



**Health Insurance Risk-Sharing Plan (HIRSP) Authority
Board of Directors Meeting**

Meeting of April 16, 2007

Committee Members Present: Dennis Conta, Jay Fulkerson, Michael Gifford, Carol Peirick, Luann Simpson, Eileen Mallow, Dianne Greenley, Michele Bachhuber M.D., Annette Stebbins, Joe Kachelski, Deborah Severson and Larry Zaroni

Committee Members Absent: Pat Jerominski and Wayne MacArdy

Others Present: Amie Goldman, Josh Weisbrod, Tom Rust, Jackie Ferris, Barry Curci, Judy Wanless, Teri Malsch, Scott Bentley, Marcia Zimmer, Michelle Skogen, Eric Peck, Nancy Wenzel, and Chris Mead

Dennis Conta called the meeting to order.

I. Review and Approval of Minutes

The February 19, 2007 Board Minutes were reviewed and approved unanimously by the HIRSP Board.

Dennis introduced a draft Conflict of Interest Policy to the board as an extra agenda item. Because of the nature of the Plan, any decision or action of the Board or a Committee could have a financial or other effect on the entities or persons represented by the Board members. In most cases, such an effect would be general and not specific to a particular entity represented by a Board member and not specific to a particular entity or individual who has any direct relationship to a Board member or Committee member.

The proposed policy recognizes that in some limited cases, a proposed decision or action of the Board or a Committee could have a discrete, identifiable, financial or health-related effect specific to (a) a particular entity represented by a Board member or (b) a particular individual or entity with whom a Board member or Committee member has a direct relationship (e.g., a family relationship, a closely-held-business relationship, or a close personal friendship). In such cases, under the proposed policy the Board member or Committee member would be subject to the following rules:

- (1) The member shall disclose, or any other member of the Board shall disclose, to the Board, the interest of the entity or individual in the proposed action or decision and disclose the member's relationship to the entity or individual;
- (2) The member may make a presentation to the Board as to whether his or her relationship constitutes a conflict of interest;

- (3) The member shall not participate in the Board's decision (i.e., shall leave the meeting during the discussion) as to whether the relationship constitutes a conflict of interest. In making its determination as to whether a conflict exists, the Board shall not consider a conflict to exist when:
- The action affects a whole class of similarly-situated interests;
 - Neither the Board member's interest, the interest of a member of the Board member's immediate family, nor the interest of a business or organization with which the official is associated is significant when compared to all affected interests in the class; and
 - The action's effect on the interests of the Board member, or a member of the Board member's immediate family, or of the related business or organization is neither significantly greater nor less than upon members of the class;
- (4) If the Board decides that a conflict of interest exists, the member may make a presentation to the Board as to his or her position on the proposed action or decision, but shall not vote or otherwise participate (i.e., shall leave the meeting during the discussion) regarding the proposed decision or action of the Board or Committee.

Under the proposed policy, a decision of the Board that a conflict of interest exists is final and binding upon the Board member or Committee member.

After reviewing the proposed policy, there was a discussion regarding some of the wording. Mike Gifford was concerned that the policy as initially drafted was too broad and suggested modifying it to state that "*In some limited cases, however, a proposed decision or action of the Board or a Committee could have a direct discrete, identifiable, financial or health-related effect specific to etc.*"

Joe Kachelski made a motion to accept the proposed Conflict of Interest Policy as drafted. The motion was seconded by Dianne Greenley. Mike Gifford offered an amendment to the policy with the word "direct" inserted as shown above. There being no second, the motion was withdrawn. The motion passed with a vote of 11 for the policy and 1 voting against the policy.

Voting for the policy: Dennis Conta, Jay Fulkerson, Carol Peirick, Luann Simpson, Eileen Mallow, Dianne Greenley, Michele Bachhuber M.D., Annette Stebbins, Joe Kachelski, Deborah Severson and Larry Zanoni

Voting against the policy: Mike Gifford

II. HIRSP Policy Revisions

Amie Goldman outlined the proposed changes to the HIRSP. The following changes were highlighted in the discussion:

1. New prior approval requirements have been added to reflect Board's intention of reducing retrospective medical necessity reviews.
2. Sections were added describing the new mail order pharmacy programs.

3. Language was added to clarify current policy on coverage of contraceptives.
4. Language was added to clarify current policy on coverage of genetic testing services.
5. Language outline a new benefit for prostate cancer screening was added.
6. Coordination of benefits with Medicare was clarified.

After a brief discussion, it was noted that on page 3 of the policy under number 6 a reference to prior authorization for injectible drugs should have been deleted from the policy. With this change, the Board voted unanimously to approve the policy.

The policy will be sent to the Office of the Commissioner of Insurance for review and approval and has a targeted effective date of July 1, 2007.

III. HIRSP Minimum Capital Requirements

Joe introduced the HIRSP Minimum Capital Requirement Policy approved by the Finance and Audit Committee. The committee had earlier approached OCI and requested that OCI evaluate the capital needs of HIRSP relative to a Risk Based Capital (RBC) model developed by the National Association of Insurance Commissioners, and to provide an opinion regarding what OCI would view as an appropriate minimum capital RBC target for HIRSP. The OCI response cited the standard that regulated insurers are encouraged to maintain an RBC level exceeding 300% RBC. However, OCI suggested that in view of the HIRSP method of financing its health care benefits, a minimum capital standard in the range of 175% RBC to 225% RBC would be appropriate.

The Finance and Audit Committee considered the OCI comments and recommends that HIRSP maintain minimum capital at the level of 175% RBC. Currently, this equates to approximately \$15.5 million.

Joe Kachelski made a motion that HIRSP will establish a policy whereby minimum retained earnings are targeted to be 175% RBC. In addition, HIRSP will target 60% of the retained earnings to be funded by policyholder premiums, 20% to be funded by insurer assessments and 20% to be funded by provider contribution. Jay Fulkerson seconded the motion and it passed unanimously.

IV. Treatment of Policyholders Surplus

Joe Kachelski reported that the Finance and Audit Committee discussed possible guidelines for evaluating annual budgets in terms of the maximum amount of policyholder surplus that would be acceptable to apply in any single budget year to offset premium charges. The committee recommended a minimum policyholder funding floor equal to 55% of annual budgeted program costs for the budget period July 1, 2007 through December 31, 2008. This level was targeted to ensure that year-to-year premium rate increases would not be excessive.

Joe Kachelski made a motion that for the period July 1, 2007 through December 31, 2008, the HIRSP Authority shall adopt the standard that policyholder premium rates will be set at a level to cover no less than 55% of budgeted plan costs, if there is sufficient policyholder surplus to fund the remaining 5% of policyholder liability. Larry Zaroni seconded the motion. The motion passed unanimously.

V. July 1, 2007 through December 31, 2007 Budget

The Board previously voted to transition from a July 1st fiscal year to a calendar year, fiscal year. As a result, the Board will need to adopt a six-month transition budget starting July 1st through December 31st.

Scott Bentley from Milliman presented the budget that was approved by the Finance and Audit Committee. Total plan costs for the six month period are estimated to be \$100,046,957. This includes the cost of the low-income subsidy program and is net of investment income and drug rebates. Under the proposed budget, provider reimbursement is maintained at 149.6% of Medicaid. The budget also reflects a 1.3% reduction in cost due to changes in pharmacy reimbursement implemented as of January 1, 2006. Administrative expenses are estimated at \$3.3 million and the subsidy program was estimated to cost \$3.0 million.

The following tables summarize the premium changes incorporated in the budget and the funding allocations for policyholders, insurers and providers. Plan 1A is the HIRSP non-Medicare \$1,000 deductible plan. Plan 1B is the HIRSP non-Medicare \$2,500 deductible plan. Plan 2 is the HIRSP Medicare \$500 deductible plan.

Premium Changes Effective 7/1/07	
Plan	Aggregate Change
Plan 1A Non-subsidized	7.4%
Plan 1A Subsidized	3.9%
Plan 1B Non-subsidized	-5.1%
Plan 2 Non-subsidized	-20.0%
Plan 2 Subsidized	-22.6%
<i>All Policyholders</i>	<i>0%</i>

Actual and Projected Balances						
	Actual 12/31/06	Projected 6/30/07	Projected 12/31/07	Target Surplus	Remaining Surplus	Projected 12/31/08*
Policyholder	\$21,655,183	\$28,108,841	\$23,556,639	\$9,147,000	\$14,409,639	\$4,940,241
Insurers	7,114,495	9,576,775	3,063,453	3,049,000	14,453	0
Providers	(2,602,781)	(1,222,264)	712,217	3,049,000	(2,336,783)	4,437,441
* Adjusted for Target Surplus						

	Required Share for 2H07	Projected Funding	Surplus Used
Policyholder	\$58.2	\$53.8	\$4.6
Insurer	20.9	14.4	6.5
Provider	20.9	22.9	(1.9)

A motion was made by Joe Kachelski to accept the July 1, 2007 through December 31, 2007 budget. Annette Stebbins seconded the motion which passed unanimously.

VI. Governor's Proposed HIRSP Pilot for Individuals with HIV/AIDS

Dennis Conta provided an overview of a three year pilot program authorized to allow up to 100 uninsured individuals with HIV or AIDS to participate in the state's HIV/AIDS Health Insurance Subsidy Program. Under the pilot program, which was included in the Governor's budget, the state could pay HIRSP premiums and prescription drug co-insurance on behalf of participating individuals.

A month after introducing the budget, the Department of Administration (DOA) sent a letter requesting that the Co-Chairs of the Joint Committee on Finance modify the budget to correct a number of errors and to better reflect the Governor's intent. In this letter, DOA clarifies that it was the Governor's intent to allow a minimum of 100 individuals and as many individuals as was determined cost-effective by DHFS. It has been suggested that as many as 250 individuals could qualify for the pilot.

The proposed pilot is estimated to increase HIRSP costs by a minimum of \$2.6 million or a maximum of over \$5 million depending on enrollment. These increased costs would be borne 60% by policyholders, 20% by insurers and 20% by providers. The pilot would also increase costs to the HIRSP low-income subsidy program by an estimated \$200,000-\$400,000 depending on enrollment, which would be borne 50% by insurers and 50% by providers.

The Board then discussed two concerns that had been raised regarding the pilot. The first relates to the savings assumed in the state budget for moving individuals participating in the pilot from the state's AIDS Drug Assistance Program (ADAP) to the premium subsidy program. The savings estimated in the Governor's budget are overstated because they do not take into account the HIRSP six-month pre-existing waiting period. During the six-month waiting period ADAP would continue to purchase HIV/AIDS-related drugs on behalf of pilot participants, which was not factored into the savings estimate.

If the HIRSP pre-ex policy is modified to exempt ADAP participants from the six month waiting period and 100 individuals enroll in the pilot, HIRSP costs would increase by approximately \$900,000 and costs for the state's ADAP program would be reduced by a corresponding amount. Act 74 eliminated the statutory requirement for a six-month pre-existing condition waiting period, so it is now HIRSP policy, rather than state law to apply a waiting period. The committee discussed the rationale for the existing waiting period policy.

The second concern relates to the HIRSP subsidy of low-income individuals currently participating in the HIV/AIDS Premium Subsidy Program administered by the Department of Health and Family Services. If a HIRSP policyholder with HIV/AIDS qualifies for a reduced premium under HIRSP and qualifies for the state's HIV/AIDS Premium Subsidy Program, the state pays the reduced premium. The cost to the HIRSP subsidy program for the Plan 1A policyholders for whom the state pays the HIRSP premium is just over \$200,000. The program experiences additional costs for the Plan 2 policyholders. Under the Governor's proposed pilot, costs to the HIRSP subsidy program are expected to increase by \$200,000 to \$400,000.

Larry Zanoni made a motion seconded by Dianne Greenley directing Amie Goldman to obtain a legal opinion as to whether it would be allowable under current statute to charge the

state an unsubsidized premium for the individuals whose premiums it pays through the HIV/AIDS Insurance Premium Subsidy Program. The motion passed unanimously.

VII. Proposed Additions to HIRSP Legislative Policy Agenda

Mike Gifford presented the five items the Legislative Committee is recommending be added to the HIRSP legislative policy agenda.

1. Low Income Subsidy Program

In order to ensure that subsidized premiums are always less than un-subsidized premiums, it is recommended that premium discounts be established for low-income policyholders as opposed to tying subsidy levels to the standard rate. The proposed subsidy discounts would be as follows:

<u>Household Income</u>	<u>Premium Discount</u>
\$0-\$9,999	30% off HIRSP premium
\$10,000-\$13,999	25% off HIRSP premium
\$14,000-\$16,999	20% off HIRSP premium
\$17,000-\$19,999	15% off HIRSP premium
\$20,000-\$24,999	10% off HIRSP premium

These proposed discounts are comparable to the value of the subsidy provided to policyholders under the subsidy program in fiscal years 2006 and 2007.

2. Medicaid Childless Adults Pilot Project

It is recommended that the Authority seek to have the childless adult pilot modified such that low-income HIRSP policyholders would not be prohibited from participating in the pilot.

This change would benefit HIRSP policyholders who would be eligible to access comprehensive health insurance under Medicaid at no cost or at a cost below the HIRSP premium. The Committee agreed that the best policy would be for the Board to have the ability to grandfather current HIRSP enrollees who did not choose to enroll in the pilot once it became operational and to require any new HIRSP applicants to enroll in the pilot if eligible.

3. Pharmacy Restrictions

It is recommended that HIRSP seek exemption from the pharmacy restrictions under Chapter 632.86 of the statutes, similar to the exemptions provided for HMOs and PPOs.

4. Health Coverage Tax Credit

It is recommended that HIRSP seek to repeal the statutory requirement for HIRSP to implement and operate an HCTC plan repealed. Instead HIRSP would advance a proposal as part of the state budget process to allow HCTC eligible individuals to purchase health care coverage under BadgerCare Plus.

5. Temporary HIRSP Provider Certification

It is recommended that a statutory change be sought to allow HIRSP to temporarily certify health care providers who are outside the state of Wisconsin and are not Medicaid certified.

The Board discussed the recommendation related to the Medicaid pilot project. Dianne suggested that the Board may want to make it optional for policyholders to have a choice between HIRSP and the pilot project. This was discussed and an alternative suggestion was made to consider grandfathering current HIRSP policyholders and only requiring new HIRSP applicants to enroll in the pilot, if eligible. Under this proposal, current HIRSP policyholders would have the option to choose between the Pilot and HIRSP. Ultimately, it was decided that the Board would seek to remove the prohibition on HIRSP policyholders applying for the Pilot and would consider the grandfathering issue if it becomes relevant in the future.

The HIRSP legislative policy agenda was approved unanimously by the Board.

VIII. Changes to HIRSP Provider Payment Rate Methodology

A workgroup of HIRSP Authority, WPS and Milliman staff have been working the past few months to evaluate the current methodology for establishing provider payment rates. After reviewing the workgroup's findings, the Finance and Audit Committee recommend that, beginning January 1, 2008, HIRSP the following changes to the payment rate methodology:

- 1) Pay **outpatient services** at 53.6% of billed charges, rather than 65.4% of billed charges. In future years the Board would adjust the discount from billed charges to reflect desired U&C payment rates. The new payment rate more accurately captures the intended 28.5% discount to convert billed charges to a U&C rate and the required provider contribution. Continue to monitor innovations in the healthcare marketplace specific to outpatient hospital payment methodologies in order to find a suitable payment alternative that is not based on billed charges.
- 2) Continue to use the DRG payment system for **inpatient hospital services**, but recalibrate the DRG weights using historical HIRSP data so that the weights reflect the relative resources associated with a HIRSP discharge, rather than a Medicaid discharge. In addition, establish a hospital-specific HIRSP base rate. The HIRSP base rates will initially be established using the Medicaid base rates as a foundation. The Medicaid base rates will be increased to the level necessary to reach the 2006 U&C rates. In other words, the new U&C rate for a particular discharge will be the HIRSP DRG weight x the HIRSP base rate. It should be noted that the newly established HIRSP base rates will take into account the adjustment needed to reflect hospital "overpayments" under the existing system. The new U&C rates will be used to establish plan costs and then the HIRSP base rates will then be adjusted in order to capture provider contribution.
- 3) Implement a new payment schedule for **professional services** that is based on the Medicare fee schedule. The Medicare fee schedule was developed taking into account the relative resources required to provide a professional service, rather than billed charges alone. It also has the advantage of being familiar to the billing staff of most medical professionals.

The HIRSP rates will be set using the Medicare methodology and payment logic, but the actual dollar amount of the payment for a particular service will be established by the Authority. In other words, if HIRSP payments for calendar year 2006 were 10% higher, on average, than Medicare payments, the HIRSP payments will be set at 110% of the Medicare rate. The final “adjustment” will take into account actual 2006 costs as well as the correction needed to account for the fact that provider contribution among HIRSP providers has not been equitable.

The resulting rates will be the HIRSP U&C rates used to calculate HIRSP plan costs. These rates will then be adjusted in order to capture the required provider contribution.

Motion: Beginning January 1, 2008 the HIRSP Authority will establish its U&C and Allowed rates as described in items 1) through 3) above. The HIRSP Board passed the motion unanimously.

IX. Navitus Annual Target Contract Provision

The HIRSP Authority/WPS Administrative Services Contract contains a performance standard for pharmacy benefit management (PBM) services. Under the contract, the Authority can establish an actuarially calculated target for annual drug costs. The contract defines the target year as a 12-month year beginning on July 1st. Under the original contract, the effective date for the standard was the year beginning July 1, 2006.

The standard is structured in such a way that the PBM fees are reduced if the annual target is not achieved. This contract provision was suspended by DHFS and WPS effective July 1, 2006, but the contract allows for the HIRSP Authority to end the suspension with 60 days notice.

At the March 15, 2007 meeting of the Finance and Audit Committee it was recommended that the PBM performance standard contract provision be reinstated effective July 1, 2007.

No action needed.

X. Executive Committee By-Law Amendment

Dennis presented a proposed amendment to the bylaws under which the Executive Committee would act as the Board’s compensation committee.

Mike Gifford made a motion to amend the bylaws by adding the following sentence at the end of section 4.3: “The executive committee shall also act as the Board’s compensation committee and approve compensation changes.” The bylaws will be entirely restated to incorporate the amendment. Larry Zanoni seconded the motion and it passed unanimously.

XI. Medicaid Eligibility and COBRA Clarifications on HIRSP Application

Josh Weisbrod reported that when WPS attempted to operationalize the Board’s directive to have low-income policy holders demonstrate ineligibility for Medicaid it was discovered that the process would not be as straightforward as originally presented to the Board. The Board had looked at using the Wisconsin on-line Access tool to verify if a person was eligible for Medicaid. It was subsequently discovered that the Access tool does not definitively

determine if you are eligible for Medicaid. Given the difficulties WPS would have incorporating the tool and the subsequent determination process into the HIRSP application process, it will not be incorporated for now. The issue can be revisited at a future date if Medicaid is further expanded to cover childless adults.

Josh also discussed questions that have been raised regarding the interaction HIRSP and COBRA coverage. HIRSP is intended to be the insurer of last resort. As such, the statutes do not allow individuals eligible for creditable coverage or Medicaid to be eligible for coverage under HIRSP. Consistent with this intent, COBRA can be treated in one of two ways for determining HIRSP eligibility:

- 1) After exhausting 18 months of COBRA coverage, an individual who applies for HIRSP within 63 days of the COBRA term date would be eligible for HIRSP without a six-month pre-existing waiting period.
- 2) If an individual elected COBRA, but does not exhaust the COBRA, they are eligible for HIRSP beginning 18 months after the initial COBRA eligibility date with a six-month pre-existing waiting period. The individual would also have to meet all other HIRSP eligibility criteria (e.g. letters of rejection, no access to group coverage, etc.) at the time of application.

HIRSP Authority legal counsel and the Wisconsin Legislative Reference Bureau agree that this treatment of COBRA is consistent with and allowable under Chapter 149 of the Statutes.

Item # 1 does not require Board action as it's already codified in statute. After discussing the issue, the Board felt that policy #2 would be too punitive and that individuals who voluntarily term COBRA coverage should be eligible to apply for HIRSP under the same conditions as an individual who did not have COBRA (e.g. demonstrate uninsurability and be subject to a six-month pre-existing condition waiting period).

Jay Fulkerson made a motion to allow individuals who voluntarily terminate COBRA coverage to apply for HIRSP subject to all the terms and conditions of the existing HIRSP eligibility requirements for medically uninsurable individuals. The motion was seconded by Annette Stebbins and passed unanimously.

XII. Pre-Existing Waiting Period for Individuals Losing Medicaid Coverage

Currently, HIRSP applies a six month waiting period for pre-existing conditions to non-HIPAA eligibles, including those individuals who apply to HIRSP after losing Medicaid coverage. The Consumer Committee discussed this issue at its March 23rd, 2007 meeting and recommended that the waiting period be waived for individuals who apply to HIRSP within 63 days of losing Medicaid eligibility.

Dianne Greenley made a motion that HIRSP will waive the six month pre-existing condition waiting period for applicants who apply to HIRSP within 63 days of losing Medicaid or BadgerCare coverage. Mike Gifford seconded the motion and it passed unanimously.

XIII. Monthly Reports

The monthly Financial and Policyholder Activity Report and the monthly grievance, complaint and independent review organization reports were provided to the Board.

XIV. Committee Reports

Dianne Greenly shared with everyone that the application for the Consumer Advisory Committee has been developed and is posted on the HIRSP website. A number of applications have already been submitted.

XV. Other Business

Meeting adjourned. 3:55