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Health Insurance Risk-Sharing Plan

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The health insurance risk-sharing plan (HIRSP) offers health insurance coverage to Wisconsin residents who cannot obtain adequate coverage in the private market due to a medical condition, or who have lost group health insurance coverage. HIRSP is financed through premiums paid by members and by assessments collected from health insurers that conduct business in Wisconsin. Health care providers also contribute to HIRSP by accepting reduced reimbursement rates for services. No state general purpose revenues support the operations or administration of HIRSP.

HIRSP was created in 1979, and was originally housed in the state Office of the Commissioner of Insurance. The Department of Health and Family Services assumed oversight of the program beginning in 1998, until 2005 Wisconsin Act 74 created the HIRSP Authority ("the Authority") as an independent body to administer the program. Aspects of public control over HIRSP remain, including the Governor's power to appoint the Authority's Board of Directors. 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 specified in Chapter 149 of the statutes.

This paper describes HIRSP eligibility requirements, plans offered, funding sources, and enrollment and expenditure trends. The paper also describes the administrative structure of HIRSP, including the responsibilities of the Authority.

In March, 2010, the enactment of the federal Patient Protection and Affordable Care Act (PPACA) provided funds to states to expand or establish high-risk pools. HIRSP administers this funding in Wisconsin, and a section of this paper summarizes this program. Unless otherwise noted, this paper describes the non-PPACA plans administered under HIRSP.

Organization and Management

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

- 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 members; and

- Five other members, including at least one representative of small businesses that buy private health insurance, one professional consumer advocate familiar with the plan, and at least two HIRSP members.

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.

To perform its duties, statutes assign 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.

In addition to these general administrative duties, Chapter 149 allows the Authority to adapt the program's insurance offerings to changes in the private health insurance market. Specifically, Wisconsin statute directs the Authority to set benefit levels, deductibles, copayment and coinsurance requirements, exclusions, and limitations that generally reflect coverage offered in the private individual market in the state, and to "develop additional benefit designs that are responsive to market conditions." Some statutory provisions limit the Authority's power to redesign the program's insurance offerings. 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 services the plans must cover.

Finally, Chapter 149 requires the Authority to qualify HIRSP as a state pharmacy assistance program. This increases the amount of HIRSP enrollees' prescription drug costs paid by Medicare Part D, and resulting in plan savings.

Eligibility Requirements

In order to obtain coverage under HIRSP, an individual must meet all of the following criteria: (a) reside in Wisconsin for at least three months; (b) be ineligible for employer-sponsored group health insurance or coverage under comprehensive medical assistance (MA) or BadgerCare Plus; and (c) qualify for HIRSP based on a medical condition, or qualify 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 at least one health insurer (2009 Wisconsin Act 84 decreased this from a rejection of coverage from two or more insurers);

- Notice of cancellation of coverage;

- 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 a premium of 50 percent or more for a current policy, unless the increase applies to substantially all of the insurer's 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.

A person also qualifies for HIRSP if he or she is already covered by Medicare because of a disability, or if he or she tested positive 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, HIRSP does not cover medical 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 exclusion period discourages adverse selection, where individuals purchase coverage in the plan only when a known need or expense presents itself. Prescription drug coverage is not subject to this exclusion period.

Eligibility Based on Loss of Employer-Offered Coverage. A person also qualifies for HIRSP if he or she satisfies the statutory definition of an "eligible individual" under the provisions of the federal Health Insurance Portability and Accountability Act (HIPAA), generally defined as somebody who loses group health insurance coverage. To qualify as a HIPAA-eligible individual, a person must meet all of the following criteria:

- Prior to applying for HIRSP, the individual was enrolled in creditable coverage for at least 18 months, with no gap in coverage that exceeded 63 days (Table 1 lists coverage that qualifies as creditable coverage);
- The individual's most recent period of creditable coverage was under a group health plan, governmental plan, federal governmental plan, church plan, or any health insurance offered in connection with those plans;
- The individual applied for HIRSP within 63 days of losing group coverage;
- The individual does not have creditable coverage, and is not eligible for coverage under a group health plan, parts A, B, or D of Medicare, comprehensive medical assistance (MA) coverage, or any successor program;
- The individual's most recent coverage was not terminated due to fraud or intentional misrepresentation of material fact or a failure to pay premiums; and
- If the individual was offered the option of continuation of employer-sponsored coverage under a federal continuation provision or a similar state provision, he or she 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.
- 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 members who qualify because of a medical condition, a person who qualifies for coverage as a HIPAA-eligible individual is not subject to the six-month pre-existing condition exclusion period. HIRSP also waives the pre-existing waiting period for other groups, such as individuals who enroll within 45 days of losing Medicaid or BadgerCare Plus coverage.

Persons Not Eligible 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 meet any of the following criteria:

- Are over 65 years of age, unless they are a HIPAA-eligible individual, or have HIRSP coverage on the date they turn 65;
- Have received over $2 million in benefits from HIRSP (2009 Wisconsin Act 83 increased this lifetime limit from $1 million);
- Are eligible for creditable coverage provided by an employer, BadgerCare Plus, or Medi-

Table 2: HIRSP Application Statistics

Year	Applications Received	Applications Approved	Basis of Approval: Eligibility Based on Medical Condition: Notice of Rejection	HIV Diagnosis	Medicare Eligibility	Benefit Reduction / Premium Increase	Loss of Group Insurance (HIPAA-Eligible Individuals)
2005	6,949	5,164	2,734	25	59	99	2,247
2006	5,262	4,328	1,791	33	13	65	2,417
2007	4,667	3,702	1,475	56	20	46	2,101
2008	4,961	3,719	1,380	51	27	13	2,247
2009	5,155	4,065	1,477	22	47	0	2,520

cal Assistance, with some exceptions.

In addition, any HIRSP member who voluntarily terminates coverage is ineligible for the following 12 months. This does not apply to HIPAA-eligible individuals, or people who terminate HIRSP coverage because of eligibility for MA.

Subject to certain statutory limitations, the Authority can expand the program's eligibility requirements. 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.

Table 2 summarizes annual application statistics for calendar years 2005 through 2009. In recent years, most applicants who obtained coverage under HIRSP were accepted either as a HIPAA-eligible individual, or because they received a notice of rejection or cancellation of coverage from an insurer.

HIRSP State Plans

HIRSP offers six health insurance plans: three standard medical plans (HIRSP 1,000, HIRSP 2,500, and HIRSP 5,000), two health savings account (HSA) qualified plans (HIRSP HSA 2,500 and HIRSP HSA 3,500) and the HIRSP Medicare Supplement plan. In general, the plan names refer to the amount of that plan's deductible. HIRSP also administers several plans partially supported with federal PPACA funding. For information on those plans, see the "HIRSP Federal Plans" section.

All six HIRSP plans offer major medical expense coverage and a prescription drug benefit, with a maximum lifetime benefit of $2 million. In order to be covered under HIRSP, all services must be provided by a participating HIRSP provider. HIRSP can exclude or limit any service deemed not medically necessary and appropriate, or not provided in accordance with generally accepted standards of medical practice. Appendix I provides a partial list of covered and non-covered benefits. None of the plans pay medical expenses covered by other available insurance, such as auto insurance or worker's compensation.

The following sections summarize each plan's premiums, deductibles, coinsurance, drug benefits, and subsidies for low-income members. Table 3 provides a comparison of the deductible, coinsurance and out-of-pocket maximum expenditure for each plan; Appendix II compares the plan premiums by plan, age and sex.

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 amounts. Only people who are not eligible for Medicare may enroll in these plans. The Authority first began offering the HIRSP 5,000 plan in 2008.

Deductibles. The names of the plans reflect how much a member must pay for covered medical ser-

Table 3: Comparison of HIRSP State Plans

	1,000	2,500	5,000	HSA 2,500	HSA 3,500	Medicare Supplement
Medical Deductible	$1,000 / year	$2,500 / year	$5,000 / year	$2,500 / year	$3,500 / year	$500 / year
Medical Coinsurance	20% of allowed amount, up to $1,000	20% of allowed amount, up to $1,000	20% of allowed amount, up to $1,000	20% of allowed amount	20% of allowed amount	None
Drug Coinsurance	---	---	---	20% of allowed amount	20% of allowed amount	---
Individual Medical Out-of-Pocket Maximum	$2,000 / year	$3,500 / year	$6,000 / year	$4,600 / year*	$5,600 / year*	$500 / year
Family Medical Out-of-Pocket Maximum	$4,000 / year	$7,000 / year	$12,000 / year	$9,200 / year*	$11,200 / year*	$1,000 / year
Drug Copayment	$5 Tier 1 / $45 Tier 2 ($2,000 maximum)	$5 Tier 1 / $45 Tier 2 ($2,000 maximum)	$5 Tier 1 / $45 Tier 2 ($2,000 maximum)	---	---	$5 Generic / $45 Brand ($1,500 maximum)
Premiums	See Appendix II for comparison of 2011 premiums by plan, age, and gender.					

* Includes maximum medical / drug coinsurance amount of $2,100 per year per individual.

vices before HIRSP pays any portion of their expense. This is the plan's "deductible." The deductible is $1,000 for HIRSP 1,000, $2,500 for HIRSP 2,500, and $5,000 for HIRSP 5,000. Prescription drugs and preventive services are not subject to the deductible for all HIRSP plans.

Premiums. The plans with higher deductibles have lower premiums (the amount a member must pay each month 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 member. In 2009, the Authority began using statewide premium rates. Previously, the state was divided into three geographic zones for determining premiums.

Medical Coinsurance. All three of these plans require members to pay a fixed percentage of covered medical expenses after satisfying the deductible, or "coinsurance." Members must pay 20 percent of allowable medical expenses, up to a $1,000 maximum. These plans also include a combined out-of-pocket maximum for the deductible and coinsurance.

Drug Benefit. Members of these three plans receive a prescription drug benefit with a fixed dollar amount that the member must pay each time he or she fills a prescription, or "copayment." In 2011, the copayment equals $5 for generic and certain low-cost brand-name drugs (Tier 1), and $45 for brand-name and certain high-cost generic drugs (Tier 2). Drug costs are subject to a $2,000 out-of-pocket maximum.

Low-income Subsidies. HIRSP provides subsidies to low-income members to reduce premiums, deductibles, and prescription drug out-of-pocket maximums. The amount of the subsidy varies according to the participant's income level and the plan in which the enrollee participates.

Members in these plans with annual household income of less than $34,000 are eligible for these subsidies. HIRSP defines household income as all income reportable for Wisconsin income tax purposes, and certain nontaxable income (such as unemployment compensation, supplemental security income, and pensions or other retirement income), with a deduction of $250 for each qualifying dependent. If an individual was married and lived

with his or her spouse during all of a given year, the incomes of both spouses are combined to determine household income.

The maximum discount levels for these plans, available to members with household income of less than $10,000, are $750 from the medical deductible, 43 percent from the premium, and a cap of $375 on out-of-pocket drug expenses. Appendix III provides a full summary of the low-income subsidy amounts.

HIRSP Health Savings Account 2,500 and 3,500. HIRSP offers two HSA qualified plans: HIRSP HSA 2,500 and HIRSP HSA 3,500. These high deductible–low premium plans qualify members to open a tax-favored savings account to pay for medical expenses such as deductibles and coinsurance. HIRSP began offering the HSA 3,500 plan in 2008, and the HSA 2,500 plan in 2010.

Deductibles. As with any plan that qualifies members to open an HSA, the HIRSP HSA plans have a high deductible (defined by U.S. Treasury as at least $1,200 for an individual, or $2,400 for a family). The HIRSP HSA 3,500 deductible is $3,500, and the HIRSP HSA 2,500 deductible is $2,500.

Premiums. As with the other HIRSP plans, HIRSP HSA premiums depend on age and sex of the member.

Medical and Drug Coinsurance. HIRSP HSA plans require members to pay combined medical and prescription drug coinsurance, instead of the medical coinsurance and drug copayment of the other plans. Members are responsible for 20 percent of covered medical costs and drug purchases after the deductible has been satisfied. The combined medical-drug coinsurance maximum is $2,100 per year for both plans.

Low-income Subsidies. Deductible and premium discounts are available to HIRSP members with annual household income under $34,000. Members with annual income of under $10,000 receive $750 off the deductible and 43 percent off the premium. Unlike the out-of-pocket drug maximum caps in the other plans, there is no subsidized cap for the drug out-of-pocket costs due to the combined medical and drug coinsurance in these plans.

HIRSP Medicare Supplement. Individuals who are enrolled in Medicare parts A, B, and D can enroll in the HIRSP Medicare Supplement plan. Participants in this plan must either be less than 65 years old and qualify for Medicare due to a disability, or be enrolled in HIRSP upon reaching 65 years of age and obtaining eligibility for Medicare. This plan is not available to individuals who did not have HIRSP coverage before turning 65.

Deductibles. The Medicare Supplement plan has a $500 annual deductible. Unlike the other HIRSP plans, this plan does not offer deductible subsidies for low-income members.

Premiums. As with the other plans, premiums for the HIRSP Medicare Supplement vary 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.

Medical Coinsurance. HIRSP Medicare Supplement members 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 members have drug copayments of $5 for generic drugs, and $45 for brand name drugs, subject to a $1,500 out-of-pocket maximum.

Low-income Subsidies. Members with less than $34,000 in household income can obtain discounts on their premiums and caps on out-of-pocket prescription drug costs. The largest premium discount is 35 percent for members with under $10,000 of household income. Prescription drug out-of-pocket maximums range from $125 to $500. No deductible discount is available for HIRSP Medicare Supplement participants.

Table 4: Number of Members by Plan and Subsidy Status, October 2010

	Non-subsidized		Subsidized		Combined Subsidized and Non-Subsidized	
	Participants	% of Total	Participants	% of Total	Participants	% of Total
HIRSP 1,000	1,014	5.5%	645	3.5%	1,659	8.9%
HIRSP 2,500	6,331	34.1	2,033	11.0	8,364	45.1
HIRSP 5,000	5,063	27.3	1,297	7.0	6,360	34.3
HSA 2,500	303	1.6	69	0.4	372	2.0
HSA 3,500	664	3.6	117	0.6	781	4.2
Medicare Supplement	587	3.2	425	2.3	1,012	5.5
Total	13,962	75.3%	4,586	24.7%	18,548	100.0%

Table 5: HIRSP Enrollment History, 2000-2010*

Year	HIRSP 1,000	HIRSP 2,500	HIRSP 5,000	HSA 2,500	HSA 3,500	Medicare Supplement	Total Enrollees	% Change in Total Enrollment
2000	6,509	2,106	-	-	-	1,427	10,042	-
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	3,783	8,736	2,330	-	429	938	16,216	-5.3
2009	2,240	9,771	3,717	-	684	969	17,381	7.2
2010	1,659	8,364	6,360	372	781	1,012	18,548	6.7

* Enrollment as of December 31 of each given year, except for October 31, 2010.

HIRSP Enrollment. Table 4 provides the number of members in each plan, and how many participants receive subsidies, as of July, 2010. Table 5 summarizes the total number of enrollees in each of the HIRSP plans from 2000 to 2010. In recent years, there has also been a shift within HIRSP enrollees, with individuals transferring from the higher premium HIRSP 1,000 to the lower premium HIRSP 2,500 and HIRSP 5,000.

Funding Sources

HIRSP is primarily financed by premiums paid by members, assessments paid by Wisconsin health insurers, and reductions to the amounts paid to health care providers who provide services to HIRSP members. In general, premiums fund 60% of HIRSP costs, with insurer assessments and provider discounts each funding 20%.

According to the 2009 HIRSP Annual Report, these three funding sources contributed the following amounts to HIRSP for calendar year 2009:

Member Premiums	$83,601,410
Insurer Assessments	25,918,885
Provider Payment Reductions	27,514,892

These sources comprise virtually all of the program's funding, with approximately $2.6 million in non-PPACA federal grants and $256,000 in investment income in 2009. The program's major funding sources are discussed below.

Member Premiums. Premiums are the largest source of funding for the program. Chapter 149 requires the Authority to set premium rates at a level sufficient to cover 60 percent of the plan's costs.

Prior to July, 2006, Wisconsin statute also required 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, 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 compared to a standard risk. The current aggregate rates across all HIRSP plans are below the historical 140 percent limit, at approximately equal to the standard risk rate.

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 plans) and the HIRSP Medicare Supplement. In 2010, premium rates for the HIRSP medical plans increased by 2.8 percent on January 1, but subsequently decreased by 5.9 percent on April 1. No change was implemented in January, 2011. Medicare Supplement premium rates decreased by 5 percent in January, 2010, and by 30 percent in January, 2011.

Table 6: Composite HIRSP Premium Rate Changes

	Percent Increase	
Effective Date	Medical Plans	Medicare Supplement
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
January 1, 2010	2.8	-5.0
April 1, 2010	-5.9	0.0
January 1, 2011	0.0	-30.0

Assessments on Insurers. Statutes require that health insurance companies doing business in Wisconsin pay assessments to fund 20 percent of HIRSP costs. These assessments also pay for 50 percent of any portion of the low-income subsidies that remain after the use of non-PPACA federal grants. The amount of each participating insurer's assessment is based on that insurer's share of aggregate Wisconsin health insurance revenue for all participating insurers during the preceding calendar year.

2005 Wisconsin Act 74 allowed insurers that pay a HIRSP assessment to claim a credit against certain other fees and taxes they pay. The amount of the credit equals the insurer's share of total HIRSP assessments, multiplied by $5 million. The total amount of the credit for all claimants cannot exceed $5 million in any fiscal year.

Reduced Provider Reimbursement. Reductions in payments to health care professionals who provide covered services to members pay for the remaining 20 percent of the plan's costs. The provider payment reductions also pay 50 percent of the cost of the low-income subsidies after the use of any non-PPACA federal grants. The Authority exempts pharmacies from this requirement.

The Authority sets usual and customary provider payment rates and calculates 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.

Subsidies for Low-Income Participants. HIRSP provides subsidies to some low-income members, as discussed above. The subsidy program expanded in January, 2009, increasing the upper limit of household income from $25,000 to $33,000. Beginning in January, 2011, the upper limit increased to $34,000. These subsidies are funded first by fed-

eral non-PPACA high-risk pool grants. Insurer assessments and adjustments to provider payment rates each cover 50 percent of any remaining costs.

In 2009, HIRSP members received $7.4 million in premium subsidies, $0.6 million in deductible subsidies, and $0.9 million in out-of-pocket drug cost subsidies. HIRSP received $2.2 million in federal grants in 2009 to fund these subsidies, with the insurer assessment and provider contribution each providing $3.3 million. As shown in Table 4, approximately 25% of HIRSP enrollees in July, 2010, received a low-income subsidy.

Financial Information

Program Costs. There are two main categories of costs associated with the HIRSP program: claims costs and administrative costs. Claims costs refer to medical and prescription drug benefits provided under HIRSP plans, and are the largest source of costs. Table 7 summarizes the costs by calendar year from 2006 to 2009, taking into account the health care provider discounts described above. Gross claims costs (before the deduction of the provider contribution) have dropped since 2007, due to decreased utilization of medical services.

Table 7: Claims and Administrative Costs

	Claims (in millions)	Administrative Costs (in millions)
2006	$164.8	$6.6
2007	168.8	6.4
2008	151.0	6.5
2009	141.1	6.6

Source: LAB Audit Reports of HIRSP Authority

Administrative costs are the second main category of HIRSP program costs. Fees paid to Wisconsin Physicians Service (WPS), an outside vendor that helps administer the HIRSP, comprise the largest component of these administrative costs. WPS is paid on a per member per month basis for the majority of the services provided. Administrative costs have remained relatively constant.

Appendix IV summarizes HIRSP's revenues, expenses and net assets for calendar years 2008 and 2009. The premiums paid by HIRSP members and the assessments paid by health insurance companies are treated as operating revenues, and reductions in the amounts paid to providers are reported as a reduction in the amount of the program's medical losses.

A portion of the plan's retained earnings are held in reserve to protect the plan and members from unexpected losses. Retained earnings attributable to member premiums in excess of the reserves are used to reduce premiums in future years. In 2009, HIRSP distributed $12 million in premium refunds to members from these excess reserves.

HIRSP Federal Plans

In March, 2010, the federal Patient Protection and Affordable Care Act (PPACA) was signed into law. The law included the Pre-existing Condition Insurance Plan (PCIP), which provided $5 billion in funding for state high-risk pools, with approximately $73 million allocated to Wisconsin for services provided between July 1, 2010 and the end of 2013. States had the option of administering the PCIP themselves, or having the federal government do so in the state. In May, Governor Jim Doyle designated the HIRSP Authority as the entity that would administer PCIP funding in Wisconsin.

The Authority established several "HIRSP Federal" plans. Due to requirements of the PPACA, the eligibility requirements and plan features of the new federal plans differ from the traditional HIRSP plans described above.

HIRSP staff projected that the amount budgeted in PPACA would be sufficient to enroll up to 8,500 individuals in the federal plans. HIRSP began accepting applications for federal plans in July, 2010. As of November 1, 2010, 248 individuals had enrolled in HIRSP federal plans.

Eligibility. Individuals must meet all of the following criteria to qualify for the HIRSP Federal plan:

- Be a resident of Wisconsin;
- Be a citizen or national of the United States, or lawfully present in the United States:
- Have not had creditable coverage in the six months prior to the HIRSP Federal Plan effective date; and
- Be ineligible for employer-offered group health insurance coverage, comprehensive Wisconsin Medicaid, or the BadgerCare Plus Standard plan.

In addition, individuals must have received at least one of the following:

- A notice of rejection from an insurer;
- A notice of reduction or limitation on coverage, including restrictive riders;
- A notice of increase in premium of 50% or more;
- Two or more offers for insurance with premiums at least 50% higher than a standard risk that would be charged for the coverage; or
- A positive test for HIV.

Individuals who would qualify for HIRSP state coverage as a HIPAA-eligible individual by losing employer-sponsored coverage cannot enroll in the HIRSP federal plan. Unlike HIRSP state coverage for individuals who qualify based on a medical condition, there is no six-month waiting period for coverage of medical services for pre-existing conditions. Under the federal plans, HIRSP pays providers at MA reimbursement rates, rather that the reduced usual and customary rates.

Plan Options. There are four HIRSP federal plans: Federal 500, Federal 1,000, Federal 2,500, and Federal 3,500. As with the standard HIRSP plans, the names of the federal plans reflect the amount of the deductible. Table 8 compares the cost-sharing requirements of the four HIRSP federal plans.

The PPACA prohibits the federal plans from having different premiums for men and women, and requires that premiums cannot exceed the standard non-group rate. Appendix V provides the monthly premiums for each federal plan for calendar year 2011, by age group. No premium or cost-sharing subsidies for low-income individuals are available for premium, deductible, or drug out-of-pocket maximums for the federal plans.

Table 8: Comparison of HIRSP Federal Plans

	Federal 500	Federal 1,000	Federal 2,500	Federal 3,500
Medical Deductible	$500 / year	$1,000 / year	$2,500 / year	$3,500 / year
Medical Coinsurance	20% of allowed amount, up to $1,000			
Individual Medical Out-of-Pocket Maximum	$1,500 / year	$2,000 / year	$3,500 / year	$4,500 / year
Family Medical Out-of-Pocket Maximum	$3,000 / year	$4,000 / year	$7,000 / year	$9,000 / year
Drug Copayment	$5 Tier 1 / $45 Tier 2			
Premiums	See Appendix V for comparison of 2011 premiums by plan, age, and gender.			

The HIRSP federal plans offer a benefit package comparable to the benefits offered by the state plans, as outlined in Appendix I. The full outlines of coverage and policy documents for the federal plans are available on the HIRSP website.

Additional Information

Additional information on HIRSP and state high-risk pools is available from the following sources:

Wisconsin Health Insurance Risk-Sharing Plan:
www.hirsp.org

National Association of State Comprehensive Health Insurance Plans:
www.naschip.org

Wisconsin Legislative Audit Bureau, 2009 HIRSP Audit Report
www.legis.state.wi.us/lab

Pre-existing Condition Insurance Plan (PCIP):
www.pcip.gov

APPENDIX I

Partial List of HIRSP Covered and Non-covered Services
As of January 1, 2011*

Partial List of Services Covered by HIRSP

- Preventive services (not subject to plan deductible)
- 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
- Spinal surgeries***
- Dental repair relating to an injury***
- Inpatient admissions---Non-emergency admissions, at least 3 business days prior to confinement
- Outpatient visits and transitional treatment of alcoholism, drug abuse and nervous or mental disorders beyond 50 visits per calendar year
- Certain pain management procedures

Partial List of Services Not Covered by HIRSP

- 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)
- Custodial care

* For a complete list of covered and non-covered services, refer to the state and federal plan policy documents available from the Authority at www.hirsp.org/plans/state-policy.shtml, and www.hirsp.org/plans/federal-policy.shtml.
** Does not apply to HIRSP Medicare Supplement Plan.
*** Prior approval not required in the event of an emergency.

APPENDIX II

2011 HIRSP State Plans
Monthly Premiums

Age	Male	Female	Age	Male	Female
HIRSP 1,000			**HSA 2,500**		
0–18	$309	$303	0–18	$135	$135
19–24	309	387	19–24	134	170
25–29	326	437	25–29	138	186
30–34	376	499	30–34	162	214
35–39	442	582	35–39	185	244
40–44	533	674	40–44	222	284
45–49	648	761	45–49	282	324
50–54	781	843	50–54	361	374
55–59	956	935	55–59	463	426
60 +	1,162	989	60 +	583	486
HIRSP 2,500			**HSA 3,500**		
0–18	$151	$151	0–18	$122	$122
19–24	150	190	19–24	121	155
25–29	156	210	25–29	126	169
30–34	182	241	30–34	147	194
35–39	208	275	35–39	168	222
40–44	251	319	40–44	202	258
45–49	316	366	45–49	256	295
50–54	408	421	50–54	328	340
55–59	521	478	55–59	421	387
60 +	656	545	60 +	530	441
HIRSP 5,000			**Medicare Supplement**		
0–18	$96	$95	0–18	$60	$60
19–24	94	121	19–24	60	83
25–29	99	133	25–29	79	106
30–34	116	153	30–34	90	115
35–39	132	174	35–39	107	141
40–44	159	201	40–44	130	162
45–49	201	231	45–49	155	186
50–54	258	266	50–54	188	210
55–59	331	303	55–59	226	232
60 +	416	346	60 +	271	251

APPENDIX III

Deductible, Premium and Drug Out-of-Pocket Maximum Subsidies
Calendar Year 2011

Household Income	Medical Deductible Discount	Premium Discount	Drug Out-of-Pocket Maximum
HIRSP 1,000/2,500/5,000			
$34,000 and Above	No Discount	No Discount	$2,000
$30,000–34,000	$150	15%	1,250
$25,000–30,000	250	20	1,000
$20,000–25,000	350	25	750
$17,000–20,000	450	29	600
$14,000–17,000	550	34	525
$10,000–14,000	650	39	450
Less than $10,000	750	43	375
HSA 2,500/HSA 3,500			
$34,000 and Above	No Discount	No Discount	Not Applicable
$30,000–34,000	$150	15%	"
$25,000–30,000	250	20	"
$20,000–25,000	350	25	"
$17,000–20,000	450	29	"
$14,000–17,000	550	34	"
$10,000–14,000	650	39	"
Less than $10,000	750	43	"
Medicare Supplement			
$34,000 and Above	No Discount	No Discount	$1,500
$30,000–34,000	"	10%	500
$25,000–30,000	"	10	250
$20,000–25,000	"	15	125
$17,000–20,000	"	20	125
$14,000–17,000	"	25	125
$10,000–14,000	"	30	125
Less than $10,000	"	35	125

*As the medical and drug benefit is combined for HIRSP HSA plans, there is no out-of-pocket maximum or subsidy for drug expenditures alone.

APPENDIX IV

HIRSP Revenues, Expenses and Net Assets
Calendar Years 2008 and 2009

	2008	2009
Operating Revenues		
Member Premiums	$89,191,448	$83,601,410
Insurer Assessments	39,291,498	27,514,892
Total Operating Revenues	*$128,482,946*	*$111,116,302*
Operating Expenses		
Gross Medical Losses	$123,458,024	$111,181,402
Provider Contributions	-39,942,539	-25,918,885
Unpaid Medical Loss Liability Change	-5,349,426	-2,687,961
Total Medical Losses	*$78,166,059*	*$82,574,556*
Gross Pharmacy Losses	$33,364,392	$32,523,666
Unpaid Pharmacy Loss Liability Change	-482,256	115,056
Total Pharmacy Losses	*$32,882,136*	*$32,638,722*
Total Medical and Pharmacy Losses	111,048,195	115,213,278
General and Administrative Expenses	6,486,953	6,630,362
Referral Fees	52,885	66,035
Total Operating Expenses	*$117,588,033*	*$121,909,675*
Total Operating Income		
(Operating Revenues minus Operating Expenses)	*$10,894,913*	*-$10,793,373*
Nonoperating Revenues and Expenses		
Federal Grant Revenue	$0	$2,561,169
Investment Income	1,340,575	255,702
Distribution to Members	-11,892,065	1,425
Total Nonoperating Income	*-$10,551,490*	*$2,818,296*
Change in Net Assets		
(Operating and Nonoperating Income)	$343,423	-$7,975,077
Net Assets		
Total Net Assets-Beginning of Year	$35,099,194	$35,442,617
Total Net Assets-End of Year	$35,442,617	$27,467,540

APPENDIX V

2011 HIRSP Federal Plans
Monthly Premiums

Age	Rate	Age	Rate
Federal 500		**Federal 2,500**	
0–18	$201	0–18	$119
19–24	214	19–24	127
25–29	227	25–29	134
30–34	258	30–34	152
35–39	306	35–39	181
40–44	364	40–44	215
45–49	450	45–49	266
50–54	559	50–54	330
55–59	686	55–59	405
60 +	802	60 +	474
Federal 1,000		**Federal 3,500**	
0–18	$165	0–18	$100
19–24	176	18–24	106
25–29	186	25–29	113
30–34	212	30–34	128
35–39	251	35–39	152
40–44	298	40–44	181
45–49	369	45–49	223
50–54	458	50–54	277
55–59	562	55–59	340
60 +	658	60 +	398