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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**
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INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

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- 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)

WISCONSIN LEGISLATIVE COUNCIL STAFF MEMORANDUM

One East Main Street, Suite 401; P.O. Box 2536; Madison, WI 53701–2536
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DATE: October 19, 1995

TO: REPRESENTATIVE SHERYL ALBERS, CHAIRPERSON, ASSEMBLY COMMITTEE ON INSURANCE, SECURITIES AND CORPORATE POLICY

FROM: Gordon A. Anderson, Senior Staff Attorney

SUBJECT: Legislative Audit Bureau Report 93-10, Relating to the Health Insurance Risk Sharing Plan

This memorandum provides a brief description of the suggestions and recommendation made in Legislative Audit Bureau (LAB) Report 93-10, *An Evaluation of the Health Insurance Risk Sharing Plan (HIRSP)*. This memorandum describes both the single recommendation made by the LAB and the items suggested for consideration by the Board of Governors or the Legislature. Each recommendation or suggestion is described under the appropriate subject heading taken from the Report.

A. PLAN STATUS

1. Limits on Accessibility

The LAB Report notes that Wisconsin places limits on eligibility and benefits, including age limits, waiting periods and maximum benefit levels. And although those limitations were found by the LAB to be comparable to those in other states, the Report notes that consumer and patient representatives expressed concern that these provisions limit access to health care or cause financial hardship for individuals. The Report stated that the Legislature may want to consider expanding HIRSP or easing its eligibility requirements to meet these needs, "although such steps are likely to further increase HIRSP costs."

2. Waiting Periods

The Report notes that the financial hardships that may result from a waiting period for newborns is a concern. The Report notes that the Board of Governors requires that a medical condition existing when a baby is born must be treated as a pre-existing condition subject to the

six-month restriction when the parents apply for HIRSP coverage of the child. The LAB also noted that 1991 Wisconsin Act 23 requires every health insurance policy to provide coverage of a newly born child of the insured from the moment of birth regardless of whether the policy covers other dependents and that the Board intends to seek an exemption from this provision because HIRSP does not provide family coverage.

B. CONTROLLING PLAN COSTS

1. Additional Insurer Assessments

The Board noted that there is a $1,750 assessment created by the Legislature to discourage insurers from discontinuing or substantially reducing coverage for high-risk individuals who are, as a result, forced into HIRSP. The Report notes that since the date of enactment, August 1991, no assessments had been levied and it appeared that there would be few, if any, in the future. The Report suggests that:

a. The Board could identify insurers who should face additional assessments when their underwriting practices result in individuals becoming eligible for HIRSP, by amending the HIRSP application to request additional information on the status of the applicant's previous health insurance coverage.

b. When applicants are likely to need costly medical care, insurers may be more willing to pay $1,750 than to assume large risks, consequently, to create an effective deterrent, the Legislature may need to establish a significantly higher assessment level.

2. Reduced Payments to Providers

The LAB Report notes that 1991 Wisconsin Act 269 reduced payments to providers of care to HIRSP participants by 10% and that providers felt that this is unfair. It noted that at least 10 other states' risk sharing plans have provider representation on their governing boards. The Report states that if the Legislature believes health care provider participation could help identify other ways to reduce HIRSP's medical costs, it could amend the statutes to provide for health care provider representation on the Board of Governors.

3. Hospital Preadmission Review

The Report notes that the Office of the Commissioner of Insurance (OCI) has contracted with a private firm to review medical necessity of hospital admissions for HIRSP policyholders. However, the effect has been limited according to the Report. The Report recommends several steps to take to increase savings from a hospital preadmission review process:

a. The Board could establish incentives to encourage policyholder compliance with a preadmission review requirement. If there is concern about financial hardship, the provision could be structured to reduce the penalty for policyholders who receive premium subsidies or to waive the penalty if a policyholder demonstrates to the Board that the penalty would result in

"undue hardship." As an alternative, the Board could establish lower penalty levels for first instances of noncompliance and higher levels for cases of repeated noncompliance.

b. The Board may also want to consider extending the preadmission review process requirement to other areas of potentially high cost medical procedures, for example, for home health care, durable medical care and hospice use.

c. At a minimum, the Board of Governors needs to improve reporting by the utilization review firm, so that it can better assess and identify ways to improve the effectiveness of the hospital review process.

d. The Board needs to require increased coordination and exchange of claims information between the plan administrator and the utilization review board and, therefore, the LAB **recommended** that the Board establish reporting requirements that assist in assessing and improving the effectiveness of the preadmission review process. [This is the only "recommendation" made by the LAB.]

4. Managed Care Plans

The Report notes that the Board was considering various incentives to encourage policyholders to select managed care plans and was considering lower deductibles or copayments because the Board does not believe the statutes allow it to differentiate policy premium rates based on participation in a health maintenance organization (HMO) or preferred provider organization (PPO). The Report recommends, as an alternative, that the Legislature may need to consider mandating the use of managed care plans if a sufficient number of policyholders do not voluntarily choose those options.

C. FUTURE CONSIDERATIONS

1. Affordability Concerns

The Report notes that the Legislature could consider various options to address concerns about future affordability and equity of premiums, including returning the premiums to a market-driven formula and expanding the subsidy program. However, unless other changes are made, these steps are likely to shift the costs back to the insurers, "which have experienced significant increases in their assessments and are likely to strongly resist efforts to further increase their assessments."

2. Plan's Future Direction

The Report notes rising medical costs, increasing demands on the policyholders and insurance industry to fund HIRSP costs and the concerns that HIRSP is not available to those in need of its coverage require the Legislature to analyze HIRSP's future direction and level of support the state should provide to HIRSP. The Report suggests that:

a. If the Legislature chooses to place a priority on availability and affordability to those already being served by the plan and consider expanding it to those currently excluded coverage, it may need to consider increasing the amount of general purpose revenue (GPR) for HIRSP or providing other sources of revenue.

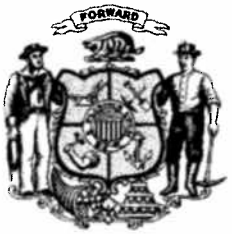
b. Conversely, if the rising costs continue to be a major concern, it may be necessary for the Legislature to place additional restrictions on HIRSP, control costs such as through penalties to encourage compliance with the HIRSP preadmission review process, and consider eliminating the current fee-for-service plan and offering only managed care plan options with significant penalties for policyholders who do not use HIRSP's selected providers.

Further, the Legislature may want to consider steps that other states have taken to limit the size of their plans, such as limiting the number of individuals enrolled in HIRSP based on available funding, limiting the amount of available benefits in a year and increasing the policyholders' deductible and copayment levels, which have remained unchanged since HIRSP was created, "although higher deductible and copayment levels will also reduce the plan's affordability for some individuals."

If you have any questions or if I can be of any further assistance, please let me know.

GAA:ky:wu;kja

WISCONSIN STATE LEGISLATURE



SPECIAL REPORT

The Wisconsin Health Insurance Risk Sharing Plan (HIRSP)

1981—1993

IP32-94

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THE WISCONSIN HEALTH INSURANCE RISK-SHARING PLAN
1981-1993

BACKGROUND

The Health Insurance Risk-Sharing Plan (HIRSP) was enacted by the Wisconsin Legislature as part of the Laws of 1979, and is set forth at Subchapter II of ch. 619, Wis. Stat. HIRSP is governed by an eight-member Board of Governors (Board), made up of four representatives of insurers, three public members, and the Commissioner of Insurance. The Commissioner serves as the chair. A list of current Board members is attached as Appendix 1. The Board's duties and responsibilities include: (1) selecting an administrator for the plan, (2) setting and collecting assessments of insurers to cover the plan deficits, (3) establishing a payment rate for covered plan expenses, (4) publicizing the plan, (5) establishing procedures under which applicants and policyholders may have grievances reviewed by an impartial body, and (6) reporting to the legislature on the operation of the plan.

Efforts to initiate this legislation came largely from the Center for Public Representation, a Madison-based public interest law firm, with the assistance of many advocacy groups such as the Wisconsin Epilepsy Foundation, the Mental Health Association in Wisconsin, and the Curative Workshop of Milwaukee. In the late 1970s, the Center for Public Representation had engaged in numerous studies with regard to the availability of health insurance to medically high-risk individuals in Wisconsin. They concluded that many individuals were uninsurable and this number was increasing steadily. Due to the private market's failure to provide insurance to higher risk individuals, the center recommended that a mechanism be created to ensure health care coverage for the uninsurable.

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 committee researched various models for structuring and financing such a pool. They focused on the states of Connecticut and Minnesota, which were at that time the only two states that had any type of pooling mechanism in effect. Minnesota ultimately served as the model for the Legislative Council's proposal.

At the same time that the Legislative Council was preparing this bill, a number of legislators also took interest in this issue. Several competing bills were introduced in late 1979 and early 1980. As a result of compromises among the sponsors, the current law evolved and was enacted, and the first HIRSP policies became available in July 1981.

At the start of the program the number of Wisconsin residents under age 65 who were unable to purchase adequate health insurance due to their health condition and therefore would be eligible for HIRSP was difficult to project; enrollment of approximately 3,000 to 5,000 individuals was not considered to be an unrealistic estimate by those involved in the process. It was obvious that a number of factors would have an impact on these estimates: 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, the financing of HIRSP, and the cost-sharing. In addition, it would be necessary to mount an extensive education and outreach program for providers, advocacy groups, insurance agents, and others to ensure that potential applicants were made aware of HIRSP.

Two major medical policies are currently available to eligible persons under HIRSP: Plan 1 and Plan 2. Plan 1 is for individuals who need a standard, comprehensive major medical policy and are not eligible for Medicare. Plan 2 is for individuals under age 65 who are eligible for Medicare by virtue of suffering from a long-term or permanent physical or mental disability.

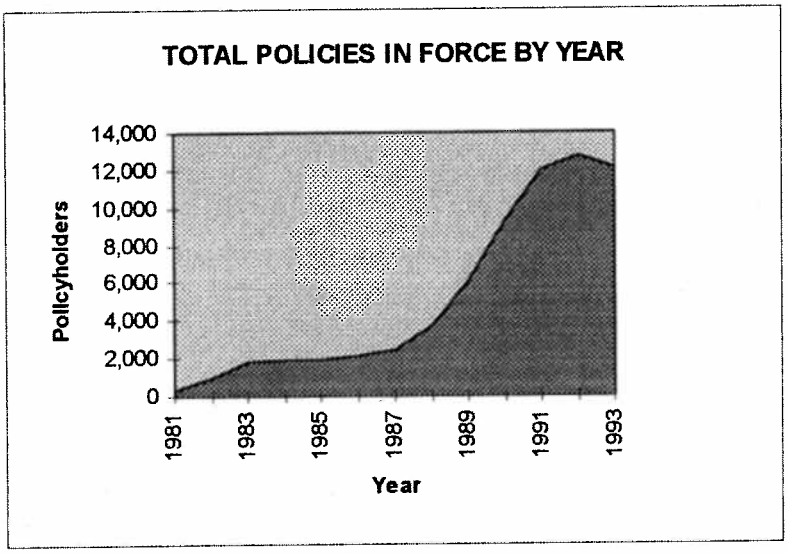
Figures 1 and 2 show the enrollment growth in HIRSP from 1981 to 1993. As the figures show, growth was steady but slow in the early years of the program. Enrollment grew dramatically from 1987 to 1992 due to several factors such as increased awareness of HIRSP, the growth in the size of the medically uninsurable population, and efforts to increase HIRSP affordability. The slight decrease in enrollment from 1992 to 1993 is attributed to new legislation that restricts medical underwriting in the small group insurance market.

FIGURE 1

POLICIES IN FORCE BY YEAR

Year	Plan 1	Plan 2	Total
1987	2,143	333	2,476
1988	3,350	410	3,760
1989	5,526	551	6,077
1990	8,529	758	9,287
1991	10,994	1,015	12,009
1992	11,388	1,319	12,707
1993	10,497	1,548	12,045

FIGURE 2



Since HIRSP's creation, there has been a continuing debate about whether HIRSP is an insurance plan or a social program. Some people believe it should be made available to all medically uninsurable, while others feel only individuals able to pay the premiums should be eligible. The divergence of opinion obviously has an effect on decision-making with regard to financing mechanisms, eligibility criteria, benefits, and coverage levels and has ultimately had an impact on the number of individuals who may be insured.

ELIGIBILITY

When HIRSP was created, one of the critical questions was how to determine who was eligible to participate. Since the goal was to provide health insurance for those individuals who were medically high-risk and had been rejected in the private market, advocacy groups believed that it should not be overly burdensome for potential policyholders to get into HIRSP. Insurers wanted assurance that no one who could be served in the private market would be lost by the industry.

There were lengthy discussions on this issue, resulting in the following eligibility criteria:

- Notices of rejection or cancellation from two or more private health insurers.
- Notice of a reduction or limitation in health insurance coverage, which substantially reduces coverage when compared to coverage available to persons considered to be standard risk.
- Notice of an increase in premium of 50% or more for a current policy, unless such increases apply to substantially all the insurer's health policies.
- A notice of 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% the premium charged to a person considered to be standard risk.

A Wisconsin resident under age 65 was determined to be eligible to apply to HIRSP if any one of the above criteria were met.

In 1986, following a survey of HIRSP policyholders and a discussion by the HIRSP Board, a report was prepared which recommended several modifications in HIRSP. This included reducing the number of rejections from two to one needed to qualify for HIRSP. This modification was enacted into law in 1987.

In 1991, another major change concerning eligibility requirements went into effect, prohibiting HIRSP coverage for any person who is eligible for health care benefits provided by an employer either on a self-funded or insured basis. In the budget bill passed in April 1992, a provision was made whereby individuals eligible for HIRSP could be offered the option of enrolling in alternative plans that use managed care and provide benefits that are similar to the benefits provided under HIRSP. A person who enrolls in such an alternative plan will be ineligible for HIRSP for 12 months after enrolling in the plan. As of this date, due to pending actions on both the state and federal level concerning health care reform, the HIRSP Board has not yet developed an alternative plan for HIRSP policyholders.

In an effort to contain costs, HIRSP was granted the authority to establish managed-care provisions in HIRSP. In 1988, the Office of the Commissioner of Insurance contracted with PROMED, a firm that conducts utilization review of hospital use within health insurance plans. PROMED's goal was to reduce medical care costs by monitoring unnecessary admissions and longer than necessary hospital stays, while encouraging the use of outpatient services. Three years later, in 1991, the contract was rebid. The current cost-containment contractor is Meridian Resource Corporation, a subsidiary of Blue Cross & Blue Shield United of Wisconsin. Meridian Resource provides preadmission review of hospital admissions, concurrent review of hospital stays, and large case management.

BENEFIT LEVELS

From the beginning there was substantial lobbying from various interest groups, particularly health care providers, with regard to benefits that would be covered under HIRSP. For example, chiropractic coverage is included in HIRSP, despite the fact that some advocates felt that those most likely to rely on HIRSP might have greater need for other benefits such as long-term care or maintenance therapy. It was accepted, however, that the individuals who would participate in HIRSP would require a high level of health care services, and that adjustments to benefit coverage might need to be made in the future when more precise information about the HIRSP population became available.

HIRSP offers two plans. Plan 1 has a $1,000 deductible and an 80/20 copayment on the next $5,000 of benefits. Plan 2, a medical disability supplement policy for those who are under age 65 and on Medicare due to a long-term or permanent physical or mental disability, has a deductible equal to the Medicare Part A deductible, and a maximum out-of-pocket expense of $500. After the deductible and out-of-pocket are met, the plan pays 100% of covered services, including prescription drugs.

Waiting Period for Preexisting Conditions

For any policyholder in Plans 1 or 2, the statutes provide that any condition which has been diagnosed or treated in the six months preceding the date of acceptance into HIRSP will not be covered for the first six months of HIRSP coverage. Originally, this waiting period for coverage of preexisting conditions was 30 days but this was modified in 1983 to reduce deficits and to slow down the increases in premium rates.

Lifetime Benefit Limitation

The lifetime maximum benefit which any Plan 1 or Plan 2 policyholder may receive for all medical conditions began at $250,000. In 1987, it was enacted into law to increase the lifetime limit of benefit coverage to $500,000.

Covered and Excluded Expenses

The current benefits available to HIRSP policyholders include coverage of the usual and customary charges for the following services:

Covered Services and Supplies

- Hospital services
- Basic medical-surgical services including both in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services, and consultation services
- In-hospital treatment for 30 days per calendar year for alcoholism and drug abuse and 60 days for mental and nervous disorders
- Outpatient services for alcoholism, drug abuse, and mental and nervous disorders (to a maximum of $2,500 per year)
- Prescription drugs
- 40 home health care visits per year (365 visits for persons on Medicare when combined with Medicare benefits)
- Radium and other radioactive materials
- Oxygen
- Anesthetics
- Prosthesis other than dental
- Durable medical equipment and supplies other than eyeglasses and hearing aids
- Diagnostic X-rays and laboratory tests
- Oral surgery for partial or completely unerupted, impacted teeth
- Oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth
- Physical therapy
- Ambulance service
- 30 days of skilled nursing care following a hospitalization (120 days for persons on Medicare)
- Processing charges for blood
- Services and supplies for treatment of diabetes, including outpatient education program
- Processing charges for blood
- Use of disposable medical services
- Chiropractic services
- Routine mammography for women age 45 and older
- Papanicolau tests, pelvic exams, or associated laboratory fees when the test or examination is performed by a licensed physician or a licensed nurse practitioner
- Diabetes treatment and outpatient self-management education program

Supplies and Services NOT Covered

- Experimental treatment
- Cosmetic treatment
- Custodial care
- Private room if not medically necessary
- Eyeglasses and hearing aids
- Dental care
- Routine physical exams
- Illness or injury due to acts of war
- Replacement fees for the first three pints of blood
- Charges in excess of usual and customary charges
- Charges for care which is not medically necessary
- Expenses incurred before effective date of coverage
- Expenses incurred after insurance ends
- Expenses for which benefits are payable under a worker's compensation or other similar law
- Expenses for which benefits are payable under other insurance policies or government programs, such as Medicare or the U.S. Veteran's Administration
- Services or supplies not within the scope of the authorized practice of the institution providing the services or supplies
- Personal services or supplies provided by a hospital or nursing home or any other nonmedical or nonprescribed service or supply
- Expense incurred for procedures or services that are of questionable medical value, experimental, or investigative (except drugs for the treatment of HIV infection)

FINANCING HIRSP

When HIRSP was created, there was an explicit expectation by the legislature that premiums paid by policyholders would eventually cover the costs of claims and expenses. 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 recognized at the time that the issue of assessments on self-insurers was a potential problem. However, the case law on the issue was not clear-cut, and a determination was made to include self-insurers in the assessment formula. 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 entire burden of financing HIRSP was therefore placed on HIRSP policyholders and the insurance industry.

In 1984, the HIRSP Board determined that this was an inequitable method of funding deficits. The Board requested that the legislature use general purpose revenue (GPR) as a funding base to offset any losses, and that the insurer assessment be phased out over four years. The statutory changes needed to accomplish this failed to be adopted by the Joint Finance Committee as part of the 1985-1987 budget bill, and the assessment subsidy from insurers continues.

The original legislation also set a "cap" on policyholder premium rates for the first three years, yielding a rate of no more than 130% 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%. It was estimated that premium increases of 370% would be necessary for HIRSP to become self-sufficient. On January 1, 1987, rates were reduced by 10%, based on an actuarial study which showed that rates in effect at the time exceeded the statutorily required 150% of the standard rate.

In the fall of 1988, the Actuarial Committee of the HIRSP Board recommended a rate increase because they found existing rates to be considerably below 150% of the standard rate. This rate increase was initially denied by the legislature. Finally, on June 1, 1990, new rates went into effect. Costs to policyholders increased on average by 10%. In July 1991 rates further increased by 28% and the legislature changed the method by which HIRSP rates are calculated. Instead of being fixed at 150% of standard rates, rates are now set to recover 60% of program operating and administrative costs. In July 1992 a three-zone rating schedule went into effect. The rating zones are based on age, gender, and varying health care costs between rural and urban areas. Policyholders living in urban areas are assigned higher premiums because of the generally higher cost of health care in an urban setting. Subsidies are available for lower income policyholders. These are discussed later in this report.

The same legislation that made the above-described changes also included a mandate that HIRSP reduce all eligible payments to health care providers by 10%. This law, s. 619.15 (3) (e), Wis. Stat., requires the HIRSP administrator to determine all amounts payable to providers and then reduce these by 10%. Providers are prohibited by law to bill HIRSP policyholders for that 10% balance of charges. The purpose of this law is to limit increases in HIRSP claim costs.

In summary, there are four sources of funding for HIRSP: (1) premiums paid by policyholders; (2) state GPR which fund, in part, the premium and deductible subsidy program for low-income policyholders; (3) assessments of health insurance companies doing business in Wisconsin; and (4) discounts from providers who, since May 1, 1992, receive only 90% of usual and customary charges for their services under HIRSP.

The new rates for Plan 1, effective July 1, 1994, are shown in the following tables:

MAJOR MEDICAL PLAN
Males

AGE GROUP	ZONE 1	ZONE 2	ZONE 3
0-24	$1,404	$1,260	$1,128
25-29	1,416	1,272	1,140
30-34	1,620	1,464	1,296
35-39	1,668	1,500	1,332
40-44	2,064	1,860	1,656
45-49	2,556	3,304	2,040
50-54	3,192	2,868	2,556
55-59	3,948	3,552	3,156
60-64	4,632	4,164	3,708

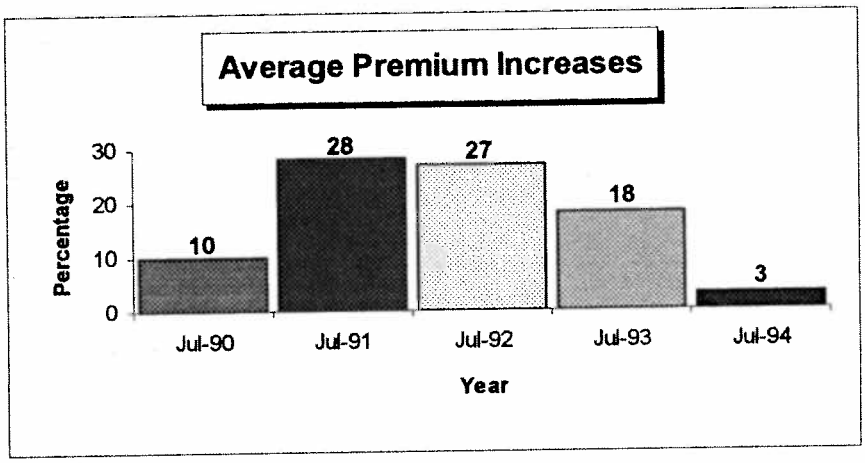
MAJOR MEDICAL PLAN
Females

AGE GROUP	ZONE 1	ZONE 2	ZONE 3
0-18	$1,404	$1,260	$1,128
19-24	1,920	1,728	1,536
25-29	1,932	1,704	1,548
30-34	2,160	1,944	1,728
35-39	2,184	1,968	1,752
40-44	2,484	2,232	1,992
45-49	2,844	2,556	2,280
50-54	3,228	2,904	2,580
55-59	3,660	3,330	2,928
60-64	4,068	3,660	3,252

Zone 1: Milwaukee area
Zone 2: Southeast Wisconsin
Zone 3: Rest of state

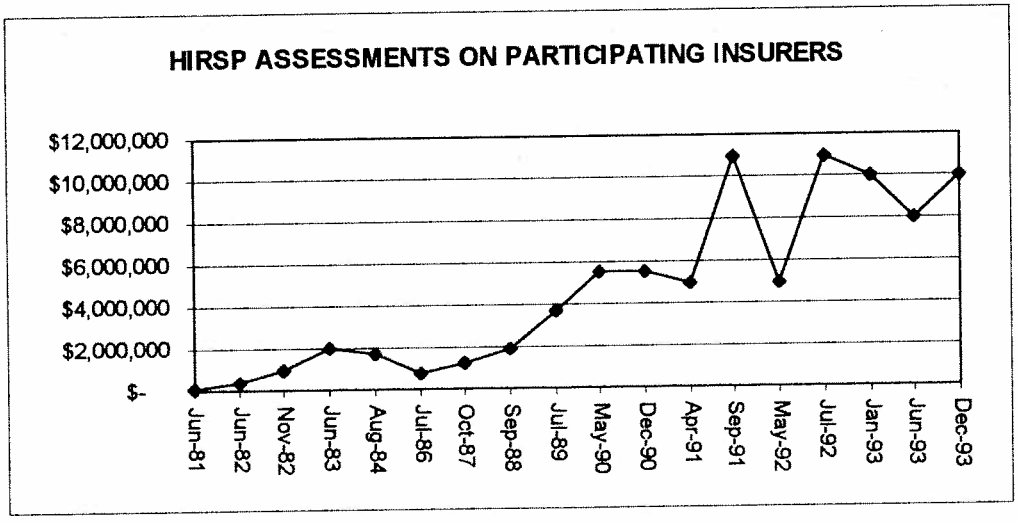
Average premium rate changes over the years are reflected in Figure 3.

FIGURE 3



Since the inception of HIRSP in 1981, participating insurers have been assessed the following amounts to make up the difference between premiums collected and benefits paid. Figure 4 below shows insurer assessments since the program began. As this figure indicates, assessments have grown in the last two years because HIRSP enrollment has increased and health care costs continue to increase steadily. Although HIRSP enrollement has declined over the past year, claim payments have continued to increase. In 1993 a total of 266 companies were assessed, based on the amount of health insurance business they do in Wisconsin.

FIGURE 4



The magnitude of recent assessments has resulted in considerably more pressure by insurers to change the funding for the program.

SUBSIDIES

Over the years it became increasingly clear to the HIRSP 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% 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 set up 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% to 30%. 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 policyholders, were enrolled in the subsidy program, for a total 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. An allocation of $937,500 in fiscal-year 1991 provided for deductible and premium reductions as follows:

Policyholder Annual Household Income	Deductible Reduction Per Policyholder	Proposed Percent Premium Reduction
$ 0 to $ 5,999	$500	33-1/3%
6,000 to 8,999	400	33-1/3
9,000 to 11,999	300	29
12,000 to 14,999	200	23
15,000 to 17,999	100	17
18,000 to 19,999	0	0

The above susbsidy schedule was in effect for policyholders until July 1992. At that time, a new subsidy schedule went into effect, when policyholders with an income level below $20,000, became eligible for a premium reduction. This increased enrollment in the subsidy program to 3,780 individuals, an 8% increase, in December of 1992. The following shows the impact of increasing the household income ceiling from $16,500 to $20,000. Even though the change was in effect only for the second half of the 1991-1992 fiscal year, the impact is readily apparent.

HIRSP Premium and Deductible Subsidy Program Payments
State General Purpose Revenue

Fiscal Year	Premium Subisdy	Deductible Subsidy	Total
1985-1986	$ 152,200	$ 0	$ 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

The current subsidy levels can be broken down as follows:

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

Standard rate applies 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.

Each year, the HIRSP Actuarial Committee surveys the top 25 health insurers in Wisconsin, regarding the premium they charge for policies similar to HIRSP. From the responses, the actuaries on the committee determine what the average industry standard is. This is the base amount used in calculating rates and is the amount that policyholders at the lowest income level ($0 to $10,000) pay for premiums.

CLAIMS DATA

Since July 1981 when the first HIRSP policies were accepted by Mutual of Omaha, through December 1991, 6,311 different individuals submitted claims. 74% of the individuals submitting claims incurred less than $10,000 in covered benefit costs; 23% have had claims paid of $10,000 to $100,000 each; 1% had claims between $100,000 and $200,000; 0.02% had claims totalling between $200,000 and $300,000; 0.06% incurred between $300,000 and $400,000 in claims; and one individual had claims between $450,000 and $455,000. The cumulative total of claim dollars paid out between 1981 and 1991 was $69,281,936.

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 July 1, 1993, to December 31, 1993, respectively. Due to the change in administrators in 1993, claim data is only available from July 1, 1993, to December 31, 1993.

FIGURE 5

HIRSP COMBINED
TOP 10 DRGs BY PATIENT
07/01/93-12/31/93

	DRG	PAYMENTS	ADMITS	DAYS	ALOS
430	Psychoses	$ 569,307	86	1,200	13.95
112	Other Cardiovascular Procedure	565,384	40	185	4.63
209	Major Joint Surgery/Reconstruction	554,918	43	297	6.91
107	Coronary Bypass *W/O catheter*	371,410	17	166	9.76
106	Coronary Bypass *W/Catheter*	287,811	11	116	10.55
104	Cardiac Valve Surgery *W/Catheter*	241,274	5	76	15.20
410	Chemotherapy	222,513	37	239	6.46
105	Cardiac Valve Surgery *W/O Catheter*	186,321	7	50	7.14
148	Major Bowel Surgery *W/CC*	177,920	16	204	12.75
110	Major Cardiovascular Procedure *W/CC*	176,996	8	71	8.88
	Subtotal	3,353,854	270	2,604	9.64
	Other DRGs	7,673,963	1,231	8,228	6.68
	Total	$11,027,817	1,501	10,832	7.22

ALOS = Average Length of Stay

FIGURE 6

HIRSP COMBINED
TOP 10 DRGs BY FREQUENCY
07/01/93-12/31/93

	DRG	PAYMENTS	ADMITS	DAYS	ALOS
430	Psychoses	$ 569,307	86	1,200	13.95
209	Major Joint Surgery/Reconstruction	554,918	43	297	6.91
112	Other Cardiovascular Procedure	565,384	40	185	4.63
410	Chemotherapy	222,513	37	239	6.46
435	Substance Abuse	114,946	35	268	7.66
182	Stomach/Intestine Infection *W/CC*	89,609	33	117	3.55
125	Circulatory Disorder *W/Cardiac Catheter*	135,764	22	60	2.73
140	Angina Pectoris	57,398	22	55	2.50
124	Circulatory Disorder *W/Cardiac Catheter*	145,548	21	119	5.67
143	Chest Pain	50,144	21	43	2.05
	Subtotal	2,505,531	360	2,583	7.18
	Other DRGs	8,522,286	1,141	8,249	7.23
	Total	$11,027,817	1,501	10,832	7.22

ALOS = Average Length of Stay

FIGURE 7

SUMMARY OF MOST FREQUENTLY UTILIZED INPATIENT FACILITIES
07/01/93-12/31/93

FACILITY	TOTAL PAYMENTS	TOTAL ADMITS	TOTAL DAYS	AVG. PAID PER DAY
St. Josephs Hosipital, Marshfield	$ 539,650	83	426	$1,266.78
St. Lukes Med. Ctr., Milwaukee	912,546	82	736	1,239.87
University Hospital, Madison	826,354	81	1,065	775.92
St. Vincents Hospital, Green Bay	485,925	63	298	1,630.62
Froedtert Mem. Hosp.,Milwaukee	531,026	42	516	1,029.12
Columbia Hospital, Milwaukee	334,945	36	325	1,030.60
Meriter Hospital Inc., Madison	238,577	34	253	942.99
Waukesha Memorial Hospital	268,337	32	225	1,192.61
St. Elizabeth Hospital, Fond du Lac	150,206	31	172	873.29
Theda Clark Reg. Ctr., Neenah	196,352	29	177	1,109.33
Subtotal	4,483,918	513	4,193	1,069.38
Other Facilities	6,543,899	988	6,639	985.68
Total	$11,027,817	1,501	10,832	$1,018.08

POLICYHOLDER SURVEYS

The HIRSP Board has surveyed HIRSP policyholders several times to obtain their perceptions about the operation of HIRSP and to gather demographic data about the current policyholder population. In March of 1993, survey questionnaires were mailed to all policyholders; 4,418 replies were received.

Analysis of data of this policyholder survey sample were similar to earlier surveys and showed the following:

- HIRSP has a relatively older population, with 51.9% of the policyholders over the age of 56.
- A majority (57.2%) of the policyholders are female.
- Most (62.6%) individuals are married.
- 14.5% of the sample have two or more persons in immediate family enrolled in HIRSP.
- 34.4% of the policyholders are from Madison and the Milwaukee area.
- Only 52.4% of the policyholders are employed.
- Approximately one-half of the respondents (51.5%) have been enrolled in HIRSP for more than two years.
- 85.7% of the sample are not currently seeking other insurance.
- 51.2% of the sample say their total covered expenses in one year have been less than their deductible.
- Many respondents have ongoing expenses that are not covered by HIRSP:
  - 44.3% have dental costs not covered.
  - 30.3% have medication that is not covered.
  - 36.7% have optical costs that are not covered.

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

- A high percentage (78.7%) found out about HIRSP through their insurance agent and 70.6% of those individuals feel that the agent provided a clear explanation of HIRSP.
- Almost all (90.2%) felt that the policy and outline of coverage are clearly written.
- Most respondents (83.2%) reported satisfaction with claims service.
- 86.6% expressed satisfaction with benefit coverage levels.
- 66.5% expressed satisfaction with the premium cost.
- The majority (58.6%) felt that the deductible cost is too high.
- Satisfaction with the waiting period for a preexisting condition was at a positive level, with 83.6% of the respondents reporting satisfaction.

Previous survey results have shown that the majority of policyholders who left HIRSP did so because they could no longer afford to pay the premiums and/or the cost of deductibles. A small number found employment with a group large enough to be eligible for group health insurance at standard rates. Small numbers also reached age 65 and became ineligible, died, moved out of state, or went on medical assistance.

A significant number of respondents expressed some degree of confusion about and/or frustration with HIRSP underwriting and claims payment practices. Survey responses given by many of the respondents demonstrates that many HIRSP policyholders do not appear to understand their health insurance policy. They do not know who makes decisions about HIRSP, why their premiums increase, who is eligible for the premium and deductible subsidy program, and what is and is not covered by HIRSP.

To address the concerns and issues raised by the survey respondents, the HIRSP board decided to strengthen policyholder awareness. As a result, the board created the Consumer Affairs Committee, on which sit three board members, three policyholders, and a representative from the HIRSP administrator. This committee serves as the "eyes and ears" for the board on issues and changes affecting policyholders.

In addition to the committee, the board also authorized creation of two publications to aid policyholders' understanding of the plan. A handbook entitled *Understanding Your Policy* is included in every new policy packet. The handbook is not intended to replace the policy, but to hi-light some of the key elements of the policy, such as deductibles and co-insurance, using less insurance lingo to make it more understandable. The other publication is a policyholder newsletter called For Your Benefit. This quarterly newsletter includes articles on issues such as plan changes, frequently asked questions, and general information that would be useful to HIRSP policyholders. Both publications have generated positive responses from policyholders.

RISK POOLS IN OTHER STATES: A COMPARISON

As of December 1993, 27 states in addition to Wisconsin had health insurance pools in effect. They are: Alaska, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Maine, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, South Dakota, Tennessee, Texas, Utah, Washington, and Wyoming. The plans vary in design and intent, so direct comparisons are not totally conclusive.

The following is a summary of the most critical elements of a risk-pool design as reflected in the information available about the 28 existing plans:

Financing

In theory, premiums are to cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient. States have consequently had to develop a combination of public and private options to recoup the losses associated with the operation of a state pool.

These options are:

STATE	PUBLIC	PRIVATE
Indiana, Iowa, Kansas, Mississippi, Missouri, Montana, Nebraska, North Dakota, Oregon, Washington, Wyoming, South Carolina, South Dakota, Texas		Premiums are paid by policyholders and all deficits are assessed to participating insurers, with credit applied against a premium tax paid annually to the state.
Alaska, Connecticut, Florida, Minnesota, Wisconsin		Same as above except for no credit against state taxes.
California	Plan losses are funded by the Major Risk Medical Insurance Fund in the State Treasury, comprised of cigarette and tobacco surtax revenues.	
Colorado	Losses are covered by a state income tax surcharge.	
Tennessee	The state appropriates $5 million toward the operation of the plan. Insurers are assessed the rest, with no premium tax offset allowed.	
Illinios, Georgia, Maine, Utah	Any deficit incurred is recouped by an appropriation made by the state.	
Louisiana	Fund the pool through a tax on gross patient service revenues of all hospitals in the state.	
New Mexico		Assesses all insurers for the loss of the pool and no credit on future taxes will be allowed until any one member's assessment reaches $75,000/year. At that time, the member receives a 30% tax credit for the amount paid over $75,000.

Of the 28 plans in effect at this time, only Wisconsin, Minnesota, Florida, Alaska, and Connecticut assess all losses to participating insurers without credit against income or premium taxes as an available option.

Benefits

Most of the other state high-risk plans provide benefit packages similar to Wisconsin's HIRSP. However some states do not cover services that Wisconsin does, such as speech therapy, prescription drugs, pregnancy, treatment for chemical dependency, treatment for mental or nervous illness, or organ and bone marrow transplants. In addition, some other states cover routine physical exams, blood, and transportation for treatment related to kidney dialysis, which HIRSP does not cover.

In some plans, the costs incurred as a result of these benefit packages have a maximum lifetime benefit for the insured individual. This benefit varies among states, ranging from a $250,000 benefit maximum to no benefit maximum. The most common benefit maximum is $500,000, and is offered by 15 of the 28 states.

One other element which varies considerably across the 27 states is the amount of the deductible (cost which must be paid out-of-pocket before full coverage begins), with a range from no deductible to $10,000.

Eligibility

All states with risk pools require that the individual must be a resident of the state, with variances depending solely on state definitions of residency.

Of the other plans in effect, Florida, Kansas, and Montana require rejection by two insurers and Mississippi by three. Others require rejection by either one insurer or offer a waiver of the rejection requirement if the primary health condition likely to cause the rejection appears on a list of health conditions which would cause insurers to automatically reject the individual. In addition, some states will cover an individual if they are presently insured with a higher premium or insured with a rider or rated policy. Finally, some states offer a reciprocity agreement which means that if an individual has been enrolled under a similar state plan, has met the waiting period for preexisting conditions, and has not used up the maximum lifetime benefit, he or she is eligible to apply in another state after meeting the residency requirement.

Four of the risk pools require a 12-month waiting period for coverage of preexisting conditions. Twenty-one have a 6-month waiting period, similar to Wisconsin's. In three states the waiting period is 90 days. In an effort to provide flexibility on this issue, one state, Indiana, has a provision whereby the preexisting condition waiting period may be waived if the individual pays a 15% premium surcharge over the life of the contract. Appendix 2 outlines the key components of each state plan.

SUMMARY

HIRSP has shown increased success in extending health insurance to a targeted group of individuals with unfavorable health histories or conditions which prevent them from obtaining coverage in the private market. Enrollment continued to increase steadily until May 1993, when it peaked at 12,800 policyholders. At the end of its first year, on December 31, 1981, 309 individuals were enrolled in HIRSP. As of December 31, 1993, the HIRSP enrollment was at 12,045 individuals.

Some of the success can be attributed to a number of modifications recommended by the HIRSP Board and approved by the legislature. These modifications include: reducing from two to one the insurance

rejections required for eligibility, raising the individual maximum lifetime benefit from $250,000 to $500,000, setting aside of GPR funds to subsidize premium payments and deductible amounts for policyholders with annual household incomes below $20,000, and the establishment of managed-care provisions in the HIRSP policies. The increase can also be attributed to strict underwriting practices by health insurance individually and as an overall industry. Increased claims for medical costs have resulted in rising health insurance premiums.

Two laws recently enacted in Wisconsin have resulted in fewer people being referred to HIRSP. The first, enacted in August 1991, sets limits on the rates insurers can charge to small businesses. The law also prohibits those who are eligible for an employer's plan from enrolling in HIRSP. In the past, many employers referred employes to HIRSP because their medical conditions caused the group's rates to increase dramatically. The second, recently adopted by the legislature, established a basic benefits plan which insurers will be required to offer to small businesses. It also prohibits insurers from medically underwriting those who apply for the basic benefit plan.

The HIRSP Board, the Office of the Commissioner of Insurance, and the Wisconsin Legislature continue to explore additional cost-containment options for HIRSP. The data continues to show that HIRSP remains a viable alternative for health insurance for Wisconsin citizens.

APPENDIX 1

HIRSP BOARD MEMBERS

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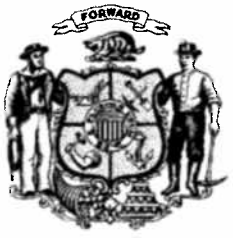
APPENDIX 2

STATE HIGH-RISK INSURANCE POOLS

State	Year Operational	1993 Enrollment	Premium Cap	Medicare Supplement	Waiting Period	Condition Period	Lifetime Benefit	Deductibles
Alaska	1993	113	200%	Yes	6 Months	3 Months	$1,000,000	$500/1,000/1,500
California	1991	16,785	125%	No	90 Days	6 Months	500,000	0/500
Colorado	1991	2,046	150-175%	No	6 Months	6 & 12 Months	500,000	300/750/2,000
Connecticut	1976	1,610	125-150%	No	12 Months	6 Months	1,000,000	500/1,000/2,000
Florida	1983	3,476	200-250%	Yes	12 Months	6 Months	500,000	1,000-10,000
Georgia	(A)	0	125-150%	No	6 Months	6 Months	500,000	500/1,500
Illinois	1989	4,693	135%	Yes	6 Months	6 Months	500,000	500-2,500
Indiana	1982	4,924	150%	No	180 Days	180 Days	No Limit	500/1,000/1,500
Iowa	1987	1,753	150%	Yes	6 Months	6 Months	250,000	500-2,000
Kansas	1993	343	None	No	90 Days	6 Months	500,000	1,000/5,000
Louisiana	1992	228	150-200%	No	6 Months	6 Months	500,000	1,000/2,000
Maine	1988	307	150%	No	90 Days	90 Days	500,000	500
Minnesota	1976	35,296	125%	Yes	6 Months	90 Days	1,000,000	500/1,000
Mississippi	1992	365	150-175%	No	6 Months	6 Months	250,000	500/1,500
Missouri	1992	987	150-200%	No	12 Months	6 Months	1,000,000	500/1,000
Montana	1987	289	150-400%	No	12 Months	5 Years	250,000	1,000
Nebraska	1986	3,282	135%	No	6 Months	6 Months	500,000	250-2,000
New Mexico	1988	1,294	150%	No	6 Months	6 Months	750,000	500/1,000/2,000
N. Dakota	1982	1,538	135%	Yes	180 Days	90 Days	500,000	500/1,000
Oregon	1990	4,091	150%	No	6 Months	6 Months	1,000,000	500
S. Carolina	1990	1,437	200-300%	No	6 Months	6 Months	250,000	500
S, Dakota	1994	0	150%	No	6 Months		500,000	500/7,500
Tennessee	1987	3,433	150%	Yes	6 Months	6 Months	500,000	1,000
Texas	(A)	0	150-200%	No	6 Months	6 Months	500,000	250/500
Utah	1991	681	150%	No	6 Months	6 Months	500,000	500/1,000
Washington	1988	4,387	150%	Yes	6 Months	6 Months	500,000	500/1,000/1,500
Wisconsin	1981	12,045	60%	Yes	6 Months	6 Months	500,000	1,000
Wyoming	1991	206	150-200%	Yes	6 Months	6 Months	250,000	500/2,000/3,000

(A) = program not yet operational


WISCONSIN STATE LEGISLATURE


FORWARD

HIRSP: History of Legislative Changes
1979 – 1991

1979 Chapter 313	HIRSP created
1983 Act 27	Program self-sufficiency requirement deleted Increased the premium cap from 130% to 150% of standard-risk premium
1983 Act 215	Increase waiting period for treatment of preexisting conditions form 30 days to six months
1985 Act 29	Premium subsidy system created for those with household incomes of less than $16,500
1987 Act 27	Maximum lifetime benefit increased from $250,000 to $500,00 Premium subsidies increased. The new range is from 17% to 33.3% for those with household incomes of less than $16,500 Deductible subsidy system created for those with household incomes of less than $16,500 Subsidies range from $100 to $500 Number of required insurance carrier rejections reduced from two to one Authorization to develop cost-containment provisions
1987 Act 239	Those receiving or eligible for medical assistance can reenter HIRSP without waiting twelve months
1991 Act 39	Premium subsidy formula changed For household incomes of less than $20,000, premiums range between 100% and 124.5% of standard risk Premiums for those earning $20,000 or more are now set to cover 60% of plan costs A $1,750 assessment to be levied against an insurer whose actions cause a policyholder to become eligible for HIRSP No person eligible for employer health insurance is eligible for HIRSP
1991 Act 269	Payments to health care providers for allowable charges reduced by 10% Authorization to offer alternative managed care plans

HIRSP: SNAPSHOT

POLICYHOLDERS

Total Number Enrolled: 10,163
- Male: 44%
- Female: 56%
- Average Age: 51.7 years

Enrollment Distribution, by zone
- Zone 1: 827 or 8%
- Zone 2: 2,251 or 25%
- Zone 3: 6,815 or 67%

Enrollment Distribution, by plan
- Plan 1: 84.8%
- Plan 2: 15.2%

FINANCING

Average Cost per Member per Month	$414
Outpatient Costs per Member per Month	$51.80
Subsidized Policyholders	35.8%

OTHER

Hospital Admissions: 250 per 1,000 policyholders

COST CONTAINMENT, FY 95

Activity	Estimated Savings
Hospital Bill Audit	$48,911
Drug Card	$285,366 *(10 months)*
Cost Containment Contract	$775,000
10 Percent Reduction	$4.2 million

HIRSP

DRAFT QUESTIONS

A. HIRSP Legislative History

1. Briefly summarize HIRSP legislative history with regard to original purpose and with particular attention to:

   a. Original premium rate schedule funding provisions.
   b. Original deficit assessment provisions.

2. Briefly summarize HIRSP legislative history with regard to program changes:

   a. ERISA preemption of assessments on ERISA-qualified self-funded health benefit plans.
   b. Repeal of sunset on insurance assessments, 1984.
   c. Addition of subsidy program funded by state GPR, 1985.
   d. Establishment of current rate setting methodology, 1992.
   e. Restrictions on eligibility requirements if employment-based insurance is offered, 1992.
   f. Caps on State GPR subsidy obligations, 1992.
   g. Provisions for managed care contracting, 1993.

B. Legislative Audit Bureau Evaluation of HIRSP

1. Briefly summarize the Legislative Audit Bureau evaluation of HIRSP prepared in March 1993:

   a. What findings or recommendations have been attended to?
   b. What findings or recommendations continue to require attention?

C. HIRSP Demographics

1. Briefly describe the demographics of the HIRSP population.

2. The HIRSP population has been steadily declining since June 1993. Program costs continue to increase dramatically.

   a. What are the reasons for the decline of the HIRSP population? ← small employer alluded to –
   b. What are the reasons for the increases in program costs?

D. HIRSP Rate Setting Methodology

1. The rate setting methodology established by the Legislature in 1991 appears to have produced rate schedules that worked well in Fiscal Year (FY) 1993 and FY 1994 to fund 60% of plan operating and administrative costs, but not well in FY 1995, and not well in the current fiscal year?

   a. Why was there no correction made in the FY 1995 rate schedule to bring it into compliance with the 60% funding requirement in statutes?
   b. Why has there been no correction made in the FY 1996 rate schedule to bring it into compliance with the 60% funding requirement in statutes?

E. Options for HIRSP Board or OCI Actions, and for Changes to the HIRSP Statutes

1. Briefly discuss the 5% supplemental rate increase approved by the HIRSP Board on September 15, 1995, and OCI's plans to implement the rate increase by emergency rule, effective January 1, 1996.

2. Briefly discuss present planning to ensure that the new rate schedule to be approved by the HIRSP Board in December 1995 for FY 1997 will fund 60% of plan operating and administrative costs.

3. Briefly discuss proposed reconfiguration of the HIRSP assessment base.

4. Briefly discuss the HIRSP Board's plans to transition the HIRSP population to a managed care environment.

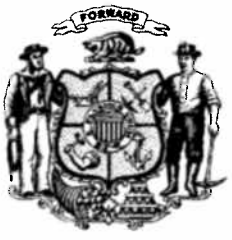
5. Briefly discuss any interim measures that may be available to the HIRSP Board to reduce program costs with regard to provider reimbursement methodology.

F. Timelines for Corrective and Legislative Action

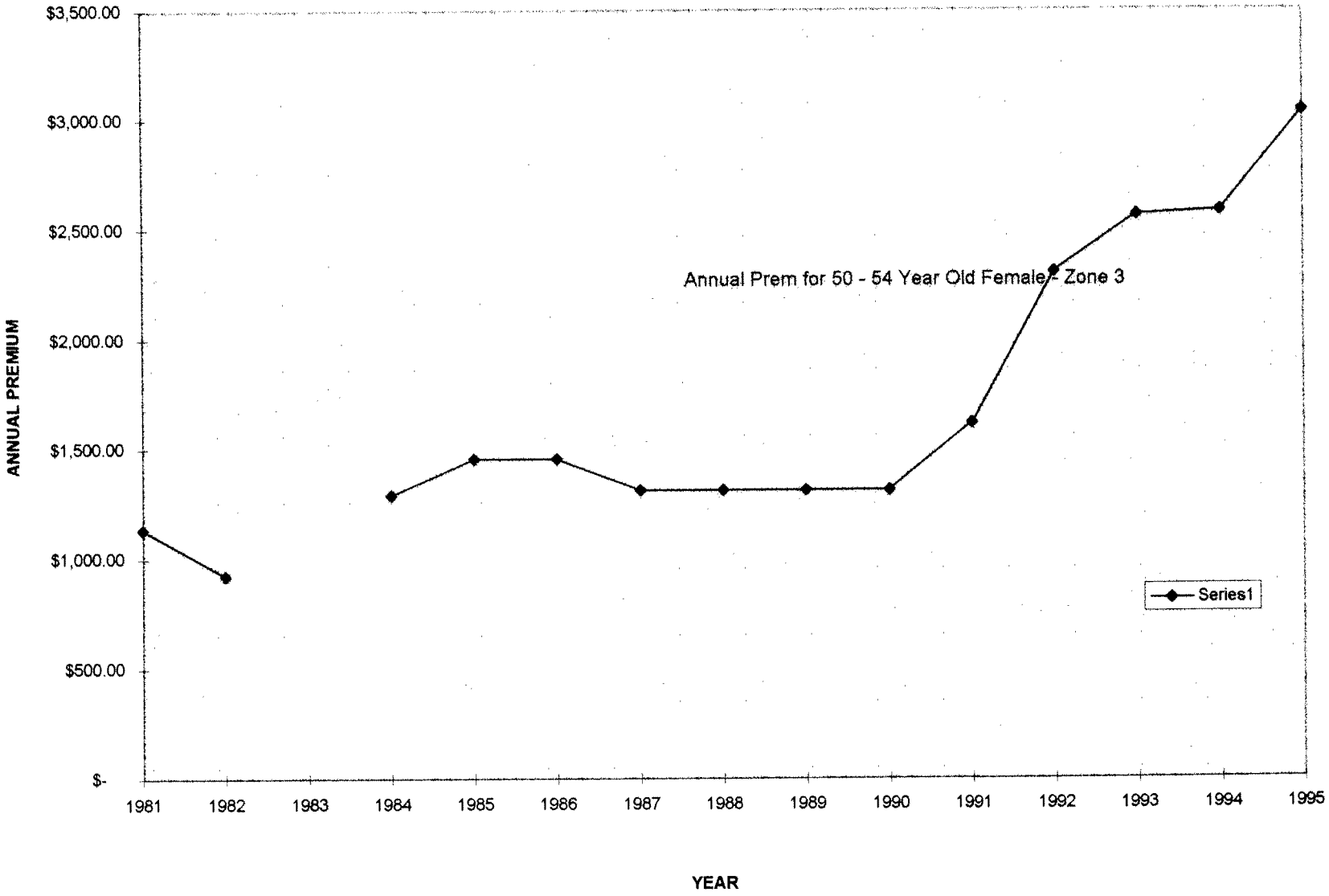
1. Briefly discuss anticipated time frames for corrective actions needed to bring rate schedule funding into improved compliance with statutes.

2. Briefly discuss anticipated time frames for proposed legislative actions.

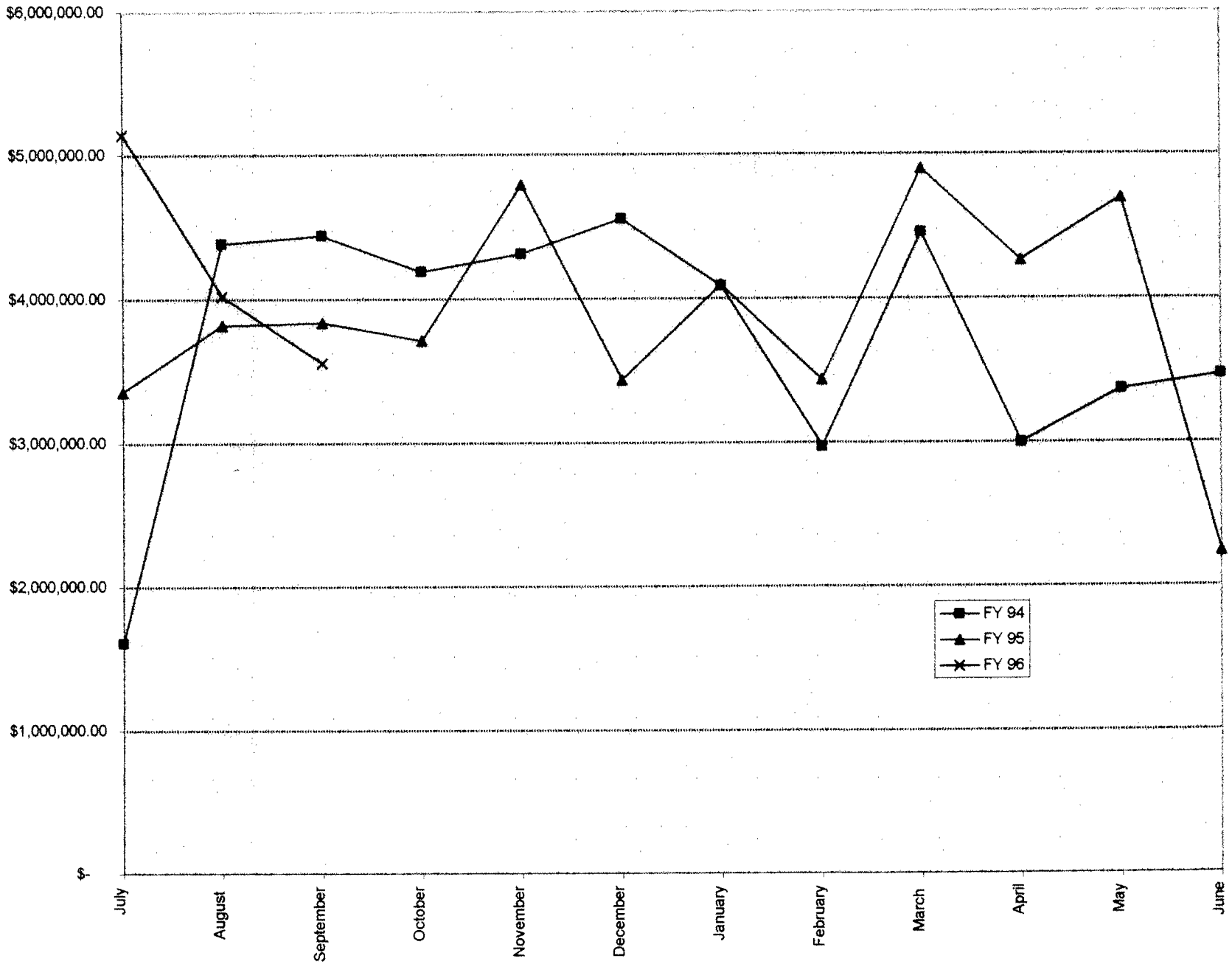
WISCONSIN STATE LEGISLATURE



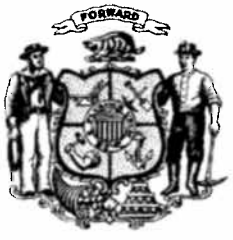
HIRSP RATE COMPARISON
1981 - 1995



HIRSP Claims Payouts by Month



WISCONSIN STATE LEGISLATURE



HIRSP: Other State Comparisons

Twenty-three states in addition to Wisconsin have health insurance risk pools. They are: Alaska, California, Colorado, Connecticut, Florida, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Mexico, North Dakota, Oregon, South Carolina, Utah, Washington, and Wyoming. Arkansas and Oklahoma have plans to establish risk pools in 1996. The plans vary in design and intent, so direct comparisons are not totally conclusive.

Financing

In theory, premiums are to cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient. States have consequently had to develop a combination of public and private options to recoup the losses associated with the operation of a state pool. Of the plans in effect, only Wisconsin, Minnesota, Florida, Alaska and Connecticut assess all losses to participating insurers without credit against income or premium taxes as an available option.

Benefits

Most of the other state pool plans provide benefit packages similar to Wisconsin's HIRSP. However some states do not cover services that Wisconsin does, such as speech therapy, prescription drugs, pregnancy, treatment for chemical dependency, treatment for mental or nervous illness, or organ and bone marrow transplants. In addition, some other states cover routine physical exams, blood, and transportation for treatment related to kidney dialysis, which HIRSP does not cover.

In some plans, the costs incurred as a result of these benefit packages have a maximum lifetime benefit for the insured individual. This benefit varies among states, ranging from a $250,000 benefit maximum to no benefit maximum. The most common benefit maximum is $500,000, and is offered by 10 of the 24 states.

One other element which varies considerably across the 24 states is the amount of the deductible (cost which must be paid out-of-pocket before full coverage begins), with a range from no deductible to $10,000.

Eligibility

All states with risk pools require that the individual must be a resident of the state, with variances depending solely on state definitions of residency.

Of the other plans in effect, Florida, Kansas, and Montana require rejection by two insurers and Mississippi by three. Others require rejection by either one insurer or offer a waiver of the rejection requirement if the primary health condition likely to cause the rejection appears on a list of health conditions which would cause insurers to automatically reject the individual. In addition, some states will cover an individual if they are presently insured with a higher premium or insured with a rider or rated policy. Finally, some states offer a reciprocity agreement which means that if an individual has been enrolled under a similar state plan, has met the waiting period for preexisting conditions, and has not used up maximum lifetime benefit, he or she is eligible to apply in another state after meeting the residency requirement.

Five of the risk pools require a 12-month waiting period for coverage of preexisting conditions. Fourteen have a 6-month waiting period, similar to Wisconsin's. In two states the waiting period is 90 days. In an effort to provide flexibility on this issue, one state, Indiana, has a provision whereby the preexisting

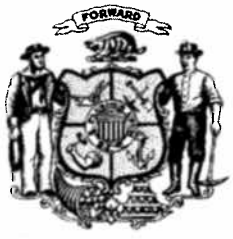
condition waiting period may be waived if the individual pays a 15 percent premium surcharge over the life of the contract.

State High-Risk Insurance Pools

State	Year Operational	1993 Enrollment	Premium Cap	Medicare Sup.	Waiting Period	Condition Period	Lifetime Benefit	Deductibles
Alaska	1993	113	200%	Yes	6 mos.	3 mos.	$1,000,000	$500/1000/1500
Arkansas	Not in operation	0	tbd	tbd	tbd	tbd	500,000	1000/5000/10000
California	1991	16785	125	No	90 days	6 mos.	500,000	0/500
Colorado	1991	2046	150-175	No	6 mos.	12 mos.	500,000	300/750/2000
Connecticut	1976	1610	125-150	No	6 mos.	6 mos.	1,000,00	500/1000/2000
Florida	1983	3476	200-250	Yes	12 mos.	6 mos.	500,000	1000-10000
Georgia	Not in operation	0	125-150	No	12 mos.	6 mos.	500,000	500/1500
Illinois	1989	4693	135	Yes	6 mos.	6 mos.	500,000	500-2500
Indiana	1982	4924	150	No	180 days	180 days	no limit	500/1000/1500
Iowa	1987	1753	150	Yes	6 mos.	6 mos.	250,000	500-2000
Kansas	1993	343	none	No	90 days	6 mos.	500,000	1000/5000
Louisiana	1992	228	150-200	No	6 mos.	6 mos.	500,000	1000/2000
Minnesota	1976	35296	125	Yes	6 mos.	90 days	1,000,000	500/1000
Mississippi	1992	365	150-175	No	6 mos.	6 mos.	250,000	500/1500
Missouri	1992	987	150-200	No	12 mos.	6 mos.	1,000,000	500/1000
Montana	1987	289	150-400	No	12 mos.	5 years	250,000	1000
Nebraska	1986	3282	135	No	6 mos.	6 mos.	500,000	250-2000
New Mexico	1988	1294	150	No	6 mos.	6 mos.	750,000	500/1000/2000
North Dakota	1982	1538	135	Yes	180 days	90 days	500,000	500/1000
Oklahoma	not in operation	tbd	tbd	tbd	6 mos.	6 mos.	500,000	6 deductibles offered
Oregon	1990	4091	150	No	6 mos.	6 mos.	1,000,000	500
South Carolina	1990	1437	200-300	No	6 mos.	6 mos.	250,000	500
Utah	1991	681	150	No	6 mos.	6 mos.	500,000	500/1000
Washington	1988	4387	150	Yes	6 mos.	6 mos.	500,000	500/1000/1500
Wisconsin	1981	12045	60	Yes	6 mos.	6 mos.	500,000	1000
Wyoming	1991	206	150-200	Yes	6 mos.	6 mos.	250,000	500/2000/3000

tbd = to be determined

WISCONSIN STATE LEGISLATURE



of how the growing deficit will be addressed – in the short term and over the long term. You'll note on the bottom of the agenda - that we will be allowing players ~~providers~~ to respond to questions of ~~the~~ committee members + they will be introduced after the presentation by staff from OCI. I would note the W Hospital Assn is not represented here today as they are holding their annual meeting. They've had input in the process of setting up this charity + been encouraged to submit to the committee any information from their meeting today which is relevant to the issue at hand. Finally – Members of the Resp board will be allowed to make ~~a~~ so, if they wish to do

Members of the [illegible] board will [illegible]

brief statements prior to taking questions from committee

members. ~~Seating up~~ Senator Dale Schultz will be chairing the actual meeting & members will need to get his attention to be called upon.

We want to move along & get out of here by 5 if

possible. The Assembly has one bill to take up at

the close of the hearing - The Senate members are not

expected to stay for that portion. David Cullen has

been excused due to death in his immediate family -

~~[illegible]~~ The Senate is not taking ~~[illegible]~~ (Lazich) however the

Assembly, because of the one bill will take up will be taking

attendance. ~~[illegible]~~ for public At my left is DD committee CC to

the senators right TE - G Anderson Leg council - written

comments will be accepted but no public testimony.

With that Danny call the roll -

Tilted - way it was written - Rob Kennedy -
Redding Jackson - Ga. Jackson - not signed by
any party - member of firm - looking for
verification -
business practices -

Environmental Decade -

- A2Law solution -
not true -
- Exchange of consideration

Rob Kennedy -

Discount it

Senator Schultz & I have scheduled this informational hearing because the HIRSP program is not as healthy as we'd like to see it. For those who are new to this committee, today's briefing will provide insight as to how the program operates - for those who are revisiting this issue today hearing is intended to expose the effects of past legislation and allow you to examine its present truth states which I should do not is not good.

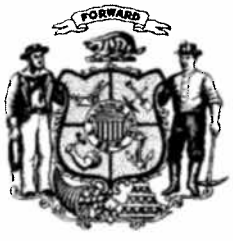
Persons involved in dividing the future of the program are many - and while each brings a different perspective to the table - the bottom line is that members have an obligation to

program
effort perspective do the table - the board

We as committee members must have an obligation
to the 8000 or so persons served by the program - to make sure its
a functional program - - meeting their health
needs.

We have invited the decision makers
here today to discuss concerns brought to our attention -
related to past audits of HRSP - you have before you
a memo prepared by D Anderson on 92 audit + issues
raised - we hope to learn why some have yet to be
addressed; the presenters will touch on
ERISA laws + how they impact this program; the
Annual report of OCI + discrepancies which
have surfaced; and finally we hope goals +
objectives will be outlined - giving us an idea -

WISCONSIN STATE LEGISLATURE



- Higher penalties needed ($1,750)

- Schedule F -

Dollar amounts -

- 96 rate
17% to 25% too low

percentage of persons in Mat state fall under self-insured

Any effort by OCT to enrole

$8 mil year and expensive -

Population on medicare

MA - Milwaukee - Mix of mandate / incentive -

- by rule not a statutory change - ~~(illegible)~~

Claire Johnson –

missed the mark inadvertently –
only 3 HMOs - ~~staff~~ models at the time –

Mandatory project – must be ~~statutory~~ –
same arguments on Medicaid will surface pursuing
managed care –

Dan Johnson – 2nd term on Bd –

91 28% 95 93 18% 19%

Not traditional type of managed care – benefit plans
needs to be targeted to audience

Prohibits rate practices high users
pre-existing –

limits out of pocket expenses
memo
adequate

LRB 1648/B

75% women

uninsurability – funded by premiums in fact

not intended to deal with uninsured market –

5% rate increase Oct 31 – he has sheet –
$15.20 per month inc $24 zone 1

$6,7 to $10. no rate inc –

Mary Beth Tietz AAL –

Family premium – – June 1 –
bring more healthy people in –
better pool –

–

Increased utilization – Declining base –

35% under $20,000 inc different co-pay deductibles etc –

$1000 deductible –

Prudent investor - Rule for trustees in every state -

2-4 weekends - 2-3 years

1st read in July 93 - 1994 - 1995

Clean up Final approval

Yr Not coordinated

Written before proliferation of investment funds

Trustees not investing -

Default rule - If trust is silent on issue other this statute must be followed

Inflation / deflation / Return on income -

Tax consequences - Often

Page 4 section six

John Frank – Trustees only –

→ Personal representatives + guardians matters – included

881.

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3 concerns –

① Cover Guardians as well as personal representatives

② Trust beneficiaries duty owed investment advisors – not clear under the language

③ Return of/and trust assets – settlor is deceased –

Adopted with modifications – particularized detail

70.19(4)(m).

Trustee – follows during life of settlor – after death of grantor

881.03–04

statement of intent

Both be on the table –

Notes from Kingston Trustee Act –