AN AUDIT

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

01-16

September 2001

2001-2002 Joint Legislative Audit Committee Members

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September 18, 2001

Senator Gary R. George and
Representative Joseph K. Leibham, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator George and Representative Leibham:

At the request of the Department of Health and Family Services, we have completed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 1999-2000. HIRSP provides medical insurance for nearly 11,500 policyholders who are unable to obtain coverage in the private market. We have provided an unqualified opinion on HIRSP's financial statements and have followed up on issues raised in prior audits.

One of these issues relates to overpayment of prescription drug claims. From July 1998 through January 2001, the Department did not have controls in place to ensure that policyholders and pharmacies were reimbursed for prescription drugs at HIRSP-allowed rates. As a result, HIRSP overpaid drug claims by an estimated $5.5 million. The Department has reinstated system controls to reimburse drug claims at HIRSP-allowed rates, and it plans to begin recovery of overpayments in fall 2001. However, because of these efforts, at least 160 pharmacies have withdrawn from the program. The Department has recently implemented an on-line pharmacy claims processing system, which it expects will help to address pharmacy concerns and streamline the drug claims process.

Another major issue pertains to HIRSP's funding approach. In April 2001, the Board of Governors voted to implement an accrual-based funding approach in response to our prior audit recommendations, and following extensive debate. HIRSP's actuary projects that in fiscal year (FY) 2001-02, the change from a cash-based to an accrual-based approach will require policyholders, insurers, and health care providers to provide an additional $16.6 million to fund an accumulated accounting deficit. An excess policyholder premium reserve will fund the policyholders' share; the required contributions paid by health care providers are expected to meet their share; and insurers will fund their share through their semi-annual assessments.

We appreciate the courtesy and cooperation extended to us by the Department and the plan administrator for HIRSP. A response from the Department is Appendix 2.

Respectfully submitted,

Janice Mueller
State Auditor

JM/DA/ss

Summary

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. As of June 30, 2001, 11,460 policyholders were enrolled in the plan, which represents a 28 percent increase from the prior year. HIRSP reported net income of nearly $1.0 million during fiscal year (FY) 1999-2000. General purpose revenue (GPR) support for HIRSP totaled $23.4 million in the 1999-2001 biennium.

At the request of the Department of Health and Family Services, we performed a financial audit of HIRSP for FY 1999-2000. We have provided an unqualified opinion on HIRSP's FY 1999-2000 financial statements and followed up on issues related to program administration, pharmacy claims, and program funding that were discussed in two prior audits (report 99-6 and 00-13).

Paid claims for prescription drugs, which totaled $13.0 million in FY 1999-2000 and $15.6 million in FY 2000-01, represent approximately 35 percent of HIRSP's total paid claims. During our FY 1998-99 audit, we found that, in response to confusion surrounding prescription drug claims, the Department had suspended system controls that ensured policyholders and pharmacies were reimbursed at the allowable rates for prescription drugs. Instead, the Department instructed pharmacies to charge the HIRSP-allowed rates for HIRSP policyholders at the point of sale. These measures were necessary in the short-term to ensure continuity of services, but the Department and the HIRSP plan administrator did not take immediate steps to subsequently reinstate system controls or ensure that pharmacies were charging appropriate rates for prescription drugs. The lack of controls resulted in significant overpayments of drug claims from July 1998 through January 2001. We estimate that HIRSP overpaid prescription drug claims by approximately $5.5 million during this period. The Department reports that on January 29, 2001, system controls were reinstated so that claims are reimbursed at HIRSP-allowed amounts.

The Department and HIRSP's Board of Governors have taken steps to address the overpayment of drug claims and, along with the Pharmacy Society of Wisconsin, have been establishing the amounts that individual pharmacies were overpaid. In fall 2001, the Department plans to issue notices to 980 pharmacies seeking approximately $1.6 million of an estimated $1.7 million in FY 1998-99 overpayments. The Department has not yet determined the amount of overpayments it will seek to recover for FY 1999-2000 and FY 2000-01, but it intends to issue recovery notices for those years before spring 2002. However, resumption of system controls and the Department's steps to recover overpayments have resulted in some pharmacies withdrawing from the program: as of June 2001, 160 pharmacies had notified the Department they will no longer service HIRSP policyholders. This has caused concern for the policyholders who would be denied access to service.

To address the pharmacies' concerns about the difficulty of complying with HIRSP's billing requirements, as well as to improve the drug claim process for both policyholders and pharmacies, the Department implemented an on-line pharmacy claims processing system using a pharmacy benefit management company on August 1, 2001. The new system gives the pharmacies that serve HIRSP policyholders on-line access to HIRSP-allowed rates for prescription drugs. However, because HIRSP currently does not include a separate coinsurance provision for prescription drugs, pharmacies do not have deductible or coinsurance information on the policyholders and, therefore, policyholders will still need to pay the full amount for their prescription drugs at the time of purchase. The pharmacy benefit management company will electronically submit policyholder claims data to HIRSP's plan administrator each week, and reimbursements will be made to those policyholders who have met deductible or coinsurance requirements.

Recently, concerns have been raised about the difficulties some policyholders are encountering with the requirement to pay in full for prescription drugs at the time of purchase. The situation of policyholders with high prescription drug costs who do not have ready access to funds to pay the up-front costs has been of special concern. Separate prescription drug coinsurance provisions included in 2001 Wisconsin Act 16, which was enacted August 30, 2001, will help to address these concerns. After changes are made to the HIRSP program and the on-line drug claims system to implement the separate coinsurance provisions, HIRSP policyholders will be charged a coinsurance amount, which the Department plans to set at 20 percent of the HIRSP-allowed rate, with a maximum of $25 for each prescription.

The Department notes that separate coinsurance provisions for prescription drugs will be beneficial to most policyholders, who will not be required to meet overall deductible levels before HIRSP begins paying drug claims. The Department estimates that a separate coinsurance provision for prescription drugs will increase HIRSP benefit costs by $683,000 annually for the immediate payment on prescription drug benefits.

Use of a pharmacy benefit management company is expected not only to improve the accuracy and efficiency of claims processing, but also to realize financial benefits for HIRSP. The annual costs to use the pharmacy benefit management company and an on-line pharmacy system are expected to be $133,000, but the plan administrator's costs to manually process HIRSP drug claims are expected to decrease by $83,000 annually. In addition, the pharmacy benefit management company receives rebates from drug companies based on the volume of its purchases from the companies, and it will share an estimated $208,000 annually in rebates with HIRSP. Therefore, it is estimated that, after the initial costs to implement the on-line pharmacy system have been recovered, HIRSP will realize net annual savings of $158,000.

Some have expressed concern that pharmaceutical providers—which include pharmacies and drug manufacturers—are not contributing adequately to the payment of HIRSP's costs because they are substantially excluded from the calculation that determines health care providers' funding contributions. Obtaining contributions from pharmaceutical providers is difficult because pharmacies serve as an intermediary between drug companies and policyholders, and a relatively small portion of the costs of drug claims is associated with pharmacists' charges, while a significant portion is the

wholesale price of drugs charged by drug companies. In report 00-13, we recommended the Department report to the Joint Legislative Audit Committee on its progress in obtaining pharmaceutical providers' contributions toward funding HIRSP. The Department reported in March 2001 that it was pursuing drug rebates through the pharmacy benefit management company used by HIRSP's plan administrator. The Department expects that HIRSP will share in an estimated $208,000 in annual drug rebates that the pharmacy benefit management company receives from drug companies.

Besides pharmaceutical rebates, the other primary way to increase pharmaceutical providers' contributions would be through discounted payment rates for drugs similar to the rates paid by commercial insurers. However, in response to pharmacies' concerns, the Legislature enacted provisions in 2001 Wisconsin Act 16 specifying that the Department may not reduce the payment rates for prescription drugs below the Medicaid-allowed rates and that the rates may not be adjusted to help fund the providers' share of the program.

During each of our past two audits of HIRSP, we had also recommended that the Department take steps to fund HIRSP on an accrual, or full-cost, basis rather than the cash-based approach used at the time. An accrual basis takes into account the full costs associated with events that occurred during a plan year and could limit the confusion that currently exists because of differences between HIRSP's funding approach and its accounting basis. It could also improve the security of HIRSP's financial position.

Under HIRSP's cash-based approach, almost $7.4 million in assets were reserved for policyholders as of June 30, 2000, and the amount available for HIRSP's general operations was reduced by the same amount. Under a statutory funding formula, policyholders are required to fund 60 percent of HIRSP's costs after the deduction of an annual GPR subsidy. Statutes also require that premiums be set at a minimum of 150 percent of standard risk rates; that is, the rates that private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP. If premiums of less than 150 percent of the standard rates are required to fund 60 percent of HIRSP's estimated costs after deduction of the GPR subsidy, premium rates are still required to be set at 150 percent of the standard rates; however, statutes also require that the excess funds be set aside to reduce premium rates in future years or for other purposes that benefit policyholders.

Taking the excess policyholder premium reserve into account, HIRSP had an accounting deficit of negative $9.1 million at the end of FY 1999-2000. That amount represents the estimated amount of additional cash HIRSP would need to pay its liabilities as of June 30, 2000, and is almost double the accounting deficit of $4.7 million reported as of June 30, 1999.

The Board of Governors recently voted to implement an accrual-based approach to funding HIRSP and to fund the accumulated accounting deficit beginning in FY 2001-02, which will have an immediate fiscal effect on the various parties funding HIRSP. The change to an accrual-based approach has been extensively debated by the Board of Governors, the Legislature, and other interested parties.

HIRSP's actuary projects that the insurers and providers each will need to provide an additional $3.3 million to fund the accounting deficit. The policyholders' share of $10.0 million will be funded by the excess policyholder premium reserve, which had accumulated on a cash-based funding approach. The policyholder premium reserve was recently reduced by a $2.5 million distribution to policyholders in January 2001.

At the same time that the Department and the Board of Governors are taking steps to change to an accrual-based funding approach and fund the accounting deficit, other factors are increasing HIRSP's ongoing costs. The number of policyholders is projected to increase an additional 12 percent in FY 2001-02, and the HIRSP actuary projects prescription drug claims costs will increase 15 percent and non-drug claims costs will increase 7.5 percent in that year.

Another continuing issue from our prior audit is the need for technical statutory amendments to clarify the determination of provider contributions. Statutory changes that were enacted as part of 1999 Wisconsin Act 9 were intended to clarify and codify the Department's practice of setting provider contribution rates at the levels required by statutes. However, they did not fully encompass the Department's practices, and they do not provide a meaningful base against which to measure the providers' contributions toward funding HIRSP. The Legislature could consider two options to clarify the issue: amending the statutory language to more closely reflect the Department's practices, or directing the Department to establish by administrative rule an appropriate method for determining health care providers' contributions toward funding HIRSP.

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The Health Insurance Risk-Sharing Plan (HIRSP) is a state program that provides health insurance to individuals who are unable to obtain coverage in the private market. As of June 30, 2001, 11,460 policy-holders were enrolled in the plan, which represents a 28 percent increase in enrollment from the prior year.

At the request of the Department of Health and Family Services, we performed a financial audit of HIRSP for fiscal year (FY) 1999-2000. During two prior audits (report 99-6 and report 00-13), we identified a number of financial and management concerns, including issues related to program funding, drug claims processing, and overall program administration. This report, which includes an unqualified opinion on HIRSP's FY 1999-2000 financial statements, follows up on these issues.

Plan Administration

The Department assumed oversight responsibility for HIRSP in January 1998.

1997 Wisconsin Act 27, which was enacted in October 1997, transferred oversight responsibility for HIRSP from the Office of the Commissioner of Insurance (OCI) to the Department of Health and Family Services as of January 1, 1998. In addition, it modified HIRSP in response to the federal Health Insurance Portability and Accountability Act of 1996 and required responsibility for daily program operations to be transferred to a new plan administrator that is also the State's fiscal agent for Medicaid. Act 27 also made significant changes to HIRSP's funding, including providing increased general purpose revenue (GPR) and increasing health care providers' funding responsibility.

The transfer of oversight responsibility from the OCI to the Department was intended to bring administration of all state-sponsored medical programs under one agency. As the agency responsible for oversight of HIRSP, the Department is required by statutes to promulgate administrative rules, including rules to:

- establish a program budget for each plan year;
- operate the plan;
- establish annual HIRSP premium rates, deductible amounts, and coinsurance payment rates;
- set and collect insurers' assessments; and

- adjust the provider payment rates as necessary to meet program funding requirements.

The Department was authorized 4.5 positions and $208,900 during FY 1999-2000 to oversee HIRSP operations and policies, as well as to provide administrative support for the 12-member advisory Board of Governors that consists of:

- the Department's Secretary (or a designee), who serves as chair;
- the Commissioner of Insurance (or a designee); and
- 10 members appointed by the Secretary for staggered 3-year terms, including 4 participating insurers (2 representing nonprofit organizations), 3 health care providers, and 3 public members.

The State's fiscal agent for Medicaid administers HIRSP's daily operations and was paid $2.5 million in FY 1999-2000.

The mandated transfer of responsibility for daily program operations to the State's Medicaid fiscal agent, EDS, was intended to allow HIRSP to take advantage of cost-containment provisions associated with Medicaid. EDS became HIRSP's plan administrator on July 1, 1998, and is responsible for:

- determining whether applicants are eligible for health insurance coverage offered through HIRSP;
- establishing procedures for collecting premiums from insured persons; and
- processing and paying eligible claims in a timely manner.

EDS was paid $2.5 million in FY 1999-2000 to administer HIRSP. That payment represents 6.3 percent of the program's total operating and administrative expenses during FY 1999-2000.

Plan Provisions

Three plans are available to policyholders.

HIRSP offers eligible applicants three plans:

- The primary plan provides coverage that is similar to coverage provided by many private major medical plans. It is available for Wisconsin residents who have received a notice of rejection, cancellation, reduction of coverage, or substantial premium increase by an insurer, or who have tested positive for the virus that causes AIDS.

- The alternative primary plan, which became available in January 1998, offers lower premium rates than the primary plan but requires policyholders to pay a higher deductible before HIRSP begins paying claims. It was introduced to comply with the federal Health Insurance Portability and Accountability Act's requirement to offer a choice of major medical expense coverage to the same individuals eligible for the primary plan.

- An additional plan is available to Wisconsin residents under the age of 65 who participate in the federal Medicare program because of a disability. Persons with coverage when they reach the age of 65 may continue in the plan.

By statute, HIRSP may reimburse only those medical services that policyholders obtain through Medicaid-certified providers. In addition, policyholders are required to share in the costs of covered services through:

- annual deductibles of $1,000 for the primary plan, $2,500 for the alternative primary plan, and $500 for the disabled Medicare beneficiaries plan, which must be paid by policyholders before insurance benefits will be available; and

- coinsurance payments of up to $1,000 per year for policyholders in the primary and alternative primary plans, which must be paid by the policyholders after their annual deductible requirements have been satisfied. There is no coinsurance requirement for the disabled Medicare beneficiaries plan.

The number of HIRSP policyholders has been increasing.

Enrollment in HIRSP has been increasing, as shown in Table 1 and Figure 1. In the last two fiscal years, enrollments have increased an average of 24 percent, and they are projected to increase another 12 percent for FY 2001-02. The Department established an Actuarial Advisory Subcommittee of the Board of Governors to review insurance industry trends and other data to evaluate the increase in HIRSP enrollment.

Table 1

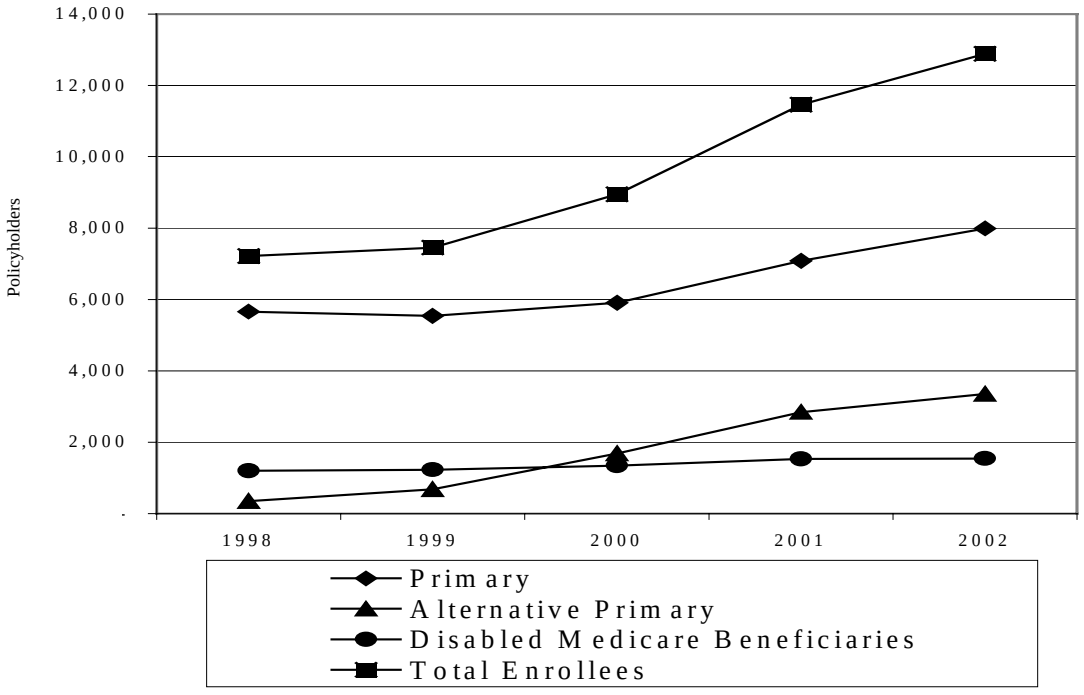
HIRSP Enrollment

Date	Primary Plan	Alternative Primary Plan	Disabled Medicare Beneficiaries Plan	Total Policyholders
June 30, 1998	5,660*	354*	1,204	7,218
June 30, 1999	5,540	683	1,231	7,454
June 30, 2000	5,909	1,692	1,348	8,949
June 30, 2001	7,081	2,849	1,530	11,460
June 30, 2002	7,991*	3,351*	1,546*	12,888*

*= estimated

Figure 1

HIRSP Enrollment by Plan



Plan Funding

GPR support for HIRSP totals $23.4 million in the 1999-01 biennium.

Before January 1, 1998, HIRSP had two primary funding sources: premiums paid by policyholders, and annual financial assessments on health insurance companies that do business in Wisconsin. 1997 Wisconsin Act 27 authorized additional funding sources that took effect when oversight responsibility was transferred from the OCI to the Department. Effective January 1, 1998, the Legislature:

- made additional GPR funding available to offset program costs other than subsidies, including $9.9 million in FY 1999-2000 and $11.9 million in FY 2000-01; and

- required providers of covered health care services and items to share equally with insurers in program costs that were not covered by premiums and GPR.

In addition, $780,800 in GPR was appropriated annually, and $1.4 million was provided by insurers and health care providers to fund premium and deductible subsidies for low-income persons during FY 1999-2000.

Statutes prescribe a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers to share in estimated operating and administrative costs remaining after the GPR subsidy has been deducted. Policyholder premiums are expected to fund 60 percent of the remaining estimated operating and administrative costs. Premium rates are statutorily required to be at least 150 percent, but not in excess of 200 percent, of standard risk rates; that is, the rates that private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP. Private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders are required to share equally in the remaining 40 percent of operating and administrative costs. In addition, insurers and health care providers share equally in the excess costs not funded by policyholder premiums when the premium rates needed to fund 60 percent of costs exceed 200 percent of standard risk rates. If premiums of less than 150 percent of the standard rates are required to fund 60 percent of HIRSP's estimated costs after the GPR subsidy has been deducted, the premium rate is nonetheless set at 150 percent of the standard rates in accordance with statutes, and excess funds are set aside to reduce rates in years that would otherwise require higher premiums, or for other purposes that benefit policyholders. A diagram of HIRSP's funding structure is Appendix 1.

Premium rates for each of HIRSP's three plans differ on the basis of gender, age, and geographic location of the policyholders. On average, premium rates for the primary plan have been at the minimum level of 150 percent of standard rates since January 1, 1998. Premium rate increases since 1998 are shown in Table 2.

Table 2

Premium Rate Changes

Effective Date	Primary and Alternative Primary Plans	Disabled Medicare Beneficiaries Plan
July 1, 1998	11.4% increase	24.0% increase
January 1, 1999	No change	10.0% increase
July 1, 1999	No change	4.0% increase
July 1, 2000	12.4% increase	18.2% increase
July 1, 2001	3.4% increase	3.4 % increase

For both the primary plan and the alternative primary plan, rate increases have matched increases in the standard rates that private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP. The disabled Medicare beneficiaries plan experienced larger rate increases than the other two plans for July 1998 through July 2000 to more closely reflect the Medicare plan's claim costs. In response to concerns about increases in the disabled Medicare beneficiaries plan premiums, 1999 Wisconsin Act 165 (which took effect May 2000) allows the Department to consider enrollment levels and other economic factors in addition to claim costs when establishing premium levels.

Examples of annual premiums effective July 1, 2001, for policyholders living in Milwaukee, where the rates are the highest, are shown in Table 3.

Table 3

Examples of Annual Premiums for a Policyholder Living in Milwaukee
Rates effective July 1, 2001

Plan Type	Male Ages 0-24	Male Ages 60-64	Female Ages 0-18	Female Ages 60-64
Primary Plan	$1,716	$7,548	$1,716	$6,360
Alternative Primary Plan	1,236	5,436	1,236	4,584
Disabled Medicare Beneficiaries Plan	1,212	5,292	1,212	4,464

In FY 1999-2000, 31 percent of low-income policyholders received subsidies costing $2.2 million.

Policyholders with annual household incomes below $20,000 are eligible for premium and deductible subsidies. Since January 1, 2000, policyholders with annual household incomes of $20,000 and no more than $25,000 have been eligible for premium subsidies, but not deductible subsidies. As noted, both types of subsidies are funded by GPR and by providers and insurers, who share equally in the subsidy program costs that are not covered by GPR. Annual premium subsidies for policyholders ranged from $132 to $2,520, between July 1, 1999 and June 30, 2000, and deductible subsidies ranged from $200 to $500. Thirty-one percent of HIRSP policyholders received subsidies costing $2.2 million in FY 1999-2000.

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In our prior audits, we identified several areas of concern related to HIRSP's prescription drug claim processing and to program funding. Controls over drug claims processing have been reinstated, and processing efficiency is being improved. Steps are also being taken to address concerns about HIRSP's funding basis. However, our prior audit concerns about pharmaceutical providers' limited contributions to program funding and about other funding issues have not yet been resolved.

Pharmacy Claims

The Department suspended controls that ensured prescription drug claims were reimbursed at allowed rates.

Paid claims for prescription drugs, which totaled $13.0 million in FY 1999-2000 and $15.6 million in FY 2000-01, represent approximately 35 percent of the value of HIRSP's paid claims. During our FY 1998-99 audit, we found the Department had suspended controls that ensured policyholders and pharmacies were reimbursed at the HIRSP-allowed rates for prescription drugs. As a result, HIRSP overpaid drug claims by a significant amount for prescriptions dispensed from July 1998 through January 2001. Since we notified the Department of the overpayments in May 2000, it has been taking steps to re-establish controls, recover the overpayments, and improve the pharmacy claims process. The Department has also considered available options for increasing pharmaceutical providers' contributions to plan funding, while at the same time taking steps to ensure pharmacies remain in the program.

Status of Prescription Drug Overpayments

Under HIRSP, policyholders typically pay pharmacies for covered prescription drugs and then seek reimbursement from the plan administrator. When the State's fiscal agent for Medicaid became the plan administrator for HIRSP on July 1, 1998, Medicaid rates for prescription drugs became the rates policyholders were to be charged by pharmacies and reimbursed under HIRSP. However, during the transition to Medicaid-based drug pricing, some policyholders paid the pharmacies' usual and customary rates for covered drugs, which typically were higher than the Medicaid rates. When these policyholders submitted their claims to HIRSP, they were reimbursed at the Medicaid rates and required to seek additional reimbursement for the difference from the pharmacies. This process resulted in confusion and complaints from both policyholders and pharmacies.

We estimate claims were overpaid by approximately $5.5 million for drugs dispensed from July 1998 through January 2001.

In response to the confusion and complaints, the Department instructed pharmacies to charge HIRSP policyholders Medicaid-allowed rates for their prescriptions at the point of sale. In addition, the Department instructed the plan administrator to suspend controls that had limited drug reimbursement payments to Medicaid rates and to simply pay the billed amount instead. These measures were necessary in the short term to ensure continuity of services, but the Department and the plan administrator did not take immediate steps to subsequently reinstate system controls or ensure that pharmacies were charging appropriate rates for prescription drugs. Consequently, over 75 percent of the FY 1998-99 and FY 1999-2000 prescriptions we tested had been paid in excess of allowed rates, and we estimate HIRSP overpaid drug claims by at least $3.7 million in these two years, and by an additional $1.8 million in the first seven months of FY 2000-01. In total, we estimate prescription drug overpayments to policyholders and pharmacies were approximately $5.5 million for the period in which controls were suspended.

The Department and the Board of Governors began considering steps to address the overpayment of drug claims in May 2000. On November 3, 2000, the Department informed pharmacies of its intent to recover the overpayments that pharmacies had received and urged the pharmacies to follow billing instructions, which were the instructions they had received in July 1998. On January 4, 2001, the Department issued pharmacies a detailed billing guide that more clearly explained the HIRSP drug reimbursement policy and notified them of the resumption of system controls to limit prescription drug payments for services received on or after January 29, 2001, to the lower of Medicaid-allowed or provider-billed amounts. The Department also issued policyholders a detailed booklet that explained how drug claims would be processed and included a reference card policyholders could use to remind pharmacies of HIRSP billing requirements.

The Department plans to begin recovery of prescription drug overpayments in fall 2001.

Subsequently, the Department, the Board of Governors, and the Pharmacy Society of Wisconsin have been working on the criteria for determining overpayment amounts owed by each pharmacy. The Department intends to recover overpayments only from in-state pharmacies and out-of-state pharmacies with Wisconsin border status. Wisconsin border status is a certification given by the Department to those providers in states bordering Wisconsin that have agreed to the same rules and contractual provisions that apply to Wisconsin providers. Neither providers classified as non-pharmacies, such as blood banks, nor out-of-state providers without Wisconsin border status received the initial billing instructions, so the Department believes it cannot legally recover overpayments from them.

The Department plans to issue recovery notices in fall 2001, seeking to recover approximately $1.6 million of the estimated $1.7 million in overpayments for FY 1998-99 from 980 in-state and out-of-state pharmacies with Wisconsin border status. The Department has not yet determined the amount of overpayments it will seek to recover for FYs 1999-2000 and 2000-01, but it intends to issue recovery notices for those years before spring 2002.

Resumption of system controls and steps to recover overpayments have resulted in 160 pharmacies withdrawing from HIRSP.

Resumption of system controls and the Department's steps to recover overpayments have resulted in pharmacies withdrawing from the program. Among the approximately 1,200 Medicaid-certified pharmacies available to provide HIRSP services, the Department is aware of at least 160 pharmacies that have withdrawn from the program as of June 30, 2001. Other pharmacies may no longer be serving HIRSP policyholders, but they have not informed the Department. The largest group of pharmacies to leave the program was 151 Walgreens pharmacies. In January 2001, the Walgreen Company informed the Department it was withdrawing from the program because of difficulties in accurately pricing prescriptions for HIRSP policyholders.

Pharmacies often require policyholders to pay in full when prescriptions are dispensed.

The Pharmacy Society of Wisconsin, which represents over 1,500 pharmacists, also communicated the frustrations its member pharmacies had with the prescription drug claims processing system. The pharmacists' concerns focused on the need to adjust their systems or procedures to accommodate HIRSP's pricing requirements, as well as on the lack of availability of deductible or coinsurance information for individual policyholders. HIRSP prescription drug prices were not available on-line, which required pharmacies serving HIRSP policyholders either to develop their own software to price drugs or to manually determine prices in order to comply with HIRSP's requirements. An additional complication was that HIRSP pharmacy benefits are included with all other benefits under a common deductible and coinsurance provision, making it difficult for pharmacies to determine when policyholders have met their deductibles through non-pharmacy services. For these reasons, pharmacies often require policyholders to pay in full when prescriptions are dispensed and to request reimbursement from HIRSP.

The Department is concerned that if other pharmacies stop serving HIRSP policyholders due to the difficulties, policyholders' access to prescription medications could be affected. For example, if the 12 largest participating companies stopped participating in HIRSP, an additional 391 pharmacies would not be available to policyholders.

Improving Pharmacy Claims Processing

The Legislature recently enacted separate coinsurance provisions for prescription drugs.

The Department is taking steps to address the pharmacies' concerns and to improve the efficiency, simplicity, and understandability of the drug claims process for both policyholders and pharmacies. An important step has been the recent implementation of a pharmacy benefit management company that will give pharmacies on-line access to proper billing rates. The Department initially believed that separate coinsurance provisions for prescription drugs would be needed so that pharmacies would be able to correctly determine the amount owed by policyholders, and with that understanding, the Department and the Board of Governors proposed statutory changes that would allow for separate coinsurance provisions. These were incorporated into 2001 Wisconsin Act 16, which was enacted August 30, 2001.

The Department has been working with the plan administrator to use its pharmacy benefit management company.

As the Department pursued statutory authority for separate drug coinsurance provisions, it has also been working with the plan administrator to use its pharmacy benefit management company, Wellpoint, to implement an on-line processing system for pharmacy claims under current plan provisions. The Department indicated that the system became operational August 1, 2001. Under this system, pharmacies have on-line prescription drug pricing information, although they do not have deductible or coinsurance information on individual policyholders. Policyholders, therefore, are required to pay in full at the time of purchase, even if they have met deductible or coinsurance requirements. However, they should be billed at Medicaid-approved rates rather than the pharmacies' usual and customary rates, and the pharmacy benefit management company will electronically submit claims data to the plan administrator each week so that reimbursements can be made more quickly to policyholders who have met deductible or coinsurance requirements.

Annual savings of $158,000 are projected by using a pharmacy benefit management company.

Implementation costs, which include the costs of project management, development and technical support, publications preparation and mailing, and temporary customer service staff, are estimated to be $177,000. Operating costs for the pharmacy benefit management company's services are estimated at $108,000 for the first four-month period; however, after the fourth month, when 97 percent of claims are expected to be processed electronically, annual operating costs are expected to be $133,000. The plan administrator estimates that its costs will decrease by $83,000 annually when processing is fully automated. In addition, the pharmacy benefit management company receives rebates from drug companies based on the volume of its purchases from these companies and will share an estimated $208,000 in rebates with HIRSP each year. Therefore, the plan administrator estimates that after the initial costs of implementing the pharmacy benefit management company's system are recovered, HIRSP will realize net annual savings of $158,000.

The Department notes that separate coinsurance provisions for prescription drugs will be beneficial to most policyholders.

Recent concerns have been raised about the difficulties some policyholders are encountering with the requirement to pay in full for prescription drugs at the time of purchase. The situation of policyholders with high prescription drug costs who do not have ready access to funds to pay the up-front costs has been of special concern. However, after changes are made to implement the separate coinsurance provisions recently enacted in 2001 Wisconsin Act 16, it is anticipated that the on-line system will provide pharmacies with deductible and coinsurance information on individual policyholders and, therefore, eliminate the need for policyholders to pay large amounts of cash up-front for prescription drugs. The Department also notes that separate coinsurance provisions for prescription drugs will be beneficial to most policyholders, who will not be required to meet overall deductible levels before HIRSP begins paying drug claims.

The Department plans to set the prescription drug co-payment at 20 percent of the HIRSP-allowed price, with a $25 maximum per prescription and annual out-of-pocket limits on the amount policyholders will be required to pay for prescription drugs. The annual out-of-pocket maximums for the drug benefit will vary by plan. The Department has proposed out-of-pocket maximums of $750 for the primary plan, $1,000 for the alternative primary plan, and $125 for the disabled Medicare beneficiaries plan.

Separate coinsurance provisions will increase HIRSP benefit costs by an estimated $683,000 annually.

With its proposed coinsurance amounts and out-of-pocket maximums, the Department projects that, on average, policyholders would pay no more in out-of-pocket costs than they do now, and policyholders in the primary and alternative primary plans would realize a financial benefit from separate drug provisions. However, it notes that a small number of policyholders could pay more. The Department estimates that the separate coinsurance provision for prescription drugs will increase HIRSP benefit costs by $683,000 annually for the immediate payment on prescription drug benefits.

Pharmaceutical Providers' Contribution to Plan Funding

A final area of concern regarding HIRSP's pharmacy claims was pharmaceutical providers' limited contribution to plan funding. An increase in the contribution of pharmaceutical providers—which includes pharmacies and drug manufacturers—would reduce the amount that other health care providers are required to contribute. However, obtaining contributions from pharmaceutical providers is difficult because only a relatively small portion of the costs of drug claims is associated with the costs pharmacists charge to dispense the drugs, while a significant portion is the wholesale price of drugs charged by drug companies.

The Department expects to receive an estimated $208,000 of annual rebates from drug manufacturers.

In our prior audit, we recommended the Department report to the Joint Legislative Audit Committee on its progress in obtaining pharmaceutical providers' contributions toward funding HIRSP. The Department acknowledged the importance of obtaining pharmaceutical providers' contributions and reported in March 2001 that it was pursuing drug rebates through the pharmacy benefit management company used by the plan administrator. As noted, the Department expects that by using the pharmacy benefit management company, HIRSP will share in an estimated $208,000 in annual drug rebates that the pharmacy benefit management company receives from drug companies.

2001 Wisconsin Act 16 excludes pharmacies from funding the providers' share.

Besides pharmaceutical rebates, the other primary way to increase pharmaceutical providers' contributions would be through discounted payment rates for drugs that are similar to the rates paid by commercial insurers. However, statutes currently require that drug claims be paid at Medicaid-allowed rates. Furthermore, in response to pharmacists' concerns, the Legislature included provisions in 2001 Wisconsin Act 16 specifying that the Department may not reduce the payment rates for prescription drugs below the Medicaid-allowed rates and that the rates may not be adjusted to help fund the providers' share of the program.

Meeting Statutory Funding Requirements

1997 Wisconsin Act 27 directs the Department to estimate, monitor, and revise premium rates, insurer assessments, and provider rates so that each party funds its appropriate share of HIRSP's costs for each plan year. The Department accumulates necessary information and reconciles the levels of funding provided by each funding source.

1999 Wisconsin Act 9 made several statutory changes to clarify and simplify the funding process. However, two areas of HIRSP's funding formula warrant continued attention:

- the funding approach does not fully cover all costs as they are incurred; and

- technical statutory amendments are needed to clarify the determination of provider discounts.

Full-Cost Funding

During each of our past two audits, we had recommended that the Department take steps to fund HIRSP on an accrual, or full-cost, basis rather than the cash-based approach used at the time. A cash basis takes into account estimated cash disbursements and has the goal of providing

sufficient cash to pay claims as they are submitted. An accrual basis takes into account the full costs associated with events that occurred during a plan year, including actuarial cost estimates for claims incurred that may not be filed until after the plan year. An accrual-based approach to funding offers several advantages, including limiting confusion that currently exists because of differences between the funding approach and accounting basis, as well as providing a more secure financial position. In addition, an accrual-based approach appears to be supported by the statutory requirement that premium rates be established at a minimum of 150 percent of rates available in the private sector, because private-sector insurance rates typically are based on accrual-based approaches.

HIRSP had an accounting deficit of negative $9.1 million as of June 30, 2000.

Under HIRSP's cash-based funding approach, almost $7.4 million in assets were reserved and not available for general operations as of June 30, 2000. The reserve represents an accumulation of premiums in excess of the policyholders' 60 percent share of costs using the cash-based approach. It may be used only to reduce premiums or for other policyholder needs as approved by the Board of Governors. Taking the reserve into account, HIRSP had an accounting deficit of negative $9.1 million at the end of FY 1999-2000. That amount represents the estimated amount of additional cash that HIRSP would need to pay its liabilities as of June 30, 2000, and it is almost double the accounting deficit of negative $4.7 million reported as of June 30, 1999.

The Board approved an accrual-based approach to fund HIRSP beginning in FY 2001-02.

In April 2001, the Board of Governors decided, on a 9-3 vote, to implement an accrual-based approach to funding HIRSP beginning in FY 2001-02. The change to an accrual-based approach requires funding the accounting deficit that has accumulated in the program under a cash-based funding approach, in addition to funding the program's costs on an accrual basis into the future. This change has been extensively debated by the Board of Governors, the Legislature, and other interested parties because of its immediate fiscal effect on the various parties funding HIRSP.

HIRSP's actuary projects that $16.6 million will be needed to fund the accounting deficit.

In determining funding levels for FY 2001-02, HIRSP's actuary projects that insurers and health care providers each will need to provide $3.3 million to fund the accounting deficit. The policyholders' share, which is projected to be $10.0 million, will be funded by the excess policyholder premium reserve, which had increased to $13.2 million as of December 31, 2000, under the cash-based funding method.

The Board of Governors also approved distribution of $2.5 million of the excess policyholder premium reserve. The Department distributed 6,605 checks to policyholders on January 18, 2001. Together, the distribution and the change to the accrual-based funding method are expected to use all but $0.7 million of the $13.2 million policyholder reserve that had accumulated through December 31, 2000.

HIRSP's budget is projected to increase 21 percent, from $71.0 million for FY 2000-01 to $86.1 million for FY 2001-02.

At the same time the Department and the Board of Governors are taking steps to change to an accrual-based funding approach and fund the accounting deficit, other factors are increasing HIRSP's ongoing costs. In addition to the 12 percent increase in policyholders projected for FY 2001-02, the actuary projects that prescription drug claims costs will increase 15 percent and non-drug claims costs will increase 7.5 percent. With these increasing costs and the change to the accrual-based funding approach, the actuary projects that HIRSP's budget will increase from $71.0 million for FY 2000-01 to $86.1 million for FY 2001-02, which is a 21 percent increase.

The increased funding levels required for FY 2001-02 have caused some concern among the various funding parties, especially insurers and policyholders. To help address these concerns, the Department held an informational meeting in May 2001 to explain HIRSP's funding methodology. In addition, the Board of Governors has provided the opportunity for actuarial representatives of insurers to participate in its Actuarial Advisory Committee, which also reviews various actuarial aspects of the funding process.

2001 Wisconsin Act 16 reduces HIRSP's GPR funding for the 2001-03 biennium by $1.8 million.

HIRSP's funding was also debated as part of the 2001-02 biennial budget process. The Senate Democratic Caucus included a provision in its amendment to the biennial budget bill that would have required HIRSP to continue using a cash-based funding methodology unless the Joint Committee on Finance approved the use of an accrual-based method at one of its regularly scheduled meetings under s. 13.10, Wis. Stats. The provision ultimately was not included in the 2001-03 biennial budget bill approved by the Legislature; instead, the Legislature included a provision that would have required that the Board of Governors study alternative funding sources for HIRSP and report the results of its study to the Joint Committee on Finance and the legislative standing committees on health no later than January 1, 2002. However, the Governor vetoed the required funding study. The 2001-03 biennial budget bill, which was enacted as 2001 Wisconsin Act 16, also reduced GPR funding for HIRSP by $1.8 million for the biennium.

In addition to the provisions relating to funding, 2001 Wisconsin Act 16 includes several other items affecting HIRSP:

- As noted, it allows the Department to establish, by rule, separate copayment amounts, coinsurance rates, and out-of-pocket limits for prescription drug coverage, subject to approval by the Board of Governors.

2001 Wisconsin Act 16 includes several other items affecting HIRSP.

- As noted, it specifies that the Department may not reduce the payment rates for prescription drugs below Medicaid-allowed rates and that the rates may not be adjusted to help fund the providers' share of the program.

- It requires the Department to conduct a three-year pilot program, beginning on July 1, 2002, under which up to 300 HIRSP policyholders are provided community-based case management services. To be eligible to participate in the program, the policyholder must be diagnosed as having a chronic disease; take two or more prescribed medications on a regular basis; or, within six months of applying for the pilot program, have been treated two or more times at a hospital emergency room or have been admitted two or more times to a hospital as an inpatient. The Department is required to select and contract with an organization that meets prescribed criteria to provide the community-based services.

- It extends and converts one contract specialist project position, which provides oversight for contracts between HIRSP and the plan administrator, to permanent status beginning FY 2001-02.

- It allows the distribution of the excess policyholder premium reserve to HIRSP policyholders, regardless of other statutory provisions regarding the determination of premiums paid by HIRSP policyholders. This provision specifically allows a distribution such as the $2.5 million distributed to policyholders in January 2001.

- It increases the number of public members on the HIRSP Board of Governors from three to four, with a requirement that at least one be an individual covered under HIRSP.

- It specifies that hospice care provided by a licensed hospice provider is a covered service under HIRSP.

Determination of Provider Discounts

Technical statutory amendments are needed for clarification.

The premiums and assessments through which policyholders and insurers contribute toward HIRSP's funding are relatively easy to determine. However, health care providers' contributions have been more difficult to measure because they are made through discounted payment rates. In an attempt to simplify and clarify a process for determining provider discounts that had been established by 1997 Wisconsin Act 27, the Department sought statutory changes that were enacted as part of 1999 Wisconsin Act 9. However, the enacted statutory changes do not appear to provide the intended results, and technical statutory amendments are needed to clarify the requirements for determining provider discounts.

The statutory changes the Department proposed were intended to clarify and codify its practice of setting provider payment rates to meet the provider contribution level required by statutes. Instead, the changes enacted as part of 1999 Wisconsin Act 9, which became effective October 29, 1999, replaced statutory language detailing a step-by-step process for determining provider discounts with language that does not fully encompass the Department's practice. Further, the statutory changes do not provide a meaningful base against which to measure providers' discounts and, therefore, their contributions. Consequently, the Department has not adopted the revised statutory formula. Instead, it is continuing its past process for determining providers' contributions.

The Department does not plan to change its past and current process for setting provider payment rates in response to the statutory changes. We concur that its current practice was the intent of the statutory changes. However, to ensure that the required funding mechanism is clearly understood by all interested parties, the Legislature could consider two options to clarify the issue: it could amend relevant sections in ch. 149, Wis. Stats., to more closely reflect the Department's practice, or it could amend the language to direct the Department to establish by administrative rule an appropriate method for determining health care providers' discounts.

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Independent Auditor's Report on the Financial Statements of the Wisconsin Health Insurance Risk-Sharing Plan

We have audited the accompanying balance sheet of the Wisconsin Health Insurance Risk-Sharing Plan as of June 30, 2000 and 1999, and the related statements of revenues, expenses, and changes in retained earnings and of cash flows for the years then ended. These financial statements are the responsibility of the Department of Health and Family Services' management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

As discussed in Note 1, the financial statements present only the Health Insurance Risk-Sharing Plan and are not intended to present fairly the financial position of the State of Wisconsin and the results of its operations and the cash flows of its enterprise funds in conformity with accounting principles generally accepted in the United States.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Health Insurance Risk-Sharing Plan as of June 30, 2000 and 1999, and the results of its operations and the cash flows for the years then ended in conformity with accounting principles generally accepted in the United States.

In accordance with *Government Auditing Standards*, we have also issued a report dated August 28, 2001, on our consideration of the Health Insurance Risk-Sharing Plan's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and grants. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be read in conjunction with this report in considering the results of our audit.

LEGISLATIVE AUDIT BUREAU

August 28, 2001 by Diann Allsen

Diann Allsen
Audit Director

Wisconsin Health Insurance Risk-Sharing Plan
Balance Sheet
June 30, 2000 and 1999

	June 30, 2000	June 30, 1999
Assets		
Cash and Cash Equivalents (Note 2)	$ 17,090,460	$ 10,224,654
State Premium and Deductible Subsidy Receivable	0	780,800
Assessments Receivable	0	11,401
Other Receivables	424,214	790,971
Prepaid Items	84,483	1,255
Total Assets	$ 17,599,157	$ 11,809,081
Liabilities and Fund Equity		
Liabilities:		
Unpaid loss liabilities (Note 3)	$ 12,792,158	$ 8,840,446
Unpaid loss adjustment expenses (Note 3)	621,900	615,228
Unearned premiums	5,539,938	3,914,020
Accounts payable and other accrued liabilities	376,954	1,162,070
Total Liabilities	19,330,950	14,531,764
Fund Equity:		
Reserved retained earnings (Note 4)	7,396,302	1,941,229
Unreserved retained earnings (Note 9)	(9,128,095)	(4,663,912)
Total Fund Equity	(1,731,793)	(2,722,683)
Total Liabilities and Fund Equity	$ 17,599,157	$ 11,809,081

The accompanying notes are an integral part of this statement.

Wisconsin Health Insurance Risk-Sharing Plan
Statement of Revenues, Expenses, and Changes in Retained Earnings
for the Years Ended June 30, 2000 and 1999

	For the Year Ended June 30, 2000	For the Year Ended June 30, 1999
Operating Revenues		
Premiums	$ 23,453,792	$ 20,569,423
State Premium Subsidy (Note 6)	599,300	629,023
Revenue from the State of Wisconsin	9,900,000	11,900,000
Insurers' Assessments (Note 5)	6,039,187	8,305,039
Total Operating Revenues	39,992,279	41,403,485
Operating Expenses		
Losses:		
Losses paid or approved for payment	$ 33,301,674	$ 32,938,258
State deductible recoveries (Note 6)	(181,500)	(151,777)
Increase (decrease) in unpaid losses	3,097,997	(1,266,554)
Total Losses	36,218,171	31,519,927
Change in Unpaid Loss Adjustment Expenses	6,672	273,744
General and Administrative Expenses (Note 7)	3,075,025	3,236,837
Referral Fees	54,740	36,365
Total Operating Expenses	39,354,608	35,066,873
Net Operating Income (Loss)	$ 637,671	$ 6,336,612
Non-Operating Revenues (Expenses)		
Investment Income	$ 353,219	$ 297,612
Total Nonoperating Revenues (Expenses)	353,219	297,612
Net Income (Loss)	$ 990,890	$ 6,634,224
Retained Earnings		
Retained Earnings, Beginning of Year	(2,722,683)	(9,356,907)
Retained Earnings, End of Year	$ (1,731,793)	$ (2,722,683)

The accompanying notes are an integral part of this statement.

Wisconsin Health Insurance Risk-Sharing Plan
Statement of Cash Flows
for the Years Ended June 30, 2000 and 1999

	For the Year Ended June 30, 2000	For the Year Ended June 30, 1999
Cash Flows from Operating Activities		
Cash Received for Premiums	$ 26,308,032	$ 22,083,126
Cash Received for Assessments	6,050,589	8,293,637
Cash Received from State of Wisconsin	9,900,000	11,900,000
Cash Payments for Losses	(31,888,870)	(32,677,890)
Cash Payments for Other Expenses	(3,857,164)	(3,748,241)
Net Cash Provided (Used) by Operating Activities	6,512,587	5,850,632
Cash Flows from Investing Activities		
Investment Income	353,219	297,613
Net Cash Provided (Used) by Investing Activities	353,219	297,613
Net Increase in Cash and Cash Equivalents	6,865,806	6,148,245
Cash and Cash Equivalents, Beginning of Year	10,224,654	4,076,409
Cash and Cash Equivalents, End of Year	$ 17,090,460	$ 10,224,654
Reconciliation of Net Operating Loss to Net Cash Provided by Operating Activities		
Net Operating Income (Loss)	$ 637,671	$ 6,336,612
Adjustments to Reconcile Net Operating Loss to Net Cash Provided By Operating Activities:		
Changes in assets and liabilities:		
Decrease (increase) in receivables	1,158,958	(437,653)
Decrease (increase) in prepaids	(83,228)	(27)
Increase (decrease) in accounts payable	(785,116)	(209,899)
Increase (decrease) in unearned premiums	1,625,918	1,166,898
Increase (decrease) in loss liabilities	3,958,384	(1,005,299)
Total Adjustments	5,874,916	(485,980)
Net Cash Provided (Used) by Operating Activities	$ 6,512,587	$ 5,850,632

The accompanying notes are an integral part of this statement.

1. Summary of Significant Accounting Policies

A. Description of the Fund - The Wisconsin Health Insurance Risk-Sharing Plan (HIRSP), which is part of the State of Wisconsin financial reporting entity and is reported as an enterprise fund in the State's Comprehensive Annual Financial Report, was established in 1980. The purpose of HIRSP is to provide medical insurance for persons unable to obtain this insurance in the private market or who otherwise qualify for eligibility under s. 149.12, Wis. Stats.

Effective January 1, 1998, HIRSP was transferred from the State of Wisconsin Office of the Commissioner of Insurance to the State of Wisconsin Department of Health and Family Services. The Department uses independent third-party administrators to provide underwriting, claims settlement, and administrative services.

Section 149.143, Wis. Stats., prescribes a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers to share in estimated costs remaining after general purpose revenue (GPR) appropriated under s. 20.435(4)(af) Wis. Stats., is deducted. Premiums, which are statutorily required to be at least 150 percent of standard risk rates, are to fund 60 percent of these estimated costs, as long as the necessary premium rates do not exceed 200 percent of standard risk rates. Private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders are to share equally in:

- costs remaining after the deduction of amounts available from premiums and the GPR appropriated under s. 20.435(4)(af), Wis. Stats.;

- premium and deductible subsidy costs in excess of GPR appropriated under s. 20.435(4)(ah), Wis. Stats., for that purpose; and

- excess costs when premium rates needed to fund 60 percent of costs exceed 200 percent of premium rates for standard risks.

B. Basis of Presentation and Accounting - The accompanying financial statements of HIRSP have been prepared in conformity with generally accepted accounting principles (GAAP) for governments as prescribed by the Governmental Accounting Standards Board (GASB).

The accompanying financial statements were prepared based upon the flow of economic resources measurement focus and the full accrual basis of accounting. Under the accrual basis of accounting, revenues are recognized in the accounting period in which they are earned and become measurable, and expenses are recognized in the period incurred if measurable. Financial Accounting Standards Board statements effective after November 30, 1989, are not applied in accounting for HIRSP's operations.

C. Accounting Estimates - The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results differ from those estimates. Estimates that are particularly susceptible to significant change are the unpaid loss liability as described in Note 1E and the provider contribution as described in Note 8. In estimating these liabilities, management used the methodologies discussed in the applicable notes.

D. Cash and Cash Equivalents - Cash and cash equivalents reported on the balance sheet and the statement of cash flows include a demand deposit account at a commercial financial institution and cash deposited with the State Treasurer, where available balances beyond immediate needs are pooled in the State Investment Fund for short-term investment purposes. Balances pooled are restricted to legally stipulated investments. These investments are valued consistent with GASB Statement No. 31, *Accounting and Financial Reporting for Investments and for External Investment Pools.*

E. Unpaid Loss Liabilities - Unpaid loss liabilities represent the accumulation of losses, net of discounts to provider payments, reported but not paid prior to the close of the accounting period and estimates of claims incurred prior to June 30 but not reported. The unpaid loss liabilities are established by an actuary employed by the plan administrator and are based on historical patterns of claim payments. Such liabilities are necessarily based on estimates and, while management believes the results of the estimates are materially correct, the ultimate liabilities may be in excess or less than the amounts provided due to uncertainties inherent in the estimation process. The method and assumptions used in making such estimates are periodically reviewed and updated, with resulting adjustments to the liabilities reflected in current operations. The unpaid loss adjustment expense is the anticipated cost for processing claims related to the unpaid loss liabilities.

F. Premium and Assessment Revenue - Premiums are recognized as revenues over the terms of the insurance policies, and a liability for unearned premiums is established to reflect premiums received applicable to subsequent accounting periods. Participating insurers are assessed every six months, and revenue is recognized in the period covered by the assessment.

G. Policy Acquisition Costs - HIRSP has no marketing staff and incurs no sales commissions. Policy acquisition costs are minimal and expensed as incurred. Insurance agents who assist individuals with the HIRSP application process are paid a one-time referral fee in the amount of $35 for each policy issued.

2. Deposits

GASB Statement No. 3 requires deposits with financial institutions to be categorized to indicate the level of risk assumed by the State at year-end. The risk categories for deposits are:

- category 1: insured or collateralized with securities held by HIRSP or by its agent in HIRSP's name;
- category 2: uninsured but collateralized by the financial institution; and
- category 3: uninsured and uncollateralized.

HIRSP's cash balances are maintained in an interest-bearing checking account with a commercial financial institution and with the State of Wisconsin Investment Board. The carrying amount of the demand deposits with the financial institution was $7,907,991 at June 30, 2000, and $10,165,408 at June 30, 1999. The bank balance was $8,370,095 at June 30, 2000, and $11,459,009 at June 30, 1999. The Federal Deposit Insurance Corporation and the Wisconsin State Deposit Guarantee Fund (s. 34.08, Wis. Stats.) cover state deposits. Of the bank balance at June 30, 2000 and June 30, 1999, $400,000 was insured and classified in risk category 1; $7,970,095 at June 30, 2000, and $11,059,009 at June 30, 1999, was uninsured and uncollateralized and was classified in risk category 3.

The State of Wisconsin Investment Board, through the State Investment Fund, invests cash deposited with the State of Wisconsin Treasurer. The carrying amount of shares in the State Investment Fund, which approximates market value, was $9,179,215 as of June 30, 2000, and $17,000 as of June 30, 1999.

Holdings of the State Investment Fund include certificates of deposit and investments consisting primarily of direct obligations of the federal government and the State, and unsecured notes of qualifying financial and industrial issuers. Shares in the State Investment Fund are not required to be categorized under GASB Statement No. 3. The State Investment Fund is not registered with the Securities and Exchange Commission.

3. Liability for Unpaid Losses and Loss Adjustment Expenses

The following represents changes in the combined Unpaid Loss Liabilities and Unpaid Loss Adjustment Expense Liability account balances for FYs 1999-2000 and 1998-99 (in thousands):

	FY 1999-2000	FY 1998-99
Balance, beginning of year	$9,456	$10,461
Incurred related to:		
Current year	40,497	35,435
Prior years	(2,072)	(4,032)
Total incurred	38,425	31,403
Paid related to:		
Current year	27,889	26,435
Prior years	6,578	5,973
Total paid	34,467	32,408
Balance, end of year	$ 13,414	$ 9,456

4. Reservation of Retained Earnings

Section 149.143(2m)(a), Wis. Stats., requires the Department to keep a separate accounting of the difference between premiums received during a plan year and the amount of premium necessary to cover the policyholders' 60 percent share of plan costs for that plan year. The use of these funds is restricted under s. 149.143(2m)(b), Wis. Stats., to reduce premiums to a floor of 150 percent of standard risk rates when premiums exceed the policyholders' share of plan costs in future plan periods, or to allow excess premiums to be used for other needs of eligible persons, with the approval of the Board of Governors.

The excess policyholder premium amount was originally determined based on estimated amounts. A statutory change required that the excess policyholder premium amount be based on actual amounts beginning in FY 1999-2000.

5. Insurer Assessments

Each participating insurer shares in the costs of HIRSP in proportion to the ratio of the insurer's total health care coverage revenue for Wisconsin residents to the aggregate health care coverage revenue of all participating insurers for Wisconsin residents. Insurers writing health insurance in Wisconsin are required to report the annual amount of accident and health insurance premiums earned to the Commissioner of Insurance, and assessments based on percentages derived from these reports are made every six months.

6. Premium and Deductible Subsidies

HIRSP provides a premium and deductible subsidy program to reduce premium and deductible levels that would otherwise be paid by low-income policyholders. Through December 31, 1999, HIRSP policyholders with annual household incomes below $20,000 were eligible for a premium and deductible subsidy. Starting January 1, 2000, a premium subsidy became available for policyholders with incomes between $20,000 and $24,999. HIRSP premiums are based on rates that standard risks would be charged under individual policies providing substantially the same coverage and deductibles as provided under HIRSP. Individuals not eligible for a premium subsidy have been paying 150 percent of the rate a standard risk would pay in recent years, although premiums can be increased to 200 percent of standard risk if necessary to meet requirements of the funding formula.

Individuals eligible for the subsidy program pay premiums based on reduced percentages of standard risk, as shown in the following table. The premium subsidy is not available for policyholders in the alternative primary plan. The deductible subsidy is only available for policyholders in the primary plan, in which unsubsidized deductibles are $1,000.

Annual Household Income		Amount of Premium	Reduction in
at Least	but Less Than	as % of Standard Risk	Deductible
$ 0	$10,000	100.0%	$500
10,000	14,000	106.5	400
14,000	17,000	115.5	300
17,000	20,000	124.5	200
20,000	25,000	130.0	N/A

Thirty-one percent of HIRSP policyholders received subsidies costing $2.2 million in FY 1999-2000 and $2.1 million in FY 1998-99. A total of $780,800 of GPR was appropriated and spent for the subsidy program in both FY 1999-2000 and FY 1998-99. Costs in excess of GPR appropriated for this purpose were shared equally by health insurers and health care providers, with each contributing $689,000 in FY 1999-2000 and $660,000 in FY 1998-99.

7. General and Administrative Expenses

General and administrative expenses include the following:

	FY 1999-2000	FY 1998-99
Plan administrator fees	$2,487,600	$2,187,648
State administrative costs	287,998	104,979
Other expenses	299,427	944,210
Total	$3,075,025	$3,236,837

8. Health Care Providers' Contributions

Statutes prescribe that health care providers contribute to their share of HIRSP costs. Provider contributions are obtained by reducing the amount reimbursed to providers for billed services. The provider contribution is not reported as a revenue in the financial statements, but rather reduces the amount of paid losses, which are reported net of the contributions on the financial statements. Disclosure of the provider contribution amount is important for full disclosure of HIRSP's funding sources and to demonstrate compliance with the statutory funding formula.

The Department estimates the provider contributions attributable to funding HIRSP were $8,643,355 for FY 1999-2000 and $7,817,619 for FY 1998-1999. The contributions are based on actuarially developed estimates of reimbursement levels under the HIRSP program prior to January 1998. Although management believes the results of the estimates are materially correct, due to uncertainties inherent in estimates the actual provider contribution may be in excess or less than the amount estimated. The Department used these provider contribution amounts to assess whether providers were providing their required level of funding for HIRSP.

9. Negative Retained Earnings

HIRSP is funded on a cash basis, in which funding levels are based on estimated cash disbursements and have the goals of providing sufficient revenues to pay claims as they are submitted, but limiting the accumulation of cash beyond current needs. In contrast, financial reporting is based on an accrual basis, which takes into account the total costs associated with events that occurred during the plan year, including actuarial cost estimates for claims that have been incurred but will not be filed until after the end of the plan year. HIRSP's unreserved negative retained earnings of $9,128,095 as of June 30, 2000, and $4,663,912 as of June 30, 1999, therefore, largely represent the difference between funding based on cash requirements and accounting based on accrued costs. In April 2001, the HIRSP Board of Governors voted to fund the program on an accrual basis beginning in FY 2001-2002.

10. Subsequent Event

In May 2000, it was determined significant overpayments had been made on prescription drug claims. Estimates are that drug claims were overpaid by a total of $3.7 million during FY 1999-2000 and FY 1998-99. Subsequent to the end of the period, the HIRSP Board of Governors has considered and approved a plan to recoup the overpayments. At this time, information is not available to accurately estimate the amount that eventually may be recovered.

Subsequent to the end of the fiscal period, the HIRSP Board of Governors approved a distribution to policyholder under s. 149.143(2m)(b)2, Wis. Stats. The Department distributed checks to 6,605 policyholders on January 18, 2001 that totaled $2,498,077. This distribution reduces the reserve for premiums received in excess of the policyholders' share of plan costs for FY 2000-01.

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Independent Auditor's Report on Compliance and on Internal Control Over Financial Reporting Based on an Audit of Financial Statements Performed in Accordance with Government Auditing Standards

We have audited the financial statements of the Wisconsin Health Insurance Risk-Sharing Plan as of and for the years ended June 30, 2000 and June 30, 1999, and have issued our report thereon dated August 28, 2001. We conducted our audits in accordance with auditing standards generally accepted in the United States and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Compliance

As part of obtaining reasonable assurance about whether the Health Insurance Risk-Sharing Plan's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, and contracts, noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed a noncompliance issue that is required to be reported under *Government Auditing Standards.* We found suspension of system controls that ensured proper payment of drug claims resulted in payment of drug claims in excess of Medicaid-allowable rates required by statute during fiscal years 1999-2000 and 1998-1999, as discussed in the accompanying report section titled "Status of Pharmacy Claims Overpayments" and Note 10 of the financial statements. The Department reported that it reinstated system controls on January 29, 2001.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the Department's internal control over the Plan's financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements and not to provide assurance on the internal control over financial reporting. Our consideration of internal control over financial reporting would not necessarily disclose all matters in the internal control over financial reporting that might be a material weakness. A material weakness is a condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. We noted no matters involving the internal control over financial reporting and its operation that we consider to be a material weakness.

This independent auditor's report is intended for the information and use of the Department's management and the Wisconsin Legislature's Joint Legislative Audit Committee. This independent auditors report, upon submission to the Joint Legislative Audit Committee, is a matter of public record and its distribution is not limited. However, because we do not express an opinion on compliance or provide assurance on internal control over financial reporting, this report is not intended to be used by anyone other than these specified parties.

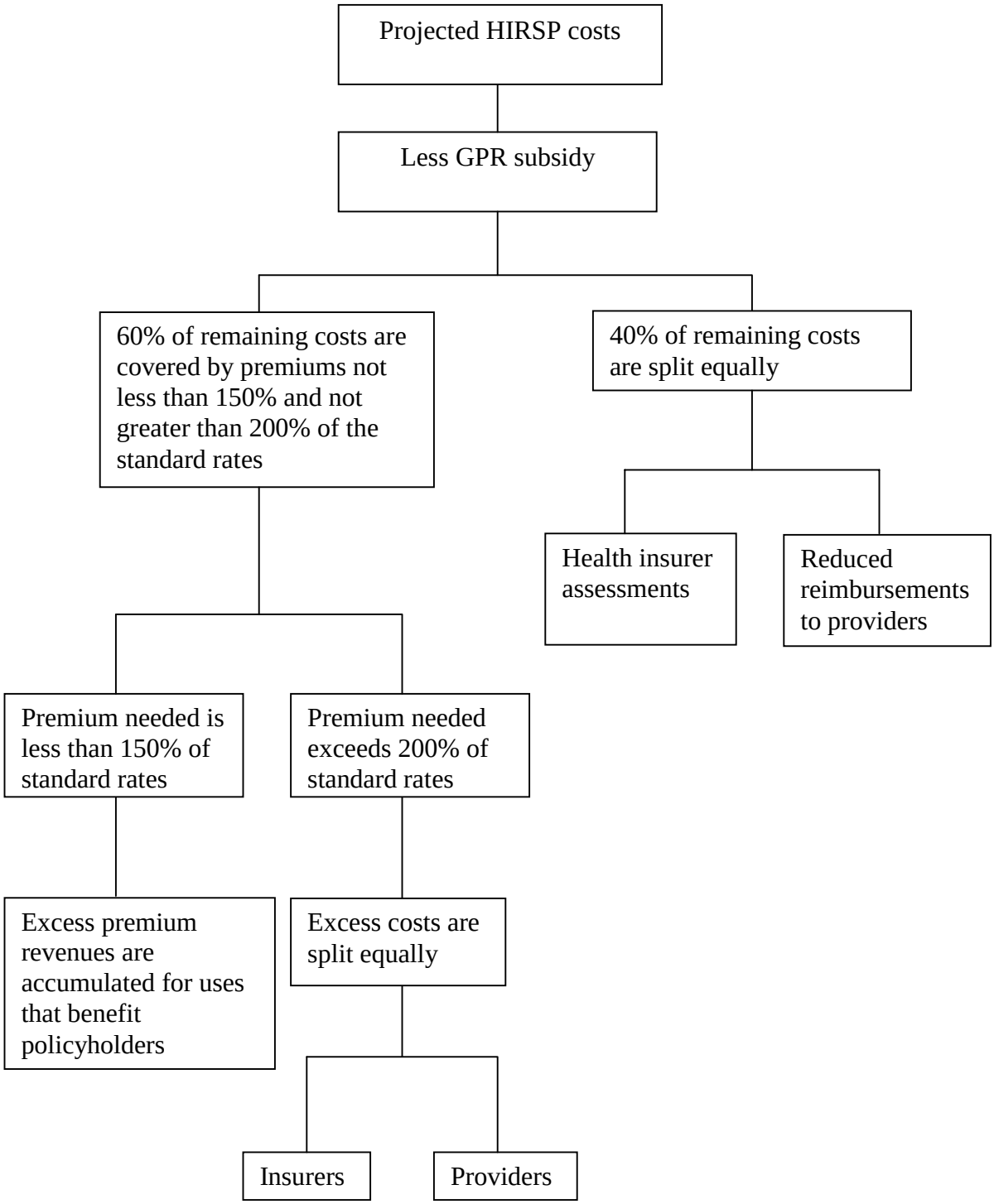
LEGISLATIVE AUDIT BUREAU

August 28, 2001 by Diann Allsen

Diann Allsen
Audit Director

Appendix 1

Payment of HIRSP Operating and Administrative Costs



State of Wisconsin
Department of Health and Family Services

Scott McCallum, Governor
Phyllis J. Dubé, Secretary

September 11, 2001

Janice Mueller, State Auditor
Legislative Audit Bureau
22 East Mifflin Street, Suite 500
Madison, WI 53703-2512

Dear Ms. Mueller:

On behalf of the Department of Health and Family Services (DHFS) and the HIRSP Board of Governors, I would like to thank you and the staff of the Legislative Audit Bureau (LAB) for conducting a comprehensive financial audit of the Health Insurance Risk Sharing Plan (HIRSP) for fiscal year 1999-2000. We appreciate your efforts to perform a thorough audit, to follow up on issues raised in prior audits, and to acknowledge the efforts of the HIRSP Board and DHFS in addressing those issues.

HIRSP is a critical safety net program for Wisconsin citizens who would otherwise have no health insurance. The HIRSP Board and DHFS have worked hard to continue to improve the administration of HIRSP as well its long-term viability. HIRSP is insuring more policyholders today than it has in several years. At the end of August, enrollment exceeded 11,700, the highest level since 1993, and approaching the 1992 historic high of 12,707. We are pleased that we have reversed the declining enrollment HIRSP experienced from 1992 to 1998. However, we are also very aware of the need to balance our steady growth with financial stability. We]lave applied sound financial practice principles to HIRSP. Even with the rapid growth in enrollment of a medically high-risk population, we have implemented accurate budgets that have allowed us to maintain stable premiums, provider payment rates and industry assessments. In addition, as the audit report points out, we have successfully transitioned from cash-based funding to funding on an accrual basis, consistent with private insurance industry practice. Thanks to the expertise and commitment of the members of the HIRSP Board, we have been able to implement major improvements in HIRSP and, as Summarized in the remainder of this letter, address the issues raised in the audit report.

One of the issues raised in the audit report relates to overpayments of prescription drug claims from July 1998 through January 2001. The HIRSP Board and DHFS have taken deliberate steps to address this issue. We have worked hard to implement corrective measures and preserve pharmacy participation in HIRSP so that HIRSP policyholders have access to needed medications. The steps taken to address prescription drug claims processing and overpayments arc Summarized in the following paragraphs.

fit January 2001, the DHFS reinstated system-pricing controls to reimburse prescription drug claims at the HIRSP allowed rates. At that time, pharmacies were still required to calculate

HIRSP's allowed rates for prescription drugs and charge accordingly. According to feedback from the Pharmacy Society of Wisconsin (PSW) and many pharmacies, it was very difficult for pharmacies to calculate HIRSP's rates. Subsequently, as the audit report points out, approximately 160 pharmacies discontinued serving HIRSP policyholders.

On August 1, 2001, HIRSP began processing prescription drug claims through a pharmacy benefits management company (PBM). The PBM utilizes an on-line system to communicate HIRSP allowed rates for prescription drugs to pharmacies at the point a medication is dispensed to a HIRSP policyholder. This eliminates the need for pharmacies to calculate HIRSP allowed rates. In addition, the system allows pharmacy providers to electronically submit claims, eliminating the need for policyholders to fill out and send in claim forms. We are pleased to report that almost all of the 160 pharmacies that had stopped serving HIRSP policyholders resumed participation in August 2001.

While the PBM system implemented in August provides on-line pricing of HIRSP-allowed rates for prescription drugs and eliminates the need for policyholders to submit their own claims, improvements are still needed. The current system requires HIRSP policyholders to pay in full for their prescription drugs at the time of purchase. This is because pharmacies do not know if a policyholder has met his or her deductible and out-of-pocket cost obligations because they are based on medical claims as well as prescription drug claims.

The DHFS and HIRSP Board developed statutory changes that would allow HIRSP to create a separate prescription drug coinsurance. Separating prescription drug coinsurance requirements from medical deductibles and coinsurance provisions would allow HIRSP to implement a system in which policyholders would only pay a coinsurance amount for prescription drugs when they obtain their medications. The PBM would be able to electronically communicate to pharmacies the correct coinsurance amount and pharmacies would collect only that amount from policyholders, submit the claim electronically, and receive reimbursement directly from HIRSP. Provisions for a separate drug coinsurance were included in the 2001 Wisconsin Act 16, which was enacted on August 30, 2001. The DHFS intends to implement these provisions on January 1, 2002, after taking the following required steps:

- Obtaining Board approval of the coinsurance amounts and per-prescription and annual maximum amounts to be paid by policyholders.
- Filing a policy amendment with the Office of the Commissioner of Insurance and obtaining approval.
- Issuing the policy amendment to policyholders by November 1, 2001. (Insurance regulations require a sixty-day advance notice to policyholders.)
- Notifying pharmacy providers.
- Publishing an emergency administrative rule to reflect the coinsurance amounts and per-prescription maximums. (The 2001 Wisconsin Act 16 granted DHFS permission for an emergency rule.)

In addition to addressing the issues associated with prescription drug claims processing, the DHFS and HIRSP Board remain committed to recovering the overpayments made to pharmacies.

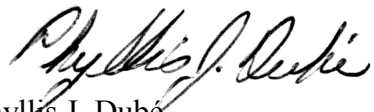
It was our intent to issue recovery notices to pharmacies early in 2001. However, as noted in the LAB report and as referenced above, approximately 160 pharmacies stopped serving HIRSP policyholders when we reinstated pricing controls in January. Feedback from the PSW and from individual pharmacies led us to conclude that many more pharmacies would stop serving HIRSP policyholders if we issued recovery notices before implementing a system that would communicate HIRSP-allowed rates to pharmacies. The DHFS decided, therefore, to delay the issuance of recovery notices until the PBM system was implemented to avoid any problems with HIRSP policyholders' access to prescription drugs. We are now finalizing calculations of overpayments and will issue recovery notices this fall.

I am pleased to report that we have also been successful in our efforts to continue to strengthen the financial stability of HIRSP. As the LAB report acknowledges, the DHFS and HIRSP Board have implemented an accrual-based funding approach as recommended by the LAB in prior audits. This is a significant accomplishment for HIRSP, as we have a much more secure funding base than under the prior cash-based funding approach. We strongly believe that this change is in the best long-term interest of the policyholders, the insurers, and providers who collectively fund the program. Most importantly, we believe this change will help contribute to the long-term financial viability of HIRSP.

We appreciate the guidance and support of the LAB as we have addressed the issues raised in the audit report.

I would also like to extend my appreciation to all of the members of the HIRSP Board of Governors for their ongoing dedication to HIRSP.

Sincerely,



Phyllis J. Dubé
Secretary