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## HEALTH INSURANCE RISK-SHARING PLAN – HIRSP

Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP), which began operations on July 1, 1981, is one of the oldest and largest state-run pools for medically uninsurable persons. Wisconsin was the third state, after Minnesota and Connecticut, to enact such a program, and it continues to offer coverage for those unable to buy health insurance in the private market because of particular health conditions.

According to the Legislative Fiscal Bureau (January 1999 Informational Paper #54), HIRSP enrolled 20,075 insureds from July 1, 1981, through December 31, 1997, and paid out a total of \$337.1 million in benefits over that period.

### ELIGIBILITY, COSTS, AND COVERAGE

**Eligibility.** To be eligible initially for the program, a person must: 1) be a state resident; 2) be ineligible for Medical Assistance (MA) or insurance through an employer; 3) be under age 65; and 4) have been denied coverage by a private insurer within the past nine months either through rejection for a new policy or cancellation of an existing one. Rejection includes substantial reduction of existing coverage or receiving premium estimates from two or more insurers that are 50% or more above standard risk policies. Individuals who test positive for the HIV virus or antibody or who have Medicare coverage because of a physical or mental impairment that will last at least 12 months are also eligible. Since October 27, 1999, a person with HIRSP coverage who turns age 65 can continue in the plan.

**HIRSP Plans.** HIRSP currently consists of three plans, which vary according to the premiums participants must pay and the levels of deductions and copayments. Plan 1A provides coverage similar to private major medical plans, and Plan 2 is a supplemental plan for persons under age 65 who participate in Medicare. Plan 1B, which first became available January 1, 1998, complies with the federal requirement that Wisconsin must offer persons eligible for Plan 1A the annual opportunity to select a higher deductible level in exchange for paying lower premiums.

Participants in Plan 1A pay an annual deductible of \$1,000. Beyond that, they are responsible for a "copay" of 20% of their additional claims costs. Their copay expenses are capped at \$1,000 per year. This means that, beyond premium costs, the maximum annual out-of-pocket cost to an individual participant in Plan 1A is \$2,000 – a deductible of \$1,000 plus copayments of \$1,000. (The family out-of-pocket maximum for two or more members is \$4,000 annually in any combination of deductibles and copayments.) The state assists Plan 1A participants who report annual household incomes of less than \$25,000 by providing subsidies to help them meet their premium and deductibles.

The Plan 1B deductible is \$2,500, and the participants in this plan, like those in Plan 1A, are required to cover copays of 20% of their annual claims costs up to an annual maximum out-

lay of \$1,000. Thus, beyond premiums, the maximum annual out-of-pocket cost to an individual Plan 1B participant is \$3,500 – a deductible of \$2,500 plus copayments of \$1,000. (The family out-of-pocket maximum for two or more members is \$7,000 annually.) There are no state subsidies for Plan 1B participants.

The annual deductible for Plan 2 participants equals the Medicare Part A (hospital insurance) deductible, which the federal government sets annually. After meeting the deductible, they must pay 20% of their claim costs, but they are limited to a total out-of-pocket maximum cost for combined deductible and copayments of \$500 per year.

<b>HIRSP Claims Activity</b>		
Year	Claims Handled	Total Payments
1989	47,182	\$9,754,100
1990	86,291	17,569,400
1991	145,079	30,725,100
1992	188,416	40,419,300
1993	122,329	43,957,200
1994	219,235	44,296,900
1995	257,530	48,761,590
1996	229,145	39,411,470
1997	213,427	39,418,930
1998	244,584	33,960,040
1999	300,538	37,032,977

Sources: Department of Health and Family Services, HIRSP – annual records; Legislative Fiscal Bureau, *Health Insurance Risk-Sharing Plan*, Informational Paper #54, January 1999.

**Coverage.** HIRSP’s major medical policies offer the same coverage as other state-regulated health insurance policies, including hospitalization, basic medical and surgical services, prescription drugs, and time-limited inpatient and outpatient care for alcoholism and other drug abuse and mental and nervous disorders. With some exceptions, policyholders have to undergo a 6-month waiting period before preexisting conditions are covered.

HIRSP sets a \$1 million lifetime maximum on benefits. 1997 Wisconsin Act 27 raised the maximum from \$500,000 to comply with federal law. (To date, no one has been affected by the \$1 million limit, and prior to the change only one person had been adversely affected by the previous maximum.)

A HIRSP policyholder who voluntarily terminates enrollment cannot be reinstated until 12 months have elapsed, unless the termination was because the person became eligible for coverage under Medical Assistance.

**HIRSP FUNDING**

Over HIRSP’s two decades, the legislature has tried a variety of funding mechanisms, attempting to balance the burdens placed on policyholders, private insurers, and medical providers. The underlying concern is that if premiums become too costly, those who need the coverage may be forced out of the program. The current statutory formula for funding HIRSP requires that, after applying the amount the state budgets annually for the program, 60% of the remaining operational and administrative costs must be covered by policy premiums. The other 40% is divided equally between insurers (20%) and providers (20%).

**Charges to Insureds.** Persons insured under HIRSP are expected to pay premiums based on their age, gender, and place of residence. The upper extent of these costs is illustrated by Plan 1A premiums in the Milwaukee area (the most expensive zone). Effective July 1, 2000, premiums for Milwaukee males insured under Plan 1A varied from \$1,656 (a total of four quarterly payments) for ages 0-24 through \$7,200 for those over age 60. Comparable premiums for females ranged from \$1,656 for ages 0-18 through \$6,084 for those over age 60. Plan

1B premiums ran about two-thirds of that scale, and Plan 2 premiums were about half of those for Plan 1A.

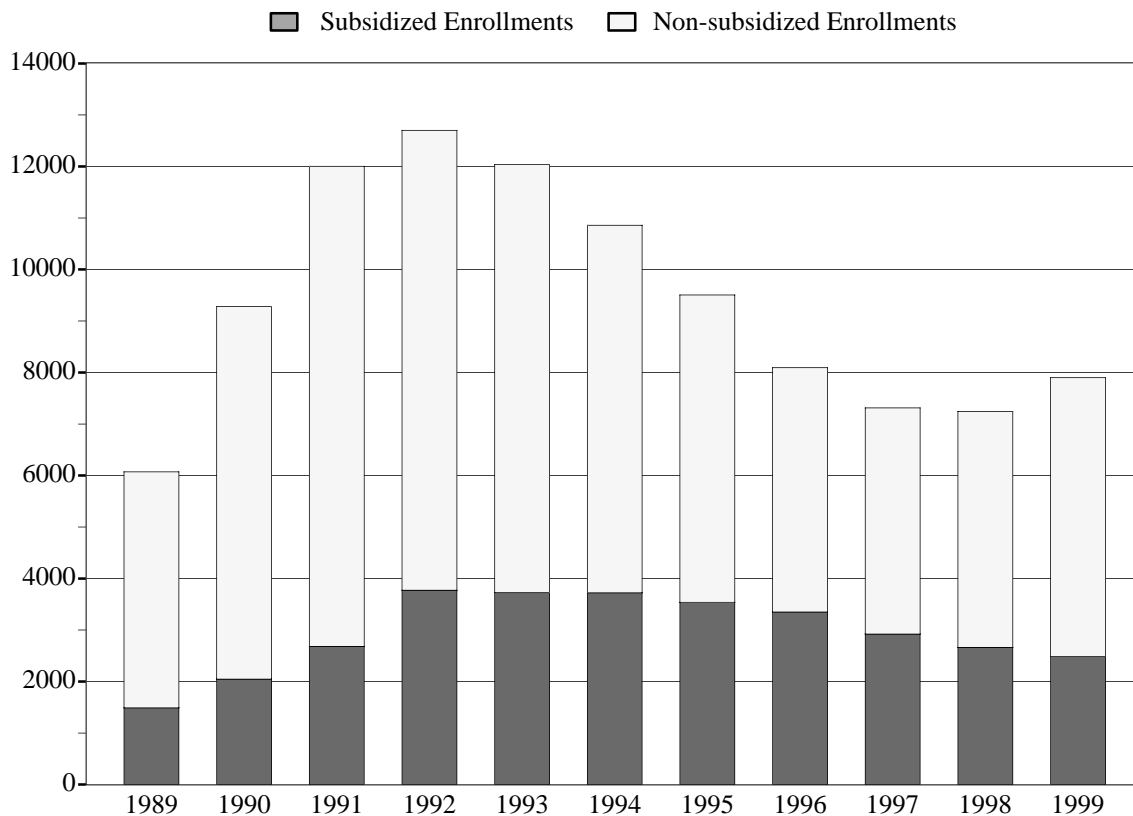
The legislature first required HIRSP premiums to cover 60% of program costs on January 1, 1992, and it also directed that each policyholder's premium must equal at least 150% of the premium for a standard risk policy that would provide essentially the same coverage and deductibles. (Federal law forced the state to create a maximum limit of 200% of standard premiums, beginning January 1, 1998.) Affordability continues to be a major concern. For example, premiums increased an average of 28% in 1992 alone. As this rate increase was followed by others, enrollments dropped from a high of 12,707 in 1992 to 7,318 in 1997.

**State Appropriations.** State assistance for HIRSP began when the 1985 Legislature created subsidies for low-income enrollees. Although subsidy use nearly doubled from 22% of total enrollees in 1991 to 41% in 1996, it did little to head off the program's decline in those years, and the state recognized that it would have to take a more active role in the program.

The 1997 and 1999 budgets authorized direct state support for HIRSP, in addition to the \$1.5 million allotted each biennium for subsidies, by creating a GPR appropriation of \$17.9 million in 1997-99 and increasing it to \$21.8 million for 1999-2001. Both budgets also made significant changes in HIRSP administration and accounting procedures.

**Costs to Insurers.** Although HIRSP was designed to be self-sufficient, companies selling health insurance in Wisconsin have always been required to make up all or some of the difference between premiums collected and benefits paid. There are some exceptions. For example,

### HIRSP Enrollments and Subsidies – 1989-99



Sources: Department of Health and Family Services, HIRSP – annual records; Legislative Fiscal Bureau, *Health Insurance Risk-Sharing Plan*, Informational Paper #54, January 1999.

the HIRSP assessment does not apply to multistate businesses, including some major corporations, that self-insure under the federal Employee Retirement Income Security Act of 1974 (ERISA plans.) Also, insurers whose Wisconsin business share is too minimal to merit an assessment are not included in the program. In the 2000-01 fiscal year, a total of 254 insurance companies were assessed \$9.9 million for HIRSP, based on their volume of business in Wisconsin.

In the late 1980s, insurers objected that because premiums were not being increased, they were faced with a disproportionate financial burden as medical costs rose sharply. 1991 Act 39 created major revisions in the cost sharing, both in terms of increasing premium requirements to 60% of costs and by adding medical providers to the funding mix.

**Costs to Medical Providers.** At first, HIRSP was financed by policyholders and insurers. Beginning May 1, 1992, health care providers were required to cover part of HIRSP costs by taking a reduction of 10% on their "usual and customary charges" for services. 1997 Wisconsin Act 27 required providers to further reduce their charges to cover 20% of costs. The providers' projected share for 2000-01 is \$10.1 million.

## HIRSP ADMINISTRATION

**Administration.** Besides improving the solvency of the program, 1997 Act 27 transferred administration of HIRSP from the Office of the Commissioner of Insurance (OCI) to the Department of Health and Family Services (DHFS), thereby consolidating all state-sponsored medical programs under one executive agency. The act also modified the plan to comply with the federal Health Insurance Portability and Accountability Act (HIPAA) of 1996, which was designed to improve access to health insurance for working parents and their children.

The DHFS secretary directs promulgation of the rules for HIRSP operations, including setting the annual premium rates, determining insurers' assessments, and establishing provider payment adjustments. OCI assists DHFS by calculating the proportion each insurer will be charged, based on revenues received from health care coverage of state residents.

Beginning July 1, 1998, Act 27 required the state's fiscal agent for Medical Assistance to serve as plan administrator for HIRSP. The plan administrator is a private contractor who processes HIRSP applications, performs eligibility checks, bills insureds for premiums, handles claims forms and submissions, and provides customer services. It also bills DHFS if expenses for HIRSP participants exceed the premiums collected.

Although HIRSP claims are not paid on the basis of MA rates, the program now must follow MA cost containment and reimbursement practices, and Act 27 required that all health care providers must be certified as MA providers.

**HIRSP Board of Governors.** HIRSP is served by an advisory 12-member board of governors, which includes the Secretary of Health and Family Services (or designee) as its chairperson and the Commissioner of Insurance (or designee). The other 10 members, appointed by the secretary, include representatives of participating insurers, physicians, hospitals, and integrated multidisciplinary health systems, as well as three public members – one of whom represents small business and two who are expected to qualify for coverage (or their parents or spouses). None of the public members may be professionally affiliated with the practice of medicine or insurance. The board must establish grievance procedures for applicants and participants, collect assessments from insurers, publicize the elements of the plan and maintain public awareness, and report annually to the governor and legislature.