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An Evaluation:

Health Insurance
Risk-Sharing Plan

May 2005

Report Highlights

HIRSP's financial position continued to improve in FY 2003-04.

Policyholder enrollment and claims costs continued to increase in FY 2003-04.

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Pharmacy claims were inappropriately paid for

The Health Insurance Risk-Sharing Plan (HIRSP) was established in 1980 to provide medical insurance for individuals who cannot obtain coverage in the private market because of the severity of their health conditions. In the late 1990s, it was also designated as Wisconsin's plan to meet federal Health Insurance Portability and Accountability Act (HIPAA) regulations and to provide health insurance to people who lose employer-sponsored group health insurance and meet other specified criteria.

HIRSP is primarily funded through policyholder premiums, financial assessments on health insurance companies that do business in Wisconsin, and reduced reimbursements to health care providers. As of March 31, 2005, 18,725 policyholders were enrolled in HIRSP.

HIRSP offers eligible applicants three plans:

- The primary plan, plan 1A, is similar to coverage provided by many private major medical plans.
- The alternative plan, plan 1B, offers the same coverage as plan 1A but at lower premium rates because policyholders pay a higher deductible before HIRSP begins paying claims.
- An additional plan, plan 2, is available to Wisconsin residents under the age of 65 who participate in the federal Medicare program because of a disability.

At the request of the Department of Health and Family Services (DHFS), we completed our seventh financial audit of HIRSP. Our audit report contains our unqualified opinion on HIRSP's financial statements and related notes for the fiscal years ending June 30, 2004 and 2003.

Financial Status of the Plan

Because of its cash-based funding approach, HIRSP had an accounting deficit of $8.2 million as of June 30, 2001. Beginning with fiscal year (FY) 2001-02, DHFS and HIRSP's Board of Governors implemented an accrual-based approach to funding HIRSP, which has contributed to a

cancelled policyholders.

Policyholder deductibles were not properly carried forward between years.

A technical issue in HIRSP's statutory funding formula needs legislative attention.

Key Facts and Findings

Almost 19,000 policyholders are enrolled in HIRSP.

HIRSP is funded through policyholder premiums, insurer assessments, and reduced reimbursements to health care providers.

We have issued an unqualifeed opinion on HIRSP's FY 2003-04 financial statements.

HIRSP's net assets increased by $7.4 million during FY 2003-04.

significant improvement in its financial position.

HIRSP's unrestricted net asset balance was $6.8 million at June 30, 2004. The improvement in HIRSP's unrestricted net asset balance over the last four years is shown in the following table.

Unrestricted Net Assets
(In Millions)

Date	Amount
June 30, 2001	$(8.2)
June 30, 2002	(6.0)
June 30, 2003	(0.9)
June 30, 2004	6.8

Statutes require policyholders to fund 60 percent of HIRSP's costs and establish a floor for policyholder premiums of at least 140 percent of standard risk rates. Statutes also require a separate accounting of premiums received in excess of the amount needed to cover policyholders' 60 percent share of HIRSP's costs.

Because the statutory floor for premium rates has typically been greater than the premiums needed to fund 60 percent of HIRSP's costs, and because actual claims costs were less than costs assumed in HIRSP's FY 2002-03 budget, the excess policyholder premium account balance increased significantly during FY 2002-03, from $3.0 million to $10.4 million as of June 30, 2003. The excess policyholder balance decreased slightly in FY 2003-04, to $10.1 million at June 30, 2004.

The use of these funds is statutorily restricted to reduce policyholder premiums to the statutory minimum; for distribution to eligible persons; or for other needs of eligible persons, with the approval of the Board of Governors.

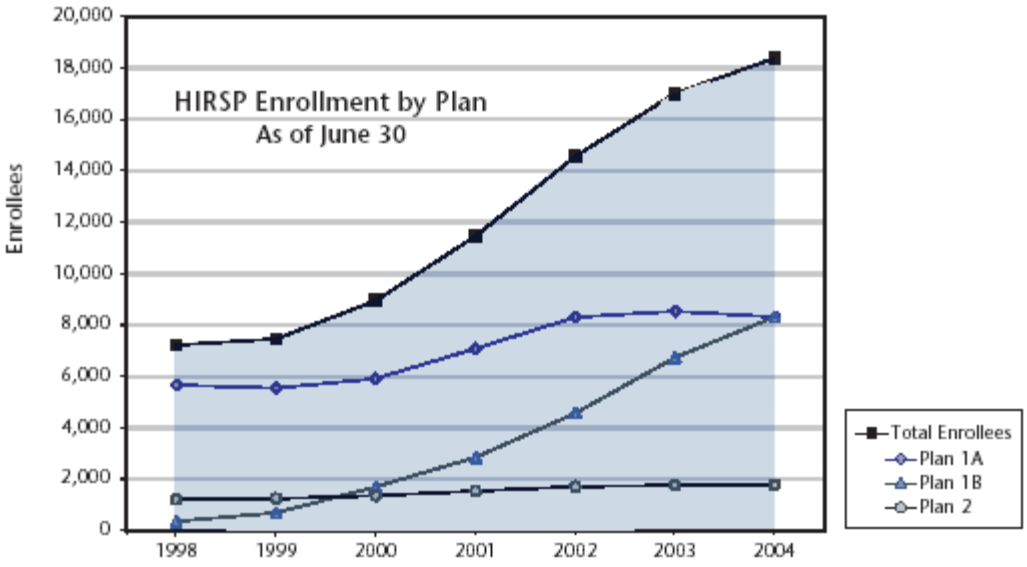
Enrollment and Claims Costs

Increasing enrollment and claims costs present continuing challenges to HIRSP's management and funding. HIRSP experienced double-digit enrollment growth for several years. Policyholder enrollment continued to increase during our audit period.

In FY 2003-04, enrollment increased by 8.1 percent for a total of 18,395 policyholders as of June 30, 2004. However, growth has slowed in the first nine months of FY 2004-05, and enrollment was 18,725 at March 31, 2005.

Enrollment in plans 1A and 2 began to level in recent years, although enrollment in plan 1B continued to increase steadily. Like enrollment, claims costs have been increasing each year. Net of health care providers' discounts, claims costs increased $67.5 million over the past five years.

A new plan administrator began administering HIRSP in April 2005.



Determination of Program Costs

Program costs shared by policyholders, insurers, and health care providers are billed medical charges that have been reduced by usual and customary discounts. These discounts have been based on reimbursement levels for the program since before 1998.

In aggregate, the discounts have been approximately 20 percent of billed charges. However, unexpected increases in program costs in 2004 caused DHFS and the Board of Governors to increase the discounts applied to billed medical claims from January 1, 2004 through June 30, 2005. On an aggregate basis, the discounts were increased to approximately 30 percent, which DHFS and the Board believed was more representative of industry averages.

Net Claims Costs[1]
(In Millions)

Fiscal Year	Amount	Percentage Change
1999-2000	$ 36.4	–
2000-01	54.1	48.6%
2001-02	67.2	24.2
2002-03	85.8	27.7
2003-04	103.9	21.1

[1] Net of health care providers' discounts.

The amount of program costs shared by the funding groups decreased as a result of this change. DHFS and the Board are currently re-evaluating the discounts that will be applied for future periods.

Claims Management Issues

We identified two types of errors in the management of claims. First, since November 2001, pharmacy claims totaling $210,689 were paid on behalf of cancelled policyholders because the former plan administrator had not reviewed a report developed to identify and communicate policy cancellations to the pharmacy benefit management company. That company operated under a subcontract with the former plan administrator. DHFS has withheld payments to the former plan administrator for the inappropriate payments and intends to refund the former administrator for any amounts collected from these individuals.

Second, the former plan administrator did not consistently ensure that deductibles were carried forward between calendar years, as required by statutes. Statutes require that expenses used to satisfy a policyholder's deductible during the last 90 days of a calendar year should also be applied to satisfy the deductible for the following year. Fourth-quarter deductibles were not properly applied for 1,582 policyholders whose overpayments for deductibles total $327,699 since 1998.

Technical Statutory Issue

DHFS and HIRSP's contracted actuary have identified a technical statutory issue that will require legislative action. Under current statutes, the method by which HIRSP's funding formula applies deductible and drug coinsurance subsidies for low-income policyholders results in policyholders being over-credited for subsidies they did not fund. DHFS and the Board of Governors decided in 2001 that $1.5 million of the resulting unallocated costs associated with the deductible subsidy credit would be paid by policyholders, insurers, and health care providers based on the statutory funding split used for HIRSP costs. These costs had accumulated during 1998, 1999, and 2000.

In April 2004, DHFS and the Board decided to reduce the excess policyholder premium account by $2.2 million for the balance of overcredited deductible subsidies that had subsequently accumulated through March 31, 2004. Proposed statutory changes to address this technical issue are included in the 2005-07 biennial budget bill, 2005 Assembly Bill 100.

Recommendations

Our recommendations address the need for Department of Health and Family Services to:

- take steps to provide refunds to policyholders who have overpaid their deductibles; and
- ensure the new plan administrator establishes procedures to properly apply fourth-quarter deductibles to the following year's deductibles *(**p. 20**).*

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