Revisiting Wisconsin's Health Insurance Risk-Sharing Plan (HIRSP)

For people living with cancer, are high-risk pools one step forward or two steps back?

A primer for policymakers, patients, doctors, and advocates

As policymakers consider how to reform the health insurance market while maintaining protections for people with pre-existing conditions, state high-risk pools have re-emerged as a possible option. Wisconsin's former high-risk pool, the Health Insurance Risk-Sharing Plan (HIRSP), is being promoted as a national model for states to consider. HIRSP existed from 1979 until the Affordable Care Act (ACA) insurance regulations were fully implemented in 2014.

This fact sheet examines HIRSP and its relative effectiveness, suggests questions policymakers should consider before moving forward with a HIRSP-like program in today's environment, and discusses the potential impact on cancer survivors and their families.

Who was eligible for HIRSP in WI?

At its peak, HIRSP covered 22,000 people, making it the third largest high-risk pool in the country[1, 2]. Forty percent of HIRSP enrollees were eligible because of a medical condition. These individuals lost or were denied other coverage based on their condition, experienced limits or premium increases that made other coverage inaccessible, received Medicare coverage because of a disability, or were diagnosed with HIV/AIDS. This is the "traditional" high-risk group we think of today.

The majority of HIRSP enrollees – 60% – were eligible based on a loss of employer coverage and were known as "eligible individuals." These individuals were eligible for HIRSP as long as they had 18 months of continuous coverage prior to enrolling in HIRSP and had exhausted other coverage options (e.g. COBRA). These individuals **may or may not** have had a medical condition preventing them from enrolling in affordable coverage in the regular market.

Note: "Eligible individuals" are **not** the population traditionally discussed in today's conversations regarding high-risk pools. Under the ACA and most current health care reform proposals, these "eligible individuals" would be covered by guaranteed issue or continuous coverage protections, and would not necessarily require high-risk pool coverage even if they had a medical condition.

What did HIRSP coverage cost?

HIRSP offered seven plans with different premium and out-of-pocket cost structures. All HIRSP plans had high deductibles – 80% of enrollees were enrolled in plans with either a $2,500 or $5,000 deductible. Premiums in HIRSP were an average of 15% higher than new policies sold in the regular market, and varied based on age and sex.

Low-income enrollees – those with household incomes below $34,000, or about 225% of the federal poverty level for a family of two in 2012[3] – were eligible for income-based subsidies to help reduce premiums, deductibles, and out-of-pocket drug costs. In 2012, approximately 25% of all HIRSP enrollees received a subsidy.

To reduce costs, HIRSP had a lifetime limit on benefits. No HIRSP enrollees reached this limit, however in 2009 the cap was raised from $1 million to $2 million, to avoid ending coverage for individuals with health care costs close to the original limit[4]. Enrollees who were eligible because of a medical condition had a 6-month pre-existing condition exclusion period during which no medical services related to their condition were covered by HIRSP (prescription drug coverage was not excluded).

Was HIRSP successful?

Overall, HIRSP was a well-managed plan that provided a stable coverage option for people who were eligible and who could afford coverage.

- HIRSP had a robust administrative structure, supported by an independent body called the HIRSP Authority, which could adapt HIRSP deductibles, benefits, and other plan details.
- The majority of HIRSP costs were paid for through enrollee premiums (60%), insurer assessments (20%), and provider contributions through lower reimbursement rates (20%). Only $2.5 million of the total $186 million in program costs came from non-ACA federal grants.
- Premiums in HIRSP were lower than in high-risk pools in other states[1].

What were HIRSP's challenges?

HIRSP was a relatively small program that was not available to all Wisconsinites and therefore had limited impact.

- HIRSP covered less than 1% of the state's population and approximately 7% of the individual insurance market[1].
- Wisconsinites who could not afford the premiums or high out-of-pocket costs were priced out of HIRSP and were left without another coverage option.
- There is no clear evidence showing the magnitude of the impact HIRSP had on premiums in the broader insurance market.

Traditional HIRSP vs. HIRSP Federal

As a part of the ACA, Wisconsin operated a version of the federal Pre-existing Condition Insurance Plan, called HIRSP Federal. HIRSP Federal was smaller than traditional HIRSP, covering 2,400 Wisconsinites at its peak. HIRSP Federal was available to individuals with pre-existing conditions who had been uninsured for at least six months.

HIRSP Federal followed the market regulations required by the ACA—no pre-existing condition exclusions or lifetime limits, and premiums equal to those for healthy individuals in the regular market, equal for men and women, with limits on how much they could vary by age. Income-based subsidies were not available for HIRSP Federal enrollees.

HIRSP Federal was a far more expensive program to manage than traditional HIRSP – presumably because of the requirement that enrollees be previously uninsured, and the absence of pre-existing condition exclusions and higher premiums used to control costs in traditional HIRSP.

A comparison of traditional HIRSP and HIRSP Federal provides a useful example of the tradeoffs between comprehensive benefits and low costs. Plans with the comprehensive benefits that cancer patients and survivors need, without limits or other cost-control strategies, can be expensive to run. To remain affordable for enrollees, these plans require a greater investment from the federal and/or state government.

Where does WI go from here?

Under current health reform proposals, states would have significant flexibility over how to design their high-risk pools. In Wisconsin, decision makers will need to address the following questions, to determine how well a new HIRSP-like program would serve high-risk individuals and how sustainable the program would be.

- Who would be eligible?
  - How would people in the individual insurance market be incentivized or required to enroll in a separate high-risk pool?
  - Would only the "traditional" high-risk individuals from HIRSP's medically eligible group be included? Since only 40% of HIRSP enrollees were in this group, shifting the pool's makeup in this direction could impact HIRSP's affordability for members and the state.
- Will it be affordable for enrollees and the state?
  - Will ACA-era consumer protections not included in the original HIRSP program, such as bans on pre-existing condition exclusions and lifetime limits, be included? If so, more state or federal resources may be needed to control costs.
  - Will subsidies be generous enough for low- and middle-income Wisconsinites to afford coverage?
- Will there be sufficient funding to cover the administrative cost of re-establishing a robust HIRSP program?
  - Funds included in current health reform proposals to support high-risk individuals could be used for a variety of programs other than high-risk pools, including a reinsurance program.

How might WI cancer patients be affected?

More than 285,000 cancer patients and survivors currently live in Wisconsin and need reliable access to health insurance that is affordable and comprehensive – free of pre-existing condition exclusions, high out-of-pocket costs, and other elements that increase the financial burden of a cancer diagnosis.

Providing this type of coverage would require that a new version of HIRSP be sufficiently funded in order to remain affordable and sustainable.

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NOTES AND SOURCES

For more information on HIRSP, see the Legislative Fiscal Bureau's Informational Paper 53, Health Insurance Risk-Sharing Plan (HIRSP).

For more information on how high health care costs impact individuals with a cancer diagnosis, see the WI CCC Issue Brief "Cost of Cancer: Policy and Programmatic Considerations."

Other Sources:

1. Karen Pollitz, "High-Risk Pools for Uninsurable Individuals," Kaiser Family Foundation. February 22, 2017. http://kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/
2. NASCHIP Enrollment Data, 2011. http://naschip.org/2012/Quick%20Checks/Pool%20Membership%202011.pdf
3. "2012 HHS Poverty Guidelines." ASPE, November 23, 2015. https://aspe.hhs.gov/2012-hhs-poverty-guidelines
4. 2009 Wisconsin Act 83; December 1, 2009. https://docs.legis.wisconsin.gov/2009/related/acts/83.

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Together we will reduce the burden of cancer in Wisconsin.

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