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☞ Details: Informational Hearing: Health Insurance Risk Sharing Program (HIRSP), October 19, 1995

(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
- Executive Sessions ... **ES**
- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

Tommy G. Thompson
Governor

Josephine W. Musser
Commissioner

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

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Testimony relating to the Health Insurance Risk-Sharing Plan
before the
Senate Insurance Committee &
Assembly Committee on Insurance, Securities, and Corporate Policy
offered on behalf of Commissioner of Insurance Josephine W. Musser
by Peter C. Farrow, Insurance Administrator
on October 19, 1995

Good afternoon. Thank you Senator Schultz, Representative Albers and members of the committees for the opportunity to share information regarding the Health Insurance Risk-Sharing Plan (HIRSP). We commend the Insurance Committee chairs for their initiative in holding this informational hearing. I am Peter Farrow, Insurance Administrator for the Office of the Commissioner of Insurance (OCI). With me is Fred Nepple, General Counsel for OCI and Eileen Mallow, OCI Coordinator for the HIRSP program.

Our testimony will include HIRSP's legislative history, the development, the demographics, the enrollment, and the rates. We are also going to discuss the implications on the HIRSP program of court decisions involving the Employe Retirement Income Security Act of 1974, more commonly known as ERISA. We will conclude our formal remarks this afternoon by offering some options for consideration by the Legislature as they continue to address the HIRSP program.

HIRSP: Definition

HIRSP is a health insurance plan for persons under age 65 who are unable to obtain health insurance in the private market due to medical conditions. Under current plan structure, policyholders are required to pay for 60 percent of the plan's administrative and claims costs through premiums. Health insurance

companies fund the remaining plan costs through an assessment, which is based on each company's market share or percentage of health insurance premiums collected in the state.

HIRSP offers two individual plans for policyholders: Plan 1 and Plan 2. No family plan is offered. Plan 1 provides major medical coverage for individuals who need a standard, comprehensive major medical policy and who are not eligible for Medicare. Plan 1 covers about 85 percent of HIRSP policyholders. Plan 2 is a Medicare supplement policy for persons under age 65 who are eligible for Medicare by virtue of suffering from a long term or permanent physical or mental disability. Plan 2 covers about 15 percent of HIRSP policyholders. Policyholders of both Plan 1 and Plan 2 have a significant out-of-pocket expense through coinsurance and deductibles before HIRSP will cover costs.

HIRSP is governed by an eight-member Board of Governors (Board), consisting of: four representatives of the health insurance industry, three representatives of consumers, and the Commissioner of Insurance (Commissioner). The Commissioner serves as chair of the Board. The Board's duties and responsibilities include:

- selecting an administrator for the plan,
- setting and collecting assessments of insurers to cover the plan deficits,
- establishing a payment rate for covered plan expenses,
- publicizing the plan, and
- establishing a grievance procedure.

Oversight of the HIRSP program and the HIRSP administrator rests with OCI. In addition to the Commissioner's responsibilities as chair of the Board, OCI devotes one full-time staff person to oversee the program, ensure compliance with Wisconsin statutes, and serve as liaison with policyholders.

HIRSP: Legislative History

HIRSP was created by 1979 Chapter 313. The statutes governing HIRSP are set forth as subchapter two of chapter 619 in the Wisconsin statutes.

In the late 1970s, studies about the availability of health insurance for medically high-risk individuals in Wisconsin concluded that the number of uninsurable individuals was increasing steadily. As a growing number of higher risk individuals were unable to find health insurance coverage, many advocacy groups recommended that a mechanism be created to address that need.

Shortly thereafter, a Legislative Council study committee began to explore the concept of a state-run health insurance pool for medically high-risk individuals who were unable to obtain health insurance in the private market due to their physical or mental health condition. The legislative committee researched various models for structuring and financing such a pool and ultimately used Minnesota's program as the model for its proposal.

When HIRSP was created, the program was expected to be self-supporting through premiums. It was specified that after a three-year period of subsidy, provided through assessments on all health insurers and all self-insured health plans doing business in Wisconsin, HIRSP would become self-sufficient.

The Legislature intended to include self-funded employe benefit plans in the assessment base. As a result of subsequent litigation (General Split decision 523 F. Supp 427) and Supreme Court decisions, which held that the states may not deem an employe welfare benefit plan to be insurance for any type of state regulation, including assessments, the legislature eliminated self-insurers from the assessment base for HIRSP. The financing of HIRSP, therefore, was placed on HIRSP policyholders and the health insurance industry.

In 1984, the Board determined that the method in place for funding deficits was inequitable. The Board requested that the Legislature use general purpose revenue (GPR) as a funding base to offset any losses, and phase out the insurer assessment over four years. The recommended statutory changes were not adopted by the Joint Finance Committee as part of the 1985-1987 budget bill, and as such the assessment subsidy from insurers continued.

HIRSP: Eligibility

Current eligibility requirements have evolved from discussions by all involved parties. The requirements reflect advocacy groups' beliefs that eligibility should not be overly burdensome and insurers' desires to protect their eligible market share. An eligible HIRSP applicant must be a Wisconsin resident under age 65 and cannot be eligible for health care benefits provided by an employer, either on a self-funded or insured basis. In addition, the individual must satisfy at least one of the following criteria, in having a:

- notice of rejection or cancellation from a private health insurer;
- notice of a reduction or limitation in health insurance coverage. *This notice must represent a reduction in coverage when compared to coverage available to persons considered to be standard risk*;
- notice of a premium increase of 50 percent or more for a current policy, unless such increases apply to substantially all the insurer's health policies; and,
- notice of a premium rate increase for health insurance applied for but not yet in effect. *This notice must be from one or more insurers, and must exceed by at least 50 percent the premium charged to a person considered to be standard risk.*

There is a specific question on the application addressing the issue of coverage available through another source. If the applicant indicates that no other coverage is available, by answering, "no," and he/she has a denial letter from an insurer, the plan administrator issues the policy. While the plan administrator may

request confirmation by the employer, it does not have the authority to demand a response as to whether the person is eligible for coverage or not. Other than through the small employer health insurance plan, there is no requirement for employers to offer coverage to all of their employes. In fact, many insurers and employers limit eligibility for coverage to employes and their dependents who meet standards. Further, anti-discriminatory laws do not prohibit underwriting standards, which facilitate this activity.

A significant number of policyholders are enrolled in HIRSP because of rejection by private insurers. Monitoring of enrollment by the plan administrator has shown that since June 1995, 400 applications have been approved for enrollment and, of those, only 13 have cited a cancellation or reduction in benefits as a reason for enrollment. State law permits an additional assessment against insurers who cancel or reduce coverage of an existing policyholder. HIRSP, however, has not enforced this provision because of the high cost of collecting a relatively small amount with little positive market effect. Other states, such as Minnesota and New York, are considering altering their assessment practices to require higher contributions from insurers with higher rejection rates. Neither state, however, has developed a methodology for implementing this type of a change in assessments at this time.

HIRSP: Demographics

The Board has surveyed HIRSP policyholders several times to obtain their perceptions about the operation of HIRSP and to gather demographic data about the current subscriber population. Analysis of data obtained from a March 1993 subscriber survey showed the following:

- HIRSP has a relatively older population, with 51.9% over the age of 56.
- 57.2% of the policyholders are female.
- 62.6% individuals are married.
- 14.5% of the sample have two or more persons of the immediate family enrolled in HIRSP.
- 34.4% of the sample are from Madison and the Milwaukee metropolitan areas.
- 52.4% of the sample are employed.

- 51.5% of the sample have been enrolled in HIRSP for more than two years.
- 85.7% of the sample were actively seeking other insurance.
- 51.2% of the sample said their total covered expenses in one year were less than their deductible.
- Many respondents have ongoing expenses that are not covered by HIRSP:
    - 44.3% have dental costs that are not covered.
    - 30.3% have medication that is not covered.
    - 36.7% have optical costs that are not covered.

Survey results from the Spring 1991 survey also detail levels of satisfaction with HIRSP and yield information about the design and operation of HIRSP as perceived by subscribers:

- 78.7% of the sample found out about HIRSP through their insurance agent
    - 70.6% of those individuals feel that the agent provided a clear explanation of HIRSP.
- 90.2% of the sample felt that the policy and outline of coverage are clearly written.
- 83.2% of the sample reported satisfaction with claims service.
- 86.6% of the sample expressed satisfaction with benefit coverage levels.
- 66.5% of the sample expressed satisfaction with the premium cost.
- 58.6% of the sample felt that the deductible cost is too high.
- 83.6% of the sample reported satisfaction with the length of the preexisting conditions waiting period.

A 1995 survey of policyholders who had recently terminated from the HIRSP program examined the reasons for leaving HIRSP:

- 90% of the sample obtained other insurance, either through Medicare, individual coverage or an employer.
- 22% of the sample indicated that premium cost affected their decision to leave HIRSP.

HIRSP: Enrollment

At the start of the HIRSP program, it was difficult to project the number of eligible Wisconsin residents. Taking into consideration a number of factors, including: the benefit levels, the design of HIRSP, including the cap on lifetime payouts, the length of time for the waiting period for preexisting conditions, the eligibility criteria, and the financing of HIRSP, and the cost-sharing, enrollment was predicted to be between 3,000 and 5,000 individuals. To ensure awareness of HIRSP by potential applicants, an extensive education and outreach program for providers, advocacy groups, insurance agents, and others was deemed necessary.

Figures 1 and 2 show the enrollment growth in HIRSP from 1981 to 1993. As the figure shows, growth was steady but slow in the early years of the program. Enrollment grew dramatically from 1987 to 1992 due to factors such as increased awareness of HIRSP, growth in the size of the medically uninsurable population, and enhanced affordability of the product.

Recent analysis indicates that policyholders are staying with the plan longer. Between June 1994 and June 1995, the average length of time a policy stayed in force increased by 6 months — from 35 months to 41 months. The most recent data on policyholder persistency (December 1994) shows 4 of 45 policies issued in August 1981 were still in force. This data represents the longest any individual has been enrolled in the program.

FIGURE 1

POLICIES IN FORCE BY YEAR

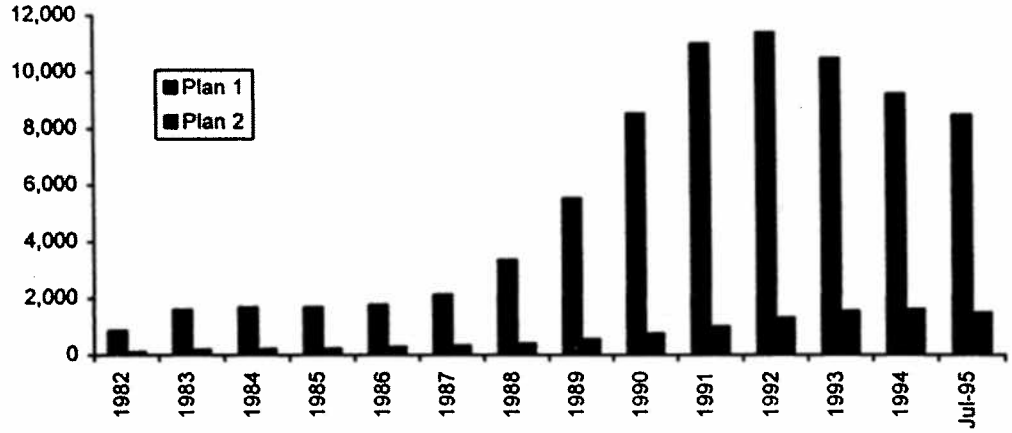
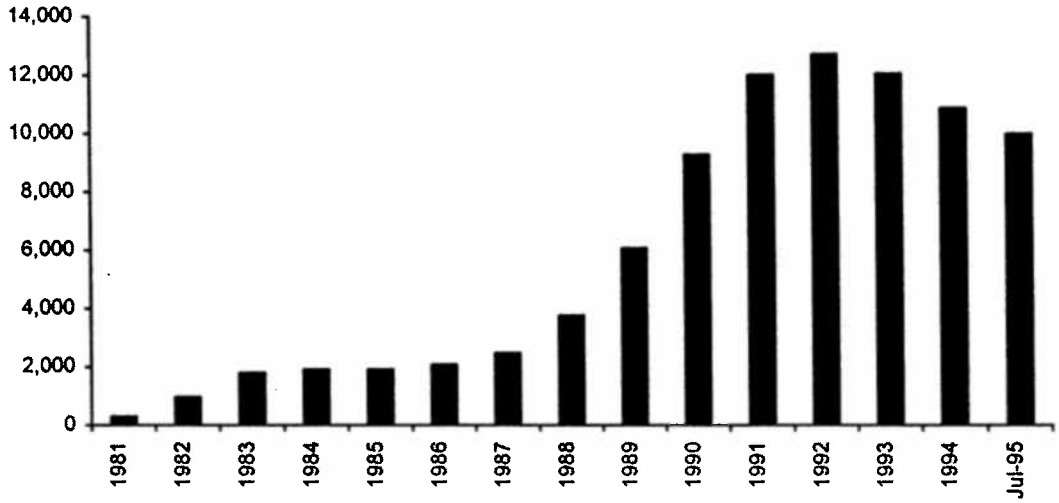


FIGURE 2

TOTAL POLICIES IN FORCE BY YEAR



During recent years, enrollment in the plan has declined significantly. Over the past four years, enrollment has declined approximately 20 percent.

HIRSP: Financing

There are three sources of funding for HIRSP:

- premiums paid by participants;
- state GPR which funds, in part, the premium and deductible subsidy program; and
- assessments of health insurance companies doing business in Wisconsin.

In addition, a 10 percent discount on approved provider billing for services covered by HIRSP, serves as a cost savings mechanism.

The original HIRSP legislation set a "cap" on subscriber premium rates for the first three years, yielding a rate of no more than 130 percent of the amount paid for standard health care coverage in the Wisconsin private market. In the 1983-1985 budget bill, the premium "cap" was increased to 150 percent. It was estimated that premium increases of 370 percent would be necessary for HIRSP to become self-sufficient. On January 1, 1987, rates were reduced by 10 percent, based on an actuarial study which showed that rates in effect at the time exceeded the statutorily required 150 percent of the standard rate.

In the fall of 1988, the Actuarial Committee to the Board recommended a rate increase because they found existing rates to be considerably below 150 percent of the standard rate. This rate increase was initially denied by the Legislature. On June 1, 1990, however, new rates went into effect. Costs to policyholders increased on average by 10 percent. In July 1991 rates increased further by 28 percent and the legislature changed the method by which HIRSP rates are calculated.

Instead of being fixed at 150 percent of standard rates, rates are now set to recover 60 percent of the program's operating and administrative costs. In July 1992, to more accurately reflect market cost, a three-zone rating schedule went into effect. The rating zones are determined based on age, gender, and

varying health care costs between rural and urban areas. Participants living in urban areas are assigned higher premiums because of the generally higher cost of health care in an urban setting.

The new rates for Plan 1, effective July 1, 1995, are shown in the following tables:

MAJOR MEDICAL PLAN ($)
Males

Age Group	Zone 1	Zone 2	Zone 3
0-24	$1,572	$1,416	$1,272
25-29	$1,608	$1,452	$1,284
30-34	$1,836	$1,656	$1,464
35-39	$1,944	$1,752	$1,560
40-44	$2,364	$2,136	$1,896
45-49	$2,928	$2,628	$2,340
50-54	$3,732	$3,360	$2,988
55-59	$4,776	$4,308	$3,816
60-64	$5,712	$5,148	$4,572

Zone 1: Milwaukee area; Zone 2: Southeast Wisconsin; Zone 3: Rest of state
Average premium rate changes over the years are reflected in Figure 3.

MAJOR MEDICAL PLAN ($)
Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,572	$1,416	$1,272
19-24	$2,232	$2,004	$1,788
25-29	$2,304	$2,064	$1,836
30-34	$2,520	$2,268	$2,016
35-39	$2,628	$2,376	$2,112
40-44	$2,880	$2,604	$2,316
45-49	$3,312	$2,988	$2,652
50-54	$3,792	$3,408	$3,036
55-59	$4,296	$3,876	$3,444
60-64	$4,956	$4,464	$3,960

Zone 1: Milwaukee area; Zone 2: Southeast Wisconsin; Zone 3: Rest of state
Average premium rate changes over the years are reflected in Figure 3.

As I stated, the Commissioner is required by statute to set premium rates, by rule, at a level that recovers 60 percent of plan costs. Due to rapidly changing factors in the rate calculation process, the setting of a target rate has not been easy. FY 94 was the last year that premiums covered 60 percent of costs; and, under the current rate structure, it does not appear as through FY 96 will meet the 60 percent target. The Board, which recommends a rate to the Commissioner, has been reluctant, at times, to propose high rate increases in recognition of the already high cost of the plan.

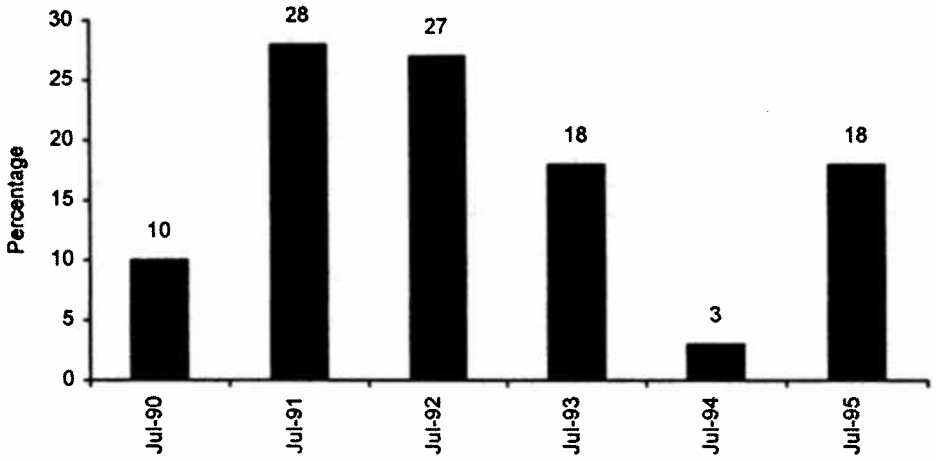
The annual rate-setting process typically begins in December with a review of present plan experience. The contracted actuarial consultant for HIRSP then determines the rate necessary to meet plan requirements. In the last year, a combination of a number of factors has made it hard to predict the rate necessary to recover 60 percent of plan costs. For example, the 1995 fiscal year rate resulted in a recovery of only 53.3 percent of plan costs. In January 1995, the actuary proposed a rate that recent experience showed would meet fiscal year 1996 requirements. By the time that 19 percent rate increase was implemented on July 1, 1995, the plan actuary predicted it was already 5 percent too low. By the September Board meeting, plan experience indicated that the 1996 rate may be as much as 17 percent to 25 percent too low.

As I stated a mid-year rate increase has never been done in HIRSP, and the Commissioner has expressed significant concerns that raising the premium rates before July 1996 would create significant affordability problems for many plan members and dramatically increase the depopulation of the plan.

According to HIRSP's actuarial consultant, premiums are now roughly 160 percent of standard market insurance rates.

FIGURE 3

AVERAGE PREMIUM INCREASES



Subsidies

Over the years it became increasingly clear to the Board that a number of individuals who were medically eligible for HIRSP were unable to afford the premiums and therefore remained uninsured. In addition, surveys of policyholders in 1982 and 1984 indicated that more than 50 percent had household incomes below $12,000, and that these individuals were undergoing severe personal financial hardship to pay premiums. In 1993, nearly one-half of surveyed respondents said they ended their HIRSP coverage because they could not afford the premium rates.

The Board requested that the Legislature provide GPR funds to extend relief to low-income policyholders, enabling them to continue their health insurance coverage. Consistent with the Legislature's intent to make affordable health insurance available to low-income Wisconsin residents, a fund was established effective July 1, 1985, to help low-income policyholders pay their HIRSP premiums.

Eligibility for premium reduction was initially based on an income level below $16,500, as defined by the Wisconsin Homestead Credit Form H. A sliding scale of percentage of premium reductions ranged from 6

percent to 30 percent. The first year the premium subsidy was in effect, 603 individuals applied and were found to be eligible, using $124,816 of the available funds for the first year of the program. On December 31, 1991, 2,688 individuals, about one-fourth of HIRSP enrollees, were enrolled in the subsidy program, with a total cost of $667,230. The premium subsidy program was expanded to include subsidizing of the $1,000 deductible paid by these policyholders. It is reduced by $0 to $500 depending on income.

In July 1992, when policyholders with an income level below $20,000 became eligible for a premium reduction, a new subsidy schedule went into effect. The subsidy is based on policyholder income and is graduated for incomes between $10,000 and $20,000. This change increased enrollment in the subsidy program to 3,780 individuals, an 8 percent increase, in December of 1992. The maximum subsidy allowed for policyholders with incomes under $10,000 is a reduction in the deductible to $500 per year and a 33.3 percent reduction in the premium. Slightly more than one-third of policyholders qualify for a subsidy. The following shows the impact of increasing the household income ceiling from $16,500 to $20,000.

The subsidy is funded by a GPR appropriation of $893,000 for FY 96 and $846,000 for FY 97. Any subsidy expenses that exceed available GPR are added to the assessment collected from the insurance industry. The subsidy amount was decreased for this biennium along with the across-the-board 5 percent decrease in all agency operations.

TOTAL HIRSP PREMIUM AND DEDUCTIBLE SUBSIDY PROGRAM PAYMENTS
STATE GENERAL PURPOSE REVENUE

Fiscal Year	Premium Subsidy	Deductible Subsidy	Total
1985-1986	$ 152,200	-	$ 152,200
1986-1987	208,900	-	208,900
1987-1988	225,500	37,100	262,600
1988-1989	343,800	80,400	424,200
1989-1990	609,700	128,700	738,400
1990-1991	895,200	203,800	1,099,000
1991-1992	1,569,500	240,100	1,809,600
1992-1993	1,569,500	240,100	1,809,600

The current subsidy levels can be broken down as follows:

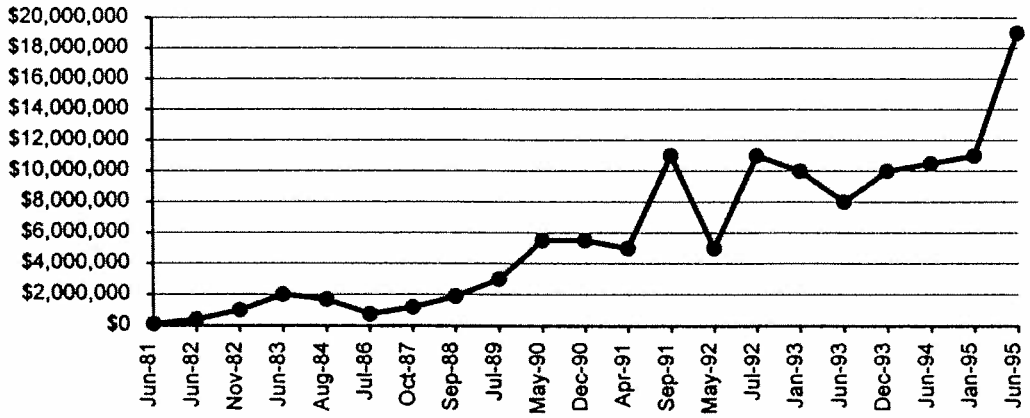
Policyholder Household Income	Reduced Premium
$0 to $9,999	100.0% of standard market rate
10,000 to 13,999	106.5% of standard market rate
14,000 to 16,999	115.5% of standard market rate
17,000 to 19,999	124.5% of standard market rate

Standard market rate comparisons apply only to those premium rates charged to policyholders receiving the subsidy for premium and deductible. These rates are a reflection of industry standard rates for a policy similar to HIRSP in coverage.

Since the inception of HIRSP in 1981, health insurers have been assessed to make up the difference between premiums collected and benefits paid. Figure 4 shows insurer assessments since the program began.

FIGURE 4

HIRSP ASSESSMENTS ON PARTICIPATING INSURERS



The magnitude of recent assessments has resulted in considerably more pressure by insurers to change the funding for the program. Industry assessments have increased as total plan costs increase.

Assessments are authorized by the Board and are intended to cover 40 percent of plan costs. The most recent assessment in June 1995 of $19 million was targeted to cover expenses during the June 1995 to January 1996 time period.

HIRSP: Claims Data

During FY 95 total claim payout incurred on behalf of HIRSP policyholders was approximately $47 million, an increase of almost 10 percent over FY 94. HIRSP premiums have been increasing as plan costs increase and the number of policyholders declines; a rate increase that averaged 19 percent was implemented on July 1, 1995.

Figures 5, 6, and 7 show the top 10 diagnostically related groups (DRGs) by incurred charges and total admissions, and the top 10 hospitals in overall payments, for January 1, 1994, to December 31, 1994, respectively.

FIGURE 5

HIRSP COMBINED TOP 10 DRGs BY COST
01/01/94–12/31/94

	DRG	Payments	Admits	Days	ALOS
112	Other Cardiovascular Procedure	$806,475	70	266	3.8
209	Major Joint Surgery Reconstruction	781,341	65	402	6.2
430	Psychoses	727,142	138	1,808	13.1
107	Coronary Bypass w/o Catheter	708,513	26	216	8.3
1	Craniotomy	520,936	22	201	9.1
468	Surgery Unrelated to Principal Diagnosis	458,028	31	323	10.4
106	Coronary Bypass w/Catheter	416,251	19	208	10.9
462	Rehabilitation	398,556	31	701	22.6
148	Major Bowel Surgery v/CC	343,414	22	306	13.9
214	Back/Neck Surgery w/CC	331,049	21	204	9.7
	Subtotal	5,491,705	445	4,635	10.4
Other DRGs		13,993,028	2,158	13,116	6.1
	Total	19,484,733	2,603	17,751	6.8

ALOS=Average Length of Stay

FIGURE 6

HIRSP COMBINED TOP 10 DRGs BY FREQUENCY
01/01/94–12/31/94

	DRG	Payments	Admits	Days	ALOS
430	Psychoses	$727,142	138	1,808	13.1
112	Other Cardiovascular Procedure	806,475	70	266	3.8
127	Heart Failure	246,701	68	332	4.9
209	Major Joint Surgery Reconstruction	781,341	65	402	6.2
435	Substance Abuse	101,275	53	262	4.9
182	Stomach/Intestine Infection w/CC	176,762	41	159	3.9
359	Hysterectomy	221,197	39	118	3.0
143	Chest Pain	101,779	38	78	2.1
88	Chronic Obstructive Pulmonary Disease	164,461	37	178	4.8
296	Nutr. & Metabolic Disorder w/CC	132,807	34	225	6.6
	Subtotal	3,459,940	583	3,828	6.6
Other DRGs		16,024,793	2,020	13,923	6.9
	Total	19,484,733	2,603	17,751	6.8

ALOS=Average Length of Stay

While DRG 430, psychoses, is the most frequent diagnosis of HIRSP policyholders, it is not the most costly. During calendar year 1994, 3 of the 10 most common DRGs cited for HIRSP policyholders were cardiac-related and accounted for about 10 percent of all inpatient charges. Claims paid for nervous and mental disorders during 1994 totaled $2.4 million, or approximately 5 percent of all HIRSP claims.

During 1994, 16 percent of HIRSP policyholders utilized the nervous and mental health benefits offered under the plan. The average age of policyholders who use the mental health benefit is younger than the average HIRSP policyholder (47 years old versus 51.4 years old for the average HIRSP policyholder). The policyholders also stay in the plan for slightly less time than the average HIRSP policyholder. During the time period since July 1993, approximately half of the policyholders who used the nervous and mental health benefit indicated they were employed when they first enrolled in the program. (NOTE: HIRSP only

collects employment data at enrollment and employment data is only available for policyholders who enrolled after July 1993.)

FIGURE 7

SUMMARY OF MOST FREQUENTLY UTILIZED INPATIENT FACILITIES
01/01/94–12/31/94

Facility	Total Payments	Total Admits	Total Days	Ave. Pd. per day
University Hospitals, Madison WI	$1,342,591	189	1,479	$907.77
St. Luke's Med. Ctr., Milwaukee WI	1,498,996	119	1,070	1,400.93
St. Joseph's Hospital, Marshfield WI	878,505	107	750	1,171.34
Froedtert Mem. Luth. Hsp., Milwaukee WI	842,971	83	693	1,216.41
Columbia Hospital, Milwaukee WI	1,083,329	78	757	1,431.08
St. Mary's Hsp. Med. Ctr., Madison WI	441,922	73	371	1,191.16
St. Vincent's Hospital, Green Bay WI	403,251	69	472	854.35
Lutheran Hospital, La Crosse WI	349,695	64	307	1,139.07
Meriter Hospital, Inc., Madison WI	424,726	64	443	958.75
Waukesha Mem. Hospital, Waukesha WI	482,870	58	442	1,092.47
Subtotal	7,748,856	904	6,784	1,142.23
Other Facilities	11,735,877	1,699	10,967	1,070.11
Total	$19,484,733	2,603	17,751	$1,097.67

HIRSP Cost Containment

HIRSP has implemented several cost containment programs. By statute, HIRSP reduces payment to every provider by 10 percent over the usual and customary payment. During the most recent fiscal year, this yielded approximately $4.4 million in savings. In addition, HIRSP contracts with Meridian Resource Corporation to audit hospital billings, provide case management services for high cost cases, and for prior authorization and concurrent stay review of hospitalizations. Prior authorization is not required to guarantee payment of a hospital claim, but the compliance rate is high.

The Board has begun work on a managed care plan. A managed care option was considered several years ago; the Board, however, was unable to develop a workable plan to distribute the risk of policyholders equitably across the health maintenance organizations (HMOs) and the effort was eventually abandoned. Concern about the rapidly escalating costs of the plan have prompted OCI and the Board to make new efforts toward developing a managed care plan. We expect that a form of managed care will be available by early next year. In addition, the plan administrator contract is due for rebid by July 1996. The bid specifications will call for the new plan administrator to make a managed care network available.

It is important to note that statutes only allow HIRSP to develop a voluntary managed care plan alternative.

HIRSP & ERISA

The federal Employe Retirement Income Security Act of 1974 (ERISA) restricts the authority of states in governing health care plans and is a major factor not only in the history of HIRSP but also in efforts to restructure it.

Recent court decisions involving ERISA impact the future of Wisconsin's HIRSP program. This afternoon, I am going to highlight and summarize the key provisions of ERISA and the ramifications of specific cases.

ERISA was enacted in 1974 primarily to regulate private pension plans, although it also applies to employer-sponsored health plans. ERISA contains a very broad provision preempting state laws that "relate to any employe benefit plan," including a health plan. This preemption clause, however, does not apply to "any law of a State which regulates insurance."

Since 1974, the courts have issues thousands of decisions on the question of whether a particular state law relates to an employe benefit plan and is, therefore, preempted. On two occasions, federal courts

have ruled on that issue with respect to HIRSP. Those cases provide the best guidance as to how ERISA preemption affects the state's authority to restructure HIRSP.

First, in 1982, the General Split case [General Split Corp. v. Mitchell, (D.C. 1981)] ruled that a state law imposing an assessment on self-funded employer health plans to partially fund HIRSP "related to" those plans, and therefore was preempted by ERISA. Via this ruling, direct assessments on self-funded plans are preempted.

Then, last month the Seventh Circuit Court of Appeals issued a decision in the Safeco case [Safeco v. Musser September 12, 1995], which stated that a state law imposing an assessment on insurers based on the premium they receive for stop loss policies issued to employers who sponsor self-funded health plans does not "relate to" the health plan.

The Safeco decision is important because it illustrates that under ERISA the state retains authority to establish funding mechanisms for HIRSP. More importantly, it illustrates how the state must structure a funding mechanism for HIRSP to withstand and ERISA challenge.

The Court of Appeals cited the U.S. Supreme Court decision in the Travelers case [New York Blue Cross v. Travelers Ins., 115 S.Ct. 1671 (1995)], which is among the cases explaining how ERISA limits the authority of the states. In doing so, it established how a state law "relates to" a health plan only if the law either makes reference to some aspect of the health plan's operations or its it has a "connection with" a health plan so as to dictate the health plan's administration or structure. The decision, therefore, supported the funding mechanism in that a state law is not "connected with" a health plan merely because the law indirectly imposes an economic burden on it.

In the Travelers case, the court determined that the payment of a higher cost for health care provider services by a health plan because of a tax imposed on the providers did not constitute a "connection with"

the health plan. Similarly, the court in the Safeco decision determined that a potential increase in premium charged to a health plan for a stop loss policy by a stop loss insurer did not constitute a "connection with" the health plan.

In both cases, the court concluded there was only an indirect economic burden, which did not regulate the health plan's structure or administration. Moreover, the tax or assessment did not "relate to" the health plan, and the state provisions were not preempted.

The Travelers and Safeco decisions illustrate how states may indirectly affect health plans without fear of ERISA preemption. Neither decision, however, suggests that the state may adopt a law that "references" health plans. To repeat, a direct assessment imposed on self-funded health plans would be preempted and this preemption could not be avoided by simply removing any references to health plans from the language of the statute. The courts are likely to look closely at any assessment or other funding mechanism which is measured by the operation of a health plan, regardless of whether there is a literal reference to health plans contained in the law.

ERISA is often complicated and unclear. Without clear guidance concerning the state's limitations, the courts' positions on ERISA appear complex. Yet the Supreme Court and the Seventh Circuit Court of Appeals have signaled a new willingness to broaden state authority in this area. The lack of clarity should encourage you to thoroughly explore the possibilities now afforded the state to take advantage of this trend.

Issues for Consideration

To further the discussion of where HIRSP should go from this point, I would like to quote from the summary of a 1993 Legislative Audit Bureau (LAB) audit of the plan. This audit has been quoted widely

over the last few months as the discussions over HIRSP have intensified. The conclusion of the audit stated:

> Rapidly rising medical costs, increasing demands on policyholders and the insurance industry to fund HIRSP's costs, and concerns that HIRSP is not available to many who need coverage will require the Legislature to analyze HIRSP's future direction and the level of support the State should provide to fund the plan. If the Legislature chooses to place a priority on availability and access, additional revenues will be required. Conversely, if the plan's rapidly rising medical costs continue to be a major concern, it may be necessary to place additional restrictions on the plan, such as mandating participation in managed health care, limiting the plan's enrollment, or limiting the plan's benefits. Ultimately, the ability to ensure affordable health insurance is available for all medically uninsurable may depend on the success of comprehensive state and national health care reforms.

The issues that led LAB to that conclusion in 1993 continue to exist, and the Legislative decisions regarding HIRSP's future also remain. What I would like to do is run down the range of options in restructuring the plan.

There are three basic ways in which the funding mix can be altered for HIRSP: reduce the cost component, raise subscriber premiums, and change the assessment mechanism.

Reducing Costs

There are three ways to reduce costs: reduce utilization through implementation of managed care, reduce reimbursement rates to providers, or reduce benefits to policyholders.

Managed Care

The Board has reviewed the implementation of managed care for the HIRSP population in the past. It is necessary to understand that the term "managed care" covers a varying range of programs from HMOs to preferred provider networks as well as utilization review and case management programs. As I stated, in 1993, Board members tried to develop a mechanism to allow contracting with HMOs in the state. Through

this mechanism, part of the HIRSP population would be placed into a voluntary managed care program. The proposal was complicated by the fear that HMOs would attract only the healthier members of HIRSP, thereby leaving behind an even sicker pool. This effort was abandoned because the Board could not determine a method for protecting against this occurrence without creating an overly bureaucratic system.

Current statute allows the Board and the Commissioner to implement a voluntary managed care program. The Board recently approved the inclusion of a managed care network component in the next HIRSP administrative services contract. The RFP for that contract will be issued later this year and will be implemented July 1, 1996.

OCI staff is also reviewing the current administrative services contract to determine the possibility of a more aggressive implementation schedule for a partial managed care program. The Board will be discussing this schedule at their next meeting.

Savings from the implementation of managed care are difficult to predict but will likely cut 10 percent or more from claims costs. Because of the lag in claims filing from date of occurrence, the full effect of any managed care implementation on July 1, 1996 will not be seen until late 1996 or early 1997.

The other option available would be a statutory change to allow the Board and the Commissioner to implement a mandatory managed care program. This program would, of course, have to account for the areas in the state that are not served by an HMO and would require a significant education effort for the HIRSP population.

Reduction in Provider Reimbursement

Reimbursements can be cut in two ways: either re-calculate the level at which HIRSP defines usual and customary rate (UCR) reimbursement, currently set at the 90th percentile, or increase the provider discount. Each has its advantages and disadvantages.

A cut in UCR reimbursement can be done as soon as January 1, 1996, with a change in policy contract language and does not require rule or statutory change. Providers would be able to balance bill subscribers for these cuts, thus increasing out-of-pocket costs for subscribers. If this were done, the Legislature could change statute to prevent providers from balance billing these costs to HIRSP enrollees.

Increasing the 10 percent discount which is applied to all bills would require a statutory change. Earliest possible implementation would be January 1, 1996, but more likely April 1 or July 1, 1996. By statute, policyholders are exempt from being billed for any portion of the 10 percent discount. Estimated savings from changes in either the UCR or provider discount depend on the magnitude of the change, but would likely range from $2 million annually to $4.5 million annually, which could be up to 10 percent of plan costs.

Reduction in Benefits

A reduction in policyholder benefits requires two primary things:

- statutory change, and
- a recognition that out-of-pocket expenses for policyholders will increase.

Raise Premiums

Premiums are set by the Commissioner via administrative rule. Rates are set annually on July 1, or the beginning of the fiscal year. A mid-year rate increase is possible, but has never been done. Due to contract language and system requirements by the plan administrator, the earliest possible effective date of a rate increase would be January 1, 1996.

As I mentioned, premiums are intended by statute to cover 60 percent of plan costs. Current estimates show premiums to be covering about 53 percent of costs, Commissioner Musser as well as many Board members have concerns about the affordability of a plan with higher premiums, resulting in more uninsured.

Changes in Assessment Formula

As the 1993 LAB audit restated, the original intent of the Legislature was to include self-funded benefit plans in the subsidization of HIRSP. This effort was blocked by ERISA. Recent court cases have increased the ability of creating a plan that will include all insurer groups.

The Board has delayed taking a position on any assessment expansion proposal to wait for the outcome of current negotiations between health insurers and medical providers. These negotiations are aimed at finding a mechanism to expand the assessment base to its original intent while remaining in compliance with federal law. Whatever the result of these negotiations, statutory changes would be required to implement any proposed shift in assessments. Depending on the structure of any proposed change, the earliest possible implementation would be in January 1997.

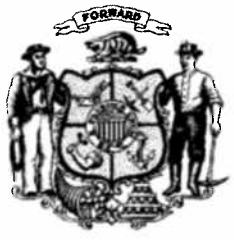
Health Insurance Reforms

The last vehicle to address the problems of HIRSP would be further reforms of the individual and group health insurance markets. One of the more significant effects of Governor Thompson's small group (2–25 employes) market reforms, which passed in 1991, is a decline in the HIRSP population. The market reforms require all small group insurers to write entire groups, without carving out sicker members, and guarantee renewability and a maximum rate variation from the lowest to highest priced group.

These reforms could be augmented by further reforms in the individual market or an expansion of the small group reforms to the larger group market. Reforms and HIRSP are significantly related. But, as members of the Legislature have encountered in previous reform debates, the effects of options need to be balanced carefully. For example, a guarantee issue provision in the individual market would eliminate the need for HIRSP, but would require a risk adjustment mechanism throughout the market to protect any one insurer from experience significantly adverse claims experience which would threaten the company's solvency.

Thank you for this opportunity to provide information on HIRSP. We would be pleased to answer your questions.

WISCONSIN STATE LEGISLATURE



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Testimony of:

Robert T. Wood
Member, HIRSP Board of Governors

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I. Introduction: The Heart of the HIRSP Problem

A. How Much Does the HIRSP Program Cost?

Over the last six years there has been more than a three-fold increase in the costs of the HIRSP program — from $13.7 million in Fiscal Year 1990 to $47.6 million in Fiscal Year 1995.

That's a 347 percent increase.

The following information is based on monthly report data submitted by the HIRSP administrator:

Fiscal Year	Total Expenses (not including deductible subsidies)	12-Month Average Population	Average Cost per Enrollee	Average Out-of-Pocket Premium Paid by Enrollees
FY 1990 (July 1, 1989 - June 30, 1990)	$13,776,083.60	6,261	$2,200.27	$1,319.05
FY 1991 (July 1, 1990 - June 30, 1991)	$25,383,477.31	9,653	$2,629.62	$1,342.76
FY 1992 (July 1, 1991 - June 30, 1992)	$39,117,067.51	12,121	$3,227.26	$1,558.40
FY 1993 (July 1, 1992 - June 30, 1993)	$41,771,376.88	12,755	$3,274.94	$1,864.59
FY 1994 (July 1, 1993 - June 30, 1994)	$46,126,837.00	11,981	$3,849.87	$2,163.71
FY 1995 (July 1, 1994 - June 30, 1995)	$47,611,384.08	10,797	$4,409.52	$2,138.83

The HIRSP population in August 1995, at a level of 9,996 individuals, is quite close to the average HIRSP population of 9,653 individuals in Fiscal Year 1991, but if HIRSP costs in July and August 1995 are even a rough predictor of total fiscal year costs, Fiscal Year 1996 HIRSP program costs will easily be double the Fiscal Year 1991 costs of $25.4 million, and will probably come in even higher than that, possibly in the $55 - 60 million range.

1. Charts and Data

a. Table: Average HIRSP Costs, Premiums and Subsidies for Calendar Years 1989 - 1994 and Fiscal Years 1990 - 1995, Showing Average HIRSP Costs Paid by Beneficiaries, by the State, and by Insurance Assessments
(See HIRSP Data Package, page 18)

b. Spreadsheet Data: HIRSP Revenues and Expenditures — Calendar Years 1992 - 1995, Fiscal Years 1993 - 1996
(See HIRSP Data Package, pages 1-8)

B. Who Pays What for HIRSP?

Beginning with the HIRSP rating period effective July 1, 1992, and thereafter, § 119.14 (5) (a), Wis. Stats., requires that "the commissioner shall set rates at 60% of the operating and administrative costs of the plan."

The Commissioner of Insurance has interpreted this statutory language to mean that:

- The premium charged to and paid by enrollees, plus the premium subsidies paid by State GPR, plus the premium subsidies paid by HIRSP insurance assessments shall be the amount intended by the statute to fund 60 percent of HIRSP operating and administrative costs.

- But that HIRSP premium and deductible costs shall not be included in determining the "operating and administrative costs of the plan."

Within these parameters, the HIRSP rate schedule adequately funded the HIRSP program in Fiscal Years 1993 - 1994 (July 1, 1992 - June 30, 1994).

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Against this background, the following information is based on monthly report data submitted by the HIRSP administrator:

Fiscal Year	Total Expenses	Total Paid by Beneficiaries	Total Paid by State GPR	Total Paid by Insurance Assessments
FY 1993 (July 1, 1992 - June 30, 1993)	$41,771,376.88	$23,782,547.57	$65,391.79	$17,923,437.52
FY 1994 (July 1, 1993 - June 30, 1994)	$46,126,837.00	$25,924,363.18	$1,505,454.72	$18,697,019.10
FY 1995 (July 1, 1994 - June 30, 1995)	$47,611,384.08	$23,093,887.58	- $0.00 -	$24,517,496.50

There are additional costs of HIRSP deductible subsidies which are not included in the above data.

Over the three fiscal years in question, these costs amounted to slightly less than $1.7 million, of which the State paid close to $370,000 and HIRSP insurance assessments paid approximately $1.3 million.

When these costs are taken into account, the data above is adjusted as follows:

Fiscal Year	Total Expenses	Total Paid by Beneficiaries	Total Paid by State GPR	Total Paid by Insurance Assessments
FY 1993 (July 1, 1992 - June 30, 1993)	$42,068,380.26	$23,782,547.57	$65,391.79	$18,220,440.90
FY 1994 (July 1, 1993 - June 30, 1994)	$46,903,378.40	$25,924,363.18	$1,875,000.00	$19,104,015.22
FY 1995 (July 1, 1994 - June 30, 1995)	$48,282,237.66	$23,093,887.58	- $0.00 -	$25,188,350.08

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1. Additional Background

HIRSP enabling legislation was enacted in 1980. The plan began operation in July 1, 1981.

HIRSP was originally intended to serve as an insurer of last resort.

HIRSP premium rates were originally intended to reflect and recover full program costs. To accomplish this, the legislation provided that HIRSP coverage could be priced at up to 150 percent of "standard" rates for comparable coverage in the marketplace.

The program worked relatively well through 1985, but during the fiscal years 1986-1990, the HIRSP Board was unable to obtain legislative agreement to keep premiums in line with program costs and in proper relationship with the costs of comparable coverage in the marketplace. Thus, for 5 years, there were no increases in Plan 1 premium rates.

Because there were no rate increases in HIRSP premiums for so many years, while the costs of health care and of all other health insurance premiums continued to rise, HIRSP premium rates lost any connection to HIRSP program costs, HIRSP became essentially low-cost insurance coverage in the marketplace, and by 1989 HIRSP was an increasingly attractive low-cost insurance option for individuals and for some employers.

As a result, HIRSP population growth increased exponentially, and program deficits mushroomed out of control. The HIRSP population more than tripled during 1989 to 1992, from just under 4,000 beneficiaries at the end of 1988 to just under 13,000 beneficiaries at the end of 1992. HIRSP deficits (that is the costs of the program not covered by the premiums paid by the individuals enrolled in HIRSP or by subsidy payments) over the same period increased almost six-fold.

The costs of the HIRSP insurance assessments are added to the costs of health insurance policies purchased by employers and individuals throughout Wisconsin. This is the direct equivalent of an indirect tax on insured health insurance benefits. The burden of this tax falls particularly heavily on small businesses in Wisconsin because the health benefit plans of many large self-insured employers are preempted from state regulation by federal law, and Wisconsin courts have interpreted this to preempt federally qualified self-insured plans from direct HIRSP insurance assessments.

Over the last six fiscal years, $96.6 million in HIRSP insurance assessments have been applied to pay the costs of HIRSP program deficits and (since Fiscal Year 1993) the costs of deductible subsidies:

FY 1990	$4.7 million	FY 1993	$18.2 million
FY 1991	$11.2 million	FY 1994	$19.1 million
FY 1992	$18.3 million	FY 1995	$25.1 million

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As these figures indicate, there has been more than a five-fold increase in HIRSP insurance assessments over the last six fiscal years.

For the first half of this period, HIRSP insurance assessments were levied only to pay the costs of program deficits.

Beginning in FY 1992, the State's contribution to HIRSP premium and deductible subsidies was capped. The cap was $1.85 million in the Fiscal Year 1992/1993 and 1994/1995 budgets, and is $1.7 million in the Fiscal Year 1996/1997 budget. Additional HIRSP insurance assessments are used to pay the costs of premium and deductible subsidies in excess of the State caps on GPR.

Since the state's funding of HIRSP subsidies was capped in FY 1992, HIRSP insurance assessments have added an additional $6.4 million HIRSP tax, an indirect tax, to the costs of health insurance policies purchased by employers and individuals throughout Wisconsin.

Again, this is an indirect tax which does not fall on the health benefit plans of most large self-insured employers (including the Wisconsin State Employes Health Benefit Plan) which are preempted under federal ERISA law from direct State regulation.

Because of the increasingly onerous burden of the HIRSP deficits, beginning in 1989, the HIRSP Board of Governors began to develop legislative recommendations intended to bring HIRSP premium rates more into line with program costs, to slow uncontrolled growth of the HIRSP population, and to reestablish HIRSP more closely along the lines of its original intent as an insurer of last resort.

Many of the Board's original recommendations were enacted into law in the August 1991 Budget Bill. As a result, we have seen some changes for the better in HIRSP operations. The growth of the HIRSP population stabilized during 1993, and has slowly declined since then to roughly the level of 1991 enrollments.

Program deficits appeared at the end of calendar year 1994 to have roughly stabilized, but the problems with inadequate rate schedule funding of HIRSP operating and administrative costs have resulted in the largest program deficit and the highest level of HIRSP insurance deficits in the program's history at the end of Fiscal Year 1995.

The Fiscal Year 1995 rate schedule appears to have been inadequate to fund required costs, at least in part, because a declining HIRSP population is, on average, using a greater volume or a more costly mix of medical services.

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2. Charts and Data

a. Rate Schedule Funding of 60% of Plan Operating and Administrative Costs

(1) Chart: HIRSP Rate Schedule Funding of 60% of Plan Operating and Administrative Costs — Fiscal Year Performance — Monthly and Cumulative Surplus/(Shortfall), Fiscal Years 1993, 1994, 1995, 1996
Table: HIRSP Rate Schedule Funding of 60% of Plan Operating and Administrative Costs — Surplus/(Shortfall), Fiscal Years 1993, 1994, 1995, 1996 — Fiscal Year Performance
(See *HIRSP Data Package*, pages 9, 10)

(2) Chart: HIRSP Rate Schedule Funding of 60% of Plan Operating and Administrative Costs — Cumulative Performance — Monthly and Cumulative Surplus/(Shortfall), Fiscal Years 1993, 1994, 1995, 1996
Table: HIRSP Rate Schedule Funding of 60% of Plan Operating and Administrative Costs — Surplus/(Shortfall), Fiscal Years 1993, 1994, 1995, 1996 — Cumulative Performance
(See *HIRSP Data Package*, pages 11, 12)

b. Who Paid What

(1) Chart: HIRSP — Who Paid What
Chart: HIRSP Program Costs
Table: Health Insurance Risk Sharing Plan (HIRSP) — Who Paid What
(See *HIRSP Data Package*, pages 13, 14, 15)

(2) Chart: Average HIRSP Costs Paid by Beneficiaries, the State and by Insurance Assessments
Chart: 12-Month HIRSP Assessments for Deficits and Subsidies
Table: Average HIRSP Costs, Premiums and Subsidies for Calendar Years 1989 - 1994 and Fiscal Years 1990 - 1995 Showing Average HIRSP Costs Paid by Beneficiaries, by the State and by Insurance Assessments
(See *HIRSP Data Package*, pages 16, 17, 18)

(3) Chart: Total HIRSP Subsidy Obligations — Fiscal Years 1993, 1994, 1995, 1996
Chart: HIRSP Premium Subsidy Obligations — Fiscal Years 1993, 1994, 1995, 1996
Chart: HIRSP Deductible Subsidy Obligations — Fiscal Years 1993, 1994, 1995, 1996
(See *HIRSP Data Package*, pages 19, 20, 21)

c. HIRSP Deficits

(1) Chart: HIRSP Premium Deficit, January 1989 - August 1995
(See *HIRSP Data Package*, page 22)

(2) Chart: Chart: HIRSP Premium Deficit, January 1989 - August 1995
(See *HIRSP Data Package*, page 23)

(3) Chart: HIRSP Premium Deficit, January 1992 - August 1995
(See *HIRSP Data Package*, page 24)

C. Who Does the HIRSP Program Serve?

A total population of 9,996 individuals was enrolled in HIRSP in August 1995, made up of 56.5 percent females and 43.5 percent males, with slightly more than 60 percent of the population aged 50 - 64 years, and nearly half of that group (close to 30 percent of total plan population) aged 60 - 64 years. In this highest age band, at ages 60 - 64 years, HIRSP enrollees are 65.7 percent female and 34.3 percent males.

In August 1995, approximately 35 percent of the HIRSP population (3,484 out of 9,996 individuals) who had eligible household income under $20,000 were receiving HIRSP subsidies. The HIRSP subsidy population tends to be more predominantly female than the HIRSP non-subsidy population, particularly in the highest age band, at ages 60 - 64 years, where the HIRSP subsidy population is 74.4 percent female and 25.6 percent male.

In December 1994, the longest amount of time an individual still enrolled in HIRSP had been enrolled was 13 years and 6 months. At that time, two individuals who had enrolled in Plan II in July 1981(the first month of plan operation) were still enrolled in HIRSP.

Also in December 1994, the *1994 HIRSP Annual Report* ("Persistency Report," pages 6, 7) indicates that for the Plan I population, and only for the Plan I population:

- In any month more than two years prior to December 1994, there is no month in which 50 percent or more of individuals with Plan I coverage that became effective in that month were still enrolled in HIRSP.

- In any month less than two years prior to December 1994, there is no month in which less than 50 percent or more of individuals with Plan I coverage that became effective in that month were still enrolled in HIRSP.

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There have been significant changes in the HIRSP population over the last six or seven years. The most important of these changes can be summarized as:

- Rapid growth followed by slow but steady decline in the HIRSP population:
  - The HIRSP population of 3,852 individuals in January 1989 grew more than three-fold during the 53-month period January 1989 - May 1993.
  - HIRSP population growth peaked in May 1993 at a population of 12,838 individuals.
  - There has been a 22 percent decline in the HIRSP population during the 27-month period June 1993 - August 1995. Most of the net loss in the HIRSP population has occurred in Plan I. In August 1995 the total HIRSP population was 9,996 individuals, a level quite close to the Fiscal Year 1991 average HIRSP population of 9,653 individuals.
- A four-fold increase in the HIRSP subsidy population:
  - From a base of 832 individuals receiving HIRSP subsidies in January 1989, the HIRSP subsidy population continued to grow through May 1993 to a population of 3,826 individuals receiving HIRSP subsidies, and now appears to be stabilizing at approximately 3,500 individuals receiving HIRSP subsidies. In August 1995, the HIRSP subsidy population of 3,484 individuals receiving HIRSP subsidies was more than four times the size of the HIRSP subsidy population in January 1989.
  - From January 1989 through June 1992, the HIRSP subsidy population fluctuated within a range of about 20 - 24 percent of the total HIRSP population.
  - During the period July 1992 through January 1995 the percent of individuals receiving HIRSP subsidies increased steadily to 35 percent, and appears to have stabilized at roughly 35 percent of the total HIRSP population though August 1985.

1. **Charts and Data**

   a. HIRSP Population

      (1) Chart: HIRSP Population, January 1989 - August 1995
      Table: HIRSP Population Data
      (See *HIRSP Data Package*, pages 25, 26)

(2) Chart: HIRSP Applications Received, January 1989 - August 1995
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(3) Chart: Net Growth/(Loss) of HIRSP Enrollments, January 1989 - August 1995
(See *HIRSP Data Package*, page 28)

(4) Chart: HIRSP Policies Issued and Canceled, January 1989 - August 1995
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(5) Chart: Reasons for Cancellation of HIRSP Policies, July 1994 - June 1995
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(See *HIRSP Data Package*, pages 30, 31)

(6) Chart: HIRSP Non-Subsidy Population — Age Distribution, August 1995
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b. HIRSP Subsidy Population

(1) Chart: Number of HIRSP Enrollees Receiving Subsidy, January 1989 - August 1995
(See *HIRSP Data Package*, page 32)

(2) Chart: Percent of HIRSP Population Receiving Subsidies, January 1989 - August 1995
(See *HIRSP Data Package*, page 33)

(3) Chart: HIRSP Subsidy Population — Age Distribution, August 1995
(See *HIRSP Data Package*, page 35)

(4) Chart: HIRSP Subsidy Population — Income Distribution, August 1995
(See *HIRSP Data Package*, page 36)

(5) Chart: HIRSP Subsidy Population — Subsidy Received, January 1992 - August 1995
(See *HIRSP Data Package*, page 37)

(6) Chart: HIRSP Subsidy Population — Age Distribution, January 1992 - August 1995
(See *HIRSP Data Package*, page 38)

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II. Critical Operations and Policy Issues Currently Before the HIRSP Board of Governors, and to be Discussed at the October 24, 1995 Meeting of the Board

A. Schedule for Recommended Emergency Rule Implementation of the Board-Approved 5% Increase in the HIRSP Premium Rate Schedule to be Effective January 1, 1996

As noted in sections I.B. and I.B.2.a., above, the Fiscal Year 1995 HIRSP premium rate schedule failed to adequately fund 60 percent of HIRSP operating and administrative costs, and it is virtually certain that the Fiscal Year 1996 HIRSP premium rate schedule will fall far short of funding 60 percent of HIRSP operating and administrative costs.

The HIRSP premium rate schedule funded only 53.3 percent of HIRSP operating and administrative costs in the fiscal year which ended June 30, 1995, and has funded only 47.0 percent of HIRSP operating and administrative costs in the first two months of the current fiscal year.

This non-compliance with statutes has resulted in the fiscal year just ended in HIRSP insurance assessments for plan deficits roughly $3.2 million more than would be expected under the HIRSP statutes.

Data for July and August 1995 suggest that in the current fiscal year HIRSP insurance assessments for plan deficits could easily be in the range of $5 - 7 million more than would be expected under the HIRSP statutes.

The subject of the inadequacy of the current Fiscal Year 1996 rate schedule to fund 60 percent of HIRSP operating and administrative costs has been under HIRSP Board of Governors continuing review and discussion since June 1, 1995.

The HIRSP Board of Governors, at their meeting on September 15, 1995, approved a motion recommending that not later than October 31, 1995, the Commissioner of Insurance implement by emergency rule a 5 percent supplemental premium rate increase effective January 1, 1996 to bring the Fiscal Year 1996 HIRSP premium rate schedule into better compliance with statutes, unless the Board can be provided at their October 24, 1995 Board meeting with some other better way to effectively bring the Fiscal Year 1996 rate schedule into compliance with statues.

B. Report on Depletion of Assessments Collected and Schedule for Board Assessment Actions to Fund Statutory Insurance Assessment Share of Fiscal Year 1996 (July 1, 1995 - June 30, 1996) Plan Operating and Administrative Costs

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The HIRSP Board of Governors, at their meeting on October 24, 1995, will review deficits in plan operating and administrative costs, and discuss the scheduling of board assessment actions to fund the appropriate statutory insurance assessment share of Fiscal Year 1996 (July 1, 1995 - June 30, 1996) plan operating and administrative costs.

C. **Schedule for Board Actions to Approve HIRSP Premium Rate Schedule Actions for Fiscal Year 1997 (July 1, 1996 - June 30, 1997)**

The HIRSP Board of Governors, at their meeting on October 24, 1995, will review planning and related Board actions needed to approve, at their December 1995 meeting, HIRSP premium rate schedule actions for Fiscal Year 1997 (July 1, 1996 - June 30, 1997).

D. **Report of Third-Party Discussions to Agree on Proposed Changes in Chapter 619 Statutory Provisions Governing HIRSP Deficit Assessments and Related Board Actions to Approve These and Other Legislative Recommendations**

1. **Expansion and Reconfiguration of the HIRSP Assessment Base**

It appears clear that it was the Legislature's intent in the original legislation enabling HIRSP to establish a broadly based and administratively simple mechanism for deficit assessments on all state health care payers which would help to fund HIRSP operations in the first three years of plan operations.

To accomplish this, the original enabling legislation created an assessment base that included all health insurers, including self insured health benefit plans. The Legislature's clear intent to levy insurance assessments on self-insured health benefit plans was subsequently set aside by a successful claim of ERISA preemption of the provisions of State law at issue.

Since then, the HIRSP Board of Governors has at various times discussed various legislative options to expand the HIRSP assessment base.

Extended discussions by the HIRSP Board on this subject were among a broad range of proposed HIRSP reforms brought before the HIRSP Board in 1989.

As these discussion were proceeding, on October 5, 1989 , the Chair of the Senate Committee on Labor, Business, Insurance, Veterans' and Military Affairs and the Senate and Assembly co-chairs of the Joint Committee for the Review of Administrative Rules

instructed the HIRSP Board of Governors, with regard to discussion of "modifications to the current law governing HIRSP," that:

> "At this time, the Board of Governors should carefully review four areas including... the mechanism used to fund plan deficits... **It would be appropriate for the HIRSP board to consider** options for deficit management including capping assessments, altering the allotment of costs or **expanding the assessment base beyond insured plans**." (emphasis added)

In responding to this direction by the Legislature, the HIRSP Board discussed expanding the HIRSP assessment base to include hospitals and other providers of health care services. In the event, the Board did not include such a recommendation in the legislative proposal approved by the Board on February 23, 1990.

In March 1993, the Legislative Audit Bureau published "*An Evaluation of Health Insurance Risk Sharing Plan*" which recommends in "*Plan's Future Direction*" (p. 32):

> "If **the Legislature** chooses to place a priority on availability and affordability to those already being served by the plan and to consider expanding it to those currently excluded from coverage, it **may need to consider** increasing the amount of GPR or **providing other sources of revenue... [by] expanding the assessment base...**" (emphasis added)

In the spring of 1995, HIRSP Board members proposed renewed consideration of expansion of the HIRSP assessment base in light of a recent U.S. Supreme Court decision that appeared to offer a new foundation for needed changes in the HIRSP statutes.

HIRSP Board actions on this subject since then can be summarized as follows:

- Consideration of changes to the HIRSP statutes to include expansion of the HIRSP assessment base to hospitals and other providers of health care services was agreed to during discussions at the July 12, 1995, meeting of the HIRSP Board of Governors.

- A discussion draft of proposed changes to the HIRSP statutes to include expansion of the HIRSP assessment base to hospitals and other health care providers was laid before the HIRSP Board of Governors on August 15, 1995. The HIRSP Board referred the discussion draft for further consideration to HIRSP Administrative Review Committee meetings scheduled on August 22 and 31, 1995, invited input from interested parties at those meetings, and scheduled related follow-up review by the HIRSP Board on September 15, 1995.

- At the HIRSP Board of Governors meeting on September 15, 1995, the HIRSP Board tabled the discussion draft to allow third parties to present alternative recommendations to the Board not later than October 24, 1995, based on discussions in process between the Wisconsin Association of Life and Health Insurers, the Wisconsin Association of HMO's, the Wisconsin Hospital Association, and the State Medical Society.

2. **Technical Statutory Changes and Corrections Affecting HIRSP Benefits (LRB-1644/3)**

   The HIRSP Board has endorsed draft legislation (LRB-1644/3) which makes technical corrections to HIRSP benefits. The Board believes these changes are non-controversial and will, in general, not be noticed by the HIRSP population.

3. **Reconsideration of the Methodology Used to Set Rates for the HIRSP Subsidy Population**

   The HIRSP Board has considered in the past, and may wish to reconsider and recommend to the Legislature changes in HIRSP statutes that would:

   - Change the calculation of rate increases for persons receiving HIRSP subsidies so that the percentage rate increases for the subsidy and non-subsidy HIRSP populations in any rating period would be, on average, roughly equivalent.

E. **Schedule for Release of the Request for Proposal for HIRSP Administrative, Managed Care and Other Contracted Services (July 1, 1996 - June 30, 1999) and Related Procurement Actions by the Office of the Commissioner of Insurance**

Transition of the HIRSP Population to a Managed Care Environment

The HIRSP Board of Governors, at their meeting on October 24, 1995, will review planning and related Board actions needed to support timely Board review and approval of the draft Request for Proposal for HIRSP Administrative, Managed Care and Other Contracted Services (July 1, 1996 - June 30, 1999), which is being developed by the Office of the Commissioner of Insurance.

The Board is particularly interested in features of this procurement which can be used to initiate and hopefully expedite transition of the HIRSP population to a more cost effective managed care environment.