.

Unlike Massachusetts, alternative plans 2 and 3 establish employer contribution requirements based on a percent of their wages. Plan 2 requires a modest minimum employer “pay-or-play” contribution for full-time workers and an employer fee for other workers. Plan 3 is funded by payroll fees on all employers and workers. The plan funding mechanism was designed to minimize any ERISA challenges. Plan 3 effectively replaces the employer-based coverage system and channels all coverage through the health insurance exchange.

Conclusion

Covering the uninsured will require some new spending in most states. The existing system of hidden cross subsidies has obscured cost accountability, making it more difficult to contain costs. An increasing share of our economy is being diverted to health care, compromising our ability to compete in a global economy. Sustaining the current system will become more difficult. The Massachusetts model and the three alternative plans that were briefly discussed ensure that everyone has access to essential medical services when needed. These approaches assign individual, employer, and government responsibilities, unlike the current health insurance system.

Covering the uninsured will require some new spending in most states.

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How Have States Like New York and Arizona Used Reinsurance to Help Businesses Control the Cost of Health Insurance?

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Policymakers are asking whether publicly funding reinsurance is a useful way to expand primary coverage and reduce the number of uninsured, particularly for small employers. Reinsurance reimburses primary insurers for cumulative claims that exceed established thresholds during a year. The main goal is to reduce premiums and encourage enrollment by subsidizing high-cost claims. Reinsurance may also help spread risk more broadly, protect the solvency of insurers, and reduce variation in premiums from year to year. Arizona and New York have both used reinsurance, although their approaches differ. Relatively modest state subsidies and other changes have helped make health insurance more affordable and have enrolled some people who were previously uninsured. Careful implementation is important to (a) maximize the impact of public dollars and (b) maintain incentives for insurers to control the cost of large medical claims that reinsurance covers.

In many states, keeping health coverage affordable is an urgent priority. The uninsured get less care, live sicker, and die younger than those with insurance. Many of the uninsured work for small employers, who often face uncertain and fluctuating costs for health care. Predicting the claims costs for small firms is harder than for large groups, and a few high-cost claims can sharply raise premiums or encourage employers to drop coverage.

The primary purpose of reinsurance is to bear the risks of large medical claims. High-cost cases account for a substantial amount of health care spending. For example, annual claims of over \$30,000 per person accounted for about 22% of insured health costs in 2004.¹ Policymakers are asking whether a carefully designed and well-executed reinsurance program is a good way to expand coverage and reduce the number of uninsured. This chapter defines reinsurance, explains why policymakers are interested, describes how New York and Arizona have used reinsurance, and raises issues that policymakers might consider.

What is Reinsurance?

Reinsurance serves as insurance for insurers, that is, for insurance companies, HMOs, and self-insured employer groups. Reinsurance protects these “primary” insurers from high-cost medical claims. Insurers, in turn, are expected to lower premiums and reduce variation in the cost of premiums from year to year. There are two main types of reinsurance: retrospective and prospective.²

High-cost cases account for a substantial amount of health care spending.

Randall R. Bovbjerg

Retrospective reinsurance reimburses a primary insurer for high-cost claims at year's end. A specified threshold operates as a kind of deductible for the primary insurer. For example, reinsurance may pay an insurer for 80% of any individual's cumulative claims that exceed \$50,000 for the entire year. The remaining 20% is then paid by the primary insurer as coinsurance. There is typically a ceiling on reinsurance as well, so that costs are shared within a "corridor" of coverage. Reinsurance is not visible to primary insurance enrollees, as the primary carrier continues to collect their premiums and pay their claims. Retrospective reinsurance is sold by private companies, and many primary insurers purchase its protection. Retrospective reinsurance can also be part of a public reform and funded by public revenues. Both New York and Arizona have used this type of reinsurance. New York covers individuals' claims costs, whereas Arizona has focused more on aggregate levels of cost for participating managed care organizations.

Prospective reinsurance is different. It allows insurers to designate individuals for reinsurance in advance, rather than submit high-cost cases for reimbursement after they have occurred. The primary insurers "cede" or transfer an individual's spending risk to a reinsurance pool at the time of enrollment. The primary insurer continues to cover the individual enrollee's claims, but is reimbursed by the reinsurance pool for some or all costs above a specified threshold. Ceding insurers pay the pool a premium up front, and all participating insurers pay a pro-rata share of any pool deficit at the end of the year, much as for workers' compensation pools.

Prospective reinsurance is a publicly created mechanism and does not exist in the private market because a high-cost individual is not an insurable risk. Prospective insurance has been enacted as part of broader reforms of the small group market that also limit insurers' ability to reject applicants or charge premiums according to health risk.³ Currently, no state is using public funds to subsidize prospective reinsurance.

Public reinsurance, whether prospective or retrospective, is seldom a stand-alone reform. Typically, it is part of a broader strategy to maintain or expand coverage.

Public reinsurance is typically part of a broader strategy to maintain or expand coverage.

Why are States Interested in Reinsurance?

The principal reason that primary insurers seek **private reinsurance** is solvency protection, that is, protection against losses that are unexpectedly high relative to their net worth or expected annual earnings. Reinsurance especially facilitates participation in the insurance market by new firms unfamiliar with market risks, or by smaller firms unable to bear high losses on their own. For example, many medium-sized firms would not self insure without reinsurance to protect their assets from catastrophic medical losses.

Private reinsurance deals quite well with unpredictable risk, such as accidents. However, it is less effective with identifiable high-risk individuals or groups, such as diabetes patients. For high-cost individuals, the only private options are to (a) pay sharply higher premiums, or (b) agree to reduced coverage. Only public intervention can help them, including through reinsurance subsidies of very high-cost cases.

There are four main reasons that states are interested in public reinsurance as a reform:

- 1) **Help Reduce Risk Selection.** Insurers worry about “adverse selection,” the tendency of enrollees to have higher than average risk of claims where individuals or small groups are choosing whether to buy coverage. Above-average claims experience forces an insurer to raise premiums, which discourages even average-risk individuals from enrolling and forces yet higher premiums, which in the extreme can cause a “death spiral.” Policymakers worry that insurers will combat adverse selection by discouraging or surcharging high-risk enrollment. Public reinsurance serves to reduce the incentive for risk selection by insurers, by assuming most of the burden of high-cost claims.
- 2) **Protect the Solvency of Insurers.** Public reinsurance has also been used to protect new market entrants. The prime example comes from states’ move to Medicaid managed care in the 1990s. No Managed Care Organization (MCO) had much experience pricing this population, and some had no experience with risk bearing at all. States used part of the Medicaid monthly capitation payments to finance public reinsurance, or required the MCOs to purchase private reinsurance to protect their solvency.⁴ Similarly, self-insured health plan groups for small employers also purchase private reinsurance to guard against insolvency.
- 3) **Lower Insurance Costs for Consumers.** Because public reinsurance lowers insurers’ claims costs, it should also cut premiums if either competition or regulation is effective. These lower premiums then encourage people to purchase insurance. Reinsurance is thus a form of premium subsidy, but one that is targeted to high-cost cases. Reinsurance can also complement policies that adjust premium subsidies by risk category; with reinsurance, payments to insurers are adjusted retrospectively, according to the level of high risks actually enrolled.
- 4) **Stabilize the Small Employers Insurance Market.** Small employers and their insurers struggle in the market because their premiums are higher and vary more than the premiums of large employers. High-cost claims can cause sudden rate increases, and insurance enrollment can change quickly as employers seek better terms elsewhere. Reinsurance assistance potentially can help stabilize the market, reducing the need for price increases and changes in carriers.

Reinsurance is a form of premium subsidy targeted to high-cost cases.

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What Approaches to Reinsurance Have States Taken?

To date, no state has chosen to use public funds to subsidize prospective reinsurance. Thus, this section focuses on several states’ proposed and existing retrospective public reinsurance programs.

Kansas is considering two types of retrospective reinsurance. First, *diagnosis-based reinsurance* is one approach that reinsures all claims paid for designated diagnoses, particularly high-cost conditions such as diabetes. Individuals with

these diagnoses are often rejected or face heavy surcharges in the private market. Second, *general small-group retrospective reinsurance* is a broad approach that could reimburse *all* primary health insurance claims above a specific threshold for *all* small-employer businesses.⁵ This mechanism, which is much more expensive to implement, has also been proposed in **Iowa**, where participation would be mandatory for businesses that employ up to 25 people; funding would come, not from businesses, but from fees on tobacco products.⁶

New York. Healthy New York is the most visible national example of using public reinsurance to expand coverage.^{7, 8, 9, 10} The program targets previously uninsured small businesses and working individuals with low incomes. Healthy New York offers coverage only through HMOs, and all such plans are required to participate, more than 20 plans in all. The benefit package is slimmed down somewhat from conventional products, omitting some otherwise state-mandated benefits. There is open-enrollment and premiums are the same for individual and group enrollees.

Participating small businesses must have (a) 50 or fewer employees who pay \$50 or less per month toward their coverage, and (b) at least 30 percent of employees who earn less than \$34,000 (adjusted annually). Individuals and sole proprietors must meet similar income requirements. Employees must pay at least 50% of premiums, and at least half of a firm's employees must participate.

State reinsurance pays 90% of an enrollee's claims between \$5,000 and \$75,000 in a calendar year. On average in 2004, Healthy New York kept medical claims cost at 82% of premiums. Without reinsurance, it would have been 115%. In 2004, the program cost \$38 million (almost 29% of all medical expenses) with costs expected to increase to \$58 million in 2005. The state subsidy of \$400 per person comes from tobacco settlement revenues and is fixed by appropriation.

Enrollment in December 2005 was approximately 107,000 with the majority being individuals. The state subsidy makes the premium lower than with conventional insurance. Despite this, enrollment could be much higher and why it is not remains unclear.

Arizona. The Healthcare Group of Arizona (HCG), a division of the state's managed care-based program for Medicaid, provides health plan choices for the state's small businesses (size 1-50) and political subdivisions.^{11, 12, 13} Groups qualify if they have not offered coverage for at least 180 days. Traditionally, only HMO plans were offered, but in late 2005 a Preferred Provider Organization (PPO) option was made available. Insurers are exempt from conventional insurance regulation, but must meet Medicaid standards, called Arizona's Health Care Cost Containment System or AHCCCS. There is open enrollment, and community-based premiums are set by age, gender, and location. High employee participation rates are required, which reduces adverse selection. As of December 2005, there were more than 17,000 enrollees in almost 6,000 small firms, heavily sole proprietors.

To help assure plan fiscal stability, HCG purchases private reinsurance that covers most annual losses over \$100,000 per enrollee. It also protects participating plans against high aggregate losses by itself making reinsurance or "stop-loss" payments

*New York's
reinsurance
program is
expected to cost
\$58 million in 2005
for about 107,000
enrollees.*

to plans that experience annual costs that are high relative to premiums, subject to the availability of funds. The target is to keep plans' medical claims costs between about 80 and 86 percent of premiums. Stop-loss payments go to plans with higher loss ratios and corresponding "stop-gain" payments are due from plans with lower ratios. These reinsurance mechanisms have at times been subsidized by state funds, largely tobacco revenues, but this subsidy was ended, effective fiscal years 2006 and 2007. Other funding comes from withholding a portion of primary premiums.

How New York and Arizona are Similar:¹⁴

- Both subsidy programs targeted limited populations for enrollment.
- Public funds reinsured high-claims losses.
- Only managed care organizations were targeted, and enrollees were given some choice among them.
- Benefits were somewhat reduced from the conventional market.
- Reinsurance funding from the state was limited rather than open-ended.
- Neither plan appears to enroll the bulk of apparent eligibles.

How New York and Arizona are Different:

- New York targeted its subsidy per high-cost enrollee, whereas Arizona protected its carriers from high losses relative to premiums in the aggregate.
- Eligible enrollees included individuals in New York, but only small businesses and political subdivisions in Arizona.
- Available information suggests that the effective public subsidy per enrollee has been higher in New York, and has now ended in Arizona.
- New York targeted previously uninsured people with low incomes, whereas Arizona targeted those poorly served by the private market.
- Arizona offers more benefits options than New York.

Neither Arizona's or New York's reinsurance plan enrolled the bulk of people who were eligible.

What Do Policymakers Interested in Reinsurance Need to Consider?

To design a reinsurance program, policymakers need to consider the experiences of other states as well as several issues pertinent to Wisconsin. In particular, state legislators may want to ask about the following:

What Groups to Target. New York targets those who have been previously uninsured. Another logical target group is small employers, because their employees and dependents constitute a large percentage of the uninsured. Small employers are important to the economy and their insurance market appears to be in flux. Because they can face sudden rate changes in the wake of high-cost claims, small employers are interested in reinsurance, whereas large employers typically are not.

States can create their own target groups, such as:

- what size of small employer group is eligible;
- whether to limit coverage to firms currently not offering coverage;
- whether to cover sole proprietors; and
- what wage, income, or other rules apply. In New York, for example, employers must have 50 or fewer employees, of whom 30% must earn less than \$34,000 annually.

Conceivably, employers or insurers may tailor their employment categories or firm structures to qualify for reinsurance. Given that insurance subsidy is not the main motivator of business decisions, such shifts may not become significant problems; however, they still bear watching, especially if the reinsurance subsidy is substantial.

Where to Focus Reinsurance Benefits. Policymakers must determine what insurers are eligible and whether participation is voluntary or mandatory. States can decide if they want to focus on the entire private market of insurers, a new purchasing pool, or another form of coverage specially created under state authority. Some standardization of covered benefits will help to streamline claims processing and keep administrative costs down.

How Much Public Funding to Provide and From What Sources. Any source of state revenue can be used to fund reinsurance, whether conventional taxes, tobacco settlement monies, or fees on tobacco products. It is possible to fund reinsurance from premiums paid by participants or assessments paid by participating insurers. However, such mechanisms fail to achieve any net subsidy or to lower the cost of insurance as intended by publicly funded reinsurance.

Allocating funds to reinsurance subsidies is an alternative to spending them on premium subsidies. Reinsurance provides subsidies on the back end by covering only high-cost claims; in contrast, premium subsidies provide public support on the front end to any eligible employee who contributes to employer-sponsored coverage.

The impact of reinsurance on premiums needs to be substantial in order to have much influence on purchasing decisions. Higher levels of support for public reinsurance can reduce premiums and encourage enrollment. More support can be implemented by lowering the threshold where reinsurance sets in (i.e., expanding the width of the corridor of claims) or by reducing the coinsurance required of primary carriers. Lower thresholds should further reduce the incentives for adverse risk selection because more claims risk would be broadly shared.

A lower reinsurance threshold could increase health care costs by decreasing insurers' incentives to control costs that reinsurance covers.

Of course, a lower reinsurance threshold would require higher state contributions and would cost more to administer because more claims would need to be processed. A lower threshold could also decrease the incentive for insurers to control costs. For example, if the reinsurance threshold is set at \$25,000 or \$30,000, insurers might not take appropriate steps to reduce costs beyond that threshold because reinsurance will cover them. States can learn from private insurers in this regard. They can require early warning of enrollees whose claims may exceed the threshold during the year, pay for investigations, and arrange for management of high-cost cases.¹⁵

Who Should Assume Responsibility? Accountability in reinsurance operations can be maintained through direct public operations or by a reinsurance board comprised of public and private representatives with insurance expertise and an eye to market response. One reason for favoring an experienced board is that many provisions of reinsurance may not be legislated, but rather decided during the implementation phase. This board can create a plan of operation under public oversight, perhaps from the Office of the Commissioner of Insurance or the Legislature.

One other possibility is contracting out some or all of the reinsurance functions to private reinsurers. A state may purchase its own private reinsurance to avoid overruns and the potential need for additional appropriations mid-year. Other functions the state may contract out include outreach and education, eligibility verification, and claims processing tasks.

Allow Sufficient Start-up Time. About 18 to 24 months seems an appropriate time to start a new reinsurance program. New York was able to start its program in slightly more than a year; however, it required significant changes shortly after it began.^{16, 17}

Provide Funding for Planning and Implementation. Reinsurance requires sufficient start-up funding. Administrative costs are likely to be higher during the planning phase because of the need for expert consultants, investment in data systems, and the like. Retrospective reinsurance will be tested only as claims appear, probably late in the first year. Thus, any glitches will be discovered relatively slowly, and fixes will take time to develop and implement.

Conclusion

In summary, policymakers are interested in reinsurance because of its potential to spread risk more broadly, reduce variability in prices from year to year, and lower premiums for primary insurers' enrollees by subsidizing their high-claim costs with public revenues. Arizona and New York have run public reinsurance programs with modest enrollments relative to the size of their uninsured populations. If Wisconsin is to implement such a program, it will need to consider whom to target, how much public funding to provide, and who should assume responsibility for designing and implementing the program.

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Reinsurance could lower insurance premiums by subsidizing high-claim costs with public revenues.

given over 100 presentations and testimonies for groups such as Congress, the National Conference of State Legislatures, the National Governors Association, the National Press Club, and the World Bank.

Ongoing Reinsurance Project in Wisconsin

Separate from prior work summarized here, Randall Bovbjerg and Bowen Garrett of The Urban Institute are leading a reinsurance project for AcademyHealth under the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program. This Reinsurance Institute project is designed to provide technical assistance to states through insurance-cost simulation modeling and other consultation on various forms of reinsurance subsidy and related reforms. The project team will be working closely with three states selected in November 2006 for intensive consultation and modeling during 2007 legislative sessions—Rhode Island, Washington, and Wisconsin. Databases used to construct the project's model of insured spending, premiums, and impact of reinsurance include MEPS, CPS, Statistics of U.S. Businesses, Society of Actuaries High Cost Claims Studies, and the National Health Accounts. Information on states is gathered through national surveys on regulatory patterns and market structure, as well as state-specific data supplied by participating states. Products will include input into state's decision making processes by memo, in person, and through short reports. Two in-person meetings and additional cyberseminars are being held with a larger group of interested states. The SCI's project webpage is <http://statecoverage.net/reinsuranceinstitute.htm>.

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Health Insurance Marketplace in Wisconsin

by Wisconsin Office of the
Commissioner of Insurance Staff

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.

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

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

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.

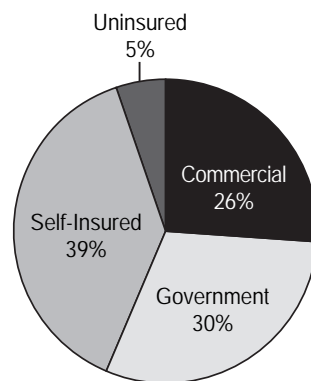
Medicaid. Medicaid encompasses a number of federal/state health care programs for low-income residents and their dependents. In Wisconsin, Medicaid recipients can participate in programs such as BadgerCare, BadgerCare Plus, FamilyCare, Medical Assistance, and SeniorCare, the state's senior prescription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

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

Figure 1. The Wisconsin Health Insurance Marketplace in 2005



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

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.

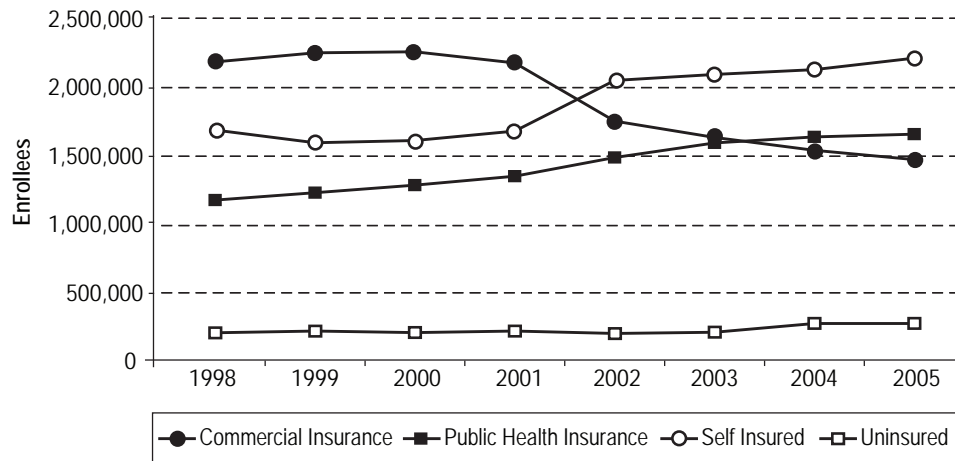
Grievance and Independent External Review. Health insurance policies are required to have an internal grievance procedure for individuals who are dissatisfied with the services they receive. If the dispute involves the denial of a claim because the insurer determined the treatment was not medically necessary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

Glossary

Adverse Selection ¹

From an insurance perspective, it occurs when those in poorer health—those more likely to require and utilize health care services—migrate toward a specific insurance plan at a higher rate than persons who are healthier and have better health expectations. Health insurance plans or providers that experience adverse selection will experience greater expenses and therefore often need to raise premium or service charges. This, in turn, may cause healthy individuals or businesses to find less expensive plans elsewhere, leaving the insurer with a still higher-cost population to cover, fewer persons able to afford the coverage, and a so-called “death spiral” for the health plan.

Attachment Point ²

For aggregate stop-loss insurance (also known as reinsurance), it is the point at which the cumulative total of claims paid within a policy year reaches its agreed upon maximum and the stop-loss insurance carriers begin to cover the incurred expenses.

Cafeteria Plan ¹

An arrangement under which employees can select among the benefits offered by an employer to meet their specific needs. For example, an employer may offer dental, health, and life insurance benefits to its employees. Employees can select none, some, or all of these benefits. The advantage of a cafeteria plan, also called a Section 125 Plan, is that employees pay for the benefits with pre-tax dollars. (See Section 125.)

Cost Shifting

The effort by health services providers to recoup the cost of care they provide to people who cannot pay for some or all of their care or for shortfalls in government program payment levels. Users of health care who are able to pay for their care through insurance or private funds are thought to pay more through increased premiums and higher health care costs to offset these shortfalls. The literature debates the degree to which such cost shifting actually accounts for variations in health insurance costs among providers and regions.

The concept of *cost shifting* has also been applied to circumstances whereby employers drop or limit the coverage they offer and instead encourage employees to enroll in state coverage programs. Or alternatively, *cost-shifting* can be extended to what is otherwise referred to as *crowd-out*, whereby new state coverage programs may provide an incentive to some employers to discontinue the coverage they provide, along with their share of the premium, leaving more employees eligible for premium subsidies from the state. Over time, the state pays more for coverage of people who had been previously covered by employer-sponsored insurance.

Community Rating¹

The method of calculating health plan premiums using the average cost of actual or anticipated health services for enrollees in a geographic area. Premiums do not vary for individuals in the plan whose claims indicate they are healthier or sicker or whose applications indicate a better or worse health status. Under modified community rating, premiums can vary based on demographic characteristics (e.g., gender and age) but cannot vary based on health status, claims history, or length of policy.

Crowd Out¹

A phenomenon whereby new or expanded public programs designed to cover the uninsured may prompt some employers who currently offer insurance to drop or limit their coverage, increasing the number who enroll in the publicly-funded insurance program.

ERISA¹

The Employee Retirement Income Security Act passed by Congress in 1974 that establishes standards and reporting requirements for employer-funded pensions and employee benefit programs including health coverage. ERISA applies to both insured and self-insured plans offered by private sector employers or unions. ERISA has a broad preemption clause that supersedes state laws related to employee health benefits. ERISA prohibits states from directly regulating employer-sponsored plans; however, under the ERISA “savings clause,” states can regulate the insurers who provide employee health plans. (See ERISA Savings Clause.)

ERISA “Savings Clause”⁴

The section in the ERISA law that gives states the right to regulate the business of insurance and persons engaged in that business. Therefore, states can regulate insured employee health plans, but not self-funded plans. For example, under the “savings clause,” states can mandate that insured health plans provide certain benefits and that health plan enrollees have access to outside appeals processes. Self-funded plans are exempt from these mandates and regulations.

External Review Laws

Laws that allow a health plan enrollee to appeal a coverage denial to an outside medical expert if dissatisfied with the plan’s internal appeal process. The goal is to settle disputes between health insurance plans and enrollees without the cost and time required if the court system were used.

Guaranteed Issue¹

The requirement that insurance carriers issue coverage to groups and/or individuals during some period each year regardless of health status. The Health Insurance Portability and Accountability Act (HIPAA) requires guaranteed issue of small employer groups (2-50 employees).

Health Insurance Exchange

A public or publicly chartered private organization that connects individuals and families with a choice of health plans. An exchange is an administratively efficient mechanism that (1) works with employers to enroll eligible workers, (2) collects workers' health care payroll deductions (and any employer contributions) from employers, (3) receives subsidy payments on behalf of low-income workers and families from the state, and (4) coordinates with private health plans to distribute enrollment information and premium payments. Where a state mandates individuals to have insurance, an exchange can assure that workers not eligible for employer coverage can choose and obtain an affordable plan using premium payments that have been deducted pre-tax by their employer. Employers benefit because their administrative burden is minimized as a result of coordinating with only one entity on behalf of their workers.

The extent to which exchanges actually offer affordable coverage depends on the degree to which they attract a broad range of participants. Voluntary programs may be subject to adverse selection—attracting only those with higher risks who are unable to attain affordable insurance through more traditional venues.

Health Insurance Risk Sharing Program (HIRSP) ²

Wisconsin's high risk health insurance pool, which offers health insurance to Wisconsin residents who are either unable to find adequate health insurance coverage in the private market due to their medical conditions or who have lost their employer-sponsored health coverage. Applicants must meet HIRSP eligibility requirements and participate in premium payments. At the end of 2005, 18,300 enrollees qualified for the program.

Universal Coverage

The achievement of health insurance coverage for virtually 100% of the population. This may be achieved through market-based or government-run programs or hybrid models.

Preemption

The term means that ERISA supercedes any and all state laws that “relate to” any employee benefit plan subject to Title I of ERISA. ERISA can preempt state law even when there is no conflict with federal law.

Premium Assistance Program ⁶

A program that uses federal and state Medicaid and/or State Children's Health Insurance Programs (SCHIP) funds to subsidize the purchase of private health insurance coverage for low-income children and families. Under current Medicaid law, states have the option of subsidizing the purchase of private group health plans for Medicaid beneficiaries (and even eligible family members) if it is “cost effective” to do so. States that develop a program without a Section 1115 waiver must ensure that beneficiaries who enroll in private coverage retain access to all benefits under the state's Medicaid program and are protected from costs

that exceed those allowed in Medicaid. Similarly, wraparound coverage must be provided and cost-sharing must be limited for families enrolled in SCHIP-funded premium assistance programs unless the state receives a waiver.

Prospective Reinsurance

An insurance policy under which the primary insurer transfers an enrollee's spending risk to the reinsurance pool at the time of enrollment. That is, the transfer occurs at the start of the year and differs from retrospective insurance, which tabulates and transfers high risk at the end of the year. The primary insurer continues to cover the enrollee's claims, but is reimbursed by the reinsurer for some or all costs above the established threshold. This reinsurance is a purely public-created mechanism because the private market will not insure a high-risk individual. Prospective reinsurance pools are typically created as part of a larger reform that commonly includes provisions that limit small-group market insurers' ability to reject an applicant or to charge premiums according to health risk. It appears no state is currently using public funds to support prospective reinsurance.

Purchasing Pool ¹

Grouping together many individuals and/or small businesses into a larger group to offer the choice of benefits and a stability of rates typically found only in large employer groups. The goal of pools is to spread risk across a broader enrolled population; consolidate purchasing responsibilities to obtain greater bargaining clout with health insurers, plans, and providers; and to reduce the administrative costs of buying, selling, and managing insurance policies.

Reinsurance

Insurance for insurers. This insurance is intended to protect an insurer from the extraordinary health care costs that just a few beneficiaries with extensive health care needs may incur. Insurers purchase reinsurance as a way to lessen or eliminate the impact of high-cost medical cases. Insurers, in turn, are expected to lower premiums and reduce fluctuation in premiums from year to year. Small employers are particularly interested in reinsurance because they can face sudden rate changes in the wake of high-cost claims. (See also retrospective reinsurance and prospective reinsurance.)

Retrospective Reinsurance

A reinsurance policy under which the reinsurer at year's end will reimburse the primary insurer for claims above a certain threshold level or attachment point during a policy year. The threshold operates as a kind of deductible for the primary insurer and the primary insurer may retain coinsurance responsibility above the threshold as well. For example, reinsurance may pay the primary insurer for 80% of any insured individual's accumulation of claims that exceed \$50,000 for the entire year. The primary insurer is responsible for the remaining 20% in claims costs. There is typically a ceiling on reinsurance as well, so that costs are shared within a "corridor" of coverage. This reinsurance is invisible to enrollees.

Section 125⁷

The section in the IRS Tax Code that allows employers to offer their employees a choice between cash salary and a variety of benefits including health care, vision and dental care, group-term life insurance, disability, adoption assistance, and certain other benefits. These benefits are excluded from an employee's gross income and thus are not taxable. Employers may also offer flexible spending accounts, including health flexible spending accounts, to employees under cafeteria plans to pay for expenses not reimbursed under any other health plan and dependent care assistance programs. Also called a cafeteria plan.

Self-Funded/Self-Insured Plans⁵

A plan in which the employer assumes direct financial responsibility for the cost of enrollees' covered medical claims as they occur. Employers sponsoring self-funded plans typically contract with a third party administrator or insurer to provide administrative services. These plans are not subject to state-level health insurance regulations or mandates, but are governed by ERISA.

Single-Payer Plan

A method of paying health care providers or insurers whereby all health care costs are paid by a government or designated administrator. The same organization would collect all health care premiums, assessments, taxes, or fees.

Small Group Market¹

The insurance market for products sold to small groups, typically employer groups. The definition of "small" varies from state to state, but 2 to 50 employees is the most common size.

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Wisconsin Family Impact Seminars Briefing Reports

Each seminar is accompanied by an in-depth briefing report that summarizes the latest research on a topic and identifies policy options state policymakers may want to consider. Since 1993, 24 seminars have been conducted on topics such as child support, juvenile crime, parenting initiatives, and welfare reform. For a list of the seminar topics and dates, please visit the Wisconsin Family Impact Seminar website at: <http://www.familyimpactseminars.org> (enter a portal and click on State Seminars). Each seminar has a page from which you can view the list of speakers, download the briefing report for printing, and, for recent seminars, listen to the audio of the speakers' seminar presentations.

If you would like to purchase a bound, printed copy of the report, please contact the UW Cooperative Extension Publications office at 877-947-7827 or <http://learningstore.uwex.edu>.

The following are the most recent Family Impact Seminar briefing reports:

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FIS 15	Rising Prescription Drug Costs: Reasons, Needs, and Policy Responses	January 2001
FIS 16	Designing a State Prescription Drug Benefit: Strategies to Control Costs.....	March 2001
FIS 17	Early Childhood Care and Education: What Are States Doing?.....	January 2002
FIS 18	Rising Health Care Costs: Employer Purchasing Pools and Other Policy Options	January 2003
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FIS 24	Affordable Strategies to Cover the Uninsured: Policy Approaches from Other States.....	January 2007

Selected Resources on ERISA, Reinsurance, and Health Care Reform

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Interests: Health insurance coverage, public coverage, income inequality and health, welfare reform

National Organizations and Associations

Academy Health
State Coverage Initiatives
Washington, DC
www.academyhealth.org
www.statecoverage.net

ERISA's Implications for State Health Access Initiatives – Ask the Expert. (Cyber Seminar, March 2005). Available at <http://www.statecoverage.net/cyberseminar/index.htm>

ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland “Fair Share Act” Court Decision. (Report, November 2006). Available at <http://www.statecoverage.net/SCINASHP.pdf>.

State of the States: Finding their Own Way. (Report, January 2006). Available at <http://www.statecoverage.net/pdf/stateofstates2006.pdf>.

The Role of Reinsurance in State Efforts to Expand Coverage. (Issue Brief, October 2004). Available at <http://www.statecoverage.net/pdf/issuebrief1004.pdf>.

Kaiser Family Foundation
Washington, DC
www.kff.org
www.kaisernetwork.org (downloadable webcasts)

Massachusetts Health Care Reform Plan. (Fact Sheet, April 2006). Available at <http://www.kff.org/uninsured/7494.cfm>.

The Massachusetts Plan: How Did They Do It? (Webcast, May 2006). Available at http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1730.

Has Massachusetts Solved the Health Insurance Puzzle? (Webcast, May 2006) http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1734.

Commonwealth Fund
New York, NY
www.cmwf.org

Reinsurance: How States Can Make Health Coverage more Affordable for Employers and Workers. (Report, July 2005). Available at http://www.cmwf.org/usr_doc/820_swartz_reinsurance.pdf.

National Academy for State Health Policy
Portland, ME
www.nashp.org

National Governors Association
Center for Best Practices
Washington, DC
www.nga.org

Helping the Working Poor Buy Insurance: Addressing Barriers to Premium Assistance. (Issue Brief, September 2006). Available at <http://www.nga.org/Files/pdf/0609INSURANCEASSIST.PDF>.

Improving and Increasing Access to Care: State Health Coverage Expansions Since 2004. (Issue Brief, September 2006). Available at <http://www.nga.org/Files/pdf/0609HEALTHCOVERAGE.PDF>.

National Conference of State Legislatures
Denver, CO
www.ncsl.org

States and Small Business Health Insurance: An Overview. (Web page, updated December 2006). Available at <http://www.ncsl.org/programs/health/SmallBusiness.htm>.

Massachusetts Passes Universal Health Care Package. (Web page, updated August 2006). Available at <http://www.ncsl.org/programs/health/massoverview.htm>.

2006 Pay or Play Bills: Can States Mandate Employer Health Insurance Benefits? (Web page, updated August 2006). Available at <http://www.ncsl.org/programs/health/payorplay2006.htm>.

Maryland's Fair Share Health Care Fund Act Overturned in ERISA Challenge. (Web page, updated July 2006). Available at <http://www.ncsl.org/programs/health/fairsharenews.htm>.



A Checklist for Assessing the Impact of Policies on Families

The first step in developing family-friendly policies is to ask the right questions:

- What can government and community institutions do to enhance the family's capacity to help itself and others?
- What effect does (or will) this policy (or program) have for families? Will it help or hurt, strengthen or weaken family life?

These questions sound simple, but they can be difficult to answer.

The Family Criteria (Ad Hoc) Task Force of the Consortium of Family Organizations (COFO) developed a checklist to assess the intended and unintended consequences of policies and programs on family stability, family relationships, and family responsibilities. The checklist includes six basic principles that serve as the criteria of how sensitive to and supportive of families policies and programs are. Each principle is accompanied by a series of family impact questions.

The principles are not rank ordered and sometimes they conflict with each other, requiring trade-offs. Cost effectiveness also must be considered. Some questions are value-neutral and others incorporate specific values. People may not always agree on these values, so sometimes the questions will require rephrasing. This tool, however, reflects a broad nonpartisan consensus, and it can be useful to people across the political spectrum.



This checklist can be used to conduct a family impact analysis of policies and programs.
For the questions that apply to your policy or program, record the impact on family well-being.

1

Principle 1. Family support and responsibilities.

Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.

Does the proposal or program:

- support and supplement parents' and other family members' ability to carry out their responsibilities?
- provide incentives for other persons to take over family functioning when doing so may not be necessary?
- set unrealistic expectations for families to assume financial and/or caregiving responsibilities for dependent, seriously ill, or disabled family members?
- enforce absent parents' obligations to provide financial support for their children?

2

Principle 2. Family membership and stability.

Whenever possible, policies and programs should encourage and reinforce marital, parental, and family commitment and stability, especially when children are involved. Intervention in family membership and living arrangements is usually justified only to protect family members from serious harm or at the request of the family itself.

Does the policy or program:

- provide incentives or disincentives to marry, separate, or divorce?
- provide incentives or disincentives to give birth to, foster, or adopt children?
- strengthen marital commitment or parental obligations?
- use appropriate criteria to justify removal of a child or adult from the family?
- allocate resources to help keep the marriage or family together when this is the appropriate goal?
- recognize that major changes in family relationships such as divorce or adoption are processes that extend over time and require continuing support and attention?

3

Principle 3. Family involvement and interdependence.

Policies and programs must recognize the interdependence of family relationships, the strength and persistence of family ties and obligations, and the wealth of resources that families can mobilize to help their members.

To what extent does the policy or program:

- recognize the reciprocal influence of family needs on individual needs, and the influence of individual needs on family needs?
- recognize the complexity and responsibilities involved in caring for family members with special needs (e.g., physically or mentally disabled, or chronically ill)?
- involve immediate and extended family members in working toward a solution?
- acknowledge the power and persistence of family ties, even when they are problematic or destructive?
- build on informal social support networks (such as community/neighborhood organizations, religious communities) that are essential to families' lives?
- respect family decisions about the division of labor?
- address issues of power inequity in families?
- ensure perspectives of all family members are represented?
- assess and balance the competing needs, rights, and interests of various family members?
- protect the rights and safety of families while respecting parents' rights and family integrity?

4

Principle 4. Family partnership and empowerment.

Policies and programs must encourage individuals and their close family members to collaborate as partners with program professionals in delivery of services to an individual. In addition, parent and family representatives are an essential resource in policy and program development, implementation, and evaluation.

In what specific ways does the policy or program:

- provide full information and a range of choices to families?
- respect family autonomy and allow families to make their own decisions? On what principles are family autonomy breached and program staff allowed to intervene and make decisions?
- encourage professionals to work in collaboration with the families of their clients, patients, or students?
- take into account the family's need to coordinate the multiple services required? Does it integrate well with other programs and services that the families use?
- make services easily accessible to families in terms of location, operating hours, and easy-to-use application and intake forms?
- prevent participating families from being devalued, stigmatized, or subjected to humiliating circumstances?
- involve parents and family representatives in policy and program development, implementation, and evaluation?

5

Principle 5. Family diversity.

Families come in many forms and configurations, and policies and programs must take into account their varying effects on different types of families. Policies and programs must acknowledge and value the diversity of family life and not discriminate against or penalize families solely for reasons of structure, roles, cultural values, or life stage.

How does the policy or program:

- affect various types of families?
- acknowledge intergenerational relationships and responsibilities among family members?
- provide good justification for targeting only certain family types, for example, only employed parents or single parents? Does it discriminate against or penalize other types of families for insufficient reason?
- identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, cultural, and geographic backgrounds that are relevant to program effectiveness?

6

Principle 6. Support of vulnerable families.

Families in greatest economic and social need, as well as those determined to be most vulnerable to breakdown, should be included in government policies and programs.

Does the policy or program:

- identify and publicly support services for families in the most extreme economic or social need?
- give support to families who are most vulnerable to breakdown and have the fewest resources?
- target efforts and resources toward preventing family problems before they become serious crises or chronic situations?

The Policy Institute for Family Impact Seminars aims to connect research and policymaking and to promote a family perspective in research, policy, and practice. The Institute has resources for researchers, policymakers, practitioners, and those who work to connect research and policymaking.

- To assist researchers and policy scholars, the Institute is building a network to facilitate cross-state dialogue and resource exchange on strategies for bringing research to bear on policymaking.
- To assist policymakers, the Institute disseminates research and policy reports that provide a family impact perspective on a wide variety of topics.
- To assist those who implement policies and programs, the Institute has available a number of family impact assessment tools for examining how responsive policies, programs, and institutions are to family well-being.
- To assist states who wish to create better dialogue between researchers and policymakers, the Institute provides technical assistance on how to establish your own state's Family Impact Seminars.

This checklist was adapted by the Institute from Ooms, T. (1995), *Taking families seriously as an essential policy tool* (<http://www.familyimpactseminars.org/reports/pins2.pdf>). The first version of this checklist was published by Ooms, T., & Preister, S. (Eds., 1988), *A strategy for strengthening families: Using family criteria in policymaking and program evaluation*. Washington DC: Family Impact Seminar.

The checklist and the papers are available from Director Karen Bogenschneider or Associate Director Heidi Normandin of the Policy Institute for Family Impact Seminars at the University of Wisconsin-Madison/Extension, 130 Human Ecology, 1300 Linden Drive, Madison, WI, 53706
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