HIRSP AUTHORITY

Health Insurance Risk-Sharing Plan (HIRSP) Authority
Board of Directors Meeting Minutes
October 27, 2011

Board Members Present: Carol Peirick, Dennis Conta, Ellen Henningsen, Patrick Cory, J.P. Wieske, Joe Kachelski, Tom Wagner, Larry Rambo, Larry Zanoni, Mike Lappin and by phone Deborah Severson, Michele Bachhuber and Wendy Arnone

Board Members Absent: Annette Stebbins

Others Present: Josh Weisbrod, Jackie Ferris, Amie Goldman, Deanne Hatzinger, Lynn Pink, Tim Stumm, Bart Hoolehan, Larkin O'Keefe, Vicki Buchholz and by phone Bryan McGuire.

Dennis opened the meeting

I. Introduction of New Board Members

Dennis introduced the new board members: Tom Wagner and Ellen Henningsen.

II. Review and Approve Minutes

Dennis asked that the minutes be approved. Larry Rambo made a motion to approve the minutes seconded by Joe Kachelski. The motion passed unanimously.

III. 2012 Policy Updates

Josh said that he would be doing items three and four together. Larry Zanoni and Mike Lappin arrived and Michele called in. Josh summarized the following minor changes to the HIRSP policy for 2012:

- HIRSP will no longer be doing retro termination for members who fail to pay their premiums on time or within the state mandated 30 day grace period.
- Moved the prior approval section under "Medical Management."
- Added definitions for Bone Anchored Hearing Devices (BAHA) and modified the cosmetic treatment have been added.
- Simplified our "experimental and investigational" language.
- Defined "psychologist."
- Updated the definition of "Reconstructive Surgery."
- Clarified our mental health parity benefit.
- Updated the definition of "blood" to include "blood plasma."
- Clarified our coverage of teeth extracted in preparation for a transplant.
- Updated our hearing aid benefit to include "implantable hearing devices."
- Clarified our preventive services benefit.
- Moved our care management language to p.4, as noted above.
- Clarified our grace period language based on feedback from our Commissioner's Office.

Josh also recommends that the HIRSP Federal members be able to receive services from providers outside of Wisconsin that are not Wisconsin Medicaid Certified consistent with the current administration of HIRSP. HIRSP Federal members would be notified of the potential to be

balanced billed. This network change would take effect on January 1, 2012 to coincide with the increased HIRSP Federal Plan reimbursement.

Dennis said that he would like one motion on all the policy changes. There were no objections to making one motion. Larry Rambo made a motion to accept the changes seconded by Tom Wagner. The motion passed unanimously.

IV. HIRSP Federal Provider Network Modifications

Josh indicated that agenda item IV was already discussed and acted on by the board under agenda item III.

V. 2011 Assessment Reallocations

Mary explained that after the final assessment billing was sent out for 2011, HIRSP was contacted by an insurer that in error had included $450 million in Medicare Advantage Premiums in the base premiums for which the assessment is calculated. When this was brought to OCI's attention, OCI also brought forth three other insurance companies that should have taken a combined $22.6 million deduction for their Medicaid hospital assessment. The overall impact of these adjustments is a reallocation of $1.8 million in assessment.

Mary said that the Commissioner of Insurance (OCI) is required under statute to determine the HIRSP assessment and to assess each qualifying company based upon the Authority's estimated total assessment. The statutes allow OCI to delegate the administrative tasks of the assessment to the HIRSP Authority. Because of this Mary said that HIRSP consulted with and asked OCI how to proceed.

Mary explained that in 2007, in order to encourage timely and accurate filings, the HIRSP Authority in consultation with OCI added language regarding a 10% penalty for companies reporting errors after they had certified the accuracy of their filing. During the recent discussions regarding the assessment adjustment the legal basis for the 10% penalty was raised and it was decided that that language should be removed from future assessment communications. OCI also agreed that sending an additional assessment billing to make the necessary adjustment should be determined by the Board with consideration of the Authority's finances.

Mary said given the large dollar amounts the Finance Committee recommendation to the Board is for HIRSP to do an assessment billing in November to reallocate the $1.8 million in assessment using a threshold of $25.00 and to remove the penalty language from all future assessment communications.

Larry Rambo wanted to know since the insurance company was the one to certify their premium amounts if there is anything that would preclude HIRSP in the future from saying if you certified a number that you could not come back later and report a modification. Amie said that that was a question for OCI because the statutory authority for this is ceded with OCI and they delegate to HIRSP the administration of sending out the billings. J. P. Wieske said HIRSP would have to show there was actual cost for making the assessment adjustment but the way the HIRSP contract is written with the TPA that administers the assessment there is no additional cost to HIRSP. Joe Kachelski wanted to know when the assessments for 2012 go out. Mary said they go out in late January and are due March 1st.

Larry Rambo made a motion to approve the recommendations from the HIRSP Finance Committee including removing the penalty language from the assessment letters. Larry Zanoni seconded the motion and it passed unanimously.

VIII. Outpatient Pricing and Utilization Analysis

Mary reported on the outpatient pricing analysis that the Strategic Planning Committee recommended. Out of the eight companies that responded to the survey, Milliman was able to use information from six of the companies and those six companies make up about 65% of the market as measured in covered lives. The survey asked for the average reimbursement rate for 54 CPT codes under 22 selected revenue codes in six regions of the state (Western, Northern, Northeastern, Southern, Southeastern and Milwaukee) These codes were selected based on frequency and dollars. In each region data was utilized from a range of 4-6 companies depending on each company's market share.

Mary said that there were two analyses prepared. The first analysis compares HIRSP 2010 average rates to the rates provided by the insurers surveyed. This showed that the HIRSP 2010 composite outpatient rate of $170 was 86.6% of the industry average of $196.

Mary said that in 2011 HIRSP moved from paying a discount off of billed charges for all outpatient services to utilizing a fee schedule for many of the outpatient services where it was deemed appropriate and continued to pay using a discount off of billed charges for the remaining outpatient services. The second analysis compared the 2011 fee schedule trended back to 2010 dollars in order to compare the 2011 fee schedule to the insurer information provided on a 2010 basis. Mary reported that this analysis showed that the HIRSP outpatient composite rate for 2011 on a 2010 basis of $123 was 37.5% lower than the industry average of $196. However, this HIRSP composite rate was slightly above the industry minimum of $121.

When HIRSP moved to the fee schedule for outpatient services for 2011 it was recognized that there were many in the industry still paying providers using a discount off of billed charges but in order to better manage costs and not be subject to increases in billed charges from providers HIRSP felt it was necessary to make the move to a fee schedule. Given the results of the survey at this time, Mary said that HIRSP staff do not recommend any changes to the outpatient fee schedule or the discount off of billed charges for 2011 and 2012.

Mary then summarized some additional analyses that measured the impact of the policy changes that were made for 2011. The first policy change that was made was moving from first dollar coverage of up to $150 on preventative services in 2010 moving to cost sharing for 2011 for preventative services. The estimated impact of that was an increase in costs of $4.3 million and to-date for the first three quarters (without claims run out) the impact is a $900,000 increase in cost. Mary said that it appears that HIRSP will be coming in well below the estimated cost of $4.3 million for the year.

The second policy change due to state law was the mental health parity. The estimated budget impact was an increase of $200,000. However, Mary noted that HIRSP's mental health costs decreased from 2010 to 2011.

Mary said that the last policy change analyzed was the move to using a fee schedule for outpatient services which was implemented in the second quarter of 2011. The actual savings due to the change for the second and third quarter without run out is almost $2.6 million. The estimated budget impact was a decrease of $4.5 million and Mary indicated that we might still reach that estimate by year end.

Mary then reviewed a comparison that was requested by the Federal Government of demographic, health risk and claims data for the HIRSP and HIRSP Federal plan.

VI. Rx Results Analysis

Amie explained that Rx Results is a company created in 2008 out of the University of Arkansas Medical School and College of Pharmacy and that she had been put in touch with them via her counterpart for the Arkansas risk pool. The goal Rx Results is to help their clients reduce prescription expenditures by applying evidence-based medicine and making changes in the pharmacy benefit that result in lower net costs.

Amie said that she and Josh met with the representative from Rx Results and they offered to take a look at HIRSP claims data at no charge to HIRSP to see where there were opportunities to modify the HIRSP formulary to reduce plan costs. They told HIRSP that they normally are able to cut costs by 10 to 20%. However, after analyzing HIRSP data they were only able to find 3.7% in savings and credited the Authority's current management of the HIRSP drug benefit. Most of the savings that were identified were in the over-active bladder and anti-ulcer therapeutic classes, specifically from the use of Nexium.

Amie noted that the results of the Rx Results analysis were reviewed with MedTrak and opportunities for improvement were discussed. During these discussions, MedTrak indicated that they were in the process of developing a number of new step-therapy programs for their clients use in 2012, including a step-therapy program for over-active bladder medications in 2012.

Amie indicated that they also spent time discussing the Rx Results recommendation to remove Nexium from the formulary. MedTrak agreed that there are now two very good and clinically equivalent generic drugs in the anti-ulcer drug class. Amie said that UnitedHealthcare only covers the generic drugs. If HIRSP only covers the generic drugs in this category then there would be members that would have to transition to a generic drug. If a member cannot take either of the generics in this class they can use the medical exception process. Alternatively, she said that the board could consider a step therapy approach, which would have less member disruption if current Nexium utilizers were grandfathered, but would be losing the current rebates tied to Nexium and the savings would be less than the first approach. Michele left the meeting. Wendy said only offering generic anti-ulcer medications have not been a problem for UnitedHealthcare members. Larkin said that MedTrak would give members a 60 day notice by mail of any formulary changes. The member is also told what generic drugs are available and that they should contact their doctor to get a new script for one of the generic alternatives.

Amie recommended that the formulary be modified to exclude Nexium and cover the two generic drugs in this drug class. Ellen asked if the notification that goes to the member could include the information about the medical exception process. Larkin said he would look at the notification and if in the medical exception language was not included he would add it. Larry wanted to know if the doctor could be notified that their patients will need new prescriptions. Larkin said that they have to notify the patient not the doctor. Amie wanted to know if the doctor could be copied on the patient notification. Larkin was not sure if they had all of the doctors' addresses.

Pat Cory arrived at the meeting.

Joe Kachelski made a motion to limit the drugs in the anti-ulcer drug category to the two generic drugs only. The motion was seconded by Larry Rambo and it passed unanimously.

VII. WellTrak Update

Bart described the WellTrak program, which is a chronic drug therapy management program that was rolled out on June 1st of this year. The program targets members with one chronic condition that take four or more prescriptions drugs. Bart said that the president of WellTrak will be presenting a detailed report on the first six months of the WellTrak program during the December board meeting.

Bart said that in mid-May 19,316 letters were sent to members that fit the WellTrak criteria. First round enrollment packets were sent to 9,135 members. Every month there are follow–up of phone calls and postcards.

There are 8,726 members that are eligible for WellTrak with 715 members enrolled in in the program and 711 members who have completed encounters with the WellTrak Pharmacists. Larkin said that members that do complete the encounter with the pharmacist have a good feeling about the program and are very satisfied.

Josh said the main issues found during the encounters were unnecessary drug therapies, adverse drug reactions, dosages being too high, different drugs needed and dosages that were too low.

IX. Monthly Reports

Mary reported on the HIRSP investments held at US Bank. Mary explained that given the state of the market and our conservative investment policy US Bank is doing good job managing the investment portfolio for HIRSP. Mary said since the beginning of the year HIRSP has pulled $5.4 million out of the market. The original investment was $20 million. This was due to HIRSP cash needs. The assessments are coming in so it will be unnecessary to pull any additional money out of the market for the rest of 2011. At this time HIRSP $14.6 million in principle has a market value of $14.7 million. The $800 thousand sitting in cash will be reinvested into the market in the next month. Mary said that the HIRSP staff is going to be working with US Bank and will plan to bring back to the Finance Committee a recommendation of whether or not there needs to be a change in the investment strategy for the portfolio given the budget projection for 2012.

Mary reviewed the HIRSP monthly financial statements as of September 30, 2011. Mary reported that total assets have decreased since July 2011 by $6.8 million. This is due to a decrease in assessment receivables of $12.7 million being offset by an increase of $4.9 million in cash and cash equivalents. The HIRSP drug rebate receivable has gone up by $1 million since July. Total liabilities decreased by $8 million due to the decrease in unearned assessments of $8 million.

She reported that the net premium revenue of $70.3 million is slightly below budget. The provider contribution of $28.9 million is below budget by $2.7 million which is a result of the medical losses of $97.8 million being below budget by $6.1 million. Pharmacy losses are comparable to budget at $31.5 million. Total administrative expenses of $5.9 million are above budget by $166 thousand due to the medication management program that was introduced after the budget was passed. The non operating revenues of $2.6 million are better than budget by $67 thousand due to income received on investments. The overall net loss of $3.1 million is better than budget by $3 million and $2 million better than the latest projection that was brought to the Board in September. As of September 30, 2011 the HIRSP policyholder reserves are at $7.6 million, the provider reserves are at $800 thousand and the insurers reserves are at $2.2 million. The total reserves are at $10.6 million which is $5.5 million below target reserves.

Mary then reviewed the financial statements as of September 30, 2011 for the HIRSP Federal program. Total assets increased by almost $146 thousand. This is due to the net effect of the $350 thousand increase in the federal government receivable and the $191 decrease in cash and cash

equivalents. These changes are due to timing of payments. The liabilities increased by $146 thousand due to the $161 thousand increase in unpaid medical loss liabilities.

She said the Federal gross premiums of $1.7 million are $200 thousand below budget. The total Federal losses of $3.6 million are better than budget by $3.0 million and the administrative costs are below budget by $74 thousand. The overall net operating costs of $2.7 million is better than budget by $2.9 million.

Josh reported that as of September there were 21,109 members in the HIRSP plans, this is an increase of almost 3,000 members from September 2010. Josh said that membership in the 5,000 plan will soon exceed the members in the 2,500 plan. The HIRSP Federal plans have 818 members. There are 5,121 members subsidized in the state plans and 28% of the members subsidized have an income of $9,999 or less. J.P. wanted to know if the marketing that was done for the Federal pool affected the state enrollment. Josh said that the federal marketing did not appear to effect the enrollment of the state plans. Amie offered to send J.P. a comparison chart on enrollment trends that Josh had done comparing the state and federal plan enrollment trends after the HIRSP Federal plan radio ads went live.

Josh said there were two appeals in October. There was one independent review since the last board meeting and the original denial was upheld. There were only two complaints since the last board meeting.

X. NASCHIP Annual Conference Update

Amie said that the NASCHIP annual conference took place about a month ago with about 160 people in attendance and that she was re-elected chair of NASCHIP for another year long term at the meeting. She said that there was considerable discussion about 2014 A fair number of states are looking at keeping their pools operational beyond 2014. They have concerns about putting everybody back into the market on day one of the exchange. They are looking at ways that people can be phased in over time.

Gorman and Associates had done an analysis of the Wisconsin market place and estimated that the impact to the market of HIRSP going back into the market would be a 16% rate increase for everyone. That was based on 2009 data. It is possible that with the data from 2011 the rates could increase 20 to 21%.

Similar to HIRSP, many states are looking at administering the reinsurance and risk adjustment components of the exchange.

The reinsurance for the state exchange is funded through an assessment that is levied on both the fully insured market and the self insured market. This is different than the assessments that are used to fund the 35 state risk pools. Those are only levied on the fully insured market. NASCHIP is trying to have the Federal Government modify the regulations in such a way as to give states flexibility that if they choose to use this mechanism that was set up under the affordable care act to also use it for the state risk pools.

A second letter was drafted to the Federal Government asking them to amend their draft regulations to clarify that states could use these assessments if they choose.

Larry Zanoni asked that Amie explain the assessment formula. Amie said in the proposed regulations the statue itself provides a total amount of funding of $10 billion, then $6 billion and then $3 billion. What they proposed in the regulations is they would calculate a national

percentage. They would look at total premium written across the country and then total medical expenses and collect $10 billion off this total. Each state would be responsible for going out and issuing assessments to the self-insured market through the TPA's and to the fully insured market and collecting the money. The money they collected would be kept in that state for the state's reinsurance. Amie said there is a bit more you have to collect to send back to the treasury. Amie will keep the Board posted on this issue.

The other take away from the meeting was good face to face dialog with federal officials from the Center for Medicare and Medicaid Services. Amie thought they better understood the implications of the structure of the program in terms of adverse selection. They would like to collect comparison data from the states that have both a state and federal pool.

Amie asked that Board members who were interested in having a copy of the NASCHIP book to let Jackie know.

XI. Agent Training

Josh said that so far 662 agents have signed up for the HIRSP agent training. After taking the training, the agents will receive a $100 referral fee as opposed to the $40 referral fee they currently receive. The agents will also receive two credits for their continuing education. Josh has done two sessions so far. Anna Marie from WPS has also been attending the trainings. Josh thought that HIRSP would be conducting the trainings again next year.

XII. Committee Reports

The new organizational chart was distributed showing the new board members. There were no other reports.

XIII. **Other Business**

Being no other business, Dennis asked that the meeting be adjourned.