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An Evaluation:

Health Insurance
Risk-Sharing Plan

April 2004

Report Highlights

HIRSP's financial position improved during FY 2002-03.

Policyholder enrollment and claims costs continue to increase.

The 2003-05 Biennial Budget Act included changes to HIRSP.

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

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; reduced reimbursements to health care providers; and, until recently, general purpose revenue (GPR). As of February 29, 2004, 17,669 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 sixth 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, 2003 and 2002.

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. This deficit represented estimated additional cash that HIRSP would eventually need to pay covered medical expenses that had been incurred but not paid before this date.

Key Facts and Findings

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

We have issued an unqualified opinion on HIRSP's FY 2002-03 financial statements.

HIRSP's accounting deficit decreased by $5.1 million to reach $0.9 million as of June 30, 2003.

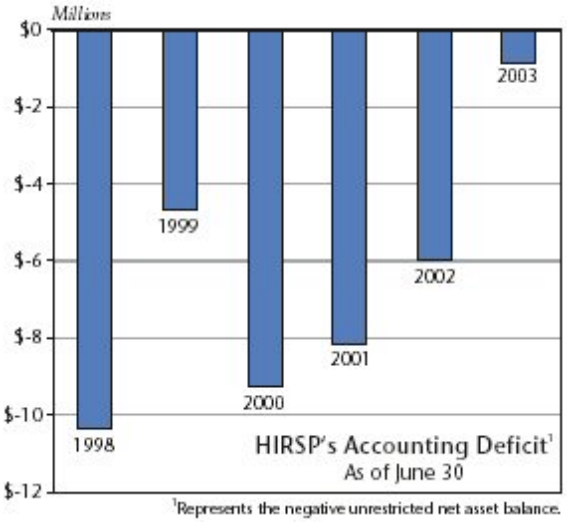
The excess policyholder premium account balance increased significantly during FY 2002-03, from 3.0 million to $10.4 million as of June 30, 2003.

Prescription drug claims represented 37.8 percent of the $85.8 million in net claims paid during FY 2002-03.

DHFS and HIRSP's Board of Governors implemented an accrual-based funding approach beginning with fiscal year (FY) 2001-02. An accrual basis takes into account the full costs associated with events that occur during a plan year, including actuarial cost estimates for incurred claims that may not be filed until after the plan year.

The change to an accrual-based approach required funding to eliminate the accounting deficit that had accumulated under the cash-based approach, as well as funding for newly incurred costs accounted for on an accrual basis.

As a result of increasing enrollment and program costs, as well as the change in the funding approach, policyholder premiums and insurer assessments increased significantly in FY 2001-02 and FY 2002-03. Total premium revenue almost doubled, while insurer assessments increased 162.7 percent.



The increased revenues that resulted from increases in premiums and insurer assessments contributed to a $5.1 million reduction in HIRSP's accounting deficit, which was $0.9 million as of June 30, 2003.

Statutes require policyholders to fund 60 percent of HIRSP's costs and establish a floor for policyholder premiums of at least 150 percent of standard risk rates through July 29, 2002, and 140 percent of standard risk rates as of July 30, 2002. 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 the 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 use of these funds is statutorily restricted for these purposes:

- to reduce policyholder premiums to the statutory minimum when the

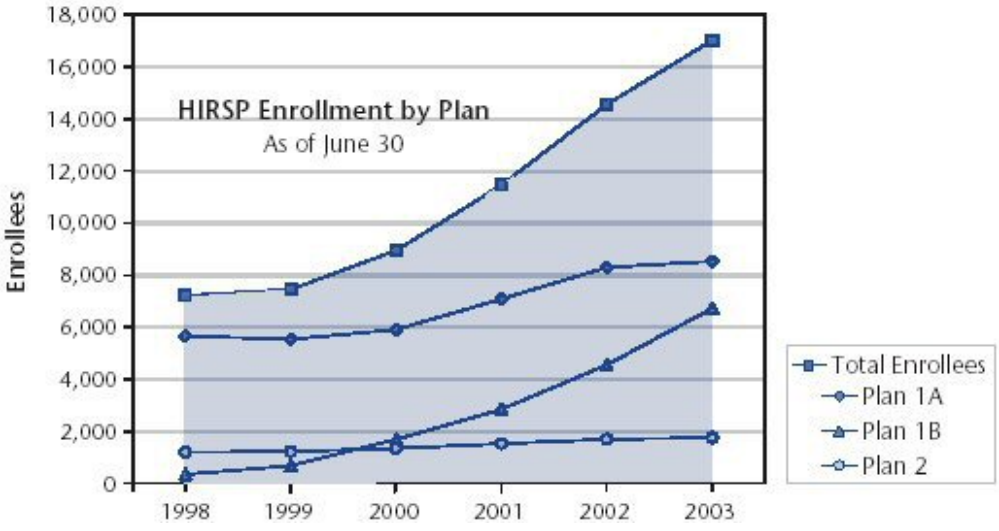
policyholders' share of costs would otherwise require a premium increase;
- for other needs of eligible persons, with the approval of the Board of Governors; or
- for distribution to eligible persons.

Increasing Enrollment and Claims Costs

Increasing enrollment and claims costs present continuing challenges to the management and funding of HIRSP.

Policyholder enrollment increased 16.9 percent during FY 2002-03, to 17,017 policyholders as of June 30, 2003. However, enrollment experience during the first eight months of FY 2003-04 suggests that enrollment growth may be beginning to slow: enrollment increased by 3.8 percent, to 17,669 as of February 29, 2004.

Enrollment in plans 1A and 2 began to level off in FY 2002-03, although enrollment in plan 1B continued to increase steadily. Further, an increasing number of participants have shifted from plan 1A to plan 1B in recent years. The greatest shift occurred in 2003, when 713 participants changed from plan 1A to plan 1B.



Net of health care providers' discounts, claims costs increased 171.1 percent, or $54.2 million, over the last five years. A large portion of these increases can be explained by the enrollment increases, although HIRSP claims costs also have been affected by medical cost increases similar to those experienced by others in the health insurance industry.

Claims Costs[1]		
Fiscal Year	Amount	Percentage Change
1998-99	$31,671,704	–
1999-2000	36,399,671	14.9%
2000-01	54,120,507	48.7
2001-02	67,180,778	24.1
2002-03	85,849,897	27.8

[1]Net of health care providers' discounts.

Legislative Activity

The Legislature began providing GPR funding to offset program costs in FY 1997-98. At that time, GPR funding to subsidize premiums and deductibles for low-income policyholders had been in place for several years. During the 2001-03 biennium, GPR support for HIRSP totaled $21.0 million.

Under 2003 Wisconsin Act 33, the 2003-05 Biennial Budget Act, all GPR support for HIRSP was eliminated beginning in FY 2003-04. The other funding parties—policyholders, insurers, and health care providers—are now required to pay for costs that had previously been funded through GPR.

Act 33 also authorizes DHFS to select the HIRSP plan administrator through a competitive procurement process. Since 1998, statutes had required that the Medicaid fiscal agent serve as HIRSP's administrator. DHFS is currently conducting a competitive procurement process with the intent of selecting and contracting with a vendor to administer HIRSP beginning in January 2005, after a six-month transition period.

In light of HIRSP's increasing costs and the loss of GPR, legislation was introduced in February 2004 to expand the funding base to include drug manufacturers and drug labelers, which are companies that repackage prescription drugs for retail sale.

Under 2003 Senate Bill 466, which was not enacted, each manufacturer or labeler that provided prescription drugs under HIRSP would have been required to pay an annual assessment based on claims that HIRSP paid for their drugs in the previous calendar year. On a per claim basis, the assessment amount would have been equal to the rebate amount the drug manufacturer or labeler pays for the drug under Medicaid.

At 37.8 percent of net claims paid during FY 2002-03, prescription drug claims represent the secondlargest portion of HIRSP's claims costs. HIRSP currently receives some drug rebates as part of the agreement with its plan administrator, including $677,118 during FY 2002-03.

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, and a related portion of costs not being allocated to any funding party.

DHFS and the Board of Governors decided in 2001 that $1.5 million of 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 March 2004, the Board's Financial Oversight Committee approved a recommendation to the Board to reduce the excess policyholder premium account by the amount of over-credited deductible subsidies as of March 31, 2004. The unallocated balance was $2.1 million as of February 29, 2004. DHFS and the Board of Governors plan to pursue statutory changes to address this technical issue during the 2005-07 legislative session.

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