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Health Insurance Risk-Sharing Plan (HIRSP) Board Proposal for Transition to Individual Market (Insurance)

CURRENT LAW

The Health Insurance Risk-Sharing Plan (HIRSP) provides health insurance coverage to individuals who cannot otherwise obtain private coverage due to a pre-existing medical condition, or who lose access to employer-sponsored insurance. HIRSP benefits and operations are funded by member premiums, assessments paid by insurance companies, and contributions providers make by accepting reduced reimbursement for services. HIRSP also administers the federal pre-existing condition insurance plan, also known as "HIRSP Federal," created under the federal Patient Protection and Affordable Care Act (ACA) and funded through member premiums and federal grant funds. Coverage in HIRSP Federal is scheduled to end in December, 2013. No state general purpose revenue (GPR) is allocated for the administration or claims payments of HIRSP or HIRSP Federal.

HIRSP members can select from various plan options that vary by premium and cost-sharing amounts, and pay premiums based on age, plan choice, and gender (premiums are based on plan choice and age for HIRSP Federal). In March, 2013, a total of 22,333 individuals were enrolled in HIRSP, and an additional 2,320 were enrolled in HIRSP Federal.

GOVERNOR

The Governor's bill does not include any provisions related to HIRSP.

DISCUSSION POINTS

1. This paper provides information on a proposal developed by the HIRSP Board of Directors ("the Board") to end HIRSP coverage and transition current HIRSP members into the private insurance market. Under this proposal, HIRSP coverage would end on January 1, 2014, or the effective date of coverage purchased through an insurance exchange, and HIRSP members

would need to purchase private coverage either inside or outside the federally-facilitated insurance exchange. After the termination of HIRSP coverage, the Office of the Commissioner of Insurance (OCI) would assume administrative responsibility for HIRSP dissolution and "wind-up." The information provided in this paper is based on Legislative Reference Bureau (LRB) Draft 1888/P5, which was drafted and unanimously approved by the Board.

Affordable Care Act Background

2. HIRSP provides insurance coverage to individuals who either cannot obtain affordable coverage on the private market due to a medical condition, or who have lost access to employer-sponsored coverage. The ACA contains several provisions that would address issues of insurability for current HIRSP members, and would, in theory, reduce the need for a state high-risk pool like HIRSP. These reforms, which go into effect on January 1, 2014, include prohibiting charging premiums based on health (known as "modified community rating"), guaranteeing issue of coverage, and prohibiting pre-existing condition exclusions.

3. January 1, 2014, is also the expected effective date of private coverage purchased through health benefits exchanges, or "marketplaces," created by the ACA. Certain individuals and families with income under 400% of the federal poverty level (FPL) who purchase coverage through an exchange will also qualify for premium and cost-sharing subsidies (in 2013, 400% of the FPL for an individual is $45,960 in annual income). Wisconsin chose not to create a state-based exchange, so the exchange will be operated by the federal government. The federal Department of Health and Human Services (HHS) is responsible for governance and implementation of this federally-facilitated exchange (FFE).

4. The ACA also established a three-year reinsurance program for plans that offer coverage through an exchange (as well as permanent risk adjustment and risk corridor programs for exchange-based plans). Under the reinsurance program, all insurance companies and self-insured plans are required to contribute funding for the operation of the program -- a nationwide total of $10 billion in 2014, $6 billion in 2014, and $4 billion in 2016. The program would pay for 80% of a plan's claims for an individual with health care costs over $60,000 in 2014 (up to claims of $250,000).

5. The reinsurance program was originally structured as a state-run program, and Wisconsin could have determined how to use contributions from Wisconsin insurers. However, in rules finalized in March, 2013, HHS decided to administer the reinsurance program nationally. This system means that all insurer assessments would be collected by HHS and aggregated into a national funding pool, which would make payments to plans with high cost enrollees in the exchanges across all states.

HIRSP Board Proposal

6. The HIRSP Board of Directors consists of representatives from multiple stakeholder groups with an interest in HIRSP. This includes representation from HIRSP policyholders, the insurance industry, health care providers, the Office of the Commissioner of Insurance (OCI), small businesses, and consumer advocates. The Board sets HIRSP's annual budget, monitors its fiscal

management, pays the plan's operating and administrative expenses, and establishes procedures for the timely collection of premiums and payment of benefits.

7. The future of state high-risk pools after the enactment of the ACA has been a topic of much discussion, as several of the ACA reforms address issues of private market insurability that state high-risk pools like HIRSP also aim to address. In 2012, the Board laid out a set of "guiding principles" to use when considering policy options for the future of HIRSP and the eventual transition of HIRSP members to the individual market.

8. These principles included the following: (a) maintain access to comprehensive and affordable insurance for HIRSP members, minimize their disruption when transitioning to the individual market, and utilize premium tax credits to benefit low-income HIRSP members; (b) minimize "rate shock" in the individual market, and, if practical and desirable, leverage the benefits of keeping high-cost individuals separate from the individual insurance market; (c) minimize the potential for increased uncompensated care, and do not disproportionately impact providers and provider reimbursement; and (d) consider the costs and risk allocation benefits for Wisconsin insurers of the HIRSP assessment and ACA reinsurance program assessment.

9. Under the original understanding of a state-run ACA reinsurance program, the Board recommended a gradual transition of HIRSP members to the individual market, in conjunction with using more of the reinsurance program funds in the second and third years of the program. This gradual closing of the plan may have helped shield the exchange from a large influx of HIRSP participants who have high health care costs, and provided HIRSP members with more time to consider private insurance options in the exchange.

10. In light of the HHS decision to administer the reinsurance program nationally, the Board determined that its original proposal for a gradual phase-out of HIRSP coverage no longer met the goals that the Board set for such a transition. The reason for this reconsideration was that if Wisconsin delayed transitioning HIRSP participants to the private market, as originally proposed, the funds that Wisconsin insurers paid into the national reinsurance program would not necessarily benefit exchange-based plans offered through Wisconsin's FFE. Wisconsin insurers would pay the reinsurance program assessments, and continue to pay HIRSP assessments as specified under current law. In addition, gradually transitioning HIRSP members to the individual market without being able to "backload" reinsurance program funding in the second and third years of the program may have reduced the effectiveness of that program to protect against increased rates in Wisconsin's exchange.

11. At its February 27, 2013, meeting, the Board voted for a revised framework for the merger of HIRSP into the individual market on January 1, 2014, or the date on which coverage through the FFE goes into effect. HIRSP staff drafted statutory language (LRB Draft 1888/P5) to accomplish this framework. Attachment 1 provides a full summary of that draft.

12. In general, the proposal would terminate all HIRSP coverage on January 1, 2014, or on the date which coverage accessed through a health benefits exchange goes into effect. The HIRSP Authority would need to notify all policyholders of the date that coverage ends at least 60

days before that date.[*] Current HIRSP members who wanted to continue purchasing health insurance coverage would need to do so through the exchange, or in the individual market outside the exchange.

13. Sixty days after termination of HIRSP coverage, OCI would take administrative responsibility for the dissolution and wind-up of HIRSP's affairs. The Board would be changed to the "HIRSP Advisory Council" attached to OCI, with the same membership as existed prior to the termination of HIRSP.

14. HIRSP carries an ongoing surplus balance to ensure plan solvency. The proposal would create a PR appropriation in OCI to hold and disburse any surplus balance that remains after all claims have been paid, and to pay for plan wind-up costs. The Board would be required to develop a plan to return any unspent funds to policyholders, insurers, and providers, as feasible, and OCI would be required to execute this plan. HIRSP currently projects surplus reserves of approximately $10 million at the end of the 2013, although this amount may change depending on actual claims costs for the rest of the year, and actual close-out costs.

15. At its April 24th meeting, the Board unanimously approved LRB Draft 1888/P5 as its official position for the transition of the HIRSP population to the individual market. However, at that meeting, concerns were raised by several Board members that exchanges would not be ready by October, 2013, to enroll people in coverage effective January 1, 2014.

16. The federal government continues to indicate that open enrollment in the exchanges will begin on October 1, 2013, with coverage going into effect on January 1, 2014. Members of the Board raised concerns, which the Committee may share, that Wisconsin's FFE will not be fully operational by January 1, 2014, that there may be technical or operational problems with the implementation of the FFE, or that there may be areas of the state where no exchange-based plans (or only one plan) will be available. Other commentators, policymakers, and interest groups have raised similar concerns. Given those concerns, the Board also voted to monitor the status of Wisconsin's FFE and determine if any changes to the proposal would be recommended in the future.

17. Despite these concerns, the draft language approved at that meeting, and described in Attachment 1, represents the HIRSP Board position at this time. If the Committee and the full Legislature adopts this proposal, any modifications recommended by the Board would require subsequent legislation.

Analysis and Alternatives

18. If the Committee agrees with the Board's proposal to merge the current HIRSP population with the individual market through statutory changes enacted as part of the biennial budget act, the Committee could adopt that proposal and incorporate the provisions of LRB Draft 1888/P5 into the budget bill (Alternative 1). This proposal has been debated and unanimously

[*] This represents the minimum notification requirement in the proposal. If this proposal is adopted, HIRSP staff plan to conduct an extensive information campaign to make policyholders aware of these changes and their coverage options after HIRSP coverage ends.

approved by Board membership representing a wide range of stakeholders including HIRSP policyholders, insurers, health care providers, consumer advocacy groups, and small businesses.

19. There are arguments for transitioning HIRSP members to the private market on January 1, 2014. For example, the ACA contained provisions that protect individuals with pre-existing conditions, such as guaranteed issue of insurance policies and modified community rating that go into effect on that date. Additionally, a gradual transition originally considered by the Board would not fully take advantage of all three years of the ACA reinsurance program, and contributions made by Wisconsin insurers to that program would be used to mitigate costs in other states.

20. HIRSP staff indicate that to effectively prepare for the proposed transition and to fully explain the changes to current HIRSP members, it is important to have any statutory changes enacted by July, 2013. Given this proposed timeline, the Board's strategic planning committee directed the HIRSP Authority to seek these changes as an amendment to the biennial budget bill, rather than pursue separate legislation. An argument could be made that the Board's proposal may have been considered for inclusion in the Governor's bill if the new information on the ACA reinsurance program had been fully known at the time the bill was drafted, and that this issue is appropriately taken up by the Joint Finance Committee in its budget deliberations.

21. The Committee may decide not to include the Board's proposal as an amendment to the budget bill, and to maintain current law with respect to HIRSP (Alternative 2). No explicit action is needed, but Alternative 2 is provided to make clear that the Committee need not adopt the Board's proposal.

22. There are also arguments for maintaining HIRSP coverage as it currently exists after the ACA implementation. For instance, some may argue that HIRSP is better able to address the needs of individuals with high health care costs than private plans purchased on the individual market. Also, transitioning HIRSP members to the individual market would be expected to raise average costs in that market, as HIRSP members' health care needs would be higher than the average enrollee. It could also be argued that, although the proposal would create an appropriation in OCI, the broader issue of merging HIRSP members into the individual market would be more appropriately addressed by a standing committee of the Legislature.

23. If the plan is not approved, some HIRSP members would enter the private market after the implementation of the ACA reforms, and some members would presumably remain in HIRSP. It is not known how many enrollees would remain in HIRSP if given the option -- if a large number HIRSP members entered the exchange to take advantage of the premium tax credits, this could adversely affect the remaining pool of HIRSP enrollees. Wisconsin insurers would contribute funds to the temporary ACA reinsurance plan, and continue to owe assessments to cover HIRSP costs. If the state decided to transition HIRSP members to the private market at some point in the future, the full ACA reinsurance program would not be available to help "cushion" the exchange from high-cost HIRSP enrollees, as that program will phase out by the end of 2016.

ALTERNATIVES

1. Modify the bill to include Health Insurance Risk Sharing Plan (HIRSP) Board of Directors proposal in LRB Draft 1888/P5, and as described in Attachment 1.

2. Take no action. Maintain current law with respect to HIRSP.

Prepared by: Sam Austin
Attachment

ATTACHMENT 1

Summary of HIRSP Board Proposal for Merger of HIRSP with Individual Market (LRB Draft 1888/P5)

Termination of HIRSP Coverage

- End all existing HIRSP coverage on January 1, 2014, or on the date that any health insurance coverage that is accessed through a health benefit exchange is effective (if later than January 1, 2014). Prohibit new HIRSP coverage from being issued after December 31, 2013, and new HIRSP Federal coverage from being issued after December 1, 2013.

- At least 60 days before HIRSP coverage ends, the HIRSP Authority must provide notice of the date that coverage will end to all HIRSP policyholders, insurers and health care providers who would be affected by the ending of HIRSP coverage, the Office of the Commissioner of Insurance (OCI), the Legislative Audit Bureau (LAB), and insurers that offer Medicare supplement or replacement policies.

- If HIRSP coverage terminates on a date after January 1, 2014 (due to coverage through the exchange not going into effect on January 1, 2014), the HIRSP Authority may allow HIRSP Federal members to transition to standard HIRSP coverage, and participate in that program until coverage ends.

Reimbursement, Grievances and Independent Review

- Require providers of medical services, devices, or prescription drugs to file any claims for HIRSP reimbursement no later than 90 days after the termination of HIRSP coverage. Any claim filed after that date would not be payable, and could not be charged to the HIRSP member who received the service.

- HIRSP members must submit any grievances in writing within 180 days of the date that HIRSP coverage terminates. HIRSP members must submit any grievance related to prior authorization denial no later than 45 days before HIRSP coverage terminates, except for such grievances that meet the requirements for expedited review must be submitted no later than the date on which HIRSP coverage terminates.

- A HIRSP member who submits a grievance after HIRSP coverage terminates must request an independent review, if any, no later than 60 days after receiving notice of the disposition of the grievance.

HIRSP Authority and Board Responsibilities

- Require the HIRSP Authority to pay plan costs in 2013, and all other plan costs associated with dissolving the plan incurred before the transfer of administrative responsibility to

OCI (see below). The Authority and OCI shall make every effort to pay plan costs in accordance with, or as closely as possible to, the manner provided in current law.

- Allow the HIRSP Authority to extend any currently effective administrative contracts into 2014, regardless of a contract's expiration date, without having to comply with requirements for extending such contracts under current law.

- Require the Authority to submit a final report to the Legislature on plan operation no later than September 30, 2013.

- Require the Board to develop a proposal, which OCI shall follow, for the dispensation of the plan's cash assets that remain after all HIRSP financial obligations are satisfied. To the extent feasible and practical, this proposal shall provide for the return of any remaining funds to the source from which it was derived, including insurers, providers, and policyholders. If returning funds directly is not feasible, the proposal shall provide for alternative dispensations, such as using remaining funds in support of activities providing an indirect benefit to insurers, providers, or policyholders.

- Require the Board to dispose of any HIRSP noncash assets as soon as possible after the closing of the Authority's administrative offices, and to make any other decisions or actions necessary to "wind up" HIRSP affairs and transfer responsibility to OCI. Require that all actions taken by the Board must be consistent with HIRSP's purpose, and not endanger its solvency.

Transfer of Administrative Responsibility to OCI

- Sixty days after the date that HIRSP coverage terminates, transfer administrative responsibility for the dissolution of the plan to OCI. The Commissioner shall take any action needed or advisable to wind up the affairs of the plan, in accordance with the proposal developed by the Board, and shall notify and provide final financial statements to the LAB when this wind-up is complete.

- Transfer all remaining HIRSP cash assets to a newly created appropriation in OCI. Specify that this new appropriation would pay for expenses related to winding up the affairs of HIRSP, including hiring consultants, limited-term employees, and experts, and distributing the unexpended HIRSP balance (in accordance with the Board plan described above). Allow this appropriation to receive any subrogation recoveries, drug rebates, or any other source related to HIRSP operations or dissolution. Specify that any expenses incurred by the HIRSP Authority or OCI may only be payable from this appropriation, or from the funds of the Authority.

- Transfer all tangible personal property of the HIRSP Authority, including records, to OCI. Transfer all existing contracts and agreements entered into by the HIRSP Board to OCI, and require OCI to carry out contractual obligations until the contract or agreement terminates, or is modified or rescinded. Transfer any pending matters, including grievances and independent reviews, payment claims, or subrogation claims, to OCI, and consider any materials submitted to or actions taken by OCI related to a pending matter as having been submitted to or taken by the

HIRSP Authority.

Transition of HIRSP Board to HIRSP Advisory Committee

- Sixty days after the date that HIRSP coverage terminates, create a HIRSP Advisory Committee consisting of the Commissioner of Insurance or his or her designee, and the 13 other members of the HIRSP Board that held office on that date. The HIRSP Advisory Committee shall advise and assist the OCI with its duties in the dissolution and wind-up of the plan. OCI shall staff and provide funding for the HIRSP Advisory Committee.

- Specify that if a vacancy occurs on the HIRSP Advisory Committee, the Governor would appoint a successor who meets the same qualifications and criteria as the outgoing committee member.

- The HIRSP Advisory Committee shall terminate 60 days after the LAB conducts the final audit of the plan.

Other Provisions

- Provide that the HIRSP Authority, Board of Directors, the Commissioner of Insurance (or any agent, employee, or representative of OCI) may not be held liable for any act or omission committed in the performance of their duties under Chapter 149 or the provisions of this phase-out plan. (This is similar to current law language limiting the liability of the Authority.)

- Require the LAB to do all of the following: (a) conduct its annual audit for calendar year 2013 by June 30, 2014; (b) complete a final audit of the plan within 90 days of receiving the final financial statements from OCI; and (c) file copies of both audit reports with the recipients designated under current law. These audit costs shall be paid out of the funds of the HIRSP Authority, and the newly-created HIRSP appropriation in OCI.

- Require insurers offering Medicare supplement or replacement policies to provide coverage to anyone who meets all the following criteria: (a) is eligible for Medicare; (b) had HIRSP coverage that terminated on January 1, 2014 (or the a date later than January 1, 2014 if exchange-based coverage did not go into effect); (c) applies for a Medicare supplement or replacement policy within 63 days of the termination of HIRSP coverage; and (d) pays the premium for the Medicare supplement or replacement policy. An insurer may not deny coverage to a person who meets all the listed criteria based on health status. The HIRSP Authority must notify such insurers of this requirement within 60 days of the effective date of the bill.

- Allow insurers to claim the tax credit for HIRSP contributions (limited to a total of $5 million per year across all insurers) for tax years that begin before January 1, 2015, as that tax credit was in effect in the 2011-13 biennium. This provision would be included to account for any carryover claims of that HIRSP tax credit after the plan has ended operation.

- Repeal Chapter 149 of the statutes, which created HIRSP and the HIRSP Authority, effective January 1, 2015.

- Make all necessary technical changes to delete statutory cross-references to Chapter 149 and the HIRSP Authority.

Effective Dates

- In general, the provisions in the bill would go into effect on the later of July 1, 2013, or the date of the bill's publication.

- Changes related to the notice requirements for HIRSP coverage when a private insurance policy is cancelled or not renewed would go into effect on December 31, 2013.

- The treatment of certain provisions related to the revenue and taxes (including the HIRSP assessment tax credit), and the deletion of Chapter 149 and all statutory cross-references to HIRSP, would go into effect on January 1, 2015.