Informational Paper 54

Health Insurance Risk-Sharing Plan

Wisconsin Legislative Fiscal Bureau
January, 2007

Health Insurance Risk-Sharing Plan

Prepared by

Eric Peck

Wisconsin Legislative Fiscal Bureau
One East Main, Suite 301
Madison, WI 53703

Health Insurance Risk-Sharing Plan

Wisconsin's health insurance risk-sharing plan (HIRSP) offers health insurance coverage to Wisconsin residents who are unable to obtain adequate coverage in the private market due to their medical conditions or who have lost their group health insurance coverage. As of June 30, 2006, there were 18,650 people enrolled in the program. HIRSP is financed through the premiums paid by these policyholders and by assessments collected from health insurance companies doing business in Wisconsin. Health care professionals also contribute to HIRSP by accepting reduced reimbursement rates for the covered medical services they provide HIRSP policyholders.

Until recently, HIRSP had been administered by the Wisconsin Department of Health and Family Services (DHFS), and its operations were subject to the state's budgeting process. With the enactment of 2005 Wisconsin Act 74, effective July 1, 2006, administrative responsibility for HIRSP was transferred to the newly-created Health Insurance Risk-Sharing Plan Authority (the Authority). The Authority is not a traditional state agency, but instead is identified in statute as a "public body corporate and politic." Its employees are not state employees and no state general purpose revenues (GPR) are used to support its operations. Nevertheless, aspects of public control over HIRSP remain, including the Governor's power (with the advice and consent of the Senate) to appoint the Authority's Board of Directors. In addition, while the Authority can adjust some aspects of its health insurance offerings to reflect conditions in the private market, other aspects of the program continue to be mandated by statute.

This paper provides information about HIRSP, including its eligibility requirements, the types of health insurance plans it offers, its funding sources, and the historical trends in plan enrollment and expenditures. The paper also describes the recent administrative restructuring of HIRSP, including the creation and responsibilities of the Authority.

Eligibility Requirements

Health insurance coverage under HIRSP is only available to Wisconsin residents. As of July 1, 2006, a resident for HIRSP eligibility purposes is a person who has been legally domiciled in Wisconsin for at least three months (before July 1, 2006, the period was 30 days). Legal domicile is established by living in Wisconsin and obtaining a Wisconsin driver's license, registering to vote, or filing a state income tax return. If a person has a disability that prevents them from doing these activities, they can establish legal domicile by living in the state. A child is a resident for purposes of HIRSP if the child resides in Wisconsin and at least one of the child's parents or the child's guardian is legally domiciled in Wisconsin.

Provided they satisfy these residency requirements, a person is eligible for health insurance coverage under HIRSP if they meet one or more of the eligibility criteria set forth in Chapter 149 of the Wisconsin Statutes. The following paragraphs provide a general summary of those eligibility criteria.

First, a person is eligible for HIRSP if, within nine months prior to submitting their application, they receive (and submit with their application) any of the following based wholly or partially on medical underwriting considerations:

- Notice of rejection of coverage from two or more health insurers;

- Notice of cancellation of coverage from one or more 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 HIRSP;

- Notice of an increase in premium of 50% or more for a current policy, unless the increase is applicable to substantially all of the insurer's health insurance policies then in effect; or

- Notice of a premium for a policy not yet in effect from two or more insurers that exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage offered by HIRSP.

As these criteria indicate, the first basis for HIRSP eligibility is the enrollee's inability to obtain adequate health insurance coverage in the private market due to "medical underwriting considerations."

Second, a person is eligible for HIRSP if they submit evidence that they tested positive for the human immunodeficiency virus (HIV) or an antibody to HIV.

Third, a person is eligible for HIRSP if they are already covered by Medicare because they have a disability as defined by the Medicare program.

Fourth, a person is eligible for HIRSP if they satisfy the statute's definition of an "eligible individual." Generally speaking, an eligible individual is somebody who had, but lost, their group health insurance coverage. More specifically, Chapter 149 defines an "eligible individual" as a person for whom all the following apply:

- The aggregate of their periods of creditable coverage is 18 months or more;

- Their 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;

- They do not have creditable coverage and are not eligible for coverage under a group health plan, Parts A, B, or D of Medicare, medical assistance (MA), or any successor program;

- Their 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 they were offered the option of continuation coverage under a federal continuation provision or a similar state provision, they elected and exhausted that coverage; and

- They have not had a break in insurance coverage greater than 63 days.

As the foregoing indicates, the concept of "creditable coverage" is important when determining whether a person meets the Chapter 149 definition of an eligible individual. In this context, creditable coverage means health care coverage under any of the following:

- a group health plan;

- health insurance (defined as surgical, medical, hospital, major-medical and other health service coverage provided on an expense-occurred basis and fixed indemnity policies);

- Medicare Parts A, B; or D;

- MA;

- TRICARE (the U.S. Department of Defense's health care program for active duty and retired uniformed services members and their families);

- Civilian Health and Medical Program of the Department of Veterans Affairs (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.

Unlike other HIRSP policyholders, a person who qualifies for coverage as an "eligible individual" is not subject to the plan's provision regarding pre-existing injuries or illnesses. That provision states that benefits under the plan are not payable during the six months after the policy's effective date for services related to a condition, whether physical or mental regardless of its cause, which was diagnosed or for which medical advice, care, or treatment was recommended or received during the six months immediately preceding the policy's effective date. The purpose of such "pre-existing condition" clauses is to protect plans from the adverse effects caused by previously uninsured people obtaining coverage and then immediately incurring significant expenses related to pre-existing medical conditions. As noted above, an "eligible individual" is not subject to the plan's pre-existing conditions provision.

Persons Ineligible for HIRSP. Chapter 149 also identifies people who are not eligible for HIRSP even if they satisfy the program's other eligibility requirements. These ineligible people include, but are not limited to, the following:

- people 65 years of age or older, unless they are an "eligible individual" or they have HIRSP coverage on the date they turn 65;

- people for whom HIRSP has paid a total of $1,000,000 or more in benefits;

- people who, with some exceptions, are eligible for creditable coverage provided by an employer on a self-insured basis or through health insurance;

- people who are eligible for health care coverage under BadgerCare, and

- people who, with some exceptions, are eligible for MA.

In addition, no person who is covered under the plan who voluntarily terminates their coverage is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage, unless the person is: (a) an eligible individual; or (b) a person who terminates HIRSP coverage because he or she is eligible for MA.

In recent years, most applicants who obtained coverage under HIRSP were accepted either because they lost their group health insurance or because they received a notice of rejection or cancellation of coverage from an insurer. This is reflected in Table 1, which summarizes HIRSP's annual application statistics for calendar years 2001 through 2005.

Subject to some statutory limitations, the Authority can expand the program's eligibility requirements to allow more people to be eligible for coverage, provided the expansion is consistent with the plan's purpose to provide health care coverage to people who cannot obtain coverage in the private market and provided the expansion does not endanger the solvency of the plan.

Table 1: HIRSP Application Statistics

Year	Applications Received	Applications Approved	Basis of Approval: Medicare Eligible	Loss of Group Insurance	Notice of Rejection	Other
2001	5,455	5,093	212	1,795	2,946	140
2002	7,163	6,454	192	2,031	4,125	106
2003	6,479	5,616	126	2,036	3,372	82
2004	6,298	5,206	99	2,180	2,796	131
2005	6,949	5,164	59	2,247	2,734	124

Overview of the HIRSP Insurance Plans

HIRSP offers participants three different health insurance plans. Plans 1A and 1B are available to people who are not enrolled in Medicare Part D, although recent changes do allow Plan 1A and 1B participants to be enrolled in Medicare Parts A and B. Plan 2, conversely, is only available to people enrolled in Medicare Parts A, B and D.

All three HIRSP plans offer major medical expense coverage that includes a prescription drug benefit. In order to be covered under HIRSP, the services (including prescription drugs) must be provided by a Medicaid-certified provider. In addition, HIRSP has the right to exclude or limit any service (including prescription drugs) that is not medically necessary and appropriate, reasonable, or provided in accordance with generally accepted standards of medical practice. Furthermore, none of the HIRSP insurance plans pay medical expenses that are payable under forms of insurance available to the policyholder such as auto insurance, worker's compensation, private insurance, Medicare and MA. Table 2 contains a partial list of the services covered, and those that are not covered, by the HIRSP insurance plans as of July 1, 2006. A complete list of the services covered and not covered by HIRSP, as well as a comprehensive description of the exclusions, conditions and limitations that apply to those services, is contained in the Policy of the Wisconsin Health Insurance Risk Sharing Plan, available from the Authority.

Table 2: Partial List of Services Covered and Services Not Covered by HIRSP as of July 1, 2006

Partial List of Services Covered by HIRSP

- Hospital services
- Basic medical-surgical services, including both in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services, and consultation services
- Inpatient treatment and outpatient services for alcohol or drug abuse and nervous and mental disorders
- Prescription drugs and insulin
- Home care
- Durable medical equipment
- Disposable medical supplies
- Diagnostic X-rays and laboratory tests
- Physical therapy services
- Emergency ambulance services
- Skilled nursing facility services
- Hospice care
- Services and supplies for treatment of diabetes
- Chiropractic services
- Maternity and newborn services

Partial List of Services Not Covered by HIRSP

- Routine examinations and related services
- Cosmetic treatments
- Eyeglasses
- Hearing aids
- Routine dental care
- Custodial care
- Infertility, impotence, and sterility services or drugs
- Charges for procedures that are determined not medically necessary and appropriate
- Expenses incurred for procedures or services that are of questionable medical value, experimental, or investigative (except drugs for the treatment of HIV infection)

While the three HIRSP plans provide coverage for the same range of medical expenses, other aspects of the plans differ. For example, Plan 1A offers lower deductibles and lower out-of-pocket maximums than Plan 1B. As a result, the premiums charged to Plan 1A policyholders are higher than those charged to Plan 1B participants. Plan 2 has its own plan design and premium levels. These and other elements of the HIRSP plans are discussed below.

Deductibles. A deductible is the amount of money a policyholder must pay for covered services during a coverage period before insurance pays any portion of their covered expenses. The three HIRSP plans contain different annual medical deductibles. Effective July 1, 2006, those deductibles were as follows:

Plan 1A	$1,000
Plan 1B	$2,500
Plan 2	$500

Coinsurance and Out-of-Pocket Maximums. The term coinsurance refers to the fixed percentage or dollar amount of covered medical expenses a policyholder must pay during a coverage period after satisfying their deductible. An out-of-pocket maximum is the maximum dollar amount a policyholder can pay during any one policy year for covered services, an amount that includes both their deductible and their coinsurance obligation. Table 3 compares the deductibles, coinsurance requirements and out-of-pocket maximums for the three HIRSP plans as of July 1, 2006.

HIRSP Funding

HIRSP is primarily financed by the following three sources: (1) premiums paid by policyholders; (2) assessments paid by health insurance companies doing business in Wisconsin; and (3) reductions to the amounts paid to health care providers who provide services to HIRSP policyholders. The premiums paid by HIRSP policyholders and the assessments paid by health insurance companies are treated as operating revenues on HIRSP's financial statements. Those same statements report the reductions in the amounts paid to health care providers as a reduction in the amount of the program's gross losses. According to unaudited figures contained in HIRSP's June, 2006, monthly report, these three

Table 3: Comparison of HIRSP Plan Features as of July 1, 2006

	Plan 1A	Plan 1B	Plan 2
Medical Deductible	$1,000 per year	$2,500 per year	$500 per year
Medical Coinsurance	20% of allowed amount $1,000 total per year	20% of allowed amount $1,000 total per year	No
Individual Medical Out-of-Pocket Maximum	$2,000 per year	$3,500 per year	$500 per year
Family Medical Out-of-Pocket Maximum, Excluding Drug Coinsurance (All family members must be on same plan)	$4,000 per year	$7,000 per year	$1,000 per year
Drug Coinsurance	20% of allowed amount up to maximum of $25 per prescription	20% of allowed amount up to maximum of $25 per prescription	20% of allowed amount up to maximum. of $25 per prescription
Drug Coinsurance Out-of-Pocket Maximum	$750 per year	$1,000 per year	$125 per year

funding sources contributed the following amounts to HIRSP during 2005-06 (HIRSP uses a July 1 to June 30 fiscal year):

Policyholder Premiums	$106,744,900
Insurers' Assessment	38,879,500
Reduction in Amounts Paid to Health Care Providers	37,361,400

Combined, these three sources comprised virtually all of the program's funding (other funding during 2005-06 included approximately $2.5 million in federal high-risk pool grants and investment income of approximately $1.9 million.) Each of the program's major funding sources is discussed below.

Policyholder Premiums. The premiums paid by HIRSP policyholders are the largest source of funding for the HIRSP program. Chapter 149 requires the Authority to set premium rates at a level sufficient to cover 60% of the plan's costs (not including the cost of providing subsidies to low-income enrollees, as discussed in further detail below).

Prior to July 1, 2006, the statute also required policyholder premiums to be set between 140% and 200% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under HIRSP. Effective July 1, 2006, Chapter 149 was amended to eliminate the 140% lower limit. As a result, the Authority currently sets premiums at levels sufficient to cover 60% of the program's anticipated costs, subject to the 200% upper limit described above.

Table 4 lists the quarterly premium rates for the three HIRSP plans effective July 1, 2006. As Table 4 indicates, premium rates differ based upon the policyholder's age, sex, and the geographic zone in which they live. Zone 1, as reflected in Table 4, pertains to certain zip codes in the Milwaukee area, and Zone 2 is for certain other counties in southeast Wisconsin and the Madison area. Zone 3 is for all other areas of the state.

According to an audit report published in 2006 by the Legislative Audit bureau (2006 LAB audit), premium rate increases for Plans 1A and 1B have been generally similar to those experienced by private insurers for comparable individual standard-risk policies. An exception is 2006-07, where the approved rates for Plan 1A and Plan 1B increased by just 5.0% because HIRSP's Board of Governors applied a portion of an accumulated balance of policyholder premiums towards the policyholder's share of program costs for that year. Table 5 summarizes the composite premium rate changes for

Table 4: HIRSP Quarterly Premiums, Effective July 1, 2006

Age Bracket	Males			Females		
	Zone 1	Zone 2	Zone 3	Zone 1	Zone 2	Zone 3
Plan 1A						
0-24	$738	$660	$588	$738	$660	$588
19-24	738	660	588	915	822	732
25-29	768	687	612	1,023	921	822
30-34	879	795	705	1,173	1,053	936
35-39	1,035	933	831	1,371	1,233	1,098
40-44	1,260	1,134	1,008	1,593	1,434	1,278
45-49	1,620	1,455	1,296	1,869	1,683	1,494
50-54	2,160	1,947	1,728	2,232	2,010	1,785
55-59	2,844	2,559	2,271	2,589	2,331	2,070
60-64	3,606	3,246	2,889	2,994	2,697	2,397
65+	3,606	3,246	2,889	2,994	2,697	2,397
Plan 1B						
0-24	$531	$474	$423	$531	$474	$423
19-24	531	474	423	660	591	528
25-29	552	495	441	738	663	591
30-34	633	573	507	846	759	675
35-39	744	672	597	987	888	792
40-44	906	816	726	1,146	1,032	921
45-49	1,167	1,047	933	1,347	1,212	1,077
50-54	1,554	1,401	1,245	1,608	1,446	1,284
55-59	2,049	1,842	1,635	1,863	1,677	1,491
60-64	2,595	2,337	2,079	2,157	1,941	1,725
65+	2,595	2,337	2,079	2,157	1,941	1,725
Plan 2						
0-24	$440	$399	$354	$440	$399	$354
19-24	440	399	354	608	549	486
25-29	577	519	462	772	693	618
30-34	664	597	531	845	762	675
35-39	785	708	627	1,039	933	831
40-44	954	858	762	1,182	1,065	945
45-49	1,132	1,017	903	1,363	1,227	1,092
50-54	1,381	1,242	1,104	1,537	1,383	1,230
55-59	1,654	1,488	1,326	1,696	1,527	1,356
60-64	1,985	1,785	1,587	1,839	1,653	1,470
65+	1,985	1,785	1,587	1,839	1,653	1,470

Table 5: Composite HIRSP Premium Rate Changes

Effective Date	Percent Increase Plans 1A & 1B	Plan 2
July 1, 2001	3.4%	3.4%
July 1, 2002	25.4	30.8
July 1, 2003	10.6	15.6
July 1, 2004	12.2	18.4
July 1, 2005	15.0	20.3
July 1, 2006	5.0	-21.5

each of the HIRSP plans from July 1, 2001, through July 1, 2006. As Table 5 also indicates, the premiums for Plan 2 had, until July 1, 2006, increased more rapidly than the premiums for Plan 1A or Plan 1B. Effective May 15, 2006, however, Plan 2 participants are now required to enroll in Medicare Part D, the newly-established prescription drug benefit under the Medicare program. As a result, Medicare Part D is now the first payer of pharmacy costs for all HIRSP Plan 2 policyholders. The 21.5% reduction in Plan 2 premiums effective July 1, 2006 reflects the anticipated pharmacy cost savings associated with this change.

Subsidies for Low-Income Participants. HIRSP provides subsidies to some low-income policyholders that reduce the amounts those policyholders pay for premiums and deductibles, as well reducing their prescription drug coinsurance requirement. The amount of the subsidies varies according to the participant's income level and the plan in which the enrollee participates. The cost of providing these low-income subsidies are funded first by any moneys received from the federal government in high-risk pool grants. In 2005-06, HIRSP received $2.5 million in such federal grants. Any remaining costs are borne 50% by the insurer assessments and 50% from the adjustments to provider payment rates.

Participants in Plan 1A and Plan 2 with annual household incomes less than $25,000 are eligible for reductions in their HIRSP insurance premium. These premium reductions, the amount of which are mandated by Chapter 149, are summarized in Table 6. Plan 1B policyholders are not currently eligible for these premium reductions.

Table 6: Premium Reductions for Low-Income Participants in Plan 1A and Plan 2

Annual Household Income		Maximum Premium
Equal or Greater Than	Less Than	Stated as Percentage of Standard Risk Rate
$0	$10,000	100.0%
10,000	14,000	106.5
14,000	17,000	115.5
17,000	20,000	124.5
20,000	25,000	130.0

Low-income participants in Plan 1A are also eligible for reductions in the amount of their medical deductible and prescription drug out-of-pocket maximum. Participants in Plan 1B and Plan 2 are not eligible for these reductions. Unlike the premium reductions described above, the amount of the reductions for medical deductibles and prescription drug coinsurance out-of-pocket maximums are not prescribed by statute, but are set by the Authority. Table 7 lists the current amount of these reductions.

Table 7: Reductions to Medical Deductibles and Prescription Drug Coinsurance Out-of-Pocket Maximums Available to Low-Income Plan 1A Participants

Annual Household Income			Drug Coinsurance
Equal or Greater Than	Less Than	Medical Deductible	Out-of-Pocket Maximum
$0	$10,000	$500	$375
10,000	14,000	600	450
14,000	17,000	700	525
17,000	20,000	800	600
20,000		1,000	750

According to the plan's June, 2006, monthly report, HIRSP policyholders received premium, deductible, and drug coinsurance subsidies totaling approximately $6,000,200 during 2005-06.

Assessments on Insurers Chapter 149 requires that 20% of HIRSP's costs be funded by assessments paid by health insurance companies doing business in Wisconsin. These assessments also pay 50% of any portion of the costs of providing the subsidies to low-income HIRSP policyholders that remain after the federal high-risk pool grants, as described above. The amount of each participating insurer's assessment is determined by the Commissioner of Insurance and is based on that insurer's total amount of health care coverage revenue for state residents during the preceding calendar year relative to the aggregate health care coverage revenue of all participating insurers for state residents during the preceding calendar year. According to the plan's June, 2006, monthly report, participating insurers paid $38,879,500 in assessments to HIRSP during 2005-06.

Pursuant to 2005 Wisconsin Act 74, participating insurers that pay a HIRSP assessment will be able to claim that assessment as a credit against certain other fees and taxes they pay. The amount of the credit will be equal to their assessment multiplied by a percentage calculated by dividing $5,000,000 by the aggregate insurer assessments under Chapter 149. The aggregate amount of the credit for all claimants cannot exceed $5,000,000 in any fiscal year. The credit will be available for taxable years beginning after December 31, 2005, but can first be claimed for taxable years beginning after December 31, 2007.

Reduced Health Care Provider Reimbursement. The third source of HIRSP funding comes in the form of reductions in the rates paid to health care professionals who provide covered services to HIRSP policyholders. Chapter 149 specifies that 20% of the plan's costs must be paid through these adjustments to provider rates. The provider rate adjustments also pay 50% of the cost of the subsidies to low-income HIRSP policyholders that remain after receipt of any federal high-risk pool grants. Pharmacies are exempt from contributing to the cost of the HIRSP program under this section of the statute.

Chapter 149 requires the Authority to set provider payment rates for covered services at a level equal to the MA reimbursement rate, plus an enhancement determined by the Authority. Chapter 149 also requires the Authority to use the same methodology that applies to MA when it establishes hospital outpatient per visit reimbursement rates and hospital inpatient reimbursement rates that are specific to diagnostically-related groups of eligible persons.

In practice, the health care providers' contributions to HIRSP are calculated in the following manner. Health care providers establish billed charges for their services. A discount is then applied to these billed charges, with the resulting rates referred to as "usual and customary" charges, a rate that is intended to reflect the typical fee providers charge for a given medical procedure. Instead of these usual and customary charges, HIRSP pays health care providers a further discounted rate that reflects their 20% contribution to plan costs. These discounted rates are referred to as "allowed charges." The difference between the providers' usual and customary charges and the allowed charges paid by HIRSP represents the health care providers' contribution to the program. According to the plan's June, 2006, monthly report, total provider contributions during 2005-06 were $37,361,400.

Select Financial and Operating Information

This section of the paper provides additional financial and operating information about HIRSP. Unless stated otherwise, the source of the information contained in this section is the 2006 LAB audit.

HIRSP Enrollment. Table 8 summarizes the total number of people enrolled in each of the HIRSP insurance plans as of June 30 for each year during the period 1999 through 2006. As indicated,

Table 8: HIRSP Enrollment as of June 30

Year	Plan 1A	Plan 1B	Plan 2	Total Number	Total % Change
1999	5,540	683	1,231	7,454	3.3%
2000	5,909	1,692	1,348	8,949	20.1
2001	7,081	2,849	1,530	11,460	28.1
2002	8,302	4,558	1,703	14,563	27.1
2003	8,532	6,729	1,756	17,017	16.9
2004	8,312	8,319	1,764	18,395	8.1
2005	8,000	9,683	1,702	19,385	5.4
2006	7,125	10,368	1,157	18,650	-3.8

almost all of the increase in total HIRSP enrollment since 1999 has come in Plan 1B, which offers lower premiums, but higher deductibles and coinsurance obligations, than Plan 1A. A second noteworthy development is the significant decrease (32%) in Plan 2 enrollment during 2005-06. This decline was related to the initiation of Medicare Part D and its prescription drug benefit. The recent decline in Plan 2 enrollment suggests that people who had been enrolled in Plan 2 primarily to receive its prescription drug benefits either switched to a different HIRSP plan or dropped HIRSP coverage altogether with the advent of Medicare Part D.

Program Costs. There are two primary categories of costs associated with the HIRSP program. The first, and by far the largest, is the payments HIRSP makes for the benefits provided under its various insurance plans. These costs are referred to as losses or "claims costs." The dollar amount of those costs for each fiscal year during the period 2000-01 through 2005-06 are summarized in Table 9. Note that Table 9 reflects "net claims costs," a figure that has already taken into account the health care provider discounts described above.

As Table 9 indicates, the total dollar amount of HIRSP's net claims costs has risen significantly in recent years. Specifically, net claims costs rose $74.9 million, or 138%, from 2000-01 to 2005-06. These increased costs are attributable to several factors, including increased enrollment (an increase of 63% from June 30, 2001, to June 30, 2006), and

Table 9: HIRSP Net Claims Costs ($ in Millions)

Fiscal Year	Net Claim Costs	% Change
2000-01	$54.1	48.7%
2001-02	67.2	24.1
2002-03	85.8	27.8
2003-04	103.9	21.1
2004-05	130.4	25.5
2005-06	129.0	-1.1

*Net claim costs for 2005-06 reflect unaudited figures contained in HIRSP's June, 2006, monthly report.

increased prescription drug and medical costs. Increased utilization of services by HIRSP policyholders has also been identified as a factor contributing to the increase in the program's total net claims costs.

The second primary category of costs for the HIRSP program is its administrative costs. The largest component of these administrative costs are the fees paid to the plan administrator, an outside vendor that helps administer the HIRSP program. As of the date of this paper, that outside vendor is Wisconsin Physicians Service (WPS), which in turn has subcontracted with Navitus Health Solutions for pharmacy benefit management services and with Milliman USA for consulting actuarial services. Table 10 tracks HIRSP's general and administrative expenses for each of the fiscal years, 2000-01 through 2005-06.

Table 10: HIRSP Administrative Costs

Fiscal Year	Total Administrative Costs	% Change
2000-01	$4,291,500	39.6%
2001-02	3,784,700	-11.8
2002-03	4,461,000	17.9
2003-04	5,060,100	13.4
2004-05	5,509,700	8.9
2005-06*	6,709,300	21.8

*Total administrative costs for 2005-06 reflect unaudited figures contained in HIRSP's June, 2006, monthly report.

Table 11 presents a simplified presentation of HIRSP's financial operations for the fiscal years ended June 30, 2005, and June 30, 2006, that summarizes much of the financial information discussed above.

Table 11: Summary of HIRSP's Financial Operations

	2004-05	2005-06*
Operating Revenues		
Policyholder Premiums	$92,726,200	$106,744,900
Insurers' Assessments	32,446,300	38,879,500
Total Operating Revenues	$125,172,500	$145,624,400
Operating Expenses		
Total Medical Losses (Net of provider contributions)	$84,649,200	$85,171,200
Total Pharmacy Losses	45,780,300	43,782,100
General and Admin. Expenses	5,509,700	6,709,300
Other Operating Expenses	84,700	183,400
Total Operating Expenses	$136,023,900	$135,846,000
Operating Income	-$10,851,500	$9,778,400
Nonoperating Revenues and Expenses		
Federal Grant Revenue	$2,222,900	$2,500,600
Investment Income	983,300	1,944,800
Other	-4,500	0
Total Nonoperating Income	$3,201,600	$4,445,400
Change in Net Assets	-$7,649,800	$14,223,800
Net Assets		
Total Net Assets -- Beginning of Year	$16,898,400	$9,248,500
Total Net Assets -- End of Year	$9,248,500	$23,472,400

*2005-06 results reflect unaudited figures contained in HIRSP's June, 2006, monthly report.

Organization and Management of HIRSP

This final section of the paper briefly outlines the recent administrative reorganization at HIRSP. Responsibility for administering HIRSP passed from DHFS to the Authority effective July 1, 2006. The Authority is not a traditional state agency, but rather is defined in Chapter 149 as a "public body corporate and politic." Its employees are not state employees, and its operations are not financed by state GPR dollars, but instead by the plan's operating revenues as described above.

Under Chapter 149, the Authority's board of directors is appointed by the Governor (with the advice and consent of the Senate), and is comprised of the following:

- the Commissioner of Insurance, or his or her designee, who is a nonvoting board member;

- four members who represent insurers participating in the plan;

- four members who represent health care providers, including one member each from the Wisconsin Medical Society, the Wisconsin Hospital Association, the Pharmacy Society of Wisconsin, and one representative of health care providers that provide services to HIRSP enrollees; and

- five members, at least one of whom represents small businesses that buy private health insurance, one of whom is a professional consumer advocate familiar with the plan, and at least two of whom are persons with coverage under the plan.

Chapter 149 assigns to the Authority responsibility for operating the program. Included within this mandate are such duties as establishing the Authority's budget, monitoring its fiscal management, paying the plan's operating and administrative expenses, and establishing procedures for the timely collection of premiums from policyholders and the timely payment of benefits to covered persons. In addition to these general administrative duties, Chapter 149 also gives the Authority the ability to adapt the program's insurance offerings to changes in the private health insurance market. Specifically, the statute directs the Authority to "provide benefit levels, deductibles, copayment and coinsurance requirements, exclusions, and limitations under the plan that the authority determines generally reflect and are commensurate

with comprehensive health insurance coverage offered in the private individual market in the state" and to "develop additional benefit designs that are responsive to market conditions." The Authority's power to redesign the program's insurance offerings, however, is not unbounded. For instance, Chapter 149 prohibits the Authority from designing an insurance plan that subjects an "eligible individual" to a preexisting condition exclusion. Other elements of the insurance plans approved by the Authority are also dictated by statute, such as many of its eligibility requirements, low-income subsidy provisions, and the list of expenses the plans must, at a minimum, cover.

2005 Wisconsin Act 74 also requires the Authority to design and administer a program of health insurance coverage called the health care tax credit program, under which a covered eligible person may receive an income tax credit for a portion of the premiums they pay for coverage under the plan. The Executive Director of the Authority indicates that the design of such a program is currently being studied. Act 74 also requires the Authority to assess the historic utilization experience and diagnosis-related needs of past and present enrollees to determine if the mental health and alcoholism and other drug abuse treatment benefit under Section 632.89 of the statutes allows for the use of evidence-based treatment to meet the mental health and alcoholism and other drug abuse treatment needs of HIRSP policyholders. Following its submission to the Joint Committee on Finance of a report of its findings, the Authority, on or after January 1, 2007, must make any necessary adjustments to the minimum required benefits under the plan to ensure appropriate access to evidence-based mental health and alcoholism and other drug abuse treatment strategies for people with health insurance coverage under HIRSP. Finally, Chapter 149 requires the Authority to qualify HIRSP as a state pharmacy assistance program (SPAP), as defined in 42 CFR 423.464. HIRSP management indicates that HIRSP has been qualified as an SPAP, and that this will result in plan savings by increasing the amount of HIRSP enrollees' prescription drug costs paid by Medicare Part D.

To perform its duties, the statute assigns to the Authority "all the powers necessary or convenient to carry out the purposes and provisions of Chapter 149" including, but not limited to, the power to adopt bylaws, policies and procedures, to hire employees, and to define those employees' duties and rates of compensation. The Authority can also contract for outside professional services, provided it follows the competitive bid process contained in Chapter 149. Under that process, the Authority must solicit competitive sealed bids or competitive sealed proposals, whichever is appropriate. The Authority can use simplified procedures if the estimated cost of the contact is $25,000 or less.

Information regarding HIRSP's future operations and financial position will continue to be publicly available through various sources, including the annual report the Authority is required to submit to the Legislature and to the Governor, and the financial audit the Legislative Audit Bureau is required to conduct annually.