WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Senate
(Assembly, Senate or Joint)

Committee on Agriculture and Insurance (SC-AI)

File Naming Example:

Record of Comm. Proceedings … RCP
- 05hr_AC-Ed_RCP_pt01a
- 05hr_AC-Ed_RCP_pt01b
- 05hr_AC-Ed_RCP_pt02

- *Committee Hearings … CH* (*Public Hearing Announcements*)
- **

- *Committee Reports … CR*
- **

- *Executive Sessions … ES*
- **

- *Record of Comm. Proceedings … RCP*
- **

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- *Appointments … Appt*
- **

- *Clearinghouse Rules … CRule*
- **

- *Hearing Records … HR* (*bills and resolutions*)
- **05hr_sb0451_SC-AI_pt01**

- *Miscellaneous … Misc*
- **

Vote Record

Committee on Agriculture and Insurance

Date: 11-28-05

Moved by: Olsen Seconded by: Brown

AB _____ SB 451 Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

☒ Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

☐ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Dan Kapanke, Chair	☑	☐	☐	☐
Senator Neal Kedzie	☑	☐	☐	☐
Senator Ronald Brown	☑	☐	☐	☐
Senator Luther Olsen	☑	☐	☐	☐
Senator Jon Erpenbach	☐	☑	☐	☐
Senator David Hansen	☑	☐	☐	☐
Senator Mark Miller	☐	☑	☐	☐
Totals:	____	____	____	____

☐ Motion Carried ☐ Motion Failed

Vote Record
Committee on Agriculture and Insurance

Date: 11-28-05

Moved by: Olsen Seconded by: Kedzie

AB _____ SB 451 Clearinghouse Rule _____

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~~A/S~~ Amdt 1

A/S Amdt _____ to A/S Amdt _____

~~A/S~~ Sub Amdt 1

A/S Amdt _____ to A/S Sub Amdt _____

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

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Senator Jon Erpenbach	☑	☐	☐	☐
Senator David Hansen	☑	☐	☐	☐
Senator Mark Miller	☑	☐	☐	☐
Totals:	____	____	____	____

☐ Motion Carried ☐ Motion Failed

Vote Record

Committee on Agriculture and Insurance

Date: 11-28-05

Moved by: Miller Seconded by: Brown

AB _____ SB ~~SB~~ 451 Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

A/S Amdt ~~SA~~ 1561

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt 1561 to A/S Sub Amdt 1

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

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Senator Ronald Brown	☐	☑	☐	☐
Senator Luther Olsen	☐	☑	☐	☐
Senator Jon Erpenbach	☑	☐	☐	☐
Senator David Hansen	☑	☐	☐	☐
Senator Mark Miller	☑	☐	☐	☐
Totals:	____	____	____	____

☐ Motion Carried ☐ Motion Failed

Vote Record

Committee on Agriculture and Insurance

Date: 11-28-05

Moved by: Miller Seconded by: Erpenbach

AB _____ SB _____ Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

A/S Amdt _____

A/S Amdt _____ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt 1567 to A/S Sub Amdt 1

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

Be recommended for:

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Senator Neal Kedzie	☐	☑	☐	☐
Senator Ronald Brown	☐	☑	☐	☐
Senator Luther Olsen	☐	☑	☐	☐
Senator Jon Erpenbach	☑	☒	☐	☐
Senator David Hansen	☑	☐	☐	☐
Senator Mark Miller	☑	☐	☐	☐
Totals:	____	____	____	____

☐ Motion Carried ☐ Motion Failed

Vote Record
Committee on Agriculture and Insurance

Date: 11-28-05

Moved by: Miller Seconded by: Hansen

AB _____ SB 451 Clearinghouse Rule _____

AJR _____ SJR _____ Appointment _____

AR _____ SR _____ Other _____

~~A/S Amdt~~ ~~a 1572~~

~~A/S Amdt~~ ~~a 1572~~ to A/S Amdt _____

A/S Sub Amdt _____

A/S Amdt 1 a 1572 to A/S Sub Amdt 1

A/S Amdt _____ to A/S Amdt _____ to A/S Sub Amdt _____

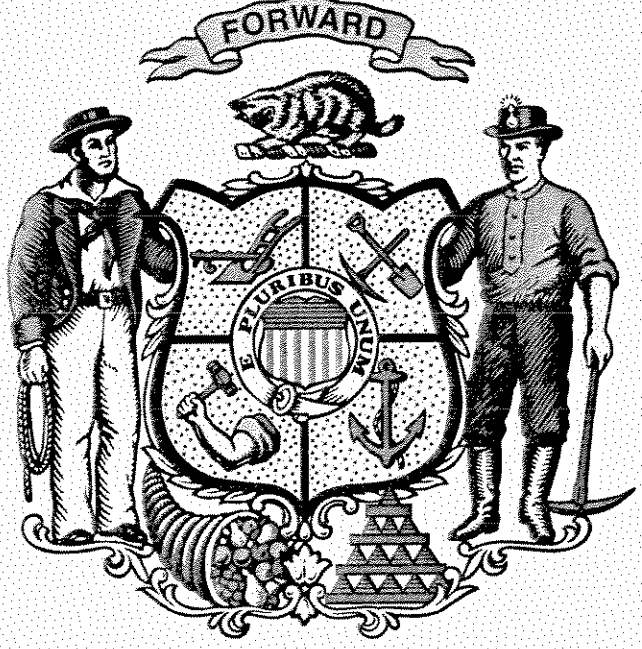
Be recommended for:

☐ Passage ☐ Adoption ☐ Confirmation ☐ Concurrence ☐ Indefinite Postponement

☑ Introduction ☐ Rejection ☐ Tabling ☐ Nonconcurrence

Committee Member	Aye	No	Absent	Not Voting
Senator Dan Kapanke, Chair	☐	☑	☐	☐
Senator Neal Kedzie	☐	☑	☐	☐
Senator Ronald Brown	☐	☑	☐	☐
Senator Luther Olsen	☐	☑	☐	☐
Senator Jon Erpenbach	☑	☐	☐	☐
Senator David Hansen	☑	☐	☐	☐
Senator Mark Miller	☑	☐	☐	☐
Totals:	____	____	____	____

☐ Motion Carried ☐ Motion Failed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Health Insurance Risk-Sharing Plan

Informational
Paper

51

Wisconsin Legislative Fiscal Bureau
January, 2005

Health Insurance Risk-Sharing Plan

Prepared by

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Health Insurance Risk-Sharing Plan

The state's health insurance risk-sharing plan (HIRSP) offers health insurance coverage to individuals with adverse medical histories and others who cannot obtain affordable health care coverage from the private sector. This paper provides information on HIRSP, including: (a) eligibility requirements; (b) covered services; (c) program funding; and (d) selected participation and utilization data. The paper also describes the responsibilities of the Board of Governors and the Department of Health and Family Services (DHFS) in administering HIRSP.

Eligibility Requirements

Wisconsin residents are eligible to enroll in HIRSP as a result of having health insurance coverage rejected or limited by an insurer, as a result of having certain diseases or disabilities, or as a result of the loss of employer-sponsored health care coverage.

Eligibility as a Result of Action by an Insurer. Individuals under the age of 65 may apply for enrollment in HIRSP if, during the nine months prior to the application, they received and submitted with their application, any of the following, based wholly or partially on medical underwriting considerations:

- Notice of rejection or cancellation of coverage from one or more health insurers.
- Notice of reduction or limitation in coverage, including restrictive riders, from an insurer if the effect of the reduction is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.
- Notice of an increase in premium of 50% or more for a current policy, unless the increase is applicable to all of the insurer's health insurance policies then in effect.
- Notice of a premium for a prospective policy from two or more insurers that is 50% or more in excess of the premium that would be paid by persons considered a standard risk for similar coverage.

Receipt of any of the above notices from a person who is an insurance intermediary (an insurance broker or agent acting only on his or her authority) is not sufficient to qualify an individual for participation in the plan. Further, the administering carrier may not certify a person as eligible for the plan without actual receipt of one or more of the appropriate qualifying notices.

Eligibility as a Result of Certain Diseases or Disabilities. Individuals under the age of 65 may also be eligible for coverage under HIRSP without having received any of the notices described above if they have certain diseases or disabilities. Persons may enroll in HIRSP if they submit evidence of:

- A positive test for the human immuno-deficiency virus (HIV) or an antibody to HIV.
- Coverage under Medicare because of a disability, defined as a condition which causes the individual to be unable to perform substantial, gainful activity because of a physical or mental impairment which will last at least 12 months.

Other Persons Eligible for HIRSP. Persons who meet the statutory definition of an "eligible individual" are also eligible to enroll in HIRSP. An "eligible individual" is an individual for whom all of the following apply:

- The aggregate of the individual's period of creditable coverage is 18 months or more.

- The individual's most recent period of creditable coverage was under a group health plan, governmental plan, federal governmental plan, or church plan, or under any health insurance offered in connection with any of those plans.

- The individual does not have creditable coverage and is not eligible for coverage under a group health plan, part A or part B of Medicare or medical assistance (MA) or any successor program.

- The individual's most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or a failure to pay premiums.

- If the individual was offered the option of continuation coverage under a federal continuation provision, the individual elected the continuation coverage.

- The individual has exhausted the federal continuation coverage.

Creditable coverage means health care coverage under:

- a group health plan;
- health insurance;
- Medicare Part A or B;
- MA;
- Tricare, formerly the Civilian Health and Medical program of the Uniformed Services (CHAMPUS);
- Civilian Health and Medical Program of the Veterans Administration (CHAMPVA);
- an Indian health services or tribal organization health plan;
- a state health benefits risk pool;
- a federal employee health plan;
- a public health plan; or
- a Peace Corps health plan.

In 2003, rejection of health insurance coverage from a commercial insurer accounted for 60% of the approvals for HIRSP coverage.

Persons Ineligible for HIRSP. Medically uninsurable persons eligible for participation in the plan by virtue of meeting any of the above conditions may still not be able to enroll if they fall under certain specific exclusions enumerated in the statutes. The following categories of persons are ineligible for HIRSP:

- Persons 65 years of age or older, except if the person meets the definition of an eligible individual or the person is a policyholder when turning 65.

- Persons for whom the plan has paid out a total of $1,000,000 in benefits.

- Persons for whom a premium, deductible or coinsurance amount is paid or reimbursed by a federal, state, county, or municipal government. However, this provision does not apply for deductibles or coinsurance amounts paid from public funds for vocational rehabilitation, for the treatment of renal disease, hemophilia or cystic fibrosis, for HIV/AIDS related insurance continuation, or for maternal and child health services. In addition, this provision does not apply to health insurance premium subsidies for HIV infected persons.

- For 12 months following termination of coverage, persons who have voluntarily ended coverage under the plan. This ineligibility provision applies to persons who terminate HIRSP coverage as a result of nonpayment of premiums. It does not apply where a person has terminated coverage because he or she began receiving or became eligible to receive medical assistance benefits.

- Persons eligible for creditable coverage provided by an employer on a self-insured basis or through health insurance, except policies that are considered supplemental insurance, policies where medical care coverage is secondary or incidental to other insurance benefits, such as liability or worker's compensation insurance, or policies where coverage is for a specific type of care or illness, such as long-term care, dental, or vision services.

- Persons eligible for MA.

HIRSP Benefits

HIRSP offers two types of plans. Both plans provide coverage for major medical expenses. Plan 1 is for individuals who meet the eligibility criteria above, but are not eligible for Medicare. Plan 2 is for individuals who meet the eligibility criteria above and are eligible for Medicare. Coverage for Plan 2 is limited to those benefits not paid by Medicare Part A or B, regardless of whether or not the individual is enrolled in Part B.

All HIRSP enrollees are required to obtain HIRSP-covered services from MA-certified providers.

Current law specifies expenses that must be covered and expenses that must be excluded under HIRSP. The HIRSP policy identifies additional covered expenses and excluded expenses. Tables 1A and 1B provide a summary of covered expenses and excluded expenses, respectively, under HIRSP.

Standard Plan Features. HIRSP contains a number of cost sharing and benefit limitation provisions which are common to traditional health insurance policies, including medical deductibles, medical and prescription drug coinsurance, limits on out-of-pocket costs, waiting periods for preexisting conditions, and lifetime maximum benefit limitations. These are described below.

Deductibles. Deductibles are specified amounts for covered services which the enrollee must personally pay during a coverage period before actual insurance benefits will be available. Deductibles are typically used to discourage the casual use of medical services and to help control program costs by reducing first dollar coverage.

Plan 1 offers two medical deductible options to enrollees. Option A has a $1,000 medical deductible for enrollees with annual household income of $20,000 or more. The medical deductible is less for enrollees with incomes at or below the annual household income of $20,000. Option B has a $2,500 medical deductible for all enrollees. Enrollees choosing Option B pay lower premiums than those choosing Option A. Current law requires that the deductible for HIRSP Plan 2 policyholders be equal to the Medicare Part A deductible ($876 in calendar year 2004), but also requires that, if the aggregate covered medical expenses not paid by HIRSP and the deductible exceed $500 for a Medicare-eligible individual, HIRSP pays 100% of all covered costs over $500 incurred by the Plan 2 policyholder - resulting in a $500 payment ceiling. DHFS currently interprets these contradictory provisions to limit the Plan 2 deductible to $500 per year.

Expenses used to satisfy the medical deductible during the last 90 days in a calendar year are also applied to satisfy the medical deductible for the following calendar year.

Coinsurance. Coinsurance is the fixed percentage or amount of covered medical expenses which an enrollee must personally pay during a coverage period after satisfying the deductible requirements. The combined deductible and coinsurance maximums usually constitute the out-of-pocket medical expense payment limit for the enrollee during a coverage period.

Table 1A: Covered Expenses Under HIRSP

- Hospital services
- Basic medical/surgical services (including inpatient and outpatient medical and surgical, diagnostic, anesthesia and consultation services)
- Inpatient treatment for up to 30 days per calendar year for alcoholism and drug abuse and up to 60 days per calendar year for mental and nervous disorders
- Some outpatient services for alcoholism, drug abuse and mental and nervous disorders (including services in a community support program for the chronically mentally ill), up to the maximum allowed per calendar year
- Prescription drugs and insulin
- Physical therapy, occupational therapy and speech and language pathology
- Up to 40 home health care visits, including hospice services if provided by a licensed hospice provider, each calendar year (up to 365 visits for persons on Medicare when combined with Medicare benefits)
- Processing charges for blood
- Use of radium and other radioactive materials
- Diagnostic x-rays and laboratory tests
- Oxygen
- Anesthesia
- Durable medical equipment other than hearing aids
- Prostheses (other than dental)
- Disposable medical supplies
- Ambulance services
- Up to 30 days of skilled nursing care for persons each period of confinement (up to 120 days in one calendar year for persons on Medicare)
- Services and supplies for treatment of diabetes, including outpatient self-management education programs
- Chiropractic services
- Limited medically necessary treatments for correction of temporomandibular disorders
- Some oral surgery procedures
- Limited dental care
- Papanicolaou (Pap) tests, pelvic exams and associated laboratory fees when a physician or a nurse practitioner performs the test or examination
- Routine mammography for women age 45 or over
- Breast reconstruction of the affected tissue incident to a mastectomy
- Initial purchase or eyeglasses or contact lenses for aphakia and keratoconus, and initial purchase following cataract surgery
- Blood lead tests for policyholders under six years of age
- Maternity and newborn services
- Hospital inpatient and outpatient treatment of kidney disease
- Gastrointestinal surgery for obesity
- Biofeedback for treatment of muscle reeducation of specific muscle groups
- Up to two visits for orthoptics (eye exercise training)
- Transplantation benefits

Table 1B: Excluded Expenses Under HIRSP

- Routine physical examinations and related services
- Experimental treatments, as determined by DHFS
- Cosmetic treatment other than surgery for the repair or treatment of an injury or a congenital bodily defect or breast reconstruction of the affected tissue incident to a mastectomy
- Custodial or domiciliary care not eligible under Medicare
- Private hospital room if not medically necessary
- Dental care (except certain surgical procedures)
- Eyeglasses (except as noted in Table 1A) and hearing aids
- Services of blood donors and replacement fees for the first three pints of blood provided to an eligible person
- Services or drugs for the treatment of infertility, impotence or sterility
- Charges and fees in excess of usual and customary charges
- Charges for care that is not medically necessary
- Personal services and supplies provided by a hospital or nursing home or any other nonmedical or nonprescription service or supply
- Services or supplies not within the scope of the authorized practice of the individual or institution providing them
- Expenses incurred before the effective date of coverage or after coverage ends
- Injuries or illness as a result of acts of war
- Smoking cessation products, programs, treatments, drugs, or supplies
- Food or liquid nutritional substances
- Treatment for obesity, including weight loss programs or drugs
- Correction of flat feet
- Allergy testing and sublingual allergy immunotherapy
- Clozapine management, except drug and laboratory testing
- Prolotherapy
- Work-related preventive treatment
- Chelation therapy, except for the treatment of digitalis or heavy metal toxicity
- Holistic medicine
- Services related to sex transformation surgery
- Acupuncture
- Ear lobe repair
- Prenatal tests done solely for sex determination
- Devices for impotency
- Certain therapies, including vocational rehabilitation, coma stimulation, aqua therapy, massage therapy, and physical fitness programs
- Over-the-counter medications, except insulin, or drugs that have an over-the-counter equivalent
- Autopsies
- Expenses for which benefits are payable under other insurance policies or by government programs

Current law specifies that if major medical expenses exceed the required medical deductible amount, the plan must pay at least 80% of any additional costs covered by the plan. However, for enrollees covered under Plan 1A, total out-of-pocket expenses during a calendar year, including medical deductibles, medical copayments and medical coinsurance, are limited to $2,000 for an individual or $4,000 for a family with more than one HIRSP enrollee. For enrollees in Plan 1B, total out-of-pocket expenses for a calendar year are limited to $3,500 for an individual or $7,000 for a family with more than one HIRSP enrollee. Under Plan 2, out-of-pocket expenses are limited to $500 per person enrolled in Medicare, including the medical deductible. Once the out-of-pocket limits are reached, HIRSP pays 100% of covered expenses for the remainder of the calendar year.

Additionally, DHFS is authorized to establish, by rule, copayments, coinsurance rates, and copayment and coinsurance out-of-pocket limits over which the plan will pay 100% of covered costs for prescription drug coverage. Establishment of the copayment amounts, the coinsurance rates, and the out-of-pocket limits is subject to the approval of the HIRSP Board.

Currently, enrollees pay HIRSP prescription drug coinsurance of 20% up to a maximum of $25 per prescription. However, for enrollees covered under Plan 1A, prescription drug coinsurance out-of-pocket maximums range from $375 to $750, based upon income levels. Plan 1B enrollees have a prescription drug coinsurance out-of-pocket maximum of $1,000. Plan 2 enrollees have a prescription drug coinsurance out-of-pocket maximum of $125. Once the out-of-pocket limits are reached, HIRSP pays 100% of covered prescription drug expenses for the remainder of the calendar year.

Table 2A illustrates how the current medical deductible and medical coinsurance payment mechanisms would operate for HIRSP enrollees under Plan 1A and 1B with different medical expense scenarios. Under these scenarios, it is assumed that only one family member is enrolled in HIRSP.

Under the first example, after applying the $1,000 medical deductible, the HIRSP Plan 1A enrollee is responsible for paying 20% of the next $950 of expenses, or $190. The plan pays the $760 balance.

Under the second example, after applying the $2,500 medical deductible, the enrollee would be responsible for paying 20% of the next $5,000 (or $1,000) of any additional covered expenses incurred during the calendar year before the plan would begin paying 100% of all additional covered medical expenses. This individual is limited to $3,500 in out-of-pocket expenses ($2,500 medical deductible and $1,000 coinsurance).

Table 2B illustrates how the current prescription drug coinsurance payments operate separately from the medical expense deductibles and coinsurance payments. The same assumptions from Table 2A apply.

Under the first example, the HIRSP Plan 1A enrollee would be responsible for paying 20% of the $4,000 in prescription drug costs, which equals $800. However, for the enrollee's income level, there is an out-of-pocket maximum of $750. Therefore, the enrollee is responsible for paying only $750 of the $4,000 prescription drug expense.

Under the second example, the HIRSP Plan 1B enrollee is responsible for paying 20% of the $4,000, which equals $800. Since the Plan 1B enrollee has an out-of-pocket maximum of $1,000, the HIRSP Plan 1B enrollee is responsible for the entire $800 amount.

Table 2A: HIRSP Plan 1 – Examples of Payments Under Medical Expense Scenarios

	Covered Expenses Balance	Enrollee Payments	HIRSP Payments
Plan 1A			
Total Covered Medical Expenses	$1,950		
Less Enrollee Payments of $1,000 Deductible	-1,000	$1,000	
Expense Remaining After Deductible Payment	950		
Less 20% Enrollee Coinsurance [Based on $950]	-190	190	
Expense Remaining After Coinsurance	760		
Less 80% HIRSP Payment [Based on $950]	-760		$760
Total	$0	$1,190	$760
Plan 1B			
Total Covered Medical Expenses	$13,500		
Less Enrollee Payments of $2,500 Deductible	-2,500	$2,500	
Expense Remaining After Deductible Payment	11,000		
Less 20% Enrollee Coinsurance [Based on next $5,000]	-1,000	1,000	
Less 80% HIRSP Payment [Based on next $5,000]	-4,000		$4,000
Expense Remaining After 80/20 Coinsurance	6,000		
Less 100% HIRSP Payment on Balance	-6,000		6,000
Total	$0	$3,500	$10,000

Table 2B: HIRSP Plan 1 – Table 2A Examples with Prescription Drug Expenses

	Covered Expenses Balance	Enrollee Payments	HIRSP Payments
Plan 1A			
Total Covered Prescription Drug Expenses	$4,000		
Less 20% Enrollee Coinsurance (up to $750 max.)	-750	$750	
Expense Remaining After Coinsurance	3,250		
Less 100% HIRSP Payment on Balance	-3,250		$3,250
Total For Prescription Drug Expenses	$0	$750	$3,250
Total For Medical Expenses (from Table 2A)	$0	$1,190	$760
Total For Medical and Drug Expenses Combined	$0	$1,940	$4,010
Plan 1B			
Total Covered Prescription Drug Expenses	$4,000		
Less 20% Enrollee Coinsurance (up to $1,000 max.)	-800	$800	
Expense Remaining After Coinsurance	3,200		
Less 100% HIRSP Payment on Balance	-3,200		$3,200
Total For Prescription Drug Expenses	$0	$800	$3,200
Total For Medical Expenses (from Table 2A)	$0	$3,500	$10,000
Total for Medical and Drug Expenses Combined	$0	$4,300	$13,200

Waiting Periods. Waiting periods are the times during which preexisting conditions diagnosed or treated before the policy was issued will not be covered. Waiting periods for preexisting conditions are used as an underwriting tool to prevent individuals from purchasing insurance only when they have a need to seek medical treatment.

Under current law, conditions that are diagnosed or treated in the six months preceding the filing of an application are not covered for the first six months that the individual is enrolled in HIRSP, except for certain individuals. If an individual has been treated or diagnosed for a particular condition at any time during the six months before the administering carrier receives the person's application for enrollment, HIRSP will not pay any claims for expenses arising from this condition during the first six months of HIRSP coverage. Health care services provided for the condition will be covered after the six-month waiting period. Eligible individuals are exempt from the six-month waiting period.

Lifetime Benefit Limits. A lifetime benefit limit is the maximum amount of medical benefits that may be received under the plan during the enrollee's lifetime. Overall benefit payment maximums are used to provide a degree of protection to insurance plans from catastrophic losses. Currently, HIRSP policyholders are subject to a $1 million lifetime limit on benefits for all medical conditions.

Cost Containment Procedures. Persons receiving services under HIRSP are subject to certain cost containment procedures to control medical costs.

Prior Authorization. Under current law, DHFS is authorized to implement, by administrative rule, the same utilization and cost control procedures used under the MA program. While MA requires prior authorization for certain services, HIRSP does not require prior authorization. Instead, DHFS encourages providers to obtain prior authorization before certain services are provided. In addition, the plan administrator reviews certain high-cost claims to ensure medical necessity.

ClaimCheck. ClaimCheck is software used in the HIRSP processing system that identifies and corrects claims payments for inappropriate procedure codes billed on HIRSP claims.

Insurance Disclosure. Health insurers are required to disclose information on the Wisconsin residents they insure for the purpose of post-payment recovery (when health insurance is retroactively identified for a HIRSP policyholder) and cost avoidance (when other health insurance is available and a provider tries to bill HIRSP prior to billing other health insurance).

Subrogation. Subrogation is recovery of monies from third parties for HIRSP policyholders who have suffered injuries for which third parties may be liable for the costs of medical services associated with the injury. Third parties could include worker's compensation and medical malpractice policies.

Disease Management. Disease management services assist enrollees with managing their diseases in a manner that reduces or delays the detrimental clinical and functional effects of the disease and reduces the need for and cost of medical care. Disease management delays or avoids complications of diseases or prevents acute exacerbations that could require hospitalization or emergency room care. Currently, HIRSP is not using disease management services. However, DHFS is negotiating with a new plan administrator to implement these services.

Prescription Drugs. Several cost containment strategies have been or will be implemented to control prescription drug costs in HIRSP. A pharmacy benefit management system (PBM) for HIRSP manages or will manage the following cost containment strategies:

- establish rebate agreements with drug manufacturers to maximize the amount of rebate

dollars generated by claims that would be returned to HIRSP;

- implement drug cost containment mechanisms, such as drug utilization review, day supply limitations, early refill policies, prior authorization for high-cost drugs, and coordination of benefits; and

- utilize a preferred drug list (PDL), which requires a pharmacist to obtain authorization from the provider for a prescribed drug not on the PDL before the drug is dispensed.

DHFS is currently in negotiations with a new plan administrator. Therefore, the details of the implementation of disease management and prescription drug cost containment mechanisms are not yet available.

HIRSP Funding

There are three sources of funding used to support HIRSP: (1) premiums paid by participants; (2) assessments on health insurance companies doing business in Wisconsin; and (3) a pro rata reduction in the billed charges of health care providers. 2003 Wisconsin Act 33 (the 2003-05 biennial budget act) eliminated state general purpose revenues (GPR) as a source of funding used to support HIRSP. Table 3 provides the amount from each funding source used to support actual HIRSP costs in 2003-04.

Participant Premiums. Current law requires that 60% of the projected operating and administrative costs of the program be funded from premium revenue.

However, HIRSP Plan 1 premium rates cannot be less than 140% to 150% of the rate that would be charged under an individual policy providing substantially the same coverage and deductibles as HIRSP. The Board is required to approve the premiums.

Table 3: HIRSP Funding (2003-04)

Funding Source	Funding Amount	% of Total
Premiums	$88,363,337	60.0%
Insurer Assessments	29,454,448	20.0
Provider Contributions	29,454,448	20.0
Total	$147,272,233	100.0%

If setting Plan 1 rates at 140% to 150% of the standard rate is not sufficient to cover 60% of plan costs, then DHFS, with the approval of the Board, has three options. First, any excess revenue premium revenue available from previous years can be used to fund any difference. Second, if the excess revenue is not sufficient to fund the difference between premium revenue and 60% of plan costs, then Plan 1 premiums can be increased above 140% to 150% of the standard rate, but no more than 200% of that rate. Third, if the projected premium revenue would not be sufficient to fund 60% of plan costs after exercising the first two options, then contributions from insurers and providers can be increased to fund the remainder of costs.

Plan 2 rates are to be based on three factors:

- a comparison between the average per capita amount of covered expenses paid by HIRSP in the previous calendar year on behalf of Plan 2 enrollees and the average per capita amount of covered expenses paid by HIRSP in the previous calendar year on behalf of Plan 1 enrollees;

- the enrollment levels of enrollees with coverage under Plan 2; and

- other economic factors DHFS and the Board consider relevant.

Table 4: HIRSP Annual Premium Rates (effective 7/1/04)

		Plan 1A ($1,000 deductible)			**Plan 1B** ($2,500 deductible)			**Plan 2** ($500 deductible)		
	Age Group	Zone 1	Zone 2	Zone 3	Zone 1	Zone 2	Zone 3	Zone 1	Zone 2	Zone 3
Males	0-18	$2,472	$2,232	$1,980	$1,776	$1,608	$1,428	$2,004	$1,800	$1,596
	19-24	2,472	2,232	1,980	1,776	1,608	1,428	2,004	1,800	1,596
	25-29	2,604	2,340	2,088	1,872	1,680	1,500	2,100	1,884	1,680
	30-34	2,940	2,652	2,352	2,112	1,908	1,692	2,364	2,136	1,896
	35-39	3,444	3,108	2,760	2,484	2,232	1,992	2,772	2,508	2,220
	40-44	4,128	3,708	3,312	2,976	2,664	2,388	3,324	2,988	2,676
	45-49	5,328	4,800	4,272	3,840	3,456	3,072	4,296	3,876	3,444
	50-54	7,128	6,420	5,700	5,136	4,620	4,104	5,748	5,172	4,584
	55-59	9,396	8,448	7,512	6,768	6,084	5,412	7,572	6,816	6,048
	60+	12,084	10,872	9,660	8,700	7,824	6,960	9,744	8,772	7,800
Females	0-18	$2,472	$2,232	$1,980	$1,776	$1,608	$1,428	$2,004	$1,800	$1,596
	19-24	3,144	2,820	2,520	2,268	2,028	1,812	2,532	2,268	2,028
	25-29	3,516	3,156	2,820	2,532	2,268	2,028	2,844	2,556	2,268
	30-34	3,936	3,528	3,144	2,832	2,544	2,268	3,180	2,844	2,532
	35-39	4,500	4,044	3,600	3,240	2,916	2,592	3,624	3,264	2,904
	40-44	5,172	4,656	4,128	3,720	3,348	2,976	4,164	3,744	3,324
	45-49	6,096	5,496	4,872	4,392	3,960	3,504	4,920	4,440	3,936
	50-54	7,296	6,564	5,844	5,256	4,728	4,212	5,880	5,292	4,716
	55-59	8,520	7,656	6,816	6,132	5,508	4,908	6,876	6,180	5,496
	60+	9,984	8,988	7,992	7,188	6,468	5,760	8,052	7,236	6,456

Zone 1: Certain zip codes in the Milwaukee area.
Zone 2: Certain zip codes in the Madison area and southeast Wisconsin.
Zone 3: The remainder of the rest of state.

As of July 1, 2004, Plan 1 premium rates were established at an amount equal to 140% of the standard rate. Plan 2 rates were approximately 81% of Plan 1A rates. The actual rate paid by an enrollee will differ based on the zip code in which he or she resides. The state's zip codes are divided into three zones. These zones include the Milwaukee area, the Madison area and southeastern Wisconsin, and the rest of the state. Table 4 identifies the premium rates effective July 1, 2004, for each of the three zones.

Table 5 illustrates how HIRSP Plan 1A premiums for one group, females ages 50 through 54 residing in Zone 1, have changed during the past 15 years.

Assessments on Insurers. Current law requires that 20% of HIRSP operating and administrative costs be paid from insurer assessments. Every participating insurer must share in the costs of the plan in propor-

Table 5: Example of Annual HIRSP Premium (Plan 1A) -- Female Age 50 through 54* (1988-89 through 2004-05)

Year	Rate
1988-89	$1,540
1989-90	1,540
1990-91	1,796
1991-92	2,248
1992-93	2,880
1993-94	3,200
1994-95	3,228
1995-96	3,228
1996-97	4,320
1997-98	3,936
1998-99	4,020
1999-00	4,020
2000-01	4,596
2001-02	4,680
2002-03	5,856
2003-04	6,480
2004-05	7,296

*Zone 1 (Milwaukee)

tion to the ratio of the insurer's total health care coverage revenue for state residents during the preceding calendar year to the aggregate health care coverage revenue of all participating insurers for state residents during the preceding calendar year. The statutes provide that "[e]very insurer shall participate in the cost of administering the plan." On its face, this provision appears to make all insurers writing health insurance in Wisconsin subject to the assessment, and initially this was the approach taken by the Office of the Commissioner of Insurance (OCI) when the first assessment was levied in 1981.

This assessment was immediately challenged by a private employer offering a self-insured health plan on the grounds that the federal Employee Retirement Income Security Act (ERISA) prohibited state regulation of self-insured plans. It was argued that self-insured plans could not be subjected to assessment in order to subsidize the operations of HIRSP. In General Split Corp. v. Mitchell (523 Federal Supplement 427, Eastern District of Wisconsin, 1981), the Court upheld the challenge and ruled that self-insured plans were not subject to Wisconsin insurance laws. Thus, self-insured plans could not be subjected to insurer assessments under HIRSP. As a result of this ruling, only private insurance companies, which are regulated by state insurance laws, may be subjected to assessments to support HIRSP.

For the July 1, 2004 through December 31, 2004 period, 256 private health insurance companies doing business in the state paid an assessment. The amount of the assessment for the period July, 2004, through December, 2004, ranged from $2.15 to $1,555,026 per insurer.

Reduced Health Care Provider Reimbursement. Current law requires that DHFS reimburse HIRSP providers for covered professional services at a rate equal to the MA reimbursement rate paid to providers, plus an enhancement determined by DHFS. Currently, the enhancement is equal to 40.4% of the MA reimbursement rate. With this enhancement, providers would be paid, on average, an amount equivalent to approximately 60% of a provider's usual and customary charges.

However, current law specifies that pharmacy costs are paid at the standard MA rate and are not subject to the enhancement. This enhancement also does not apply to inpatient and outpatient hospital claims or Medicare crossover claims. Inpatient hospital services use hospital-specific inpatient rates and HIRSP-specific weights for diagnostically related groups. Payment rates for hospital outpatient services may not exceed 61.32% of charges.

The MA enhancement, weights for diagnostically related groups, and percentage of charges are adjusted annually, based on actuarial recommendations, to reflect the amount needed from providers for their share of HIRSP costs. Current law requires that HIRSP providers fund 20% of the HIRSP costs. The providers' contribution is collected by reducing reimbursements, as indicated above, by an amount that would total 20% of projected plan costs. Except for copayments, coinsurance, or deductibles required or authorized under the plan, providers are expressly prohibited from billing the HIRSP enrollee for any of the unreimbursed amount.

Premium and Deductible Subsidy Program. Currently, individuals with less than $25,000 in annual household income are eligible for a subsidy to cover a portion of their premium if enrolled in Plan 1A or Plan 2. Individuals with annual income less than $20,000 are eligible for a subsidy to cover a portion of their deductible if enrolled in Plan 1A. Enrollees in Plan 2 are not eligible for a deductible subsidy. Enrollees in Plan 1B are not eligible for premium or deductible subsidies.

In 2004-05, premium and deductible subsidies are expected to total approximately $5.4 million. This amount will be funded equally from assessments on health insurers and reduced provider payments.

Table 6 identifies the current annual household income eligibility levels for the premium and de-

ductible subsidy program for Plan 1A and the amount of the subsidies at each income level. Table 7 compares the growth in the number of HIRSP enrollees for Plans 1A and 2 and the number of premium and deductible subsidy program participants for the years 1996 through 2004. HIRSP enrollees for Plan 1B are not included in the table since these enrollees are not eligible for premium or deductible subsidies.

Table 6: HIRSP Plan 1A Premium and Deductible Subsidies Levels

Annual Household Income Level		Amount of Premium	Medical	Prescription Drug
At Least	But Less Than	as % of Standard Risk	Deductible Amount	Deductible Amount
$0	$10,000	100.0%	$500	$375
10,000	14,000	106.5	600	450
14,000	17,000	115.5	700	525
17,000	20,000	124.5	800	600
20,000	25,000	130.0	1,000	750

Table 7: HIRSP Plan 1A and 2 Enrollees and Subsidy Participants (as of June 30 of Each Year)

	HIRSP Plan 1A and 2 Enrollees	Subsidy Enrollees	
Year	Number	Number	% of Total Enrollees
1996	8,934	3,411	38.2%
1997	7,667	3,267	42.6
1998	7,218	2,862	39.7
1999	6,771	2,598	38.4
2000	7,257	2,808	38.7
2001	8,611	3,319	38.5
2002	10,005	3,687	36.9
2003	10,288	3,903	37.9
2004	10,076	3,971	39.4

Organization and Management of HIRSP

Board of Governors. The plan has a 13-member Board of Governors. The Board consists of the DHFS Secretary (or a designee from DHFS), who serves as chair, the Commissioner of Insurance (or a designee from OCI) and the following 11 members appointed by the Secretary of DHFS to staggered, three-year terms: two participating insurers representing nonprofit organizations, two other participating insurers, three health care providers, and four public members. Of the four public members, at least one must have coverage under HIRSP, and one must be a representative of a small business in the state. Further, none of the public members may be professionally affiliated with the practice of medicine, a hospital, or an insurer. Finally, the three health care provider representatives must include one representative of the Wisconsin Medical Society, one representative of the Wisconsin Hospital Association, and one representative of an integrated multi-disciplinary health system.

The Board's statutory duties and responsibilities include: (1) collecting assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the assessment period; (2) developing and implementing a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan; (3) establishing procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the Board; (4) advising DHFS on the choice of coverage; (5) establishing oversight committees to address various administrative issues, such as financial management of the plan and performance standards for the plan administrator; (6) reporting to the appropriate legislative standing committees and to members of the plan summarizing the activities of the plan in the preceding calendar year, and in the report, defining the cost burden imposed by the plan on all policyholders in the state; (7) submitting a report annually to the Legislature and Governor on the operation of the plan, including any recommendations to change the plan; and (8) approving the program budget prepared by DHFS before its implementation.

Current law authorizes the Board to prepare and distribute eligibility and enrollment forms to insurance solicitors, agents and brokers, and the general public. The Board is further authorized to provide for the reinsurance of risks incurred by the plan and may enter into reinsurance agreements with insurers to establish a reinsurance plan for risks of coverage described in the plan or obtain commercial reinsurance to reduce the risk of loss through HIRSP. By administrative rule, the Board may provide for agent commissions. The statutes require agents and insurers to provide assistance in filing applications. DHFS is authorized to establish any additional powers and duties of the Board by administrative rule.

Plan Administrator. Current law requires the HIRSP plan administrator to: (1) perform all eligibility and administrative claims payment functions relating to the plan; (2) establish premium billing procedures for collection of premiums from insured persons; (3) perform all necessary functions to assure timely payment of benefits to persons covered under the plan, including making information available relating to the proper manner of submitting a claim and distribution of claim submission forms, evaluating the eligibility of each claim for payment under the plan, and notifying each claimant within 30 days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected, or compromised; (4) under the direction of DHFS, pay claims expenses from the premium payments received from or on behalf of persons covered under the plan. If the plan administrator's payments for claims expenses exceeds premium payments, the Board of Governors must forward to DHFS, and DHFS must provide to the plan administrator, additional funds for payment of claims expenses.

The plan administrator is paid for its direct and indirect costs from the health insurance risk-sharing fund. Allowable expenses include that portion of the administrator's costs for printing, claims administration, customer service, financial and operational reporting, building overhead costs, and other actual operating and administrative expenses. DHFS currently pays the plan administrator, and its subcontractors, approximately $322,000 monthly for HIRSP administrative costs.

2003 Wisconsin Act 33 eliminated the requirement that the HIRSP plan administrator be the state's MA fiscal agent. Electronic Data Systems (EDS), the state's current MA fiscal agent, had been the plan administrator for HIRSP since July 1, 1998. DHFS has issued an intent to award a contract to Wisconsin Physicians Service to be the new plan administrator. The new plan administrator is expected to be fully operational beginning April 1, 2005.

In addition to contracting with the plan administrator for administrative services, DHFS contracts with the Legislative Audit Bureau to conduct annual financial audits of HIRSP.

Oversight by DHFS. The Secretary of DHFS, in addition to chairing the HIRSP Board of Governors, has a number of responsibilities relating to the operation of the plan. The statutes require the Secretary to promulgate a variety of administrative rules governing the operation of HIRSP, including rules to: (1) operate the plan; (2) establish annual HIRSP premium rates, insurers' assessments, and provider payment rates; (3) adjust premiums, insurers' assessments, and provider payment rates as necessary to meet the costs of the plan; and (4) permit certain persons who receive government reimbursements or copayments to continue to be eligible for the plan. DHFS may also promulgate rules relating to premium rates, insurer assessments, and provider payment adjustments as emergency rules.

DHFS may establish the following limits on covered services by promulgating administrative rules to:

- apply the same utilization and cost control procedures that apply under rules established for MA, except that DHFS cannot apply the same co-

payments to HIRSP plan participants as apply to MA recipients;

- limit the amount of services provided to individuals with chronic mental illness in community support programs; and

- establish copayments, coinsurance, and out-of pocket limits for prescription drugs, subject to the approval of the Board of Governors.

Further, DHFS may limit coverage of prescription drugs to only those claims submitted by pharmacists directly to the plan administrator.

Finally, DHFS, in consultation with the Board, is required to establish a program budget for each plan year. DHFS may not implement the budget unless approved by the Board.

In 2004-05, DHFS was budgeted approximately $5.0 million in segregated revenue for administration of HIRSP.

Oversight by OCI. Under current law, OCI is required to assess each insurer its proportional share of the HIRSP costs to be paid by insurers as determined by DHFS. OCI is required to calculate each insurer's portion and to notify DHFS of the insurers that are to share in the costs. OCI may, by rule, exempt as a class, those insurers whose share would be so minimal as to not exceed the estimated cost of levying the assessment.

OCI may, by rule, require insurers to submit information that is necessary for OCI, DHFS, and the Board of Governors to carry out their responsibilities related to the administration of HIRSP.

However, DHFS, with the agreement of OCI, may perform the various administrative functions related to the assessment of insurers.

Participation Levels, Claims Activity and Utilization Summary

Plan Enrollments. Enrollment in HIRSP increased from 7,240 in July, 1998, to 18,468 in October, 2004. Some of the increase since 1997 is due to the creation of Plan 1B in 1998 to comply with the federal Health Insurance Portability, Accountability and Access Act of 1996 (HIPAA). The number of restated policies in force for Plan 1B as of October 31, 2004, was 8,542. According to DHFS, some of the increase in enrollment may also be due to the increasing number of insurers that are no longer providing coverage to small businesses.

Table 8: HIRSP Enrollment as of October, 2004

Plan	Number of HIRSP Enrollees
Plan 1A	8,189
Plan 1B	8,542
Plan 2	1,737
Total	18,468

As of October, 2004, 44% of HIRSP participants were enrolled in Plan 1A and 56% of HIRSP enrollees were female.

Length of HIRSP Participation in Plan. Relatively few HIRSP enrollees are long-term participants. For participants who cancelled their HIRSP coverage in 2003, the average period of enrollment was two years and six months for Plan 1A, one year and 10 months for Plan 1B, and five years and four months for Plan 2. The average period of enrollment for all plans combined was two years and six months.

Table 9: HIRSP Claims -- Calendar Year 2003

	Plan 1, Option A		Plan 1, Option B		Plan 2		Total	
	Expenditures	% of Total	Expenditures	% of Total	Expenditures	% of Total	Expenditures	% of Total
Inpatient Hospital	$17,792,035	31%	$8,035,700	36%	$591,160	4%	$26,418,895	28%
Pharmaceuticals	17,583,124	31	6,649,196	30	12,474,024	80	36,706,344	39
Physician	10,805,324	19	3,843,356	17	1,069,175	7	15,717,855	16
Outpatient Hospital	9,510,762	16	3,383,332	15	949,259	6	13,843,353	15
Durable Med. Equipment	1,583,364	3	435,965	2	343,905	2	2,363,234	2
Nursing Home	42,021	0	20,757	0	113,960	1	176,738	0
Totals	$57,316,630	100%	$22,368,306	100%	$15,541,483	100%	$95,226,419	100%

Participant Claims Data. Many HIRSP policyholders do not have benefits paid on their behalf. In calendar year 2003, 67% of HIRSP policyholders did not meet their medical deductible requirement and therefore, did not have any medical benefits paid on their behalf. This amount varies significantly between the HIRSP plans. For individuals enrolled in Plan 1A (which has a deductible from $500 to $1,000), 56% did not meet the medical deductible requirement. For individuals enrolled in Plan 1B (which has a $2,500 deductible), 83% did not meet the medical deductible requirement. For individuals enrolled in Plan 2, which has the lowest deductible ($500), 43% did not meet the medical deductible requirement.

According to unaudited financial reports, benefit costs for HIRSP totaled $143.3 million in 2003-04. These costs consisted of approximately $103.8 million in claims paid after accounting for rebates, refunds, and subsidies. An additional $39.5 million was funded by provider reductions.

Utilization Summary. For calendar year 2003, 67% of total HIRSP claims were paid for either pharmaceuticals or inpatient hospital services. Table 9 identifies HIRSP claims activity for calendar year 2003 by service type.

Over 60% of total HIRSP costs were paid on behalf of policyholders in Plan 1A. This is not surprising because approximately 48% of all HIRSP policyholders were enrolled in Plan 1A, and Plan 1A has a lower deductible.

HIRSP paid approximately 80% of Plan 2 expenditures for pharmaceuticals. The reason such a significant portion of Plan 2 costs are attributable to pharmaceuticals is because Medicare does not cover outpatient pharmaceuticals.

Expenditures for Plan 1B are lower due, in part, to a higher deductible ($2,500 compared with $1,000 for Plan 1A). Plan 1B is an alternative for individuals that are less certain they will incur high medical expenses. For individuals more certain that they will incur high medical expenses during the plan year, Plan 1A is more likely to be an appealing option, despite its higher premiums.

Summary of Recent Changes

Accrual Accounting. In 2001, the HIRSP Board of Governors approved the conversion from cash to accrual accounting. The Legislative Audit Bureau recommended this change in its audit reports for state fiscal years 1999 and 2000. The accrual method of accounting recognizes liabilities when incurred to ensure sufficient reserves if HIRSP enrollment suddenly and significantly declined. Cash accounting ignores liabilities until they are paid.

The conversion to accrual accounting required increased contributions to the plan to build reserves. These increased contributions resulted in higher premium rates, an increase in insurer assessments, and lower provider reimbursement rates.

Case Management Pilot Program. 2001 Wisconsin Act 16 directed DHFS to establish a community-based case management services demonstration pilot. The pilot program would last three years and may include up to 300 enrollees. Participation in the program is voluntary. Each enrollee must satisfy any of the following criteria:

- Enrollee was diagnosed with a chronic disease.

- Enrollee takes two or more prescribed medications on a regular basis.

- Enrollee was treated at least twice in a hospital emergency room, or admitted at least twice to a hospital as an inpatient, within six months of applying for the pilot.

A team provides the community-based case management services. The team consists of a nurse case manager, a pharmacist, a social worker, and the primary care physician. The services provided include initial intake assessment, development of a treatment plan, coordination of health care services, patient education, family support, and monitoring and reporting of patient outcomes and costs.

The service provider must:

- be a private, nonprofit, integrated health care system that provides access to health care in a medically underserved area or in a health professional shortage area;

- operate an existing community-based case management program with demonstrated successful client and program outcomes; and

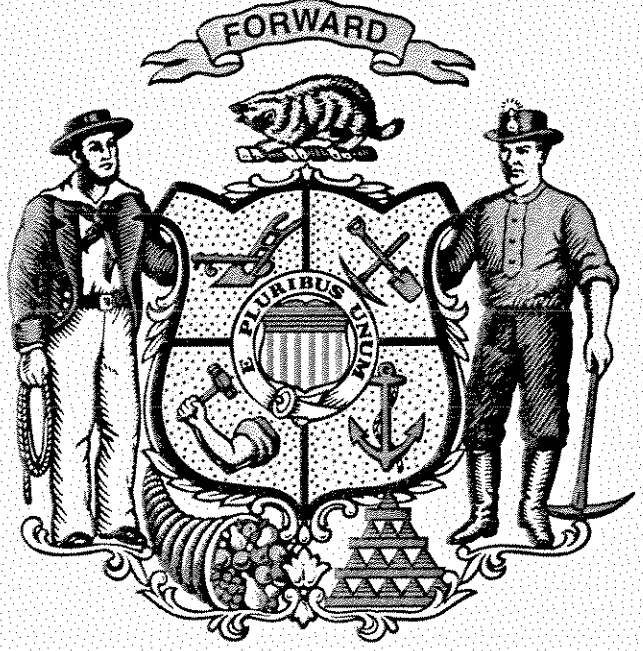
- demonstrate an ability to assemble and coordinate an interdisciplinary team of health care professionals.

DHFS must conduct a study to evaluate the pilot program in terms of health care outcomes and cost avoidance. DHFS will submit a report on the results of the study to the Legislature and to the Governor.

DHFS received proposals from two service providers. However, because HIRSP is attempting to include disease management as a cost control measure in its contract with the new plan administrator, DHFS is requesting in its 2005-07 biennial budget request that it no longer be required to establish a separate case management pilot program.

HIRSP Plan Administrator. 2003 Wisconsin Act 33 authorized DHFS to select a new plan administrator. As a result, DHFS prepared and issued a request for proposals to establish a new HIRSP plan administrator through a competitive bidding process.

DHFS has issued an intent to award the contract to Wisconsin Physicians Service for the period beginning April 1, 2005, and ending March 31, 2008. The contract would contain three possible one-year renewal options, which could be exercised upon mutual agreement of both parties. As part of the contract, Wisconsin Physicians Service has indicated that Navitus would be its pharmacy benefits manager.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WISCONSIN DEPARTMENT OF
ADMINISTRATION

JIM DOYLE
GOVERNOR
STEPHEN E. BABLITCH
SECRETARY
Division of Executive Budget and Finance
Post Office Box 7864
Madison, WI 53707-7864
Voice (608) 266-1736
Fax (608) 267-0372
TTY (608) 267-9629

Date: November 16, 2005

To: Steve Bablitch, Secretary
Sean Dilweg, Executive Assistant

From: Jim Johnston and Susan Jablonsky

Subject: Summary of Health Insurance Risk Sharing Plan (HIRSP) Changes

We are writing to provide you with a summary of the changes included in the HIRSP legislative reform package. The package modifies Chapter 149, Wisconsin State Statutes, to provide the program with greater flexibility to respond to market changes while ensuring that policyholders' rights are protected.

HIRSP Authority

The HIRSP reform legislative package creates a new HIRSP Authority with a board of directors composed of 13 voting members plus the Insurance Commissioner as an ex-officio member. Members and the chair person will be appointed by the Governor. Members are appointed with the advice and consent of the Senate.

- Four members will represent insurers,
- Four members will represent health care providers with:
  - one member representing the State Medical Society,
  - one member representing the Wisconsin Hospital Association,
  - one member representing the State Pharmacy Society,
  - one member representing health care providers,
- Two members will be policy holders and the remaining
- One member representing small businesses that purchase private health insurance, and
- Two members will represent the public.

Members will serve in staggered three year terms.

The authority will operate as a quasi-governmental unit subject to open records, open meetings, competitive bid processes and reviews by the Department of Administration, the Legislative Audit Bureau and the Legislative Fiscal Bureau. The authority has immunity for any act or omission unless it constitutes willful misconduct.

The authority may appoint an executive director and other staff.

Benefit Design

The HIRSP reform legislative package retains the detailed list of services currently in the statutes. For some services the description has been modified to comport with National Association of Insurance Commissioners model language, while maintaining compliance with state insurance mandates. For some services, coverage levels are explicitly linked to insurance mandated levels.

Premiums continue to be capped at 200 percent, but the 140 percent floor is removed.
Subsidy costs continue to be funded by insurers and providers, split 50/50.
Other plan costs are funded: 60 percent by policy holders, 20 percent by insurers and 20 percent by providers. Any federal funds received will be applied to subsidy costs.
Subsidy income levels remain unchanged in the statutes. Provider rates and certification remain linked to Medicaid rates and certification.
HIRSP will coordinate with the new Medicare Part D drug plan and the HIRSP plan will not cover expenses paid for by Medicare. The HIRSP plan is required to apply as a state pharmacy assistance program under Medicare.

The benefit design shall provide benefit levels, deductibles, co-payment levels and coinsurance requirements, exclusions and limitations that generally reflect and are commensurate with comprehensive health insurance coverage offered in the private insurance market, and the board may develop additional benefit designs that are responsive to market conditions.

Office of the Commissioner of Insurance (OCI) Review

The Insurance Commissioner shall enforce and collect the insurers' assessment for the plan costs. In addition, benefit design changes are subject to approval by the Commissioner based on the following review criteria:

- The benefit design is to be comparable to a typical comprehensive individual health insurance policy;
- The benefit levels are to be generally reflective and commensurate with comprehensive private individual market plans;
- The co-payments, deductibles and coinsurance levels are to be actuarially equivalent to comprehensive individual plans and cannot create undue financial hardship; or
- The benefit design must be consistent with the purpose of providing health care coverage to those unable to obtain coverage in the private market.

Insurer Tax Credit

Starting in tax year 2006 insurers are eligible for a HIRSP assessment credit. The total credit amount is limited to $5 million per fiscal year. The Department of Revenue, in consultation with OCI, will determine the percentage split for each eligible insurer. Credits can be carried forward for 15 years, and are first payable in FY08.

Eligibility Changes

The HIRSP reform legislative package allows certain Medicaid recipients receiving only limited coverage under Medicaid to apply for HIRSP coverage. The HIRSP plan will not cover expenses paid for by Medicaid. The HIRSP reform legislative package also creates a new health care plan administered by the authority for individuals eligible for federal Health Coverage Tax Credits (HCTC). Non-HIPAA eligible policyholders must have lived in Wisconsin for 3 months and have been rejected by two insurers before they are eligible for HIRSP coverage. The authority shall establish policies for determining and verifying the continued eligibility of policyholders.

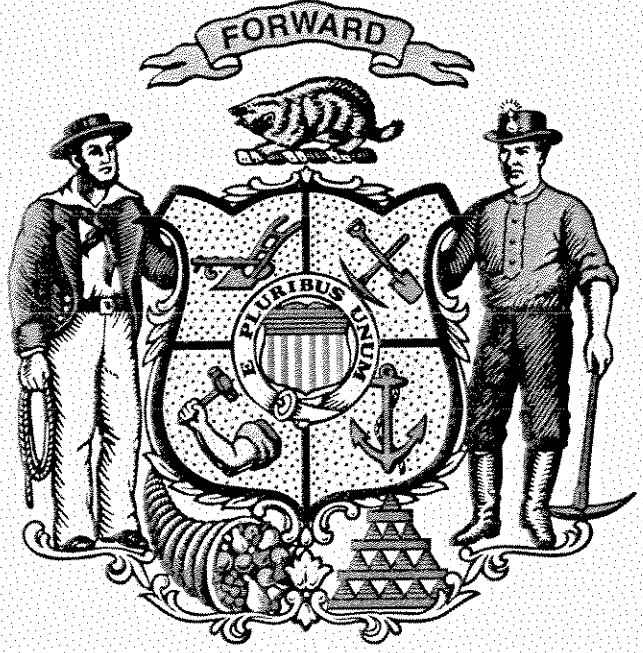
Effective Dates

January 1, 2006, implement changes to coordinate with Medicare Part D.

July 1, 2006, authority takes over administration of HIRSP.

January 1, 2007, authority can begin implementing OCI approved modifications to the benefit design.

cc: David Schmiedicke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Perlich, John H.

From: Paul Merline [pmerline@tds.net]
Sent: Tuesday, November 22, 2005 6:57 PM
To: Peer, Adam; John.O'Brien@legis.state.wi.us; Perlich, John H.
Cc: 'Nancy Wenzel'; pkmerline@direcway.com
Subject: HIRSP Co-Sponsor Update

Gentlemen,

Based on contacts that we have made, here is a list of Legislators who have expressed interest in likely co-authoring the HIRSP reform proposal (Rep. Nischke and Sen. Kapanke are also included).

YOUR OFFICES WILL NEED TO HEAR DIRECTLY FROM EACH INDIVIDUAL LEGISLATIVE OFFICE WITH THEIR ACTUAL INTENT TO SIGN ON TO THE LEGISLATION, THE LIST BELOW INCLUDES ONLY LIKELY CO-AUTHORS.

If you haven't heard from one of these legislators or their office yet, please let me know and we will follow up. Also, please hit 'Reply All' to make sure that I can view your reply to this e-mail from home. I will be contacting your offices in the morning as well.

I may be missing others who may have contacted your offices directly. If possible, please send an updated list of co-authors thus far so we do not duplicate efforts. If you have any questions or concerns, please let me know.

The best way to reach me tomorrow will be either on my cell, (608) 516-3237 or at home (608) 592-5923. Thanks!

Paul

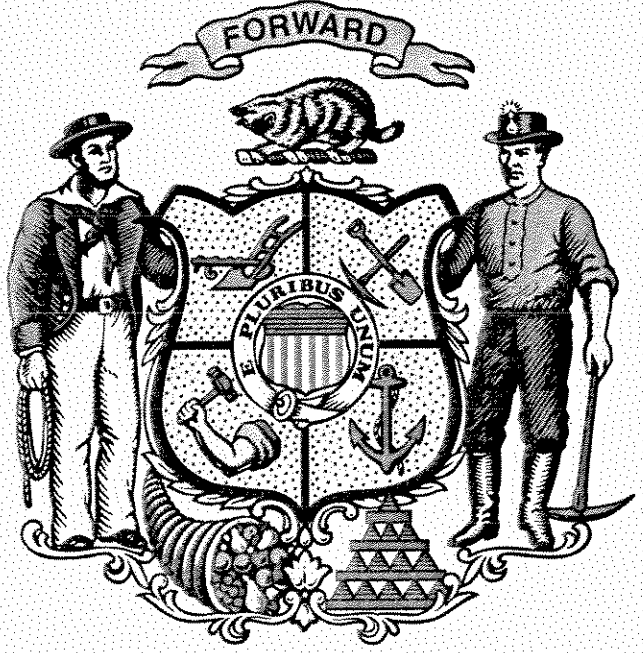
Assembly
Nischke
Gielow
Rhoades
(Otherwise in order as appropiate)
Gard
Huebsch
Kreuser
Sheridan
Shilling
Vruwink
Fitzgerald
Underheim
Montgomery
Wieckert
McCormick
Van Roy
Honadel
Moulton
Ballweg
Jensen
Krawczyk
Siedel

Senate

Kapanke
Brown
(Otherwise in order as appropriate)
Schultz
Fitzgerald
Darling
Olsen
Roessler
Taylor

PAUL W. MERLINE
Legislative/Agency Liaison
pmerline@tds.net

Wisconsin Association of Health Plans
10 East Doty Street • Suite 503 • Madison, WI 53703
608-255-8599 • Fax 608-255-8627
www.wihealthplans.org


FORWARD
E PLURIBUS UNUM

Wisconsin Association of Health Plans

November 22, 2005

TO: Members of the Wisconsin Legislature

FROM: Wisconsin Association of Health Plans

RE: HIRSP Reform Benefits All Program Stakeholders

The Health Insurance Risk Sharing Plan (HIRSP) is a safety-net program serving an important role for all Wisconsin residents. In its current form, however, it is a growing source of health care cost-shifting in Wisconsin. Since 2000:

- Annual HIRSP program costs more than quadrupled to $207 million.
- Average individual policyholder payments doubled.
- Annual HIRSP assessments and provider discounts skyrocketed to $78 million—a cost-shift that makes health care coverage more expensive.

The growth in HIRSP costs is unsustainable. To ease the financial burden of the program, which receives no state general purpose revenue, **we urge you to support the HIRSP reform proposal being circulated by Rep. Ann Nischke and Sen. Dan Kapanke**. The bill is based on the proposal included in the Legislature's 2005-2007 State Budget, but addresses the concerns raised by Governor Doyle in his veto message.

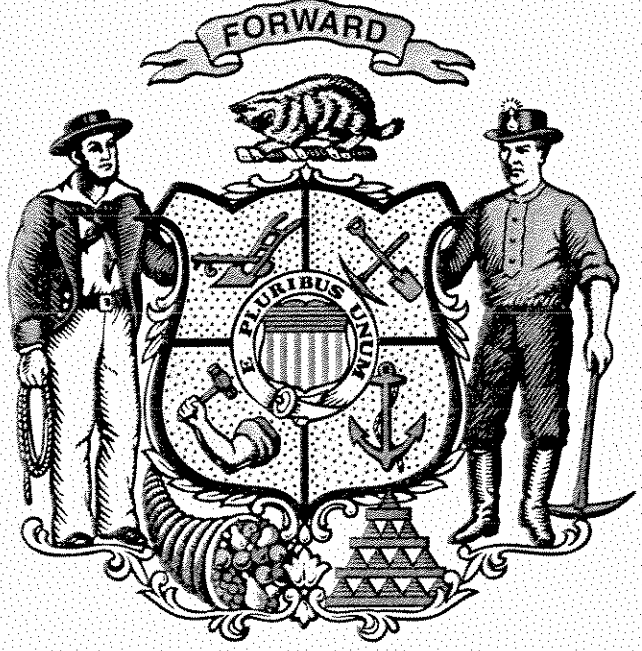
Since its creation in 1980, the HIRSP benefit design has changed very little. As a result, HIRSP has failed to keep pace with cost-saving innovations in health care coverage, which are introduced every year. Without proven cost-containment strategies in place, HIRSP costs grow faster than the cost of other programs. To stem this growth, new, more flexible governance is needed to make HIRSP more responsive to change.

The HIRSP reform proposal:

- Transforms HIRSP into a quasi-governmental authority governed by a Board of Directors composed of HIRSP policyholders, health care providers, insurers and small business. The authority would feature adequate government oversight mechanisms, such as open records and meetings.
- Empowers the HIRSP Board to make cost-saving, market-focused changes in administration, care management, benefit designs and other program areas. The Board would more effectively respond to changes in health care and take advantage of opportunities to control costs while meeting policyholder needs.
- Produces more equitable HIRSP cost-sharing through a tax credit first claimable after December 31, 2007, for insurers that pay taxes and HIRSP assessments.

We urge you to make HIRSP more responsive to market changes and opportunities for cost savings. Please support and add your name to the bipartisan list of co-authors of the HIRSP reform proposal.

10 East Doty Street • Suite 503 • Madison, WI 53703
608-255-8599 • Fax 608-255-8627 • www.wihealthplans.org


FORWARD
E PLURIBUS UNUM

ANN
Nischke
www.RepNischke.com

TO: MEMBERS
ASSEMBLY COMMITTEE ON INSURANCE

From: Representative Ann Nischke, Chair
Committee on Insurance

Date: November 22, 2005

RE: REMINDER Insurance Committee Meeting Dates, Times, and Locations

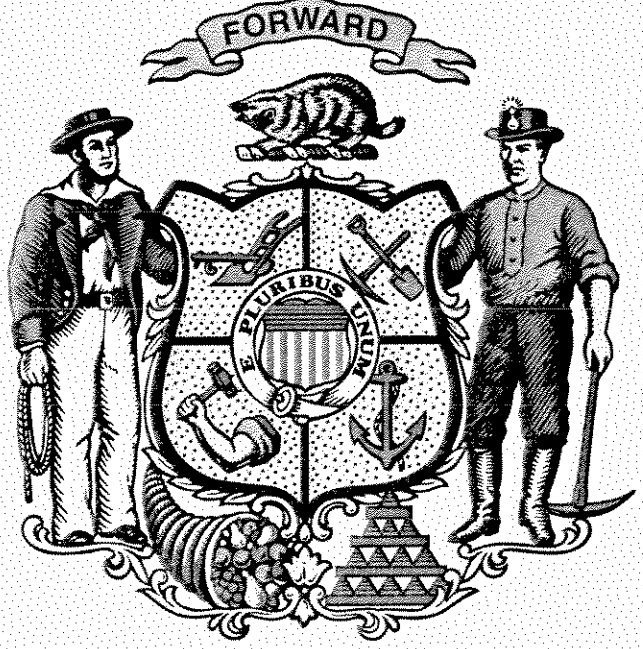
The Assembly Committee on Insurance will to meet on the following days:

- In Joint Public Hearing with the Senate Committee on Agriculture & Insurance, Monday, November 28, 2005 at 1 PM in Room 412 East.
- In Executive Session, Tuesday, November 29, 2005 at 9 AM 415 NW.

A meeting notice is expected to be published on tomorrow, November 23, 2005 in the late afternoon. If you have any questions, please contact the committee clerk, Adam Peer, for more information.

ASP

State Capitol, Room 8 North, PO Box 8953, Madison, WI 53705-8953
Capitol: 608-266-8580, Fax 608-282-3697


FORWARD
E PLURIBUS UNUM

ANN
Nischke
www.RepNischke.com

TO: STATE LEGISLATORS

From: Representative Ann Nischke
Senator Dan Kapanke

Date: November 22, 2005

RE: Short Deadline 3 PM 11-23-2005: Cosponsorship: Nischke/Kapanke: LRB 3798/2 and LRB 4087/1: Creating a HIRSP Authority

The Health Insurance Risk Sharing Plan (HIRSP) is a state program created to provide for the major medical health insurance needs of people that are generally ineligible for traditional insurance for a variety of reasons. The program is funded by premiums paid by covered persons, insurer assessments, and provider payment discounts.

Legislative Audit Bureau (LAB) Report 05-9 of the program highlighted great increased costs since 2000 that translated into:

1. Premiums that doubled for HIRSP participants.
2. Assessments that have quadrupled to $207 million

This bill would give HIRSP the ability to address skyrocketing costs and changing market needs by:

1. Transforming HIRSP into a quasi-governmental authority with a board of directors appointed by the Governor and confirmed by the Senate. Members would include HIRSP policyholders, healthcare providers, insurers, and small business.
2. Give the HIRSP board the ability to respond to changing policyholder needs and changing market conditions. Plans proposed by the HIRSP authority would still need to be approved by the Office of the Insurance Commissioner (OCI).

For more information please see the attached bill draft and LRB analysis.

Contact Adam Peer (Representative Nischke) or John Perlich (Senator Kapanke) by 3 PM, November 23, 2005 to be made a co sponsor or co author of this bill.

The Senate Committee on Agriculture and Insurance and the Assembly Committee on Insurance plan to hold a public hearing and executive session next week. Please see the appropriate hearing notices for more information.

AMN:DK:asp

State Capitol, Room 8 North, PO Box 8953, Madison, WI 53705-8953
Capitol: 608-266-8580, Fax 608-282-3697

Analysis by the Legislative Reference Bureau

Background of Health Insurance Risk−Sharing Plan

The Health Insurance Risk−Sharing Plan (HIRSP) under current law provides major medical health insurance coverage for persons who are covered under Medicare because they are disabled, persons who have tested positive for human immunodeficiency virus (HIV), persons who have been refused coverage, or coverage at an affordable price, in the private health insurance market because of their mental or physical health condition, as well as persons (called "eligible individuals" in the statutes) who do not currently have health insurance coverage, but who were covered under certain types of health insurance coverage (called creditable coverage) for at least 18 months in the past. HIRSP is funded by premiums paid by covered persons, insurer assessments, and provider payment discounts, and is administered by the Department of Health and Family Services (DHFS), a board of governors, and a plan administrator.

Creation of Health Insurance Risk−Sharing Plan Authority

This bill creates the Health Insurance Risk−Sharing Plan Authority (HIRSP Authority) for the primary purpose of assuming the administration of HIRSP, beginning on July 1, 2006. An authority is a public body with a board of directors that is created by state law but that is not a state agency. The board of directors of the HIRSP Authority consists of the commissioner of insurance (commissioner), or the commissioner's designee, as a nonvoting member and 13 other members who are appointed by the governor, with the advice and consent of the senate, for three−year terms. These 13 members must include persons with coverage under HIRSP and representatives of insurers, health care providers, and small businesses. The board may appoint an executive director, who may not be a member of the board.

Because the HIRSP Authority is not a state agency, numerous laws that apply to state agencies do not apply to the HIRSP Authority. However, the HIRSP Authority is treated like a state agency in the following respects, among others: 1) it is generally subject to the open records and open meetings laws; 2) it is treated like a state agency for purposes of the law regulating lobbying; 3) its employees may not engage in political activities while engaged in official duties; 4) it must use a competitive bid or proposal process whenever contracting for professional services; and 5) the Code of Ethics for Public Officials and Employees covers the HIRSP Authority.

The HIRSP Authority is unlike a state agency in many other ways, including: 1) it approves its own budget without going through the state budgetary process; 2) its employees are not state employees, are not included in the state system of personnel management, may not participate in the system for state retirement benefits or health insurance coverage, and are hired outside the state hiring system; 3) it is not subject to statutory rule−making procedures, including requirements for legislative review of proposed rules; and 4) although HIRSP is subject to an annual financial audit by the Legislative Audit Bureau, the HIRSP Authority is not subject to auditing by the Legislative Audit Bureau.

Unlike most other authorities under current law, the HIRSP Authority may not

issue bonds. It pays the administrative and operating expenses of HIRSP, as under current law, through premiums paid by persons with coverage under HIRSP, insurer assessments, and provider payment discounts. The HIRSP Authority must annually submit a report to the legislature and to the governor on the operation of HIRSP.

Changes to the Health Insurance Risk–Sharing Plan

This bill makes a number of changes to HIRSP, including the following:

1. *Administration.* Under current law, HIRSP is administered by DHFS, a board of governors, and a plan administrator under contract with DHFS. Effective July 1, 2006, the bill eliminates the HIRSP board of governors and transfers administrative authority over HIRSP from DHFS to the HIRSP Authority and its board of directors. The bill requires DHFS to terminate its contract with the plan administrator, effective July 1, 2006, and requires the HIRSP Authority to enter into an identical contract with the same plan administrator with a beginning date of July 1, 2006, and an ending date that is the same as the ending date of the original contract between DHFS and the plan administrator. Because the bill authorizes the HIRSP Authority to enter into contracts for the administration of HIRSP, after the end of its contract with the current plan administrator, it may contract with the same or a different plan administrator, but must use a competitive request–for–proposals process to do so.

2. *Eligibility.* To be eligible for HIRSP, a person must be a state resident. The bill changes from 30 days to three months the length of time that a person must be domiciled in this state to be considered a state resident for purposes of HIRSP eligibility.

In general, a person who is eligible for Medical Assistance (MA) is not eligible for HIRSP. The bill provides that persons who are eligible for only certain limited services provided under MA, such as family planning services for low–income women and payment of Medicare premiums, deductibles, and coinsurance for persons eligible for Medicare who meet the income and resource limitations, are not ineligible for HIRSP coverage because of their eligibility for only those MA services. The bill provides, however, that HIRSP will not pay for services that are reimbursed under MA. The bill also specifically provides that persons who are eligible for certain listed programs or benefits, such as the Badger Care Health Care Program and Long–Term Support Community Options Program, are ineligible for HIRSP coverage.

Under current law, a person who is rejected for health insurance coverage by one or more insurers within nine months of applying for HIRSP coverage is eligible for HIRSP. The bill changes that requirement to two or more insurers.

The bill adds Medicare Part D, which is the prescription drug benefit under Medicare, to the definition of Medicare for purposes of HIRSP. Thus, a person who is eligible for HIRSP based on their coverage under Medicare because they are disabled would be eligible for HIRSP coverage if they had coverage under Medicare Part D. In addition, HIRSP does not pay for benefits that are paid for by Medicare, so HIRSP would not pay for prescription drugs covered under the person's Medicare Part D coverage.

3. *Benefit design.* Benefits provided by HIRSP, as well as deductibles and out–of–pocket limits, are specified in the statutes. Except for eligible individuals, who are not subject to any preexisting condition exclusion, a condition that a person was diagnosed with or treated for within six months of obtaining coverage under

HIRSP is excluded from coverage for the first six months. Current law authorizes DHFS to establish copayments and out−of−pocket limits for prescription drug coverage. The bill retains all current law benefits, deductibles, copayments, out−of−pocket limits, and the preexisting condition exclusion through December 31, 2006. Beginning on January 1, 2007, benefits are modified somewhat, mostly by limiting the extent of certain benefits to the extent that commercial insurers are required to provide under the statutes known as health insurance mandates, and coverage for the services of a home health agency, to the extent required by the health insurance mandate, is added. No benefits are eliminated. Also beginning on that date, the HIRSP Authority is authorized to establish deductibles, copayments, coinsurance, limitations, and, except for eligible individuals, exclusions that are not specified in the statutes, and to develop additional benefit designs that are responsive to market conditions. The Office of the Commissioner of Insurance (OCI) may disapprove any policy developed by the HIRSP Authority if the benefit design is not comparable to a typical comprehensive individual health insurance policy in the private market, the benefit levels do not generally reflect comprehensive individual health insurance in the private market, or the deductibles, copayments, or coinsurance are not actuarially equivalent to comprehensive individual health insurance in the private market or would create undue financial hardship.

4. *Payment of plan costs.* Current law sets out a complex formula for payment of the administrative and operating expenses of HIRSP. In general, premiums must be set at a rate that pays for 60 percent of costs and may not exceed 200 percent of the rate a standard risk would be charged for the same coverage and deductibles. Insurer assessments and provider payment discounts must each pay for half of the remaining 40 percent of costs. The bill eliminates the formula but retains the requirements that premiums must be set at a rate to pay for 60 percent of costs, excluding premium, deductible, and copayment subsidy costs (subsidy costs), and may not exceed 200 percent of rates applicable to standard risks, that insurer assessments must be set at an amount to cover 20 percent of costs, excluding subsidy costs, and that provider payment discounts must be set at a rate to cover 20 percent of costs, excluding subsidy costs. Subsidy costs are to be paid first from any federal high risk pool grant funds that are received by OCI, and the remainder of subsidy costs are paid equally through insurer assessments and provider payment discounts. If federal high risk pool grant funds received in a year exceed subsidy costs in that year, the excess federal funds must be used to pay the administrative and operating costs before premiums, insurer assessments, and provider discounts are applied to the costs.

5. *Subsidies.* Under current law, generally, persons with coverage under HIRSP who have household incomes below $25,000 receive premium and deductible subsidies and may receive prescription drug copayment subsidies. For a person who is eligible for a subsidy, the statutes set out, on the basis of the person's household income category, the specific deductible amount that the person must pay and the premium rate that the person must pay as a percentage of the rate that a standard risk would be charged for the same coverage and deductibles. The bill retains the subsidies and makes no changes to the categories of persons who are eligible for subsidies and no changes to the standard risk rates that are the basis for premium reductions. Beginning on January 1, 2007, however, the specific reduced deductible amounts are eliminated and the HIRSP Authority is directed to establish and

provide deductible subsidies for those persons paying reduced deductibles under current law and is authorized to provide prescription drug copayment subsidies for those same persons.

Health Care Tax Credit Program

The federal Trade Adjustment Assistance Reform Act of 2002 (TAA) provides, among other benefits related to employment, a federal income tax credit for up to 65 percent of the amount of the premium paid by eligible persons for coverage for themselves and their dependents under qualified health insurance. Eligible persons are those who are eligible for TAA employment–related benefits because they have lost their jobs or experienced reduced work hours and wages because of increased imports and those who are at least 55 years of age and receiving benefits from the Pension Benefit Guaranty Corporation. The bill requires the HIRSP Authority to design and administer, as long as the federal income tax credit is available, a plan of health care coverage that satisfies the requirements for qualified health insurance for coverage of persons who are eligible for the tax credit.

Assessment Credits

The bill creates an income and franchise tax credit and a license fee credit for insurers that pay assessments to OCI. The amount of the credit is equal to a percentage of the amount of the assessment that the insurer paid in the calendar year in which the insurer's taxable year begins. The Department of Revenue and OCI determine the percentage of the amount that each insurer may claim in each taxable year so that the total amount of the credits awarded to all insurers in each fiscal year is approximately $5,000,000. Although the credits apply to taxable years beginning after December 31, 2005, the credits awarded for the 2006 and 2007 taxable years may not be claimed until taxable years beginning after December 31, 2007.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.

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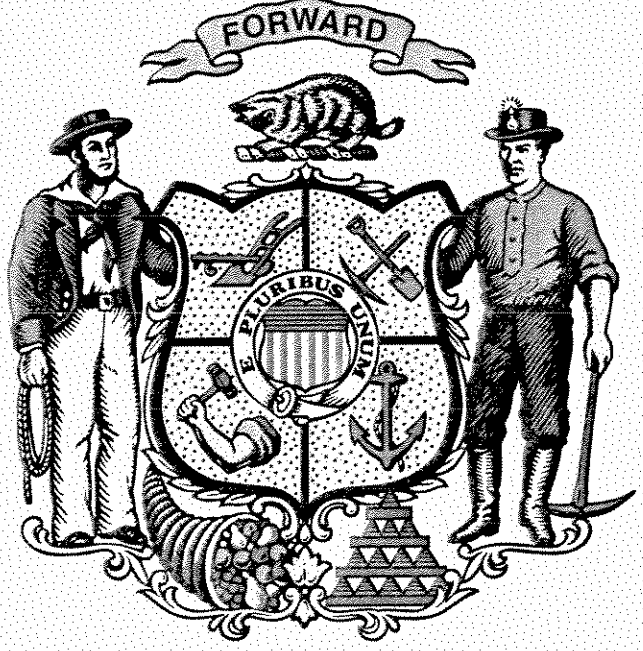
Capitol: 608-266-8580, Fax 608-282-3697


FORWARD
E PLURIBUS UNUM

Perlich, John H.

From: Rep.Nischke
Sent: Tuesday, November 22, 2005 1:28 PM
To: *Legislative Senate Democrats; *Legislative Senate Republicans; *Legislative Assembly Democrats; *Legislative Assembly Republicans
Subject: Short Deadline 3 PM 11-23-2005: Cosponsorship: Nischke/Kapanke: LRB 3798/2 and LRB 4087/1: Creating a HIRSP Authority
Attachments: 05-37982.pdf

TO: STATE LEGISLATORS

From: Representative Ann Nischke
Senator Dan Kapanke

Date: November 22, 2005

RE: Short Deadline 3 PM 11-23-2005: Cosponsorship: Nischke/Kapanke: LRB 3798/2 and LRB 4087/1: Creating a HIRSP Authority

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For more information please see the attached bill draft and LRB analysis.

Contact Adam Peer (Representative Nischke) or John Perlich (Senator Kapanke) by 3 PM, November 23, 2005 to be made a co sponsor or co author of this bill. Unless you indicate otherwise, you will be made a co author or co sponsor of both bills.

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hold a public hearing and executive session next week. Please see the appropriate hearing notices for more information.

AMN:DK:asp

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3. *Benefit design.* Benefits provided by HIRSP, as well as deductibles and out-of-pocket limits, are specified in the statutes. Except for eligible individuals, who are not subject to any preexisting condition exclusion, a condition that a person was diagnosed with or treated for within six months of obtaining coverage under HIRSP is excluded from coverage for the first six months. Current law authorizes DHFS to establish copayments and out-of-pocket limits for prescription drug coverage. The bill retains all current law benefits, deductibles, copayments, out-of-pocket limits, and the preexisting condition exclusion through December 31, 2006. Beginning on January 1, 2007, benefits are modified somewhat, mostly by limiting the extent of certain benefits to the extent that commercial insurers are

required to provide under the statutes known as health insurance mandates, and coverage for the services of a home health agency, to the extent required by the health insurance mandate, is added. No benefits are eliminated. Also beginning on that date, the HIRSP Authority is authorized to establish deductibles, copayments, coinsurance, limitations, and, except for eligible individuals, exclusions that are not specified in the statutes, and to develop additional benefit designs that are responsive to market conditions. The Office of the Commissioner of Insurance (OCI) may disapprove any policy developed by the HIRSP Authority if the benefit design is not comparable to a typical comprehensive individual health insurance policy in the private market, the benefit levels do not generally reflect comprehensive individual health insurance in the private market, or the deductibles, copayments, or coinsurance are not actuarially equivalent to comprehensive individual health insurance in the private market or would create undue financial hardship.

4. *Payment of plan costs.* Current law sets out a complex formula for payment of the administrative and operating expenses of HIRSP. In general, premiums must be set at a rate that pays for 60 percent of costs and may not exceed 200 percent of the rate a standard risk would be charged for the same coverage and deductibles. Insurer assessments and provider payment discounts must each pay for half of the remaining 40 percent of costs. The bill eliminates the formula but retains the requirements that premiums must be set at a rate to pay for 60 percent of costs, excluding premium, deductible, and copayment subsidy costs (subsidy costs), and may not exceed 200 percent of rates applicable to standard risks, that insurer assessments must be set at an amount to cover 20 percent of costs, excluding subsidy costs, and that provider payment discounts must be set at a rate to cover 20 percent of costs, excluding subsidy costs. Subsidy costs are to be paid first from any federal high risk pool grant funds that are received by OCI, and the remainder of subsidy costs are paid equally through insurer assessments and provider payment discounts. If federal high risk pool grant funds received in a year exceed subsidy costs in that year, the excess federal funds must be used to pay the administrative and operating costs before premiums, insurer assessments, and provider discounts are applied to the costs.

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Health Care Tax Credit Program

The federal Trade Adjustment Assistance Reform Act of 2002 (TAA) provides, among other benefits related to employment, a federal income tax credit for up to 65 percent of the amount of the premium paid by eligible persons for coverage for themselves and their dependents under qualified health insurance. Eligible persons

are those who are eligible for TAA employment–related benefits because they have lost their jobs or experienced reduced work hours and wages because of increased imports and those who are at least 55 years of age and receiving benefits from the Pension Benefit Guaranty Corporation. The bill requires the HIRSP Authority to design and administer, as long as the federal income tax credit is available, a plan of health care coverage that satisfies the requirements for qualified health insurance for coverage of persons who are eligible for the tax credit.

Assessment Credits

The bill creates an income and franchise tax credit and a license fee credit for insurers that pay assessments to OCI. The amount of the credit is equal to a percentage of the amount of the assessment that the insurer paid in the calendar year in which the insurer's taxable year begins. The Department of Revenue and OCI determine the percentage of the amount that each insurer may claim in each taxable year so that the total amount of the credits awarded to all insurers in each fiscal year is approximately $5,000,000. Although the credits apply to taxable years beginning after December 31, 2005, the credits awarded for the 2006 and 2007 taxable years may not be claimed until taxable years beginning after December 31, 2007.

For further information see the ***state and local*** fiscal estimate, which will be printed as an appendix to this bill.