Health Insurance Risk-Sharing Plan (HIRSP)

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Health Insurance Risk-Sharing Plan (HIRSP)

The health insurance risk-sharing plan (HIRSP) offers health insurance coverage to Wisconsin residents who cannot purchase adequate private coverage due to a medical condition, or who have lost employer-sponsored group health insurance. As of June, 2012, 21,770 individuals had coverage through plans provided by HIRSP. HIRSP is financed through premiums paid by plan members, assessments collected from Wisconsin health insurers, and reduced payments to health care providers for services provided to members. No state general purpose revenues support the plan's operation or administration.

The state Office of the Commissioner of Insurance administered HIRSP from the plan's creation in 1979 until 1998, when the plan was transferred to the Department of Health and Family Services. In 2005, legislation created an independent body called the HIRSP Authority to administer the plan, while maintaining state control over certain aspects of the program under Chapter 149 of the statutes.

In March, 2010, the federal Patient Protection and Affordable Care Act (ACA) established the Pre-existing Condition Insurance Plan and provided funds to states to expand or establish "high-risk pools" to cover individuals with pre-existing conditions. HIRSP administers this program in Wisconsin as "HIRSP Federal," and offers partially federally-funded plans in addition to the traditional HIRSP plans. As of June 30, 2012 1,633 individuals had coverage under the HIRSP Federal plans. Unless otherwise noted, this paper describes the non-federal plans administered under HIRSP.

Eligibility Requirements

In order to purchase coverage under HIRSP, an individual must meet certain eligibility criteria. All participants must have resided in Wisconsin for at least three months, and may not qualify for coverage under an employer-sponsored group health insurance plan or under comprehensive medical assistance (MA) or BadgerCare Plus. In addition to these general criteria, an individual must qualify for HIRSP in one of two ways, as described below: (a) based on a medical condition, or (b) based on a loss of employer-sponsored group health insurance coverage.

Eligibility Based on a Medical Condition. A person qualifies for HIRSP based on a medical condition if he or she meets at least one of the following criteria.

First, a person is eligible if no more than nine months before applying to HIRSP he or she receives any of the following, based on medical information collected by a health insurer:

- Notice of rejection of coverage from at least one insurer;

- Notice of cancellation of coverage;

- Notice of reduction or limitation in coverage compared to that available to a person considered a standard risk for the type of coverage provided by HIRSP;

- Notice of an increase in a premium of 50 percent or more for a current policy, unless the increase applies to substantially all of the insurer's policies; or

• Notice from two or more insurers of a premium for a policy not yet in effect that exceeds by at least 50 percent the premium for a person considered a standard risk for the type of coverage offered by HIRSP.

A person also qualifies for HIRSP if he or she has Medicare coverage because of a disability, or if he or she tests positive for human immunodeficiency virus (HIV).

All HIRSP participants qualifying because of a medical condition are subject to a six-month pre-existing condition waiting period. During this period, HIRSP does not cover medical services related to a condition which was diagnosed, or for which medical treatment was recommended or received, during the six months preceding the policy's effective date. This exclusion period mirrors similar provisions in private insurance coverage that discourage individuals from purchasing coverage in the plan only when a known need or expense presents itself. As this exclusion period only applies to medical services, a new HIRSP member has full prescription drug coverage during those six months.

Eligibility Based on Loss of Employer-Offered Coverage ("Eligible Individual"). A person also qualifies for HIRSP if he or she is an "eligible individual," a term generally defined in statute as somebody who loses group health insurance coverage. To qualify as an eligible individual, a person must meet all of the following criteria:

• Prior to applying for HIRSP, the individual was enrolled in "creditable coverage" for at least 18 months, with no gap in coverage of more than 63 days (see Table 1 for a list of creditable coverage);

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

Table 1: Qualifying Creditable Coverage

- 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
- Medical Assistance
- 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
- A Peace Corps health plan

• The individual applied for HIRSP within 63 days of losing group coverage;

• The individual does not currently have creditable coverage, and is not eligible for coverage under a group health plan, parts A, B, or D of Medicare, comprehensive MA, or any successor program;

• The individual's most recent coverage was not terminated due to fraud or intentional misrepresentation of material fact, or a failure to pay premiums; and

• If available, the individual accepted and exhausted continuation of employer-sponsored coverage under a federal or state continuation provision, (generally referred to as "COBRA" coverage).

Unlike members who qualify because of a medical condition, the six-month pre-existing condition exclusion period does not apply to a person who qualifies for coverage as an eligible individual. HIRSP also waives the pre-existing waiting period for other groups, such as individuals who enroll within 45 days of losing Medicaid or BadgerCare Plus coverage.

Table 2: HIRSP Application Statistics

			Reason for Application Approval				
			Based on Medical Condition				Loss of Group
Year	Applications Received	Applications Approved	Notice of Denial of Private Coverage	HIV Diagnosis	Medicare Eligibility	Benefit Reduction/ Premium Increase	Insurance ("Eligible Individuals")
2007	4,667	3,702	1,475	56	20	46	2,101
2008	4,961	3,719	1,380	51	27	13	2,247
2009	5,155	4,065	1,477	22	47	0	2,520
2010	8,453	6,773	2,767	38	52	3	3,905
2011	10,793	7,752	3,583	59	97	0	3,978

Persons Not Eligible for HIRSP. Chapter 149 specifies certain people who cannot participate in HIRSP even if they satisfy the program's other eligibility requirements:

- People over age 65, unless they qualify as an eligible individual, or have HIRSP coverage when they turn 65;

- Have received over $2 million in benefits from HIRSP;

- Are eligible for creditable coverage provided by an employer, BadgerCare Plus, or Medical Assistance, with some exceptions.

In addition, a HIRSP member who voluntarily terminates coverage generally cannot participate in HIRSP for the next 12 months. This does not apply to eligible individuals, or people who terminate HIRSP coverage because of eligibility for MA.

Subject to certain statutory limitations, the HIRSP Authority can expand the program's eligibility requirements. Any expansion must comply with the plan's purpose to provide coverage to people who cannot obtain it in the private market, and must not endanger the solvency of the plan.

Table 2 provides annual application statistics, including reason for application approval, for calendar years 2007 through 2011. For 2010 and 2011, the statistics include applications to both the HIRSP plans and the HIRSP Federal plans.

HIRSP Plans

HIRSP offers a total of seven plan options in three categories. In general, the plan name refers to the dollar amount of that plan's deductible:

- Four standard medical plans:
  HIRSP 1,000
  HIRSP 2,500
  HIRSP 5,000
  HIRSP 7,500

- Two plans that qualify the member to open a health savings account (HSA):
  HIRSP HSA 2,500
  HIRSP HSA 3,500

- One plan for Medicare beneficiaries:
  HIRSP Medicare Supplement

(HIRSP also administers several plans partially supported with federal ACA funding. For information on those plans, see the "HIRSP Federal Plans" section.)

All seven HIRSP plans offer major medical coverage and a prescription drug benefit, with a

maximum lifetime benefit of $2 million. In order for a medical service to be fully covered under HIRSP, it must be provided by a participating HIRSP provider, with members liable for additional charges for services provided by a non-HIRSP certified provider. All prescription drugs must be obtained through a HIRSP-certified pharmacy. HIRSP may exclude or limit any service deemed not medically necessary and appropriate, or not provided in accordance with generally accepted standards of medical practice. Appendix I provides a partial list of covered and non-covered benefits. None of the plans pay medical expenses covered by other available insurance, such as auto insurance or worker's compensation.

The following sections summarize the HIRSP plan designs, including member cost-sharing. Table 3 provides a comparison of the each plan's deductible, coinsurance and out-of-pocket maximum expenditure, and first year the plan was offered; Appendix II compares the 2013 plan premiums by plan, age and sex.

Traditional Plans. *HIRSP 1,000, HIRSP 2,500, HIRSP 5,000* and *HIRSP 7,500* are all standard medical plans. These four plans have the same eligibility criteria and benefits, but differ in premium and deductible amounts.

Premiums. A plan's premium is the amount a member must pay each month for coverage. The plans with higher deductibles have lower premiums. For instance, *HIRSP 1,000* is a low-deductible, high-premium plan; *HIRSP 7,500* is a high-deductible, low-premium plan. The actual premium amounts depend on the age and sex of the member, as shown in Appendix II.

Table 3: Comparison of HIRSP Plans

	HIRSP 1,000	**HIRSP 2,500**	**HIRSP 5,000**	**HIRSP 7,500**	**HSA 2,500**	**HSA 3,500**	**Medicare Supplement**
First Year Offered	1979	1998	2008	2013	2008	2010	1979
Annual Medical Deductible	$1,000	$2,500	$5,000	$7,500	$2,500	$3,500	$500
Medical Coinsurance	20% of allowed amount, up to $1,000				20% of allowed amount (up to $2,100 maximum combined With Drug Coinsurance)		None
Drug Coinsurance	---	---	---	---	20% of allowed amount (up To $2,100 maximum combined With Medical Coinsurance)		---
Annual Individual Medical Out-of-Pocket Maximum	$2,000	$3,500	$6,000	$8,500	$4,600*	$5,600*	$500
Drug Copayment	$5 Tier 1/$55 Tier 2/$75 Tier 3 ($2,500 maximum)				---	---	$5 Tier 1/$55 Tier 2/ $75 Tier 3 ($1,750 maximum)
Premiums	See Appendix II for 2013 premiums by plan, age, and gender.						

*Includes maximum medical/drug coinsurance amount of $2,100 per year per individual.

Deductibles. The names of the plans reflect the plan's deductible, or the annual dollar amount that a member must pay for covered medical services before HIRSP pays any portion of medical expenses. Payment of premiums does not count towards the deductible. Prescription drugs and preventive services are not subject to the deductible for any HIRSP plan. The deductible is $1,000 for *HIRSP 1,000*, $2,500 for *HIRSP 2,500*, $5,000 for *HIRSP 5,000*, and $7,500 for *HIRSP 7,500.*

Medical Coinsurance. After a member has paid the entire deductible amount, HIRSP begins to pay for a portion of medical costs, with the members paying a fixed percentage of covered medical expenses, or coinsurance. Members must pay coinsurance of 20 percent of allowable medical expenses. Once a member has spent $1,000 in coinsurance costs in a year, the plan pays for 100% of services for the remainder of the year. The cap on member coinsurance results in a combined annual out-of-pocket maximum for the deductible and coinsurance. For instance, the maximum combined out-of-pocket amount (in addition to premiums) that a member in *HIRSP 2,500* could be required to pay is $3,500 ($2,500 to satisfy the deductible, and up to $1,000 in coinsurance).

Drug Benefit. Members of these plans receive a prescription drug benefit with a fixed dollar amount that the member must pay each time he or she fills a prescription, or copayment. The copayment equals $5 for most generic drugs (Tier 1), $55 for brand-name and certain high-cost and specialty generic drugs (Tier 2), and $75 for specialty brand-name drugs (Tier 3). Drug costs are subject to a $2,500 out-of-pocket maximum (separate from the medical deductible and coinsurance out-of-pocket maximum).

Low-income Subsidies. HIRSP discounts premiums, deductibles, and prescription drug out-of-pocket maximums for low-income members. The amount of the subsidy varies according to the participant's income and the plan in which the enrollee participates.

Members in these plans with annual household income of less than $34,000 qualify for subsidies. Household income includes all income reported for Wisconsin income tax purposes, and certain nontaxable income (such as unemployment compensation), with a deduction of $500 for each dependent. The income of spouses is included to determine household income.

The maximum discount levels for these plans are available to members with household income of less than $10,000, reducing the medical deductible by $750 and the applicable premium by 43 percent, and capping annual out-of-pocket drug expenses at $425. Appendix III provides a full summary of the low-income subsidy amounts.

HIRSP Health Savings Account 2,500 and 3,500. HIRSP offers two HSA qualified plans: *HIRSP HSA 2,500* and *HIRSP HSA 3,500*. Members who enroll in these high deductible–low premium plans can open a tax-favored savings account to pay for medical expenses, such as deductibles and coinsurance.

Premiums. As with the other HIRSP plans, HIRSP HSA premiums depend on the age and sex of the member (see Appendix II).

Deductibles. As with any plan that qualifies members to open an HSA, the HIRSP HSA plans have a high deductible (defined by U.S. Treasury as at least $1,200 for an individual, or $2,400 for a family). The *HIRSP HSA 2,500* deductible is $2,500, and the *HIRSP HSA 3,500* deductible is $3,500.

Medical and Drug Coinsurance. HIRSP HSA plans require members to pay combined medical and prescription drug coinsurance, instead of the medical coinsurance and drug copayment of the other plans. Members are responsible for 20

percent of covered medical costs and drug purchases, up to $2,100 per year, after the deductible has been satisfied.

Low-income Subsidies. As with the standard medical plans, deductible and premium discounts are available to HIRSP members with annual household income under $34,000. Members with annual income of under $10,000 qualify for the maximum discount of $750 from the deductible and 43 percent from the premium. However, as there is a combined medical and drug coinsurance requirement in these plans, there is no subsidy for out-of-pocket drug costs.

HIRSP Medicare Supplement. Individuals who are enrolled in Medicare parts A, B, and D can enroll in the *HIRSP Medicare Supplement* plan. Participants in this plan must either be younger than 65 years old and qualify for Medicare due to a disability, or be enrolled in HIRSP upon reaching 65 years of age and obtaining eligibility for Medicare. This plan is not available to individuals who did not have HIRSP coverage before turning 65.

Premiums. As with the other plans, premiums for the *HIRSP Medicare Supplement* vary by age and sex (see Appendix II).

Deductibles. The Medicare Supplement plan has a $500 annual deductible. Unlike the other HIRSP plans, this plan does not offer deductible subsidies for low-income members.

Medical Coinsurance. HIRSP Medicare Supplement members do not pay any medical coinsurance. Once the individual pays the full deductible, he or she is not responsible for any additional share of medical costs.

Drug Benefit. Members in the *HIRSP Medicare Supplement* have drug copayments of $5 for Tier 1 drugs, $55 for Tier 2 drugs, and $75 for Tier 3 drugs, subject to a $1,750 out-of-pocket maximum.

Low-income Subsidies. Members with less than $34,000 in household income can obtain discounts on their premiums, and caps on out-of-pocket prescription drug costs. For members with under $10,000 of household income who qualify for the largest subsidies, the plan premium is discounted by 35%, and the annual drug out-of-pocket maximum is set at $150. *HIRSP Medicare Supplement* participants do not receive a discount on their medical deductible.

HIRSP Enrollment. Table 4 provides the number of members in each plan, and how many participants receive subsidies, at the end of June, 2012. Table 5 shows total enrollment in each of the HIRSP plans from 2003 to 2012. In recent

Table 4: Number of Members by Plan and Subsidy Status, June, 2012*

	Number of Members			% of Total
	Non-subsidized	Subsidized	Total	Membership
HIRSP 1,000	670	361	1,031	4.7%
HIRSP 2,500	5,440	1,955	7,395	34.0
HIRSP 5,000	8,185	2,258	10,443	48.0
HSA 2,500	701	139	840	3.9
HSA 3,500	721	123	844	3.9
Medicare Supplement	740	477	1,217	5.6
Total	16,457	5,313	21,770	100.0%

*Enrollment in HIRSP 7,500 not shown, as that plan will be first offered in January, 2013.

Table 5: HIRSP Enrollment History, 2003-2012*

Year	HIRSP 1,000	HIRSP 2,500	HIRSP 5,000	HSA 2,500	HSA 3,500	Medicare Supplement	Total Enrollees	% Change in Total Enrollment
2003	8,421	7,286	-	-	-	1,740	17,447	
2004	8,104	8,510	-	-	-	1,727	18,341	5.1%
2005	7,657	9,720	-	-	-	1,570	18,947	3.3
2006	6,813	10,258	-	-	-	987	18,058	-4.7
2007	5,879	10,312	-	-	-	935	17,126	-5.2
2008	3,762	8,747	2,377	-	454	944	16,284	-4.9
2009	2,240	8,771	3,717	-	684	969	16,381	0.6
2010	1,632	8,408	6,685	421	800	1,019	18,965	15.8
2011	1,324	8,425	8,791	755	877	1,145	21,317	12.4
2012	1,031	7,395	10,443	840	844	1,217	21,770	2.1

*Enrollment as of December 31 of each given year, except for June 30, 2012. Enrollment in HIRSP 7,500 not shown, as that plan will be first offered in January, 2013.

years, there has been a general trend of HIRSP members shifting from the higher premium *HIRSP 1,000* plan to the lower premium *HIRSP 2,500* and *HIRSP 5,000* plans.

HIRSP Federal Plans

The federal Patient Protection and Affordable Care Act (ACA), enacted in March, 2010, created the Pre-existing Condition Insurance Plan (PCIP), which provided $5 billion in funding for high-risk pools nationwide. Wisconsin's initial allocation equaled approximately $73 million for services provided between July 1, 2010 and December 31, 2013. States had the option of administering the PCIP themselves, or having the federal government do so in the state. In May, 2010, the HIRSP Authority was designated as the administrator of PCIP in Wisconsin.

As a result of these ACA provisions, HIRSP administers several "HIRSP Federal" plans in addition to the HIRSP plans. The eligibility requirements and plan features of the new federal plans differ from the traditional HIRSP plans.

Federal Plan Eligibility. Individuals must meet all of the following criteria to qualify for the HIRSP Federal plan:

- Be a resident of Wisconsin;

- Be a citizen or national of the United States, or lawfully present in the United States; and

- Have not had creditable coverage in the six months prior to the HIRSP Federal Plan effective date.

In addition, individuals must have received at least one of the following:

- A physician's letter from within the last nine months that confirms diagnosis or treatment in the last five years of a set list of conditions (these include a wide range of physical and mental conditions, including HIV, diabetes, and cardiovascular diseases);

- A notice of rejection from an insurer;

- A notice of reduction or limitation on coverage, including restrictive riders;

- A notice of a premium increase of 50% or more; or

• Two or more offers for insurance with premiums at least 50% higher than a standard risk would be charged for the coverage.

Unlike coverage under the HIRSP plans, individuals cannot qualify for HIRSP Federal plans by losing employer-sponsored coverage. Also, there is no six-month waiting period for coverage of medical services for pre-existing conditions for HIRSP Federal plan members. Compared to the reduced usual and customary rates paid under the HIRSP plans, HIRSP Federal plans are lower, and currently equal 191% of provider reimbursement rates paid by the state's Medicaid program.

HIRSP staff projected that the amount budgeted for Wisconsin under the ACA would be sufficient to enroll up to 8,500 individuals in the federal plans. HIRSP began accepting applications for federal plans in July, 2010, and as of June 30, 2012, a total of 1,543 individuals were enrolled.

Federal Plan Options. There are four HIRSP Federal plans: *Federal 500, Federal 1,000, Federal 2,500*, and *Federal 3,500*. As with the HIRSP plans, the names of the federal plans refer to the amount of that plan's deductible. Table 6 compares the cost-sharing requirements of the four HIRSP Federal plans. All four plans have medical coinsurance of 20% (up to a maximum of $1,000), and drug copayments of $5 for Tier 1 drugs, and $45 for Tier 2 drugs (there is no separate designation for Tier 3 drugs for the federal plans).

The ACA prohibits the federal plans from having different premiums for men and women, requires that premiums cannot exceed the standard non-group rate, and prohibits premiums from varying by age by more than a factor of 4 to 1. Appendix V provides the monthly premiums for each federal plan for calendar year 2013, by age group. No premium or cost-sharing subsidies for low-income individuals are available for premium, deductible, or drug out-of-pocket maximums for the federal plans.

The HIRSP Federal plans offer a benefit package comparable to the benefits offered by the HIRSP plans, as outlined in Appendix I. The full outlines of coverage and policy documents for the HIRSP Federal plans are available on the HIRSP website.

HIRSP after Full ACA Implementation. The ACA made other changes to the private insurance market that would benefit individuals who would traditionally utilize HIRSP coverage, most of which will go into effect in 2014. For instance, the ACA requires private health insurance companies to accept anyone who applies for coverage, prohibits pre-existing condition

Table 6: Comparison of HIRSP Federal Plans

	Federal 500	Federal 1,000	Federal 2,500	Federal 3,500
Medical Deductible	$500/year	$1,000/year	$2,500/year	$3,500/year
Medical Coinsurance	20% of allowed amount, up to $1,000			
Individual Medical Out-of-Pocket Maximum	$1,500/year	$2,000/year	$3,500/year	$4,500/year
Drug Copayment	$5 Tier 1/$45 Tier 2 (Up to a $2,000 Maximum)			
Premiums	See Appendix V for comparison of 2011 premiums by plan, age, and gender.			

exclusion periods, and prohibits insurance companies from charging premiums based on health status. At this point it is not clear what role HIRSP and high risk pools in other states will have in state insurance markets when the ACA provisions are fully implemented in 2014. The National Association of State Comprehensive Health Insurance Plans (NASCHIP), a group that represents 35 state high-risk pools, has advocated for a continued role as a safety net for individuals with high medical costs for a transition period.

Funding and Financial Information

HIRSP funds benefit and administrative costs by collecting member premiums, receiving funds from insurance companies, and reducing provider reimbursement. The plan's main costs are for payment of claims. This section describes these revenues and costs, and provides additional financial information.

Revenues. HIRSP is primarily funded through three sources: (a) premiums paid by members: (b) assessments paid by Wisconsin health insurance companies; and (c) reductions in reimbursement to HIRSP-certified health care providers. In general, premiums fund 60% of HIRSP costs, with insurer assessments and provider discounts each funding 20%. These three funding sources contributed the following amounts, in millions of dollars, to HIRSP in calendar year 2011:

Member Premiums	*$96.3*
Insurer Assessments	*43.5*
Provider Payment Reductions	*39.4*

These sources comprise virtually all of the program's funding (with approximately $2.5 million in non-ACA federal grants, and $213,000 in investment income in 2011). The program's major funding sources are discussed below.

Member Premiums. Premiums are the largest source of HIRSP funding. Chapter 149 of the statutes requires the Authority to set premium rates at a level sufficient to cover 60 percent of the plan's costs. Prior to July, 2006, Wisconsin statute also required premiums to be set between 140 percent and 200 percent 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, 2006, Chapter 149 was amended to eliminate the 140 percent lower limit. As a result, the Authority currently sets premiums at levels sufficient to cover 60 percent of the program's anticipated costs, subject to the 200 percent upper limit compared to a standard risk. The current aggregate rates across all HIRSP plans are below the historical 140 percent limit (at approximately equal to the standard risk rate when looking at all private policies, and approximately 15% higher than new policies that are sold in the private market).

Table 7 provides additional detail on HIRSP premium adjustments for the HIRSP plans since 2007. Premiums for all plans (except the Medicare Supplement) increased by 15 percent on July 1, 2011, by 9 percent for all plans on January 1, 2012, and by 3 percent for all plans on January 1, 2013.

Insurer Assessments. Statutes require that health insurance companies doing business in Wisconsin pay assessments to fund 20 percent of HIRSP costs. These assessments also fund 50 percent of the subsidies for low-income members, after the use of non-ACA federal grants. The amount of each participating insurer's assessment is based on that insurer's share of aggregate Wisconsin health insurance premiums for all participating insurers during the preceding calendar year. Insurers that pay a HIRSP assessment can claim a credit against certain other taxes and fees, with the total amount of the credit for all insurers not exceeding $5 million in any fiscal year.

Table 7: HIRSP Premium Rate Changes

Effective Date	HIRSP 1,000	HIRSP 2,500	HIRSP 5,000	HSA 2,500	HSA 3,500	HIRSP Medicare Supplement
July 1, 2007	7.4%	-5.1%	-	-	-	-20.0%
January 1, 2008	15.0	6.1	-	-	-	0.0
April 1, 2008	-2.7	-10.0	-10.0%	-	-10.0%	0.0
January 1, 2009	5.9	3.7	3.6	-	3.5	-9.8
January 1, 2010	11.0	6.0	-15.0	-	-2.0	-5.0
April 1, 2010	-7.2	-7.5	0.0	0.0%	-5.2	0.0
January 1, 2011	0.0	0.0	0.0	0.0	0.0	-30.0
July 1, 2011	15.0	15.0	15.0	15.0	15.0	0.0
January 1, 2012	9.0	9.0	9.0	9.0	9.0	9.0
January 1, 2013	3.0	3.0	3.0	3.0	3.0	3.0

Reduced Provider Reimbursement. Reductions in payments to health care professionals (except for pharmacies) who provide covered services to members pay for the remaining 20 percent of the plan's costs. The provider payment reductions also pay 50 percent of the cost of the low-income subsidies after the use of any non-ACA federal grants. HIRSP sets usual and customary provider payment rates and calculates an adjustment to these rates to fund the providers required contribution to HIRSP plan costs. The difference between the usual and customary charges and the allowed charges paid by HIRSP represents the health care providers' contribution to the program. For 2013, HIRSP provider payments are set at 73% of providers' usual and customary rates.

Costs. There are two main categories of costs associated with the HIRSP program: claims costs and administrative costs. Also, as discussed above, HIRSP members with low incomes qualify for premium and cost-sharing subsidies. Table 8 summarizes the HIRSP plan and HIRSP Federal plan costs from calendar year 2007 to 2011, taking into account the health care provider discounts described above.

Claims costs refer to medical and prescription drug benefits provided under HIRSP plans, and are the largest source of costs. Administrative costs include policyholder and provider services, claims administration, and coordination of benefits. There are also several administrative initiatives for disease and medication management. Fees paid to Wisconsin Physicians Service (WPS), a private vendor that helps administer HIRSP, are the largest component of these administrative costs. HIRSP pays WPS on a per member per month basis for most services.

Table 8: Claims and Administrative Costs (in millions)

	HIRSP Plans		HIRSP Federal Plans	
	Claims	Administrative Costs	Claims	Administrative Costs
2007	$168.8	$6.4	-	-
2008	151.0	6.5	-	-
2009	141.1	6.6	-	-
2010	156.0	6.7	$0.7	$0.6
2011	178.2	7.8	5.3	1.0

Subsidies for Low-Income Participants. HIRSP subsidies to low-income members are funded first by federal non-ACA high-risk pool grants, with insurer assessments and provider payment reductions each covering 50 percent of any remaining costs. In 2011, HIRSP members received $9.9 million in subsidies for premiums, medical deductible and drug costs. Individuals with annual incomes of up to $34,000 qualify for subsidies (this level has increased over time, most recently from $33,000 in 2011).

Financial Information. Appendix IV summarizes HIRSP's revenues, expenses and net assets for calendar years 2010 and 2011. The premiums paid by HIRSP members and the assessments paid by health insurance companies are treated as operating revenues, and reductions in the amounts paid to providers are reported as a reduction in the amount of the program's medical losses. For more detailed financial information, and for supporting notes to the financial statements shown in Appendix IV, refer to the HIRSP 2011 Annual Report, or the Legislative Audit Bureau's May, 2012, audit report.

HIRSP Management

The HIRSP Authority administers the program under Chapter 149 of the statutes. The Authority functions as an independent body, and receives no state general revenue funds. The Authority's sets HIRSP's annual budget, monitors its fiscal management, pays the plan's operating and administrative expenses, and establishes procedures for the timely collection of premiums and payment of benefits.

To perform these duties, statutes assign 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.

In addition to these general administrative duties, Chapter 149 allows the Authority to adapt the program's insurance offerings to changes in the private health insurance market. Specifically, Wisconsin statute directs the Authority to set benefit levels, deductibles, copayment and coinsurance requirements, exclusions, and limitations that generally reflect coverage offered in the private individual market in the state, and to "develop additional benefit designs that are responsive to market conditions." Some statutory provisions limit the Authority's power to redesign the program's insurance offerings. Statute also dictates other elements of the insurance plans approved by the Authority, including many of its eligibility requirements, low-income subsidy provisions, and the list of minimum services the plans must cover.

Finally, Chapter 149 requires the Authority to qualify HIRSP as a state pharmacy assistance program. This allows HIRSP payments on drug claims to count toward the member's out-of-pocket liability under Medicare Part D.

Board of Directors. The Governor appoints the Authority's Board of Directors, composed of the following representatives:

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

- Four members representing insurers participating in the plan;

- Four members representing 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 members; and

- Five other members, including at least one representative of small businesses that buy private health insurance, one professional consumer advocate familiar with the plan, and at least two HIRSP members.

All board members, besides the Commissioner of Insurance, serve three-year terms, and the state Senate must consent to their appointment.

Additional Information

Additional information on HIRSP and state high-risk pools is available from the following sources:

Wisconsin Health Insurance Risk-Sharing Plan
www.hirsp.org

National Association of State Comprehensive Health Insurance Plans
www.naschip.org

Wisconsin Legislative Audit Bureau, 2012 HIRSP Audit Report
legis.wisconsin.gov/lab/reports/12-9full.pdf

Pre-existing Condition Insurance Plan (PCIP)
www.pcip.gov

APPENDIX I

Partial List of HIRSP Covered and Non-covered Services
As of January 1, 2013*

Services Covered by HIRSP
- Preventive services (not subject to plan deductible)
- Medical-surgical services
- Anesthesia services
- Consultations
- Prescription drugs
- Home care
- Radiology services
- Laboratory supplies
- Pap test and pelvic exam
- Skilled nursing care
- Hospice care

Services Requiring Prior Approval**
- Transplant services
- Durable medical equipment costing more than $1,500
- Prosthetics costing more than $1,500
- Surgical services for morbid obesity
- Spinal surgeries***
- Dental repair relating to an injury***
- Inpatient admissions---Non-emergency admissions, at least 3 business days prior to admission
- Outpatient visits and transitional treatment of alcoholism, drug abuse and nervous or mental disorders beyond 50 visits per calendar year
- Certain pain management procedures

Services Not Covered by HIRSP
- Cosmetic treatments
- Eyeglasses
- Hearing aids
- Routine dental 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)
- Custodial care

* For a complete list of covered and non-covered services, refer to the HIRSP and HIRSP Federal plan policy documents available from the Authority at *www.hirsp.org/plans/state-policy.shtml*, and *www.hirsp.org/plans/federal-policy.shtml*.
** Does not apply to HIRSP Medicare Supplement Plan.
*** Prior approval not required in the event of an emergency.

APPENDIX II

2013 HIRSP Plans
Monthly Premiums

Age	Male	Female	Age	Male	Female	Age	Male	Female	Age	Male	Female
HIRSP 1,000			**HIRSP 2,500**			**HIRSP 5,000**			**HIRSP 7,500**		
0–18	$399	$390	0–18	$196	$196	0–18	$124	$123	0–18	$107	$106
19–24	399	500	19–24	195	246	19–24	122	157	19–24	106	136
25–29	421	564	25–29	201	272	25–29	128	172	25–29	111	149
30–34	485	645	30–34	235	311	30–34	149	198	30–34	129	171
35–39	571	751	35–39	269	354	35–39	171	225	35–39	148	195
40–44	688	870	40–44	324	412	40–44	205	260	40–44	177	225
45–49	836	983	45–49	408	473	45–49	260	299	45–49	225	259
50–54	1,008	1,088	50–54	526	544	50–54	334	344	50–54	289	298
55–59	1,234	1,207	55–59	673	618	55–59	427	390	55–59	369	337
60 +	1,500	1,276	60 +	847	703	60 +	537	447	60 +	465	387
HSA 2,500			**HSA 3,500**			**Medicare Supplement**					
0–18	$174	$174	0–18	$158	$158	0–18	$67	$67			
19–24	173	220	19–24	157	200	19–24	67	93			
25–29	178	240	25–29	163	217	25–29	89	119			
30–34	209	276	30–34	190	250	30–34	101	129			
35–39	239	315	35–39	216	286	35–39	121	159			
40–44	286	367	40–44	261	334	40–44	146	182			
45–49	364	419	45–49	330	381	45–49	174	209			
50–54	466	483	50–54	423	439	50–54	211	236			
55–59	597	550	55–59	544	500	55–59	253	261			
60 +	752	627	60 +	685	570	60 +	304	282			

APPENDIX III

Deductible, Premium and Drug Out-of-Pocket Maximum Subsidies*
Calendar Year 2013

Household Income	Maximum Deductible Discount	Premium Discount	Maximum Out-of-Pocket Drug Cost
HIRSP 1,000/2,500/5,000/7,500			
$34,000 and Above	No Discount	No Discount	$2,500
$30,000–34,000	$150	15%	1,500
$25,000–30,000	250	20	1,125
$20,000–25,000	350	25	850
$17,000–20,000	450	29	675
$14,000–17,000	550	34	575
$10,000–14,000	650	39	500
Less than $10,000	750	43	425
HSA 2,500/HSA 3,500			
$34,000 and Above	No Discount	No Discount	Not Applicable**
$30,000–34,000	$150	15%	"
$25,000–30,000	250	20	"
$20,000–25,000	350	25	"
$17,000–20,000	450	29	"
$14,000–17,000	550	34	"
$10,000–14,000	650	39	"
Less than $10,000	750	43	"
Medicare Supplement			
$34,000 and Above	No Discount	No Discount	$1,750
$30,000–34,000	"	10%	750
$25,000–30,000	"	10	500
$20,000–25,000	"	15	350
$17,000–20,000	"	20	300
$14,000–17,000	"	25	250
$10,000–14,000	"	30	200
Less than $10,000	"	35	150

*Medical Deductible Discount and Premium Discount columns show amount of reduction to regular HIRSP premium. Maximum Out-of-Pocket Drug Cost column shows the applicable out-of-pocket maximum, after the subsidy is applied.

**As the HIRSP HSA plans have a combined out-of-pocket maximum for medical services and prescription drugs, there is no subsidy for out-of-pocket drug expenditures alone.

APPENDIX IV

HIRSP Revenues, Expenses and Net Assets*
Calendar Years 2010 and 2011

	2010	2011
Operating Revenues		
Member Premiums	$81,525,797	$96,302,130
Insurer Assessments	30,955,033	43,579,955
Total Operating Revenues	*$112,480,830*	*$139,882,085*
Operating Expenses		
Medical Losses		
Gross Medical Losses	$116,070,719	$135,368,932
Provider Contributions	-33,005,722	-39,389,116
Unpaid Medical Loss Change	4,100,766	783,415
Total	$87,165,763	$96,763,231
Pharmacy Losses		
Gross Pharmacy Losses	$35,671,813	$41,914,460
Unpaid Pharmacy Loss Change	137,316	147,298
Total	$35,809,129	$42,061,758
Other Expenses		
General and Administrative Expenses	$6,725,423	$7,821,735
Referral Fees	112,325	154,400
Total Operating Expenses	*$129,812,640*	*$146,801,124*
Total Operating Income (Revenues minus Expenses)	**-$17,331,810**	**-$6,919,039**
Nonoperating Revenues and Expenses		
Federal Grant Revenue	$3,536,213	$2,502,217
Investment Income	71,280	213,979
Miscellaneous Income or Expense	-3,909	4,472
Total Nonoperating Income	$3,603,584	$2,720,668
Change in Net Assets (Operating and Nonoperating Income)	**-$13,728,226**	**-$4,198,371**
Net Assets		
Total Net Assets - Beginning of Year	$27,467,540	$13,739,314
Total Net Assets - End of Year	$13,739,314	$9,540,943

*****Does not include revenues or expenses for the HIRSP Federal plans.

APPENDIX V

2013 HIRSP Federal Plans
Monthly Premiums

Age	Rate	Age	Rate
Federal 500		**Federal 1,000**	
0–18	$189	0–18	$155
19–24	202	19–24	165
25–29	213	25–29	175
30–34	243	30–34	199
35–39	288	35–39	236
40–44	342	40–44	281
45–49	423	45–49	347
50–54	526	50–54	431
55–59	645	55–59	529
60 +	754	60 +	618
Federal 2,500		**Federal 3,500**	
0–18	$112	0–18	$94
19–24	119	18–24	100
25–29	126	25–29	106
30–34	143	30–34	120
35–39	170	35–39	143
40–44	202	40–44	170
45–49	250	45–49	210
50–54	310	50–54	261
55–59	381	55–59	320
60 +	445	60 +	374