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Health Insurance Risk-Sharing Plan

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Health Insurance Risk-Sharing Plan

Wisconsin's health insurance risk-sharing plan (HIRSP) offers health insurance coverage to residents who are unable to obtain adequate coverage in the private market due a medical condition, or who have lost their group health insurance coverage. HIRSP is financed through the premiums paid by these policyholders and by assessments collected from health insurance companies that conduct business in Wisconsin. Health care providers also contribute to HIRSP by accepting reduced reimbursement rates for the covered medical services provided to HIRSP policyholders.

The Health Insurance Risk-Sharing Plan Authority ("the Authority") administers HIRSP. The Authority is not a traditional state agency, but rather a "public body corporate and politic." No state general purpose revenues (GPR) support its operations. Nevertheless, aspects of public control over HIRSP remain, including the Governor's power to appoint the Authority's Board of Directors, with the advice and consent of the Senate. In addition, while the Authority can adjust certain aspects of its health insurance offerings to reflect conditions in the private market, other aspects of the program are mandated by statute.

This paper provides information about HIRSP, including eligibility requirements, the types of health insurance plans offered, funding sources, and the historical trends in plan enrollment and expenditures. The paper also describes the administrative structure of HIRSP, including the creation and responsibilities of the Authority.

Eligibility Requirements

In order to obtain coverage under HIRSP, an individual must: (a) be a Wisconsin resident (defined as having been legally domiciled in Wisconsin for at least three months); (b) be ineligible for employer-sponsored group health insurance; (c) be ineligible for coverage under medical assistance (MA) or BadgerCare Plus; and (d) either qualify for HIRSP coverage based on a medical condition, or due to a loss of coverage under an employer-sponsored group health insurance policy.

Eligibility Based on a Medical Condition. For a person to qualify for HIRSP coverage because of a medical condition, he or she must meet at least one of the following requirements.

First, a person is eligible for HIRSP if, within nine months prior to submitting their application, they receive any of the following, based wholly or partially on medical underwriting considerations:

- Notice of rejection of coverage from two or more health insurers;

- Notice of cancellation of coverage from one or more insurers;

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

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

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

offered by HIRSP.

Second, a person is eligible for HIRSP if they are already covered by Medicare because of a disability defined by the Medicare program.

Third, a person is eligible if they submit evidence of a positive test for the human immunodeficiency virus (HIV) or an antibody to HIV.

All HIRSP participants qualifying because of a medical condition are subject to a six-month pre-existing condition waiting period. During this period, plan benefits are not provided for services related to a condition which was diagnosed or for which medical treatment was recommended or received during the six months preceding the policy's effective date. This clause protects the plan from the adverse effects caused by individuals only accessing coverage when a known need or expense presents itself. Insurance pools rely on individuals paying premiums both in times when they need care and time when they do not need care.

Eligibility Based on Loss of Employer-Offered Coverage. A person qualifies for HIRSP if he or she satisfies the statutory definition of an "eligible individual," generally defined as somebody who loses group health insurance coverage. Specifically, Chapter 149 of the statutes defines an "eligible individual" as a person for whom all of the following apply:

- Their periods of creditable coverage totaled at least 18 months, with no gap in coverage that exceeded 63 days, and they applied for HIRSP within 63 days of losing their employer-sponsored group health insurance (Table 1 lists coverage that qualifies as creditable coverage);

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

- They do not have creditable coverage and are not eligible for coverage under a group health plan, parts A, B, or D of Medicare, medical assistance (MA), or any successor program;

- Their most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or a failure to pay premiums; and

- If they were offered the option of continuation coverage under a federal continuation provision or a similar state provision, they accepted and exhausted that coverage.

Table 1: Qualifying Creditable Coverage

- A group health plan
- Health insurance (defined as surgical, medical, hospital, major-medical and other health service coverage provided on an expense-occurred basis and fixed indemnity policies)
- Medicare Parts A, B, or D
- Medical Assistance (MA)
- TRICARE (the U.S. Department of Defense's health care program for active duty and retired uniformed services members and their families)
- Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA)
- An Indian health services or tribal organization health plan
- A state health benefits risk pool
- A federal employee health plan
- A public health plan
- A Peace Corps health plan

Unlike HIRSP policyholders who qualify because of a medical condition, a person who qualifies for coverage as an eligible individual is not subject to a six-month waiting period before full coverage begins. HIRSP policy also waives the pre-existing waiting period to individuals who come to enroll within 45 days of losing Medicaid or BadgerCare Plus coverage. For the past several years, eligible individuals constitute the majority of new HIRSP enrollment.

Table 2: Summary of HIRSP Application Statistics

Year	Applications Received	Applications Approved	Eligible Based on Medical Condition: Medicare Eligible	HIV+ Diagnosis	Notice of Rejection	Benefit Reduction	Notice of Premium Increase of >50%	Eligible Based on Loss of Group Insurance ("Eligible Individuals")
2001	5,455	5,093	212	38	2,946	77	25	1,795
2002	7,163	6,454	192	27	4,125	60	19	2,031
2003	6,479	5,616	126	29	3,372	48	5	2,036
2004	6,298	5,206	99	35	2,796	95	1	2,180
2005	6,949	5,164	59	25	2,734	82	17	2,247
2006	5,262	4,319	13	33	1,791	52	13	2,417
2007	4,667	3,698	20	56	1,475	36	10	2,101

Persons Ineligible for HIRSP. Chapter 149 identifies people who are not eligible for HIRSP even if they satisfy the program's other eligibility requirements. This applies to people who are:

• over 65 years of age, unless they are an "eligible individual" or have HIRSP coverage on the date they turn 65;

• recipients of over $1,000,000 of benefits from HIRSP;

• eligible for creditable coverage provided by an employer on a self-insured basis or through health insurance;

• eligible for health care coverage under BadgerCare; and

• eligible for MA, with some exceptions.

In addition, any HIRSP policyholder who voluntarily terminates coverage is ineligible until 12 months have passed since the person's termination of coverage. This does not apply to "eligible individuals" or people who terminate HIRSP coverage because of eligibility for MA.

In recent years, most applicants who obtained coverage under HIRSP were accepted either because they lost their group health insurance or because they received a notice of rejection or cancellation of coverage from an insurer. Table 2 summarizes HIRSP's annual application statistics for calendar years 2001 through 2007.

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

Overview of the HIRSP Insurance Plans

HIRSP offers participants five different health insurance plans. These include three plans that have been available for many years, but whose names have changed (Plan 1A, Plan 1B, and Plan 2 became HIRSP 1,000, HIRSP 2,500 and HIRSP Medicare Supplement, respectively) and two new plans (HIRSP 5,000 and HIRSP Health Savings Account (HSA)).

Table 3 provides a comparison of the deductible, coinsurance and out-of-pocket maximum expenditure for each plan. This section discusses these characteristics in detail. Appendix I compares HIRSP premiums by plan, age and sex.

Table 3: Comparison of HIRSP Plan Features*

	HIRSP 1,000	HIRSP 2,500	HIRSP 5,000	HIRSP Medicare Supplement	HIRSP Health Savings Account
Medical Deductible	$1,000 / year	$2,500 / year	$5,000 / year	$500 / year	$3,500 / year
Medical Coinsurance	20% of allowed amount	20% of allowed amount	20% of allowed amount	None	20% of allowed amount
Drug Coinsurance	-	-	-	-	20% of allowed amount
Individual Medical Out-of-Pocket Maximum	$2,000 / year	$3,500 / year	$6,000 / year	$500 / year	$5,600 / year (includes maximum medical / / drug coninsurance amount of $2,100 / year)
Family Medical Out-of-Pocket Maximum (All family members must be on same plan)	$4,000 / year	$7,000 / year	$12,000 / year	$1,000 / year	$11,200 / year (includes maximum medical / drug coinsurance)
Drug Copay	$10 Tier 1 / $30 Tier 2	$10 Tier 1 / $30 Tier 2	$10 Tier 1 / $30 Tier 2	$10 Generic / $30 Brand	-

*See Appendix I for comparison of annual premiums by plan, age, and gender.

All five HIRSP plans offer major medical expense coverage and a prescription drug benefit, with a maximum lifetime benefit of $1,000,000. In order to be covered under HIRSP, all services must be provided by a Medicaid-certified provider. HIRSP has the right to exclude or limit any service (including prescription drugs) that is not deemed medically necessary and appropriate, or provided in accordance with generally accepted standards of medical practice. For a partial list of covered and non-covered benefits, see Appendix II. None of the HIRSP insurance plans pay medical expenses payable under insurance available to the policyholder, such as auto insurance, worker's compensation, private insurance, Medicare or MA.

The following sections summarize the deductible, premium, coinsurance, drug benefits, and available discounts for low-income policyholders of each of the five plans.

HIRSP 1,000, HIRSP 2,500 and HIRSP 5,000. These three plans have the same eligibility criteria and benefits, but differ in premium and deductible amount. Only people who are not eligible for Medicare may enroll in these plans.

Deductibles. The names of the plans reflect the level of that plan's deductible (the amount a policyholder must pay for covered services before insurance pays any portion of their expenses). The deductible is $1,000 for HIRSP 1,000, $2,500 for HIRSP 2,500, and $5,000 for HIRSP 5,000.

Premiums. The plans with higher deductibles have lower premiums (the fixed amount a policyholder must pay each quarter for coverage). For instance, HIRSP 1,000 is a low-deductible, high-premium plan; HIRSP 5,000 is a high-deductible, low-premium plan. The actual premium amount depends on the age and sex of the policyholder. In 2009, the Authority began using statewide premium rates to simplify and improve the equity of the premium structure. Previously, the state was divided into three geographic zones for determining premiums. For a full comparison of plan premiums, see Appendix I.

Medical Coinsurance. All three of these plans require policyholders to pay medical coinsurance (the fixed percentage of covered medical expenses an individual must pay during a coverage period after satisfaction of the deductible). Policyholders must pay 20 percent of allowable medical

expenses, up to a $1,000 maximum. These plans also include an out-of-pocket maximum for combined deductible and coinsurance obligation.

Drug Benefit. Policyholders of these three plans receive a prescription drug benefit. This benefit includes a copayment (a fixed dollar amount that the policyholder must pay each time he or she fills or refills a prescription) of up to $10 for Tier 1 drugs (generic and certain low-cost brand-name drugs), and up to $30 for Tier 2 drugs (brand-name and certain higher cost generic drugs).

Available Discounts. HIRSP provides subsidies to some low-income policyholders to reduce premiums, deductibles, and prescription drug coinsurance requirements. The amount of the subsidy varies according to the participant's income level and the plan in which the enrollee participates.

Low-income HIRSP 1,000, HIRSP 2,500 and HIRSP 5,000 policyholders with annual household income less than $33,000 are eligible for these subsidies. The maximum discount levels (for policyholders with household income of less than $10,000) are $500 from the medical deductible, 43 percent from the premium, and a cap of $375 on out-of-pocket drug expenses. A full summary HIRSP subsidy levels is available in Appendix III.

HIRSP Medicare Supplement. This plan is only available to Medicare eligible applicants who are enrolled in Medicare parts A, B, and D. Participants in this plan must either be less than 65 years of age and qualify for Medicare due to a disability, or be enrolled in HIRSP upon reaching 65 years of age and obtaining eligibility for Medicare.

Deductibles. The HIRSP Medicare Supplement plan has a $500 annual deductible. Unlike HIRSP 1,000, HIRSP 2,500 and HIRSP 5,000, this plan does not offer any deductible reductions to low-income policyholders.

Premiums. As with the other plans, the quarterly premium amount for HIRSP Medicare Supplement varies by age and sex. For most age brackets, the premium amounts for this plan are roughly equivalent to or lower than the premiums for HIRSP 5,000 (the low premium plan).

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

Drug Benefit. HIRSP Medicare Supplement policyholders have drug copayments of up to $10 for generic drugs, and up to $30 for brand name drugs.

Available Discounts. Policyholders with less than $33,000 in household income can obtain discounts on their premiums and caps on out-of-pocket prescription drug costs. The largest available premium discount is 35 percent for policyholders with under $10,000 of household income. All policyholders with under $25,000 in household income receive a prescription drug out-of-pocket maximum of $125. Out-of-pocket maximums are $250 for policyholders with income between $25,000 and $29,999 and $500 for policyholders with income between $30,000 and $32,999. No deductible discount is available for HIRSP Medicare Supplement participants.

HIRSP Health Savings Account. The fifth plan is the newly-created HIRSP Health Savings Account, or HIRSP HSA. This high deductible-low premium plan qualifies policyholders to open a tax-favored savings account for use towards future medical expenses. These accounts are designed to give individuals more control over their health care spending and to encourage account holders to "shop around" for the best health care value. Additional information on HSAs can be found on the U.S. Department of the Treasury website at http://www.ustreas.gov/offices/public-affairs/hsa/.

Deductibles. As with any plan that qualifies policyholders to open an HSA, the HIRSP HSA plan has a high deductible (defined by U.S. Treasury as at least $1,100 for an individual, or

$2,200 for a family). The HIRSP HSA annual deductible is $3,500.

Premiums. As with the other four HIRSP plans, HIRSP HSA premiums depend on age and sex of the policyholder. Refer to Appendix I for a full summary of premiums.

Medical and Drug Coinsurance. HIRSP HSA requires policyholders to pay medical and drug coinsurance (instead of the medical coinsurance and drug copay of the other four plans). Policyholders are responsible for 20 percent of covered medical costs and 20 percent of all covered drug purchases after the deductible has been satisfied. The combined medical-drug coinsurance maximum is $2,100 per year.

*Available Discounts***.** Deductible and premium discounts are available to HIRSP policyholders with annual household income under $33,000. Policyholders with annual income of under $10,000 receive the largest discounts ($500 off the deductible and 43 percent off the premium). Unlike the available out-of-pocket drug copay caps in the other four plans, there is no additional cap available for the drug coinsurance due to the combination of medical and drug benefits in the HIRSP HSA plan.

HIRSP Enrollment. HIRSP Medicare Supplement plan enrollment decreased by 32 percent during 2005-06. This decline was related to the initiation of the Medicare Part D prescription drug benefit. The recent decline in the HIRSP Medicare Supplement enrollment suggests that people who had been enrolled in that plan to receive the prescription drug benefits no longer had a need for HIRSP coverage with the advent of Medicare Part D. The number of children participating in HIRSP has also dropped since the implementation of BadgerCare Plus in February, 2008.

Table 4 provides the number of policyholders in each plan, showing how many participants receive subsidized discounts, as of November, 2008. HIRSP 2,500 has the most participants, and HIRSP HSA has the least. Table 5 summarizes the total number of enrollees in each of the HIRSP insurance plans from 1997 to 2008. Almost all of the increase in total HIRSP enrollment since 1999 comes from increases in Plan 1B (now HIRSP 2,500).

Table 4: Number of Policyholders by Plan and Subsidy Status, November, 2008

Plan		Number of Policyholders	% of Total
HIRSP 1,000	Non-subsidized	2,206	13.6%
	Subsidized	1,589	9.8
	Total	3,795	23.4%
HIRSP 2,500	Non-subsidized	8,012	49.3%
	Subsidized	738	4.5
	Total	8,750	53.9%
HIRSP 5,000	Non-subsidized	2,033	12.5%
	Subsidized	300	1.8
	Total	2,333	14.4%
HIRSP Medicare Supplement	Non-subsidized	551	3.4%
	Subsidized	388	2.4
	Total	939	5.8%
HIRSP HSA	Non-subsidized	403	2.5%
	Subsidized	27	0.2
	Total	430	2.6%
Total	Non-subsidized	13,205	81.3%
	Subsidized	3,042	18.7
	Grand Total	16,247	100.0%

HIRSP Funding

HIRSP is primarily financed by the following three sources: (1) premiums paid by policyholders; (2) assessments paid by health insurance companies doing business in Wisconsin; and (3) reductions to the amounts paid to health care providers who provide services to HIRSP policyholders. The premiums paid by HIRSP policyholders and the assessments paid by health insurance companies are treated as operating revenues on HIRSP's financial statements. Reductions in the amounts paid to health care providers are reported as a reduction in the amount of the program's gross losses.

Table 5: HIRSP Enrollment History, 1997-2008*

Year	HIRSP 1,000 (Plan 1A)	HIRSP 2,500 (Plan 1B)	HIRSP Medicare Supplement (Plan 2)	HIRSP 5,000	HIRSP HSA	Total Enrollees	Percent Change in Total Percent
1997	6,109	0	1,209	-	-	7,318	
1998	5,575	437	1,236	-	-	7,248	-1.0%
1999	5,625	987	1,292	-	-	7,904	9.1
2000	6,509	2,106	1,427	-	-	10,042	27.0
2001	7,634	3,371	1,601	-	-	12,606	25.5
2002	8,711	5,438	1,733	-	-	15,882	26.0
2003	8,421	7,286	1,740	-	-	17,447	9.9
2004	8,104	8,510	1,727	-	-	18,341	5.1
2005	7,657	9,720	1,570	-	-	18,947	3.3
2006	6,813	10,258	987	-	-	18,058	-4.7
2007	5,879	10,312	935	-	-	17,126	-5.2
2008	3,795	8,750	939	2,333	430	16,247	-5.1

*Enrollment as of December of each year, except for November, 2008.

According to unaudited figures in the 2007 HIRSP Annual Report, these three funding sources contributed the following amounts to HIRSP for calendar year 2007 (effective January 1, 2008, HIRSP uses a calendar year convention for budgeting, assessments, and financial reporting):

Policyholder Premiums	$100,822,869
Insurer Assessments	33,582,671
Reduction in Amounts Paid to Health Care Providers	42,296,578

These three sources combined comprise virtually all of the program's funding (other funding during calendar year 2007 included approximately $2.1 million in federal high-risk pool grants and $3.2 million in investment income). Each of the program's major funding sources is discussed below.

Policyholder Premiums. The premiums paid by HIRSP policyholders are the largest source of funding for the HIRSP program. Chapter 149 requires the Authority to set premium rates at a level sufficient to cover 60 percent of the plan's costs (not including the cost of providing subsidies to low-income enrollees, as discussed in further detail below).

Prior to July 1, 2006, Wisconsin statute also required policyholder premiums to be set between 140 percent and 200 percent of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under HIRSP. Effective July 1, 2006, Chapter 149 was amended to eliminate the 140 percent lower limit. As a result, the Authority currently sets premiums at levels sufficient to cover 60 percent of the program's anticipated costs, subject to the 200 percent upper limit described above. Current rates are below the historical limit, at approximately 120 percent of the standard risk rate.

Premiums for the Medicare Supplement policy have not increased since July, 2005, and have been decreased three times by as much as 21 percent. Premiums for the non-Medicare plans have increased at rates below the commercial market. The highest rate increase was 10 percent on January 1, 2008, but the rates were decreased by almost 9 percent on April 1, 2008. For calendar year 2009, the composite premium increase is 4.5 percent compared to 10 percent in the private individual market. Table 6 provides additional detail on HIRSP premium adjustments for the medical plans (HIRSP 1,000, HIRSP 2,500, HIRSP 5,000 and HIRSP HSA) and the HIRSP Medicare supplement.

Subsidies for Low-Income Participants. HIRSP provides subsidies to some low-income policy-

Table 6: Composite HIRSP Premium Rate Changes

Effective Date	Percent Increase: Medical Plans	Percent Increase: Medicare Supplemental Plans
July 1, 2004	12.2%	18.4%
July 1, 2005	15.0	20.3
July 1, 2006	5.0	-21.0
July 1, 2007	0.0	-20.0
January 1, 2008	10.0	0.0
April 1, 2008	-8.8	0.0
January 1, 2009	4.5	-9.8

holders, as discussed above (see Appendix III for a summary of subsidy levels). The subsidy program will be expanded for the first time in ten years beginning January, 2009, increasing the upper limit of household income from $25,000 to $33,000. These subsidies are funded first by any moneys received from the federal government in high-risk pool grants. Insurer assessments and adjustments to provider payment rates each bear 50 percent of any remaining costs. For 2009, HIRSP will receive $2.6 million in federal grants. Of this amount, approximately $2.2 million will be used to support the expanded program.

According to the plan's 2007 Annual Report, HIRSP policyholders received premium, deductible, and drug coinsurance subsidies totaling $5,781,500 during calendar year 2007. These subsidies were paid for by $2,089,200 in federal grants, $1,846,100 in provider payment adjustments, and $1,846,100 in insurer assessments.

Assessments on Insurers. Chapter 149 of the statutes requires that assessments paid by health insurance companies doing business in Wisconsin fund 20 percent of HIRSP's costs. These assessments also pay for 50 percent of any portion of the subsidies to low-income HIRSP policyholders that remain after the use of federal high-risk pool grants, as described above. The amount of each participating insurer's assessment is based on that insurer's share of the aggregate health care coverage revenue of all participating insurers for state residents during the preceding calendar year. Participating insurers paid $39,291,498 in assessments to HIRSP during calendar year 2008.

Pursuant to 2005 Wisconsin Act 74, participating insurers that pay a HIRSP assessment may claim that assessment as a credit against certain other fees and taxes they pay. The amount of the credit equals the insurer's assessment multiplied by a percentage calculated by dividing $5,000,000 by the total insurer assessments under Chapter 149. The aggregate amount of the credit for all claimants cannot exceed $5,000,000 in any fiscal year.

Reduced Health Care Provider Reimbursement. The third source of HIRSP funding comes from reductions in the rates paid to health care professionals who provide covered services to HIRSP policyholders. Chapter 149 specifies that these adjustments to provider rates must pay for 20 percent of the plan's costs. The provider rate adjustments also pay 50 percent of the cost of the subsidies to low-income HIRSP policyholders after the use of any federal high-risk pool grants. The Authority's Board of Directors exempts pharmacies from this requirement.

Chapter 149 requires the Authority to set usual and customary provider payment rates and to calculate an adjustment to these rates that is sufficient to fund the providers required contribution to HIRSP plan costs. The difference between the providers' usual and customary charges and the allowed charges paid by HIRSP represents the health care providers' contribution to the program. Under Chapter 149, providers are required to accept the HIRSP payment as payment in full. According to the plan's 2007 Annual Report, total provider contributions were $42,296,578 during calendar year 2007.

Select Financial and Operating Information

This section provides additional financial and operating information about HIRSP. Much of the information referenced below can be found in the

HIRSP Annual Reports from 2006 and 2007, available through the Authority's website (www.hirsp.org).

Program Costs. There are two primary categories of costs associated with the HIRSP program: medical service and prescription drug benefit costs and administrative costs (Table 7 summarizes the costs for each calendar year from 2003 to 2007). The largest cost is HIRSP payments for benefits provided under its plans. These costs are referred to as losses or "claims costs." Note that Table 7 reflects "claims costs," a figure that takes into account the health care provider discounts described above.

As Table 7 indicates, the total dollar amount of HIRSP's claims costs have been relatively stable and in some years decreasing since 2005. Program staff expects this trend to continue through 2008. This is primarily due to slightly declining enrollment, and a variety of initiatives to control plan costs, such as improved prescription drug pricing.

Table 7: Net Claims and Administrative Costs of HIRSP (Calendar Years 2003 through 2007)

Year	Claims Costs	% Change From Previous Year	Admin. Costs	% Change from Previous Year
2003	$123,188,155	-	$5,148,400	-
2004	153,682,873	24.8%	4,878,100	-5.3%
2005	170,174,338	10.7	6,545,200	34.2
2006	167,229,081	-1.7	6,615,800	1.1
2007	172,664,912	3.3	6,407,500	-3.1

Administrative costs are the second primary category of HIRSP program costs. The largest component of these administrative costs is the fees paid to the plan administrator, an outside vendor that helps administer the HIRSP program. Beginning in April 2005, that outside vendor is Wisconsin Physicians Service (WPS). WPS is paid on a per member per month basis for the majority of the services provided.

Table 8 presents a simplified presentation of HIRSP's financial operations for calendar years 2006 and 2007, summarizing much of the financial information discussed above.

A portion of the plans retained earnings are held in reserve to protect the plan and policyholders from unexpected losses. Retained earnings attributable to policyholder premiums in excess of the reserves are used to reduce premiums in future years. For example, premiums for calendar year 2008 and calendar year 2009 were set at a level to fund 55 percent, rather than 60 percent, of expected program costs in order to utilize the policyholder surplus.

Organization and Management of HIRSP

This section of the paper outlines the organization of HIRSP. As described above, the Authority is not a traditional state agency and receives no state general revenue funds. Under Chapter 149, the Governor appoints the Authority's Board of Directors, comprised of the following:

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

- four members representing insurers participating in the plan;

- four members representing health care providers, including one member each from the Wisconsin Medical Society, the Wisconsin Hospital Association, the Pharmacy Society of Wisconsin, and one representative of health care providers that provide services to HIRSP policyholders; and

- five other members, at least one of whom represents small businesses that buy private health insurance, one of whom is a professional consumer advocate familiar with the plan, and at least two of whom are HIRSP policyholders.

Table 8: Summary of HIRSP Financial Operations, Calendar Years 2006 and 2007

	2006	2007
Operating Revenues		
Policyholder Premiums	$105,393,294	$100,822,871
Insurer Assessments	39,836,465	33,582,671
Total Operating Revenue	$145,229,759	$134,405,542
Operating Expenses		
Gross Medical Losses	$130,881,288	$130,017,451
Provider Contributions	-36,779,894	-42,296,580
Increase or Decrease in Unpaid Medical Loss Liabilities	-7,300,630	1,481,144
Subtotal - Medical Losses	$86,800,764	$89,202,015
Gross Pharmacy Losses	$41,418,121	$37,243,581
Increase or Decrease in Unpaid Pharmacy Loss Liabilities	-193,379	46,689
Subtotal --Total Pharmacy Losses	$41,224,742	$37,290,270
Total Medical and Pharmacy Losses	$128,025,506	$126,492,285
Other Expenses		
Loss Adjustment Expense	$110,000	$0
General and Admin. Expenses	6,615,817	6,407,505
Referral Fees	61,985	55,370
Subtotal -- Other Expenses	$6,787,802	$6,462,875
Total Operating Expenses	$134,813,308	$132,955,160
Net Operating Income	$10,416,451	$1,450,382
Nonoperating Revenues and Expense		
Federal Grant Revenue	$2,333,710	$2,089,225
Investment Income	2,592,942	3,228,579
Transfer to General Fund	41	0
Total Non-Operating Income	$4,926,693	$5,317,804
Change in Net Assets	$15,343,144	$6,768,186
Net Assets		
Beginning of Year	$12,987,864	$28,331,008
End of Year	$28,331,008	$35,099,194

Chapter 149 of the statutes assigns to the Authority responsibility for operating the program. Included within this mandate are establishing the Authority's budget, monitoring its fiscal management, paying the plan's operating and administrative expenses, and establishing procedures for the timely collection of premiums and payment of benefits.

In addition to these general administrative duties, Chapter 149 also gives the Authority the ability to adapt the program's insurance offerings to changes in the private health insurance market. Specifically, Wisconsin statute directs the Authority to "provide benefit levels, deductibles, co-payment and coinsurance requirements, exclusions, and limitations under the plan that the authority determines generally reflect and are commensurate with comprehensive health insurance coverage offered in the private individual market in the state" and to "develop additional benefit designs that are responsive to market conditions."

However, some statutory limitations apply to the Authority's power to redesign the program's insurance offerings. For instance, Chapter 149 prohibits the Authority from designing an insurance plan that imposes a pre-existing condition waiting period on an individual who qualifies for HIRSP as an "eligible individual" because of losing group coverage. Statute also dictates other elements of the insurance plans approved by the Authority, including many of its eligibility requirements, low-income subsidy provisions, and the list of minimum expenses the plans must cover.

Finally, Chapter 149 requires the Authority to qualify HIRSP as a state pharmacy assistance program (SPAP), as defined in 42 CFR 423.464. HIRSP management indicates that HIRSP has been qualified as an SPAP, resulting in plan savings by increasing the amount of HIRSP enrollees' prescription drug costs paid by Medicare Part D.

To perform its duties, the statute assigns the Authority "all the powers necessary or convenient to carry out the purposes and provisions of Chapter 149" including, but not limited to, the power to adopt bylaws, policies and procedures, to

hire employees, and to define those employees' duties and rates of compensation. The Authority can also contract for outside professional services, provided it follows the competitive bid process contained in Chapter 149. Under that process, the Authority must solicit competitive sealed bids or competitive sealed proposals, as appropriate. The Authority can use simplified procedures if the estimated cost of the contract is $25,000 or less.

Information regarding HIRSP's future operations and financial position will continue to be publicly available through various sources, including the annual report submitted to the Legislature and the Governor, and the required annual financial audit by the Legislative Audit Bureau.

APPENDIX I

HIRSP Annual Premium Rates, Effective January 1, 2009

Age Bracket	Males	Females
HIRSP 1,000		
0-18	$3,600	$3,540
19-24	3,600	4,512
25-29	3,792	5,088
30-34	4,380	5,820
35-39	5,148	6,780
40-44	6,204	7,848
45-49	7,548	8,868
50-54	9,108	9,828
55-59	11,136	10,896
60 +	13,536	11,520
HIRSP 2,500		
0-18	$1,848	$1,848
19-24	1,836	2,328
25-29	1,908	2,568
30-34	2,232	2,952
35-39	2,544	3,360
40-44	3,072	3,900
45-49	3,876	4,488
50-54	4,992	5,148
55-59	6,384	5,856
60 +	8,040	6,684
HIRSP 5,000		
0-18	$1,356	$1,344
19-24	1,332	1,704
25-29	1,404	1,884
30-34	1,632	2,160
35-39	1,860	2,460
40-44	2,244	2,844
45-49	2,844	3,264
50-54	3,648	3,756
55-59	4,668	4,272
60 +	5,868	4,884
HIRSP Medicare Supplement		
0-18	$1,080	$1,080
19-24	1,080	1,500
25-29	1,428	1,908
30-34	1,632	2,076
35-39	1,932	2,556
40-44	2,352	2,916
45-49	2,796	3,360
50-54	3,396	3,792
55-59	4,080	4,176
60 +	4,884	4,524
HIRSP Health Savings Account		
0-18	$1,596	$1,596
19-24	1,584	2,016
25-29	1,644	2,208
30-34	1,920	2,532
35-39	2,184	2,892
40-44	2,640	3,360
45-49	3,336	3,852
50-54	4,284	4,428
55-59	5,496	5,052
60 +	6,912	5,748

APPENDIX II

Partial List of HIRSP Covered and Non-covered Services, as of January 1, 2009*

Partial List of Services Covered by HIRSP

- Medical-surgical services
- Anesthesia services
- Consultations
- Prescription drugs
- Home care
- Radiology services
- Laboratory supplies
- Pap test and pelvic exam
- Prostate cancer screening
- Skilled nursing care
- Hospice care
- Services and supplies for treatment of diabetes

Partial List of Services Requiring Prior Approval**

- Transplant services
- Durable medical equipment costing more than $1,500
- Prosthetics costing more than $1,500
- Surgical services for morbid obesity
- Reduction mammoplasty, septoplasty, and blepharoplasty
- Spinal surgeries***
- Positron emission tomography (PET) scans***
- Magnetic resonance angiography (MRA) studies***
- Dental repair relating to an injury***
- Inpatient admissions---Non-emergency admissions, at least 3 business days prior to confinement
- Tay-Sachs testing
- Outpatient visits and transitional treatment of alcoholism, drug abuse and nervous or mental disorders beyond 50 visits per calendar year
- Pain management procedures

Partial List of Services Not Covered by HIRSP

- Routine examinations and related services---yearly physicals
- Cosmetic treatments
- Eyeglasses
- Hearing aids
- Routine dental care
- Weight loss programs
- Infertility, impotence, and sterility services or drugs
- Charges for procedures that are determined not medically necessary and appropriate
- Expenses incurred for procedures or services that are of questionable medical value, experimental, or investigative (except drugs for the treatment of HIV infection)
- Health care services performed by member of the policyholder's immediate family, or anyone living with the policyholder
- Custodial care

* For a complete list of covered and non-covered services, refer to the Policy of the Wisconsin Health Insurance Risk Sharing Plan, available from the Authority at http://www.hirsp.org/policyholder/policy.shtml.
**Does not apply to HIRSP Medicare Supplement Plan
***Prior approval not required in the event of an emergency

APPENDIX III

Deductible and Premium Deductions

HIRSP 1,000 / HIRSP 2,500 / HIRSP 5,000

Household Income	Medical Deductible Discount	Premium Discount	Drug Out-of-Pocket Maximum
$33,000 and Above	No Discount	No Discount	$2,000
$30,000- $32,999.99	$100	15%	1,250
$25,000 - $29,999.99	100	20	1,000
$20,000 - $24,999.99	100	25	750
$17,000 - $19,999.99	200	29	600
$14,000 - $16,999.99	300	34	525
$10,000 - $13,999.99	400	39	450
Less than $10,000	500	43	375

HIRSP Medicare Supplement

Household Income	Medical Deductible Discount	Premium Discount	Drug Out-of-Pocket Maximum
$33,000 and Above	No Discount	No Discount	$1,500
$30,000- $32,999.99	No Discount	10%	500
$25,000 - $29,999.99	No Discount	10	250
$20,000 - $24,999.99	No Discount	10	125
$17,000 - $19,999.99	No Discount	20	125
$14,000 - $16,999.99	No Discount	25	125
$10,000 - $13,999.99	No Discount	30	125
Less than $10,000	No Discount	35	125

HIRSP Health Savings Account

Household Income	Medical Deductible Discount	Premium Discount	Drug Out-of-Pocket Maximum*
$33,000 and Above	No Discount	No Discount	N.A.
$30,000 - $32,999.99	$100	15%	N.A.
$25,000 - $29,999.99	100	20	N.A.
$20,000 - $24,999.99	100	25	N.A.
$17,000 - $19,999.99	200	29	N.A.
$14,000 - $16,999.99	300	34	N.A.
$10,000 - $13,999.99	400	39	N.A.
Less than $10,000	500	43	N.A.

*The medical and drug benefit for HIRSP HSA is a combined benefit; a cap on out of pocket drug costs is not available.