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Details:

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WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

2007-08
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on ... Insurance
(AC-In)

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* Contents organized for archiving by: Mike Barman (LRB) (Aug/2010)

HIRSP
AUTHORITY

Health Insurance Risk-Sharing Plan (HIRSP) Authority
Senate Bill 226 and Assembly Bill 445
July 2007

A. HIRSP Plan Design

1. **Pharmacy Network:** Allow HIRSP to establish a pharmacy network that could include pharmacies that are not Wisconsin Medicaid certified.

2. **Low-Income Subsidy Plan Options:** Allow individuals eligible for the low-income subsidy program to apply the premium and deductible subsidy to any plan offered by HIRSP.

3. **Low-Income Subsidy Discounts**: Establish discounts for individuals eligible for low-income subsidy, rather than establishing subsidized premiums in comparison to the standard market rate for an insurance policy comparable to HIRSP.

4. **Definition of Group Coverage:** Allow the HIRSP Authority Board of Directors to define exceptions to the definition of employer-sponsored coverage for the purposes of determining HIRSP eligibility.

B. HIRSP Authority Administrative Issues

1. **Medicaid Payment Rates:** Remove the requirement that HIRSP provider payment rates be calculated as Medicaid enhanced rates. Maintain statutory requirement that provider payment rates be adjusted such that providers fund 20% of the plan costs.

2. **HCTC Plan:** Repeal the statutory requirement for HIRSP to implement and operate an HCTC plan.

3. **Temporary HIRSP Provider Certification:** Authorize HIRSP to temporarily certify health care providers who are outside the state of Wisconsin and are not Medicaid certified.

A detailed discussion of each item follows.

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A. HIRSP Plan Design

1. Allow HIRSP to establish a pharmacy network that could include Medicaid and non-Medicaid pharmacies.

Background: Chapter 149 of the statutes limits payment under HIRSP to services or articles provided by a Wisconsin Medicaid certified provider. Currently, WPS is the HIRSP plan administrator and Navitus is the pharmacy benefit manager. Under previous direction from DHFS, WPS and Navitus implemented a specialty pharmacy mail order program for select HIRSP policyholders using high-cost prescription drugs such as those for rheumatoid arthritis or HIV/AIDS. The specialty pharmacy program offers a number of benefits to policyholder and to the plan, including reduced costs for these drugs through the mail order pharmacy. Mail order pharmacies may not be Medicaid certified.

Goal: Modify the statutes to specify that HIRSP is authorized to pay for any prescription drugs provided by a network of pharmacies approved by the Board of Directors. This would allow the Authority to develop a pharmacy benefit design that leverages mail order options. Mail order pharmacy services offer opportunities for costs savings and improved patient care.

3. Allow individuals eligible for the low-income subsidy program to apply the premium and deductible subsidy to any plan offered by HIRSP.

Background: Under Wisconsin law, HIRSP policyholders in Plan 1A or Plan 2 with household income below $25,000 are eligible for premium and deductible subsidies. Concerns have been raised by policyholders, HIRSP Authority board members and other stakeholders about the fact that low-income policyholders are not afforded the same choice of coverage as other policyholders. Under current law, the subsidy is only available to policyholders that select Plan 1A, the $1,000 deductible plan or Plan 2. If the policyholder selects Plan 1B, the $2,500 deductible plan, they are disqualified from subsidy.

Allowing for subsidy portability between plans provides the following advantages:

- Regardless of income, policyholders would be afforded choice on the most appropriate plan design for their individual situation;
- Cost for the premium subsidy program could be reduced as subsidized policyholders choose higher deductible, lower premium plan options. The structure of the subsidy is such that the rate by which the premium is reduced is held constant regardless of plan choice. In other words, if the subsidy reduced the premium by 15% for a particular income category, the cost of reducing a Plan 1A quarterly premium of $1,869 is more than the cost of reducing a Plan 1B quarterly premium of $1,347 by 15%.

Goal: Allow individuals who qualify for subsidy under HIRSP to choose any plan option offered to policyholders.

4. Establish discounts for individuals eligible for low-income subsidy, rather than establishing subsidized premiums in comparison to the standard market rate for an insurance policy comparable to HIRSP.

Background: Under Wisconsin law, HIRSP policyholders in Plan 1A or Plan 2 with household income below $25,000 are eligible for a premium subsidy. Premium subsidies are set at a level relative to the "standard rate". The standard rate is calculated as the rate a standard risk would be charged under an individual policy offering substantially the same coverage and deductible as HIRSP. Prior to Act 74, HIRSP premiums could not be set at a level less than 140% of the standard rate. Currently, unsubsidized HIRSP premiums are set at 143.2% of the standard rate.

The premium subsidies as established in statute are summarized below:

Household Income	**Subsidized Premium Amount**
$0-$9,999	100% of standard rate
$10,000-$13,999	106.5% of standard rate
$14,000-$16,999	115.5% of standard rate
$17,000-$19,999	124.5% of standard rate
$20,000-$24,999	130% of standard rate

A concern has been raised regarding the current system where subsidies are tied to the "standard rate". Without a statutory minimum for HIRSP premiums, there is the possibility that subsidized premiums could be more than the un-subsidized premiums. For example, the HIRSP actuary recently conducted an analysis to illustrate what premiums would have been for fiscal year 2006 if the budget had been established at the level of actual expenditures. In that year, the board approved applying over $7.5 million of policyholder surplus to reduce rate increases. The analysis demonstrated that this surplus could have reduced premiums to 123% of the standard rate. Had that happened, subsidized individuals with incomes between $17,000 and $24,999 would have paid higher rates (124.5% and 130%, respectively) than policyholders who are not eligible for subsidy.

The current method of calculating premium subsidies is very confusing for policyholders. Premium discounts will be easier to understand and administer.

Goal: Establish premium discounts for low-income policyholders as opposed to tying subsidy levels to the standard rate. Actual discounts would be determined by the Board of Directors and would be at a minimum as follows:

Household Income	**Premium Discount**
$0-$9,999	30% off HIRSP premium
$10,000-$13,999	25% off HIRSP premium
$14,000-$16,999	20% off HIRSP premium
$17,000-$19,999	15% off HIRSP premium

$20,000-$24,999	10% off HIRSP premium

These proposed minimum discounts are comparable to the value of the subsidy provided to policyholders under the subsidy program in fiscal years 2006 and 2007. The Board would also be provided the authority to establish discounts for individuals with income over $24,999 who may qualify for low-income subsidy in the future.

5. Allow the HIRSP Authority Board of Directors to define exceptions to the definition of employer-sponsored coverage for the purposes of determining HIRSP eligibility.

Background: Under Wisconsin law, an individual who is eligible for creditable coverage that is provided by an employer on a self-insured basis or through health insurance is not eligible for HIRSP.

In the past, grievances have been filed by individuals working for employers that offer health care policies with low annual limits (e.g. $2,000 to $10,000). These policies are sometimes referred to as "mini med insurance policies". The advantage of mini med policies is that they are less expensive to the employer than a major medical health insurance policy. Another advantage for employers is that mini med policies can be offered on a voluntary basis with no employer contribution toward the premium. It is believed that the advent of mini med policies has resulted in increased access to health insurance for individuals who otherwise did not have access. For example, mini med policies may be used by employment service agencies to offer coverage to temporary workers.

In recent years, there have been a number of grievances filed by individuals who are offered these policies by their or their spouse's employer. These individuals are seeking HIRSP coverage because the employer-offered policy does not provide sufficient coverage for their health care needs. For example, the Authority recently received a communication from an individual who was seeking part-time employment with H&R Block. In this particular situation, H&R Block offered a policy with a $10,000 annual limit and did not contribute to the premium. This individual's wife was applying to HIRSP, but would have been ineligible if her husband worked for H&R Block during the tax season. The $10,000 policy did not offer sufficient coverage and protection for his wife, a cancer patient, so the individual chose to forgo employment with H&R Block

Goal: Allow the Board of Directors to define employer sponsored coverage that would not preclude HIRSP eligibility.

B. HIRSP Authority Administrative Issues

1. Remove the requirement that HIRSP provider payment rates be calculated as Medicaid enhanced rates. Maintain statutory requirement that provider payment rates be adjusted such that providers fund 20% of the plan costs.

Background: Chapter 149 requires HIRSP to pay providers the Medicaid rate plus an enhancement determined by the Authority. The resulting rates must be sufficient to cover the required provider contribution for plan costs.

In practice, DHFS and now the Authority establish the HIRSP payment rates by first establishing a "usual and customary" payment, which is calculated by discounting provider's billed charges. The usual and customary amounts are further discounted to capture the provider contribution to plan costs. The resulting rates are then converted to a Medicaid enhanced rate. In order to complete this step, the Authority and its actuary need to collect and analyze Medicaid payment rates. When the HIRSP Plan administrator was the Medicaid fiscal agent there may have been administrative efficiencies associated with relating HIRSP payment rates to Medicaid payment rates in terms of claims processing. However, in the current environment, this requirement creates additional work and cost for the Plan without any benefit. Another disadvantage is that HIRSP is reliant on the DHFS timetable for updating Medicaid payment rates.

Goal: Remove the statutory requirement to establish provider rates as enhanced Medicaid rates. Maintain the requirement that the Authority establish usual and customary payment rates and adjust those rates to ensure the providers' required contribution under 149.143(1)(c) and (2)(b).

2. Remove the statutory requirement for HIRSP to implement and operate a Health Coverage Tax Credit (HCTC) Plan.

Background: 2005 Wisconsin Act 74 requires HIRSP to develop and implement a federal health coverage tax credit (HCTC) qualified plan. There are a limited number of Wisconsin residents that qualify for the federal HCTC. Upon losing their job, there are a variety of reasons that one would not use the available tax credit:

- The individual accesses insurance through a spouse's employer.
- The individual takes a new job with employer-sponsored coverage.
- The individual chooses to remain uninsured while they seek new employment.

Nationally, of those that do utilize the tax credit, the majority use the credit to subsidize the cost of COBRA offered by their employer. Only 40% (or 6,126 across the country) utilize a state qualified plan.

Based on the data available from the Internal Revenue Service, Authority staff estimates that only 100 individuals would participate in a state qualified plan in Wisconsin. The Authority Board of Directors has determined that this level of enrollment is not sufficient to administer a financially solvent plan. In other words, there are too few covered lives to spread risk and have sufficient revenues to cover medical losses. The Authority would also need start-up funds to implement the plan.

These issues were discussed with the Department of Administration (DOA) and DHFS. It was agreed that a good option to explore would be for the HCTC population to buy into BadgerCare Plus, similar to plans in the Governor's budget for children with income over 300% of the federal poverty level. This option would be acceptable to the federal government and 60% of the

BadgerCare Plus premiums could be paid under the federal HCTC program. Through the state budget process, the Authority is seeking to have BadgerCare Plus accessible to HCTC qualified individuals.

Goal: Repeal the statutory requirement for HIRSP to implement and operate an HCTC plan.

3. Allow HIRSP to temporarily certify out-of-state health care providers.

Background: The statutes limit HIRSP coverage to services provided by Medicaid certified providers. Under DHFS administration of HIRSP, a practice was established where out-of-state providers who treated HIRSP policyholders in emergency medical situations could be retroactively certified as a Medicaid provider on a temporary basis. A form was created for providers to apply for the temporary certification, which lasted one year. HIRSP would then pay the provider the HIRSP rate.

In reviewing the temporary Medicaid certification process it was discovered that the providers were not actually Medicaid certified, contrary to what the certification form states. Wisconsin Medicaid does not have a process for issuing temporary Medicaid certification. This process was created solely for the benefit of HIRSP and the information was never transmitted from HIRSP to Medicaid. In effect, the provider was temporarily certified to provide services under HIRSP and the practice is not compliant with the statutes.

Goal: Authorize HIRSP to temporarily certify health care providers who are outside the state of Wisconsin and are not Medicaid certified.


FORWARD
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HIRSP
AUTHORITY

Assembly Committee on Insurance

Public Hearing on Assembly Substitute Amendment to Assembly Bill 445
September 11, 2007

Dear Members of the Insurance Committee:

Thank you for the opportunity to testify today on the Assembly Substitute Amendment to Assembly Bill 445 which makes a number of important changes to the Health Insurance Risk-Sharing Plan (HIRSP). As you know, administration of HIRSP, Wisconsin's high-risk insurance pool, was transferred to the newly created HIRSP Authority in July of 2006.

In creating the HIRSP Authority under 2005 Wisconsin Act 74, the legislature directed the HIRSP Board of Directors to establish plan designs that " the Authority determines generally reflect and are commensurate with comprehensive health insurance coverage offered in the private individual market in the state" and that are "responsive to market conditions."

Since that time, the HIRSP Board of Directors and staff have been busy working to achieve the legislative goal of improving the administration of HIRSP through the Authority. I am pleased to report today that significant progress has been made in this regard over the last year.

One of the Authority's first accomplishments was completing a comprehensive evaluation of the mental health/AODA benefit under HIRSP to determine whether the existing benefit design supported evidenced-based treatment for mental health and substance abuse. The evaluation illustrated a benefit design that favored inpatient hospital treatment which is not consistent with evidence-based practices of community treatment and is not always cost effective. As a result, the Board is considering a re-design of these benefits this fall.

Prescription drug spending accounts for over one-third of all HIRSP costs. This aspect of HIRSP, therefore, deserves careful consideration and management. The Board has approved a number of changes to HIRSP that will improve the plan's ability to manage its prescription drug costs more effectively and to improve the quality of care delivered to policyholders. HIRSP is also in the process of expanding its disease and care management activities to further improve care delivery.

The Authority also analyzed the current plan design of HIRSP and found it lacking in a number of important ways. First, even HIRSP's higher deductible ($2,500) plan option was still unaffordable for many eligible individuals. Considering this and the fact that the majority of HIRSP policyholders don't meet their deductible in a given year, higher deductible plan options were explored. The Board also recognized that HIRSP was out of step with market trends by not having a health savings account qualified plan available for individuals interested in taking advantage of federal tax incentives. Consequently, the Board decided to make two new plan

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options available as of January 1, 2008 – a $5,000 traditional high-deductible plan and a $3,500 health savings account high-deductible plan. These new plans are expected to provide financial relief to current policyholders and to make HIRSP a more affordable option for some of Wisconsin's uninsured.

The above mentioned changes are in addition to many other administrative enhancements that have been implemented to improve the efficiency and effectiveness of HIRSP operations, including a new rate setting methodology that no longer holds HIRSP hostage to annual increases in billed charges for professional and inpatient hospital services.

As it continues its efforts to achieve the vision established by the legislature in creating the HIRSP Authority, the Board has identified a number of statutory changes that would allow HIRSP to be administered more efficiently and equitably. Each item contained in Senate Bill 226 was carefully reviewed by at least one standing committee of the Board of Directors and was recommended unanimously by the full Board. A brief summary of the items contained in the bill is provided below:

A. HIRSP Plan Design

1. **Pharmacy Network:** Allow HIRSP to establish a pharmacy network that could include pharmacies that are not Wisconsin Medicaid certified. This change would allow HIRSP to broaden its pharmacy network and increase access for policyholders.

2. **Low-Income Subsidy Plan Options:** Allow individuals eligible for the low-income subsidy program to apply the premium and deductible subsidy to any plan offered by HIRSP. This change affords low-income policyholders the same choice of plan options (e.g. high versus low deductible) available to all other policyholders.

3. **Low-Income Subsidy Discounts**: Establish discounts for individuals eligible for low-income subsidy, rather than establishing subsidized premiums in comparison to the standard market rate for an insurance policy comparable to HIRSP. This change will significantly simplify the administration of the subsidy program and will make it more understandable to policyholders.

4. **Definition of Group Coverage:** Allow the HIRSP Authority Board of Directors with the approval of the Commissioner of Insurance to define exceptions to the definition of employer-offered coverage for the purposes of determining HIRSP eligibility. This change will allow the Board to respond to changes in the commercial insurance market, including the offering of new, limited benefit insurance products (e.g. policies with $2,000 maximum annual benefits).

B. HIRSP Authority Administrative Issues

1. **Investment Policy:** Allow the HIRSP Authority to invest the plan's assets with the State of Wisconsin Investment Board (SWIB) at the direction of the HIRSP Authority Board

of Directors. This provision will provide the Board with an improved ability to effectively manage HIRSP's assets.

2. **WRS Participation:** Allow HIRSP Authority staff to participate in the Wisconsin Retirement System (WRS). This change treats the HIRSP Authority like other similar state authorities and will allow for the most cost-effective provision of health insurance and other benefits to Authority staff.

3. **OCI Appropriations:** Allow the HIRSP Authority to receive HIRSP insurer assessments and federal high-risk federal grant funds directly. Under current law, the monies go to the Office of the Commissioner (OCI) of Insurance and then to HIRSP. This provision will remove administrative redundancies between OCI and HIRSP.

4. **Medicaid Payment Rates:** Remove the requirement that HIRSP provider payment rates be calculated as Medicaid enhanced rates. Maintain statutory requirement that provider payment rates be adjusted such that providers fund 20% of the plan costs. The requirement that HIRSP rates be calculated as Medicaid rates is a holdover from the Department of Health and Family Services (DHFS) administration of HIRSP and is no longer necessary under the Authority model.

5. **HCTC Plan:** Repeal the statutory requirement for HIRSP to implement and operate an HCTC plan. This change recognizes the Boards determination that there would not be sufficient enrollment in an HCTC plan to operate a financially solvent plan. The Board has worked collaboratively with the Department of Administration, DHFS and the legislature to develop an alternative mechanism for establishing an HCTC plan through the proposed BadgerCare Plus program. This alternative is included in Senate Bill 40.

6. **Temporary HIRSP Provider Certification:** Authorize HIRSP to temporarily certify health care providers who are outside the state of Wisconsin and are not Medicaid certified. The Authority inherited a practice from DHFS for certifying out-of-state providers who treat HIRSP policyholders in emergency medical situations that was out of compliance with the statutes. This charge would authorize HIRSP to temporarily certify providers for these types of situations.

Thank you in advance for your support of the changes sought by the HIRSP Authority Board of Directors.

Amie Goldman, CEO
On behalf of the HIRSP Authority Board of Directors