AN AUDIT

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

00-13

November 2000

1999-2000 Joint Legislative Audit Committee Members

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November 9, 2000

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

Dear Senator George and Representative Kelso:

At the request of the Department of Health and Family Services (DHFS), we have completed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year 1998-99. HIRSP provides medical insurance for individuals unable to obtain coverage in the private market. At the end of calendar year 1999, 7,904 policyholders were enrolled in the plan. We were able to provide an unqualified opinion on the HIRSP financial statements and we note that HIRSP had net income of $6.6 million, which is a considerable improvement over the $9.4 million loss the previous year.

Oversight responsibility for HIRSP transferred to DHFS from the Office of the Commissioner of Insurance in 1998. DHFS has taken steps to address problems experienced with that transition and changes in statutes affecting the program. However, some of our prior audit concerns related to HIRSP's funding structure and service delivery still need to be addressed, and improved reporting is needed to help DHFS manage the program.

We also found DHFS does not have controls in place to ensure that policyholders are charged and pharmacies are reimbursed at HIRSP-allowed rates for prescription drugs, which represent 45 percent of HIRSP's total claim costs. As the result of suspending important system controls, we estimate that HIRSP overpaid drug claims during fiscal years 1998-99 and 1999-2000 by at least $3.7 million. DHFS is taking steps to recover these overpayments, as well as to improve its drug claims process.

We appreciate the courtesy and cooperation extended to us by DHFS and the plan administrators. The response from DHFS is the appendix.

Respectfully submitted,

Janice Mueller
State Auditor

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SUMMARY

The Health Insurance Risk-Sharing Plan (HIRSP) was established in 1980 to provide major medical insurance and Medicare supplemental insurance for individuals who cannot obtain coverage in the private market because of the severity of their health conditions. As of December 31, 1999, 7,904 policyholders were enrolled in the plan.

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 (DHFS), 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 plan funding, including providing increased general purpose revenue (GPR) of $17.9 million during the 1997-99 biennium and increasing health care providers' responsibility for HIRSP funding.

During our first financial audit of HIRSP (report 99-6), we identified several areas of concern related to the transfer of oversight responsibilities from OCI to DHFS and the implementation of new program provisions affecting funding and administration. Since our prior audit, DHFS and the Legislature have addressed many of these concerns. For example, 1999 Wisconsin Act 9 codified HIRSP's provider payment practices, clarified requirements for an annual reconciliation process, and established state appropriations for HIRSP's program benefit costs and administration. The Legislature also continued GPR support for the program by providing GPR funding of $23.4 million in the 1999-2001 biennium.

As a result of these legislative changes and management efforts, DHFS has made significant progress in meeting the program's funding requirements. In addition, the program's financial position has improved: HIRSP had net income of $6.6 million during fiscal year (FY) 1998-99, which was a considerable improvement over the $9.4 million loss in the previous year.

However, we have identified a number of concerns related to payment of prescription drug claims, which totaled $12.6 million during FY 1998-99 and $16.5 million during FY 1999-2000 and represented approximately 45 percent of HIRSP's total claim costs for both years. Despite the significant costs of these claims, DHFS has insufficient

controls in place to ensure that policyholders are charged and pharmacies are reimbursed at the allowable rates for prescription drugs.

On July 1, 1998, when Electronic Data Systems (EDS) became the plan administrator as required by 1997 Wisconsin Act 27, the process for submitting drug claims changed and Medicaid rates became the effective rates for prescription drugs under HIRSP. However, confusion and complaints occurred during the transition as policyholders who had paid more than Medicaid rates when they received their prescriptions sought reimbursement directly from the pharmacies for charges in excess of the allowable amounts.

In response to complaints from both policyholders and providers regarding the new Medicaid-based system, DHFS instructed pharmacies to charge Medicaid-allowed rates for HIRSP policyholders' prescriptions at the point of sale. In addition, the plan administrator was instructed to suspend system controls that limited payment to the allowed rates and instead to pay the amounts billed by pharmacies. However, neither DHFS nor the plan administrator took compensating steps to ensure that pharmacies were, in fact, following billing instructions and charging the appropriate rates.

In a test of claims paid for 90 prescription drugs during FY 1998-99, we found that over 75 percent of the tested prescriptions had been paid in excess of the Medicaid rates allowed by HIRSP. Based on our sample, we projected that HIRSP had overpaid drug claims by $1.7 million during FY 1998-99. It is likely that drug claims were overpaid by a similar or a greater amount during FY 1999-2000. In May 2000, we alerted DHFS of our findings. DHFS and the HIRSP Board of Governors are currently taking steps to address the overpayment issue, including re-initiating system controls and implementing a plan to recover the overpayments.

DHFS and HIRSP's Board are also considering longer-term options to improve the efficiency, simplicity, and understandability of the drug claims payment process by computerizing the process. One option they are considering is contracting with a pharmacy benefit management company, which administers pharmacy claims through a network of pharmacies. Another is implementing a "point-of-sale" system specific to HIRSP. Implementing either method is complicated by the current need to coordinate drug and non-drug claims and apply both when determining individual policyholder deductibles and out-of-pocket maximums. DHFS plans to implement a separate drug copayment to address these difficulties. However, we believe statutory changes may be needed if DHFS is to implement a separate drug copayment that is not applied toward other deductibles or out-of-pocket maximums, as currently required by statute.

Some have expressed concern that pharmaceutical providers are not contributing to the payment of HIRSP's costs because these providers are substantially excluded from the calculation of the health care providers' funding contribution. However, obtaining contributions from pharmaceutical providers is more difficult than obtaining contributions from other providers because pharmacies serve as an intermediary between drug companies and policyholders. Only a relatively small portion of the costs of drug claims are associated with the costs pharmacists charge to dispense drugs. The significant portion is the wholesale price of drugs charged by drug companies. DHFS and a financial oversight committee of the Board of Governors are evaluating options to obtain contributions from the pharmaceutical providers, including the option to establish lower rates for drugs and to seek rebates from the drug companies. To ensure legislative oversight of the process to secure pharmaceutical provider rebates or discounted drug rates, *we recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by January 31, 2001, on its progress in obtaining pharmaceutical providers' contributions to funding HIRSP*.

During our prior audit, we found that DHFS could not determine whether HIRSP had been funded in accordance with statutory provisions from January 1, 1998, through June 30, 1998, because DHFS had not accumulated information from which it could determine whether health care providers had provided their appropriate share through discounted reimbursement rates. Therefore, we qualified our auditor's report on the FY 1997-98 financial statements. DHFS subsequently developed a system to measure and report the provider contribution amounts and was able to reconcile actual funding levels with statutory funding requirements. Therefore, we were able to issue an unqualified, or "clean," opinion on HIRSP's FY 1998-99 financial statements.

However, we believe two areas of HIRSP's funding formula warrant continued legislative attention. First, DHFS funds HIRSP on a cash basis, which only takes into account estimated cash disbursements and does not fully consider all costs. If HIRSP were funded using a full-cost approach that is used for financial reporting—which would include not only cash disbursements, but also actuarial estimates of the costs of claims that have been incurred but not yet paid—several improvements could incur. For example, a full-cost approach could provide a more secure financial position and reduce confusion that arises because of differences between the funding approach and the accounting basis.

In addition, a full-cost 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 rates typically are based on full-cost approaches. HIRSP's current use of a cash-based, rather than a full-cost, funding method

appears to have contributed to an estimated $5.9 million in policyholder premiums being accumulated in excess of required funding needs through December 31, 1999.

Regardless of the funding method used, policyholder premiums could not have been set lower than the statutory minimum of 150 percent of the standard rates, so the amount of premium revenue collected would not have changed. However, under the cash-based funding method, policyholders contributed almost 71 percent of plan costs, rather than their required share of 60 percent of costs after the GPR subsidy was deducted during calendar year 1999. In comparison, if funding levels had been established under the full-cost approach, policyholders would have paid only slightly more than their share of costs during FY 1998-99. However, implementation of a full-cost funding approach would likely require increases in funding from the program's contributors. Furthermore, the Board of Governors is considering returning a portion of the excess premiums to policyholders as refunds, which may need to be reconsidered if a full-cost funding basis is implemented.

DHFS also sought statutory changes to clarify and codify its practice of setting provider rates to meet the provider contribution level required by statute. However, the changes enacted as part of 1999 Wisconsin Act 9 did not fully encompass the practice DHFS's proposal was intended to codify and do not provide a meaningful base against which to measure the providers' discounts and, therefore, their contributions. The Legislature could consider two options to clarify the issue: it could amend the statutory language to more closely reflect DHFS's practices, or it could amend the language to direct DHFS to establish by administrative rule an appropriate method for determining health care providers' discounts.

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INTRODUCTION

The Health Insurance Risk-Sharing Plan (HIRSP) is a state program that provides health insurance to individuals unable to obtain coverage in the private market. As of December 31, 1999, 7,904 policyholders were enrolled in the plan. At the request of the Department of Health and Family Services (DHFS), we performed a financial audit of HIRSP for fiscal year (FY) 1998-99. This is our second annual financial audit of HIRSP. The first, which we completed in 1999 (report 99-6), included a qualified opinion on the FY 1997-98 financial statements and addressed issues related to program funding, as well as management concerns related to service delivery and program administration.

This report, which includes an unqualified opinion on HIRSP's FY 1998-99 financial statements, analyzes concerns related to the cost of prescription drug claims, which accounted for approximately 45 percent of the program's total claim costs in FYs 1998-99 and 1999-2000. In addition, it follows up on the program funding and management concerns raised in our prior audit.

Plan Administration

DHFS 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 DHFS on 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 plan funding, including providing increased general purpose revenue (GPR) and increasing health care providers' responsibility for HIRSP funding.

The transfer of oversight responsibility from OCI to DHFS was intended to bring administration of all state-sponsored medical programs under one agency. As the agency responsible for oversight of HIRSP, DHFS 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.

DHFS was authorized 1.5 positions and $94,600 during FY 1998-99 to oversee all HIRSP operations and policies, as well as to provide administrative support for the 12-member advisory Board of Governors that consists of:

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

The State's fiscal agent for Medicaid administers HIRSP's daily operations.

The transfer of responsibility for daily program operations to the State's fiscal agent for Medicaid, Electronic Data Systems (EDS), was intended to allow HIRSP to take advantage of cost-containment provisions associated with Medicaid. EDS became HIRSP's plan administrator July 1, 1998. The plan administrator 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 $2.2 million in FY 1998-99 to administer HIRSP. That payment represents 6.2 percent of the program's total operating and administrative expenses during FY 1998-99.

Plan Provisions

Three plans are available to policyholders.

HIRSP offers its policyholders 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.

- A Medicare supplement 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 Medicare supplement Plan.

- The alternate primary plan is a third plan that became available in January 1998. 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. This plan offers lower premium rates but requires policyholders to pay a higher deductible before HIRSP begins paying claims.

According to statute, HIRSP may reimburse only those medical services that HIRSP 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, $500 for the Medicare supplement plan, and $2,500 for the alternate primary 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 alternate primary plans, which must be paid by the policyholders after their annual deductible requirements have been satisfied. There is no coinsurance requirement for the Medicare supplement plan.

Plan Funding

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. Additional funding was provided by health care providers who were reimbursed for their services at 10 percent less than usual and customary fees and by premium and deductible subsidy programs for lower-income policyholders, which were funded by insurers and the State.

Effective January 1, 1998, the Legislature authorized additional GPR support for the program.

By the end of 1998, enrollment in HIRSP had declined to almost half the level it had been in 1992, when enrollment peaked at 12,707. To address both policyholders' concerns about program affordability and insurers' concerns about increases in their annual financial assessments for HIRSP, 1997 Wisconsin Act 27 authorized additional funding sources that took effect when oversight responsibility was transferred from OCI to DHFS. Effective January 1, 1998, the Legislature:

- made $6.0 million in GPR funding available to offset program costs other than subsidies in FY 1997-98, and $11.9 million in FY 1998-99; 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.

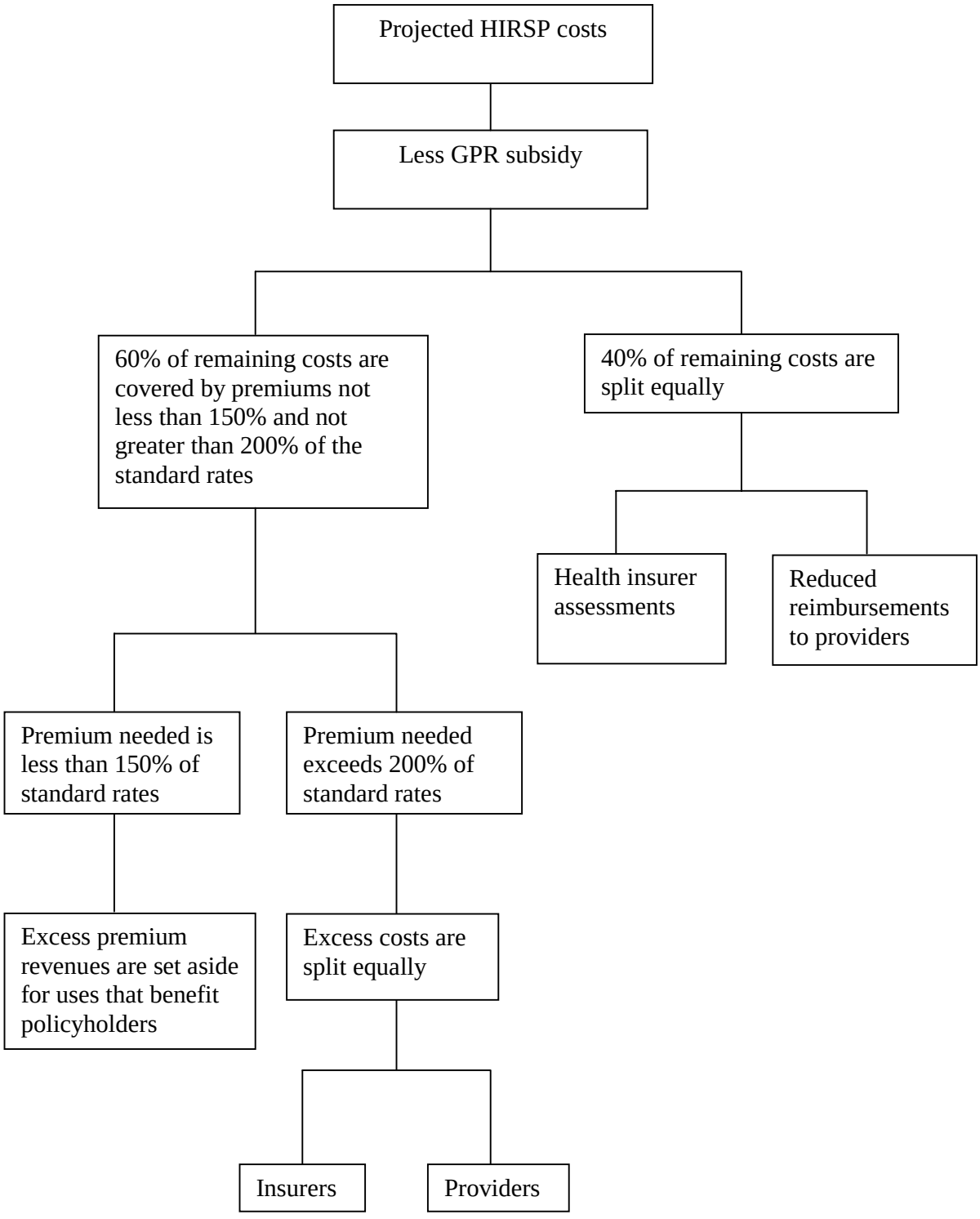
In addition, $780,800 in GPR was appropriated, and $1.3 million was provided by insurers and health care providers to fund premium and deductible subsidies during FY 1998-99.

Changes in HIRSP's funding requirements caused provider contributions to increase significantly. They also may account for an 11.8 percent increase in HIRSP enrollment, from 7,068 at the end of 1998 to 7,904 as of December 31, 1999.

As shown in Figure 1, the premiums that policyholders pay are expected to cover 60 percent of HIRSP's operating and administrative costs after the GPR subsidy has been deducted. The remaining 40 percent of operating and administrative costs are expected to be shared equally by insurers and health care providers. If a premium of more than 200 percent of the standard rates—rates private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP—is required to fund 60 percent of HIRSP's estimated costs after the GPR subsidy has been deducted, then both provider payment rates and insurer assessments must be adjusted so that excess costs are shared equally by providers and insurers. If a premium of less than 150 percent of the standard rate is required to fund 60 percent of HIRSP's estimated costs after the GPR

Figure 1

Payment of HIRSP Operating and Administrative Costs



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 eligible persons.

Premium rates for each of HIRSP's three plans differ on the basis of gender, age, and geographic location of the insured. On average, premium rates for the primary plan have been 150 percent of standard rates since January 1, 1998. For both the primary plan and the alternate primary plan, rate increases have matched increases in the standard rates. Rates for the Medicare supplement plan were historically set at 50 percent of primary plan rates, but during the last two years additional increases in the Medicare supplement plan rates were made in response to increasing claims costs. Premium rate increases since 1998 are shown in Table 1.

Table 1

Premium Rate Changes

Effective Date	Primary and Alternative Primary Plans	Medicare Supplement 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

Examples of annual premiums effective July 1, 2000, for a policyholder living in Milwaukee, where the rates are the highest, are shown in Table 2.

Table 2

Examples of Annual Premiums for a Policyholder Living in Milwaukee
Rates effective July 1, 2000

Plan Type	Male Ages 0-24	Male Ages 60-64	Female Ages 0-18	Female Ages 60-64
Primary Plan	$1,656	$7,200	$1,656	$6,084
Medicare Supplement	1,176	5,064	1,176	4,272
Alternate Primary Plan	1,188	5,184	1,188	4,380

Low-income policyholders are eligible for premium and deductible subsidies.

Policyholders with annual household incomes below $20,000 are eligible for premium and deductible subsidies. Beginning January 1, 2000, policyholders with annual household incomes of $20,000 and no more than $25,000 are eligible for premium but not deductible subsidies. As noted, these 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 with household incomes of up to $20,000 ranged from $144 to $2,160, and deductible subsidies ranged from $200 to $500.

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PROGRAM MANAGEMENT

DHFS had less than three months to prepare for its new program oversight responsibility, and implementation of funding and other program changes were more complex than expected. As a result, our 1999 financial audit identified significant concerns related to the program funding and the implementation of the new program provisions.

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

Since our 1999 audit, DHFS and the Legislature have addressed many of our earlier concerns. For example, 1999 Wisconsin Act 9:

- statutorily authorizes HIRSP's provider payment practices by allowing DHFS to establish payment rates to the various provider groups based on Medicaid reimbursement rates. For example, Act 9 specifies that prescription drugs must be reimbursed at Medicaid rates and that physicians and other care professionals be paid at an enhanced Medicaid rate, which is the maximum allowable reimbursement rate under the Medicaid program plus an additional amount determined by DHFS to meet funding requirements. Further, Act 9 requires that DHFS create HIRSP-specific hospital payment rates based on diagnostic-related groups using the same methodology that DHFS uses to establish Medicaid hospital payment rates.

- requires DHFS to conduct an annual reconciliation process by April 30 each year, based on the prior calendar year data, and to implement necessary adjustments to premiums, insurance assessments, and provider reimbursement rates in the subsequent fiscal year.

- recreates the HIRSP fund, to comprise all funds received from insurance assessments, policyholder premiums, and the GPR appropriations for HIRSP costs and premium and deductible subsidies, and creates a continuing appropriation to support HIRSP program benefit costs. In addition, Act 9 authorizes the State of Wisconsin Investment Board to invest monies from the HIRSP fund.

- requires the Board of Governors to establish administrative oversight committees to address various issues, such as financial management of HIRSP and plan administrator performance standards. Act 9 also requires DHFS to obtain the Board's approval of HIRSP's annual budget, the plan administrator contract, and any rule changes that would affect policyholders' access to health care services.

- authorizes DHFS to establish, by rule, copayments for prescription drug coverage after obtaining approval of the Board of Governors for the amount of the copayment. Act 9 also authorizes DHFS to require pharmacies and pharmacists that participate in HIRSP to bill the plan administrator directly for drug reimbursement.

- provides GPR funding of $9.9 million in FY 1999-2000 and $11.9 million in FY 2000-01 for HIRSP's operating and administrative costs, and GPR funding of $780,800 annually for premium and deductible subsidies to low-income policyholders.

HIRSP's financial position has improved.

As a result of these legislative changes and management efforts, a number of funding and service delivery concerns have been addressed. For example, DHFS has made significant progress in developing a method for determining health care providers' contributions for program funding and in reconciling the levels of funding provided by each funding source. Therefore, we have issued an unqualified auditor's report for the FY 1998-99 financial statements. In addition, the financial position of HIRSP has improved: HIRSP had net income of $6.6 million during FY 1998-99, which was a considerable improvement over the $9.4 million loss in the previous year. However, we found attention needs to be devoted to controlling prescription drug claim costs, which HIRSP has been overpaying for the last two years. In addition, some of our prior audit concerns related to the application of HIRSP's funding structure need to be addressed, and improved reporting by the plan administrator is needed to help DHFS manage the program.

Controlling Prescription Drug Claim Costs

Prescription drug claim costs represent approximately 45 percent of total claim costs.

Claims for prescription drugs, which totaled $12.6 million during FY 1998-99 and $16.5 million during FY 1999-2000, represented approximately 45 percent of HIRSP's total claim costs for both years. Despite the significant portion of claim costs that are attributable to prescription drugs, we found DHFS does not have controls in place adequate to ensure that policyholders are charged and pharmacies are reimbursed at the HIRSP-allowed rates for prescription drugs. The lack of adequate controls contributed to a significant overpayment of drug claims over the last two fiscal years, which DHFS currently is taking steps to address.

Overpayment of Drug Claims

In 1998, confusion and complaints occurred with changes in the drug claim process.

As noted, the State's fiscal agent for Medicaid, EDS, became the plan administrator for HIRSP so that HIRSP could take advantage of cost-control measures associated with Medicaid. Before EDS became the plan administrator, drug claims were processed by a hired pharmacy benefit management company and were paid based on the company's allowed rates. On July 1, 1998, when 1997 Wisconsin Act 27 transferred responsibility for daily program operations to EDS, Medicaid rates became the effective rates for prescription drug payments under HIRSP. However, confusion and complaints occurred during the transition to Medicaid-based drug pricing when the program reimbursed policyholders less than they had been charged for prescription drugs and then required them to seek additional reimbursement from pharmacies that had billed at their usual and customary charges rather than at Medicaid rates.

Many HIRSP policyholders pay pharmacies with their own funds when their prescriptions are filled and later file a claim with HIRSP for reimbursement. When DHFS implemented the Medicaid rates on July 1, 1998, most pharmacies did not begin pricing prescription drugs sold to HIRSP policyholders at the Medicaid-allowed rates, but instead charged their usual and customary rates, as they do with the Medicaid program. When pharmacies charge the Medicaid program those rates, they are reimbursed at the appropriate Medicaid-allowed rates, which are typically lower. Similarly, when HIRSP policyholders who had been charged the pharmacies' usual and customary rates submitted their claims to HIRSP for reimbursement, they were reimbursed at the lower Medicaid-allowed rates. Policyholders were then instructed by DHFS to seek reimbursement from the pharmacies for any amounts they had paid in excess of the allowable amounts. In accordance with a statutory provision that prohibits providers from charging policyholders for amounts in excess of the allowed amounts, pharmacies were required to reimburse the policyholders for these amounts.

In response to complaints, system controls that had limited payment to allowed rates were suspended.

During the first few weeks with EDS, DHFS received numerous complaints about the drug claim process, which was becoming increasingly confusing and difficult for both pharmacies and policyholders. In response to these complaints, DHFS met with EDS and representatives from the Pharmacy Society of Wisconsin and subsequently instructed pharmacies to charge HIRSP policyholders Medicaid-allowed rates for their prescriptions at the point of sale. In addition, DHFS instructed EDS to modify the claims system so that controls that limited payment to allowed rates were suspended, and to simply pay the amount billed by the pharmacy.

Although DHFS's changes quickly addressed the complaints it was receiving and helped to ensure that policyholders would be able to obtain needed medications during the transition to EDS, pricing controls were never reinstated. Furthermore, neither DHFS nor EDS adequately monitored drug claims to ensure that pharmacies were complying with DHFS's billing instructions. A reasonable program expectation would have been to review a sample of drug claims to determine whether claims were being billed at the allowed rates. As a result of continuing operations without controls or monitoring, we found that pharmacies charged rates in excess of the Medicaid rates allowed by HIRSP, policyholders and pharmacies made claims at these excess prices and were paid by EDS, and the overpayments were not detected by either EDS or DHFS.

We estimate that drug claims were overpaid by $1.7 million during FY 1998-99.

In a test of claims paid for 90 prescriptions drugs during FY 1998-99, we found that over 75 percent of the tested prescriptions were paid in excess of the Medicaid rates allowed by HIRSP. Based on our sample, we projected that HIRSP had overpaid drug claims by $1.7 million and, in May 2000, we alerted DHFS of our sample results. Upon notification of our sample results, DHFS also completed an analysis of HIRSP's drug claims and likewise found claims had been overpaid by $1.7 million during FY 1998-99.

Furthermore, it is likely that during FY 1999-2000, drug claims have been overpaid by a similar or a greater amount. In FY 1999-2000, total drug claim costs increased by $3.9 million over FY 1998-99 levels. If a similar portion of drug claims has been improperly paid, we estimate the overpayment for FY 1999-2000 at more than $2.0 million and the overpayment for both years at $3.7 million.

Pharmacies may not be consistently following requirements to dispense generic drugs.

In addition to concerns that pharmacies are not charging or being paid the correct rates for prescription drugs covered by HIRSP, there are concerns that pharmacies may not be consistently following requirements for dispensing brand-name drugs and their generic equivalents, which are typically less-expensive. In September 1999, pharmacies were instructed to follow Medicaid policies and benefit limitations when providing services to HIRSP policyholders. These policies and limitations restrict policyholders' benefits to widely

available generic equivalents of brand-name drugs, unless a brand-name drug is considered medically necessary by the doctor. Again, neither DHFS nor EDS took steps to monitor pharmacies' compliance with this provision. An analysis of drug claims paid in April 2000, which was completed by an insurance industry member of the Board of Governors, found that 5 percent of prescriptions were filled with a brand-name product when a generic product was available. The board member indicated that amount was well above the industry goal of less than 1 percent.

DHFS reported the drug claim overpayments to a financial oversight committee of the HIRSP Board of Governors, which is working with DHFS to implement steps to address the overpayment issue. At the Board's direction, DHFS is taking steps to recover overpayments, communicate concerns to pharmacies, and to re-initiate system controls that will prevent reimbursement of drug claims in excess of allowed amounts.

DHFS is taking steps to recover the drug claim overpayments.

Because overpayment of drug claims results in policyholders, insurers, and other health care providers such as physicians, clinics, and hospitals being charged more than their share of program costs, recovery of the drug claim overpayments is important to ensure that the various parties are properly treated in accordance with statutory provisions. As DHFS and the financial oversight committee take steps to recover the drug claim overpayments, a major concern they face is the reaction of pharmacies and policyholders.

DHFS is concerned that pharmacies may respond to any recovery efforts by no longer providing services to HIRSP policyholders. Additionally, based on concerns that changing policyholder copayments and deductible amounts would likely be confusing to policyholders, as well as present a complex administrative challenge, DHFS plans to recover overpayments from pharmacies without reprocessing claims and changing policyholder amounts. In doing so, it is important that DHFS carefully consider the legal implications and communicate the process clearly to affected parties, including the pharmacies and policyholders.

We recommend the Department of Health and Family Services continue to take steps to address overpayment of drug claim payments in HIRSP, including:

- *recovery of the drug claim overpayments during FY 1998-99 and FY 1999-2000;*

- *reinstatement of the system controls to ensure that Medicaid rates are paid;*

- *implementation of interim controls to monitor pharmacies compliance with drug payment policies; and*

- *communication with pharmacies and policyholders concerning the overpayment problem and steps the Department is taking to address it*.

Improving the Drug Claims Payment Process

Even before the discovery of the overpayments on drug claims, DHFS and the Board of Governors had recognized the need to improve the efficiency, simplicity, and understandability of the drug claims payment process for policyholders and pharmacies. One of their primary goals has been to limit the need for policyholders to submit drug claims. In 1999, DHFS sought statutory authority to require that pharmacies bill HIRSP directly for prescriptions filled for HIRSP policyholders and to establish copayments for drugs. That authority was granted in 1999 Wisconsin Act 9. However, it has not yet been exercised because of difficulties associated with implementation.

DHFS is evaluating options for improving the drug claims process.

Currently, DHFS and a committee established by the Board of Governors are considering two options: contracting with a pharmacy benefit management company for drug claim administration, or implementing a "point-of-sale" system specific to HIRSP. Each option presents advantages and disadvantages.

A pharmacy benefit management company would administer pharmacy claims through a network of pharmacies.

A pharmacy benefit management company administers pharmacy claims through a network of pharmacies that have access to policyholder eligibility and drug pricing data, which facilitates proper claim submission. Pharmacy benefit management companies typically require a deposit from the contracting plan, which they use to pay claims as they are submitted by pharmacies. Pharmacies are paid according to rates negotiated with the company. Claim information is electronically relayed to the contracting plan on a periodic basis.

In addition to negotiated rates and electronic processing of claims, pharmacy benefit management companies offer multiple plan design options and cost-control features, including:

- an ability to develop and administer a drug formulary, which is a listing of drugs covered by the plan that controls costs by limiting access to the newest, most expensive brand-name drugs to those cases where they are deemed medically necessary. Drug formularies are used by most health maintenance organizations, which also often develop safeguards to ensure policyholders are not denied medications until decisions can be made on the acceptability of the drug under the plan provisions.

- coordination of benefits, a proactive measure to help control plan costs by determining whether benefits are payable under another policy. Since HIRSP policyholders are not eligible for health insurance other than Medicare, other benefits would presumably be limited to coverage for accidents provided by automobile insurance and by worker's compensation insurance.

- possible sharing of rebates obtained from drug companies based on the volume of the pharmacy benefit management company's purchases. Some companies are willing to share the rebates they obtain from drug companies with their contracting groups. The extent to which they are willing to share these rebates varies and is subject to negotiation. In FY 1997-98, HIRSP received $109,400 in rebates through the prior plan administrator's contract with a pharmacy benefit management company. These funds reduced HIRSP's claim costs for that year.

DHFS could implement a point-of-sale system that would provide pharmacies with access to computerized information.

Under the second option being considered, HIRSP would implement its own point-of-sale system that would provide computer links to a network of pharmacies. The links would give the pharmacies ready access to computerized information from which they could determine policyholder eligibility and price drugs accurately at the point of sale. Under such a system, pharmacies could also be given access to policyholder deductible and copayment levels, so that they could collect the policyholder's share of the prescription drug cost and submit claims directly to HIRSP, as allowed under 1999 Act 9. However, if pharmacies are to collect the correct amounts from policyholders, they must have accurate, up-to-date information on policyholder deductible and copayment levels. Providing that information would likely require extensive changes to HIRSP's current claims processing system, which allows EDS to process claims on a weekly basis.

If a point-of-sale system were designed specifically for HIRSP, DHFS and EDS could retain full responsibility for pharmacy claim administration and could have flexibility in the prices paid for prescription drugs. The point-of-sale system could be programmed to pay whatever rate is allowed on drug claims, whether the rate is determined to be Medicaid or some lower rate. Similarly, DHFS could have increased flexibility in developing a drug formulary that may be more suitable to the HIRSP population, and implementing it in a manner that better prepares HIRSP policyholders for the restrictions. Disadvantages to implementing its own point-of-sale system are that HIRSP would not benefit from the expertise and economies offered by pharmacy benefit management companies and likely would be unable to obtain rebates from drug companies because HIRSP's relatively small size makes it difficult to negotiate rebates directly with the companies.

Implementing either method will require additional costs to be incurred. DHFS estimates indicate the cost of implementing a point-of-sale system specific to HIRSP would be approximately $1.0 million, plus an unknown addition to ongoing plan administrator costs. In contrast, use of a pharmacy benefit management company is not likely to require a significant initial investment to implement, but it would require payment of fees—on a per claim or some other basis—to the company.

Hiring a pharmacy benefit management company or implementing a point-of-sale system would be further complicated by the need to coordinate and apply drug claims with non-drug claims in determining individual deductibles and out-of-pocket maximums for HIRSP policyholders. Various health insurance plans require separate drug copayments that are not applied toward plan deductibles and overall out-of-pocket maximums, although the plans may have drug copayment maximums. The drug copayments are often a fixed dollar payment per prescription. Separate drug copayments can be beneficial to policyholders because policyholders are not required to meet overall deductible levels before the health insurance plan will begin paying on drug claims; however, at the same time, some policyholders may be required to increase their contribution toward claims, especially if there are no maximums for drug copayments.

Legislation may be needed to permit separate drug copayments that do not apply to overall plan deductibles and out-of-pocket maximums.

Current statutes require that drug copayments be applied to an individual's deductibles and out-of-pocket maximums. However, DHFS is considering implementing a separate copayment for prescription drugs because it believes that the benefit of receiving immediate drug benefits is actuarially comparable to applying the copayments to deductibles and maximums for the plan overall. However, we question whether the statutory provisions allow for such a broad interpretation and believe such a change warrants legislative consideration. Therefore, *we recommend that if the Department of Health and Family Services wishes to implement a separate drug copayment that is not applied*

toward other plan deductibles or out-of-pocket maximums, it seek statutory authority to do so.

Pharmaceutical Providers' Contribution to Plan Funding

Pharmaceutical providers are not contributing toward the health care providers' share of costs.

In the context of evaluating the best method to improve HIRSP's drug claim process, some have expressed a concern that pharmaceutical providers are not contributing to the payment of HIRSP's costs. Currently, pharmaceutical providers do not significantly participate in providing the health care providers' funding contribution.

Increased participation in HIRSP's funding by pharmaceutical providers would reduce the amount that other health care providers are required to contribute. For example, if pharmaceutical providers were to contribute an amount relative to their portion of claims, their share would have been approximately $2.8 million for FY 1998-99. However, obtaining contributions from pharmaceutical providers is more difficult than obtaining contributions from other providers because pharmacies serve as an intermediary between drug companies and the policyholders. Only a relatively small portion of the costs of drug claims are associated with the costs pharmacists charge to dispense the drugs. The significant portion is the wholesale price of drugs charged by drug companies.

Pharmaceutical providers' contributions could be increased through rebates and discounted payment rates.

DHFS and the financial oversight subcommittee are seeking ways to increase contributions by pharmaceutical providers. Two primary ways to obtain pharmaceutical providers' contributions are to establish discounted payment rates for drugs similar to those of commercial insurers, and to seek rebates from the drug companies. Since statutes currently prescribe the payment of drug claims at Medicaid-allowed rates, statutory changes likely would be needed to establish rates lower than those paid for Medicaid. DHFS currently can pursue rebates from drug companies, although as noted, HIRSP's relatively small size limits its negotiating ability with the companies. As a result, DHFS likely will need to work with a pharmacy benefit management company or determine whether it could combine its efforts with other government programs.

In order to ensure legislative oversight of the process to secure pharmaceutical provider rebates or discounted prescription drug rates, *we recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by January 31, 2001, on its progress in obtaining pharmaceutical providers' contributions toward funding HIRSP*.

Meeting Statutory Funding Requirements

1997 Wisconsin Act 27 directed DHFS 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. During our prior audit, we found that DHFS could not determine whether HIRSP had been funded in accordance with the statutory provisions from January 1, 1998 through June 30, 1998, because DHFS had not accumulated information from which it could determine whether health care providers had contributed their appropriate share of program funding through discounted reimbursement rates. Therefore, we qualified our auditor's opinion on the FY 1997-98 financial statements.

DHFS has made significant progress in reconciling the levels of funding provided by each funding source.

During our audit period, and in conjunction with the financial oversight committee of HIRSP's Board of Governors, DHFS made significant progress in developing a method to accumulate necessary information and reconcile the levels of funding provided by each funding source. DHFS was able to provide a reasonable estimate of amounts that health care providers contributed through discounted claims, and we have issued an unqualified, or "clean," auditor's opinion on the FY 1998-99 financial statements.

Further, several statutory changes that help to clarify and simplify the funding process have been included in 1999 Wisconsin Act 9. Among these changes is a requirement that an annual reconciliation of actual experience and funding requirements be performed no later than April 30. However, we believe two areas of HIRSP's funding formula warrant continued legislative attention:

- the funding approach does not fully consider all costs; and

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

Full-Cost Funding Basis

DHFS funds HIRSP on a cash basis, which takes into account estimated cash disbursements and has the goals of providing sufficient revenues to pay claims as they are submitted while limiting the accumulation of cash beyond current needs. However, HIRSP's financial reports are presented on an accrual basis, which 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. If HIRSP were funded using a full-cost approach—which would include not only cash disbursements, but also actuarial

estimates of the costs of claims that have been incurred but not yet paid—several improvements could occur:

- a more secure financial position would be provided. While HIRSP is currently solvent and able to pay claims as they come due on a cash basis, a full-cost basis would better ensure HIRSP could pay claims in the future, even in the event it were to cease operations;

- the ability to control the funding process in ways that may be possible under a cash-based system, such as by delaying claim payments, would be limited; and

- the confusion that arises because of differences between the funding approach and the accounting basis could be reduced.

In addition, a full-cost 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 rates typically are based on full-cost approaches. HIRSP's current use of a cash-based, rather than a full-cost, funding method appears to have contributed to an estimated $5.9 million in policyholder premiums being accumulated in excess of required funding needs through December 31, 1999.

Under HIRSP's current funding approach, policyholders paid more than their required share of 60 percent of program costs.

Regardless of the funding method used, policyholder premiums could not have been set lower than the statutory minimum of 150 percent of the standard rates, so the amount of premium revenue collected would not have changed. However, under HIRSP's current cash-based funding approach, premium rates established at the minimum 150 percent of the standard rates have resulted in policyholders contributing more than their required funding share of 60 percent of HIRSP's administrative and operating costs over the past three years. For example, in its reconciliation of HIRSP's actual funding levels in 1999, DHFS determined that while providers and insurers had each contributed approximately their respective 20 percent of plan costs after the GPR subsidy had been deducted, policyholders had contributed almost 71 percent of plan costs.

In comparison, if funding levels had been established under the full-cost approach, policyholders would have paid only slightly more than their share of costs during calendar year 1999. It should be noted, though, that a full-cost basis also would have required an increase in insurers' and providers' contributions during 1999. Furthermore, the Board of Governors is considering returning a portion of the excess premiums to

policyholders as refunds, which may need to be reconsidered if a full-cost funding basis is implemented.

The initial result of changing to a full-cost funding approach would likely be increases in funding levels to eliminate HIRSP's negative unreserved retained earnings of $4.7 million. Although HIRSP had net income of $6.6 million during FY 1998-99, the negative retained earnings represent outstanding liabilities not yet funded. However, the implementation of a full-cost funding approach could be phased in. DHFS believes insurer or provider representatives may oppose any change to its funding approach for HIRSP unless statutes require it. Therefore, *we recommend the Department of Health and Family Services pursue legislation that would require a full-cost funding approach for HIRSP*.

Determination of Provider Discounts

Technical statutory amendments are needed to clarify requirements for determining provider discounts.

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 prescribed by 1997 Wisconsin Act 27, DHFS sought statutory changes that were enacted as part of 1999 Wisconsin Act 9. However, the requested 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 DHFS 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 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 practice DHFS's proposal was intended to codify. Further, the statutory changes do not provide a meaningful base against which to measure providers' discounts and, therefore, their contributions. Consequently, DHFS has not adopted the revised statutory formula. Instead, DHFS is continuing its past process for determining providers' contributions.

DHFS does not plan to change its past and current process for setting provider payment rates in response to the statutory changes. We concur that DHFS's 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 DHFS's practice, or it could

amend the language to direct DHFS to establish by administrative rule an appropriate method for determining health care providers' discounts. Therefore, *we recommend the Department of Health and Family Services seek statutory changes to clarify the process for determining health care providers' discounts.*

Program and Administrative Issues

The number of abandoned calls for the program currently averages 1,200 per month.

During our 1999 audit, we identified several service delivery and administrative problems that had occurred when oversight responsibility for HIRSP was transferred from OCI to DHFS. These included concerns related to the plan administrator's ability to process claims and provide customer service in a timely manner, and communication with policyholders and providers. In response to our 1999 recommendation, DHFS established performance standards for the plan administrator that addressed timeliness in claims processing; communication with policyholders and providers, including both the number of telephone calls abandoned and response time for written correspondence; and claims accuracy. As a result:

- The plan administrator reports that currently, the average time required to process claims is less than 10 days, compared to 21 days in early 1999.

- By increasing customer service staff and adding telephone lines and voice mail, the plan administrator has been able to reduce the number and percentage of calls that are abandoned before they are answered. The average number of abandoned calls per month has been reduced by almost half since early 1999, and the percentage of calls abandoned has decreased from 40 percent to 12 percent. However, even with these improvements, the number of abandoned calls remains high at an average of 1,200 calls per month.

DHFS has also improved communication with policyholders and providers through quarterly newsletters and a new provider handbook. Although the number of abandoned calls has decreased, the overall number of calls has increased with questions about premium billings and claims submissions, which suggests continued efforts in communicating HIRSP policies and procedures may be needed.

Continued attention is needed to provide more timely and reliable management information.

Finally, DHFS has been working to improve the quality and quantity of management information available to DHFS staff, the Board of Governors, HIRSP policyholders, the Legislature, and other interested parties. The plan administrator has been regularly producing a variety of monthly reports that provide basic information on HIRSP's financial and program activities, including financial and funding summaries, applicant activity, policy information, customer service reports, and claims processing data. Further, a subcommittee of the Board has been working with DHFS on improving the format of the monthly reports and developing a format for annual reports. However, continued attention is needed to anticipate other information needs and to be able to provide more timely and reliable management information and respond to ad hoc requests for information.

Although reliable information is available on total premiums collected and claims paid, the reported information on premium and claim amounts by plan type that was used to support premium rate increases does not appear consistent in relation to the reported number of policyholders. For example, total premiums reported for the alternate major medical plan suggest that all policyholders in that plan paid a premium rate in excess of the highest premium bracket. More reliable summaries of information by plan type are needed to make and support management decisions. Therefore, *we recommend the Department of Health and Family Services expand its current project to improve monthly reporting to include reliable premium and claim information segregated by plan type*.

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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, 1999 and 1998, 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 generally accepted auditing standards 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 audits 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 provides 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 generally accepted accounting principles.

As discussed in Note 8, the Department could not accurately determine and disclose the amount of provider contributions attributable to funding the Health Insurance Risk-Sharing Plan for the period January 1, 1998 through June 30, 1998, because the value of discounts applied to provider payments during this period was not recorded. The value of provider discounts is necessary to fully disclose all the funding sources statutorily required and provided to contribute to the Health Insurance Risk-Sharing Plan's costs. In our opinion, disclosure of the amount of provider discounts is required by generally accepted accounting principles to ensure the financial statements and notes are complete. The Department subsequently was able to develop and disclose estimates of the providers contributions for the period July 1, 1998 through June 30, 1999.

In our opinion, except for the effect of the omission of the information discussed in the preceding paragraph on the fiscal year 1997-98 financial statements, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of the Health Insurance Risk-Sharing Plan as of June 30, 1999 and June 30, 1998, and the results of its operations and the cash flows for the years then ended in conformity with generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we have also issued a report dated October 10, 2000, 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, and contracts.

LEGISLATIVE AUDIT BUREAU

October 10, 2000 by

Diann Allsen
Audit Director

Wisconsin Health Insurance Risk-Sharing Plan
Balance Sheet
June 30, 1999 and 1998

	June 30, 1999	June 30, 1998
Assets		
Cash and Cash Equivalents (Note 2)	$ 10,224,654	$ 4,076,409
State Premium and Deductible Subsidy Receivable	780,800	435,600
Assessments Receivable	11,401	0
Other Receivables	790,971	709,918
Prepaid Items	1,255	1,227
Total Assets	$ 11,809,081	$ 5,223,154
Liabilities and Fund Equity		
Liabilities:		
Unpaid loss liabilities (note 3)	$ 8,840,446	$ 10,119,489
Unpaid loss adjustment expenses (note 3)	615,228	341,484
Unearned premiums	3,914,020	2,747,122
Accounts payable and other accrued liabilities	1,162,070	1,371,966
Total Liabilities	14,531,764	14,580,061
Fund Equity:		
Reserved retained earnings (note 4)	1,941,229	1,018,594
Unreserved retained earnings (note 9)	(4,663,912)	(10,375,501)
Total Fund Equity	(2,722,683)	(9,356,907)
Total Liabilities and Fund Equity	$ 11,809,081	$ 5,223,154

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, 1999 and 1998

	For the Year Ended June 30, 1999	For the Year Ended June 30, 1998
Operating Revenues		
Premiums	$ 20,569,423	$ 19,490,562
State Premium Subsidy (Note 6)	629,023	351,094
Revenue from the State of Wisconsin	11,900,000	6,000,000
Insurers' Assessments (Note 5)	8,305,039	7,460,892
Total Operating Revenues	41,403,485	33,302,548
Operating Expenses		
Losses:		
Losses paid or approved for payment	$ 32,938,258	$ 36,246,815
State deductible recoveries (Note 6)	(151,777)	(84,506)
Increase (decrease) in unpaid losses	(1,266,554)	3,581,000
Total Losses	31,519,927	39,743,309
Change in Unpaid Loss Adjustment Expenses (Note 1.C)	273,744	14,181
General and Administrative Expenses (Note 7)	3,236,837	3,019,012
Referral Fees	36,365	27,125
Total Operating Expenses	35,066,873	42,803,627
Net Operating Income (Loss)	$ 6,336,612	$ (9,501,079)
Non-Operating Revenues (Expenses)		
Investment Income	$ 297,612	$ 143,215
Loss on Disposal of Fixed Assets	0	(4,828)
Total Nonoperating Revenues (Expenses)	297,612	138,387
Net Income (Loss)	$ 6,634,224	$ (9,362,692)
Retained Earnings		
Retained Earnings, Beginning of Year	(9,356,907)	5,785
Retained Earnings, End of Year	$ (2,722,683)	$ (9,356,907)

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, 1999 and 1998

	For the Year Ended June 30, 1999	For the Year Ended June 30, 1998
Cash Flows from Operating Activities		
Cash Received for Premiums	$ 22,083,126	$ 21,404,912
Cash Received for Assessments	8,293,637	9,612,624
Cash Received from State of Wisconsin	11,900,000	6,000,000
Cash Payments for Losses	(32,677,890)	(36,578,045)
Cash Payments for Other Expenses	(3,748,241)	(1,934,359)
Net Cash Provided (Used) by Operating Activities	5,850,632	(1,494,868)
Cash Flows from Investing Activities		
Cash Received from Sale of Investments	0	11,939,713
Cash Paid for Purchase of Investments	0	(6,973,043)
Investment Income	297,613	143,215
Net Cash Provided (Used) by Investing Activities	297,613	5,109,885
Net Increase in Cash and Cash Equivalents	6,148,245	3,615,017
Cash and Cash Equivalents, Beginning of Year	4,076,409	461,392
Cash and Cash Equivalents, End of Year	$ 10,224,654	$ 4,076,409

Reconciliation of Net Operating Loss to Net Cash Provided by Operating Activities

Net Operating Income (Loss)	$ 6,336,612	$ (9,501,079)
Adjustments to Reconcile Net Operating Loss to Net Cash Provided By Operating Activities:		
Changes in Assets and Liabilities:		
Decrease (increase) in receivables	(437,653)	7,148,390
Decrease (increase) in prepaids	(27)	(532)
Increase (decrease) in accounts payable	(209,899)	(104,603)
Increase (decrease) in unearned premiums	1,166,898	(2,199,825)
Increase (decrease) in loss liabilities	(1,005,299)	3,162,781
Total Adjustments	(485,980)	8,006,211
Net Cash Provided (Used) by Operating Activities	$ 5,850,632	$ (1,494,868)

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 major medical insurance and Medicare supplemental 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(5)(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(5)(af), Wis. Stats.;

- premium and deductible subsidy costs in excess of GPR appropriated under s. 20.435(5)(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 and Presentation Changes - The following accounting and presentation changes were made to HIRSP's FY 1997-98 and FY 1998-99 financial statements:

Change in Basis for Reporting - Prior to the financial statements prepared for FY 1997-98, audited financial statements were prepared in conformity with statutory accounting practices prescribed or permitted by the State of Wisconsin's Commissioner of Insurance. The use of GAAP is preferred in order to be consistent with the basis used for financial reporting for the State of Wisconsin. As a result of the change to GAAP, the July 1, 1997 retained earnings balance increased $5,785.

Recognition of Assessment Revenues - In years prior to FY 1997-98, retained earnings were reported at zero at the end of the fiscal year because any deficit incurred under the plan was to be funded by assessment of insurance companies. This allowed HIRSP to recognize additional assessment revenues and establish an additional receivable entitled Assessments receivable—unbilled, in its financial statements to cover excess claims and expenses. With the enactment of statutory changes related to plan funding as part of 1997 Wisconsin Act 27, deficits are no longer entirely the responsibility of the insurance industry. Therefore, beginning in FY 1997-98, additional revenues are not recognized and receivables are not established to cover deficits, as was done in previous years.

Reservation of Retained Earnings Balances - 1997 Wisconsin Act 27 included a provision requiring that funds be set aside when the amount of enrollee premiums estimated to be received, based on premium rates set at 150 percent of standard risk rates, exceeds the policyholders' 60 percent share of estimated plan year costs. Use of the funds thus set aside is legally restricted to reduce premiums in future periods when premiums above 150 percent of standard risk rates are indicated by cost projections or, effective in FY 1999-2000, for other needs of eligible persons with the approval of the Board. Accounting standards require a reservation of fund equity when a portion is legally segregated for a specific future use. Therefore, a portion of retained earnings equivalent to the amount of the set-aside required by statute was reserved in FY 1998-99, and a similar reservation of retained earnings was retroactively made for FY 1997-98 (see Note 4).

Accounting Treatment of Subsidy Revenue - The changes in HIRSP's statutory funding provisions also required a change in the accounting treatment of premium and deductible subsidies. Prior to January 1, 1998, premium and deductible subsidies were funded by GPR and insurer assessments and were accounted for in a revenue account titled State Subsidy Premiums and a contra-expense account titled State Deductible Recoveries. The deductible subsidies were recognized upon payment of associated claims, and premium subsidies were recognized as revenue as corresponding premiums paid by policyholders were recognized.

Beginning January 1, 1998, providers are also required to share in the cost of premium and deductible subsidies. To provide for a consistent presentation with other funding provided by insurer assessments and provider discounts, insurer contributions toward subsidies are recognized as assessment revenue when assessed and provider contributions toward the subsidies are incorporated in the determination of provider discounts, as disclosed in Note 8. GPR appropriated for subsidies is recognized as used to fund premium and deductible subsidies.

Prior-period corrections were made to the FY 1997-98 financial statements to account for the funding change that was effective January 1, 1998. The State Subsidy Premium and State Deductible Recovery accounts were decreased by $2,516,077 and $514,142, respectively, to only include GPR funding for the subsidies. Insurer assessment revenue was increased $3,520,316 to account for the reclassification from the subsidy accounts and to recognize $490,097 of premium subsidies that previously had been reported as unearned. The net effect of these changes was to increase net income and retained earnings by $490,097 as of June 30, 1998.

Loss Adjustment Expenses - Prior to FY 1998-99, expenses incurred in the course of settling claims were segregated from other plan administrator expenses included in the General and Administrative Expense Account. These expenses were presented in the statement of revenues, expenses, and changes in retained earnings in an account titled Loss Adjustment Expenses, along with the change in unpaid loss adjustment expenses. The allocation of plan administrator expenses was not performed in FY 1998-99, and administrative expenses related to claims settlement were included with other plan administrator expenses in the General and Administrative Expense account. In order to provide comparability between years presented in the comparative statements, FY 1997-98 claims settlement expenses in the amount of $1,071,610 are reclassified as General and Administrative Expenses, and the $14,181 Change in Unpaid Loss Adjustment Expenses is shown separately.

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 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. Unpaid loss adjustment expenses are the anticipated costs to adjudicate and process outstanding claims.

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 - Since 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 primarily maintained in an interest-bearing checking account with a commercial financial institution. The carrying amount of the demand deposits with the financial institution was $10,165,408 at June 30, 1999, and $4,020,385 at June 30, 1998. The bank balance was $11,459,009 at June 30, 1999, and $4,559,040 at June 30, 1998. State deposits are covered by the Federal Deposit Insurance Corporation and the Wisconsin State Deposit Guarantee Fund (s. 34.08, Wis. Stats.) Of the bank balance at June 30, 1999 and June 30, 1998, $400,000 was insured and classified in risk category 1; $11,059,009 at June 30, 1999, and $4,159,040 at June 30, 1998, was uninsured and uncollateralized and was classified in risk category 3. After the end of FY 1998-99, the checking account balance was collateralized and, as of April 2000, the checking account balance beyond current cash needs is being deposited in the State Investment Fund.

Cash deposited with the State of Wisconsin Treasurer is invested by the State of Wisconsin Investment Board through the State Investment Fund. The carrying amount of shares in the State Investment Fund, which approximates market value, was $17,000 as of June 30, 1999, and $56,000 as of June 30, 1998. 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 fiscal years 1998-99 and 1997-98 (in thousands):

	FY 1998-99	FY 1997-98
Balance, beginning of year	$10,461	$ 7,298
Incurred related to:		
Current year	35,435	41,682
Prior years	(4,032)	(768)
Total incurred	31,403	40,914
Paid related to:		
Current year	26,435	31,304
Prior years	5,973	6,447
Total paid	32,408	37,751
Balance, end of year	$ 9,456	$10,461

4. Reservation of Retained Earnings

Section 149.143(2)(a)1.c., Wis. Stats., requires that when estimated premium revenues, with premium rates set at the minimum of 150 percent of standard risk rates, exceed the estimate of the policyholders' share of costs, the excess is to be deposited in the appropriation account under s. 20.435(5)(gh), Wis. Stats. The use of these funds is restricted under s. 149.143(1)(b)1.b, Wis. Stats., to reduce premiums in future periods when the policyholders' share of plan costs is expected to exceed premium revenues with premium rates set at 150 percent of standard risk rates. Effective in FY 1999-2000, s. 149.143 (2m)(b)2, Wis. Stats., allows excess premiums to also be used for other needs of eligible persons with the approval of the Board.

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 FY 1998-99, HIRSP policyholders with an annual household income below $20,000 were eligible for a premium and deductible subsidy. 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 alternate primary plan. The deductible subsidy is only available for policyholders in the primary plan, in which unsubsidized deductibles are $1,000.

Annual Household Income At Least	But Less Than	Amount of Premium as % of Standard Risk	Reduction in 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

Wisconsin Act 9 added a fifth income bracket of $20,000 to $25,000 for eligibility for the premium subsidy, effective for policies issued or renewed after October 29, 1999. Policyholders within this income bracket pay premiums at 130 percent of standard risk but receive no reduction in their deductible.

Thirty-five percent of HIRSP policyholders received subsidies costing $2.1 million in FY 1998-99 and $3.1 million in FY 1997-98. A total of $780,800 of GPR was appropriated and spent for the subsidy program in FY 1998-99, and $435,600 in FY 1997-98. Costs in excess of GPR appropriated for this purpose were shared equally by health insurers and health care providers in FY 1998-99, with each contributing $660,000. In FY 1997-98, insurers contributed $2.1 million and providers contributed $564,400 toward the subsidy program.

7. General and Administrative Expense

General and administrative expenses include the following:

	FY 1998-99	FY 1997-98
Plan administrator fees	$2,187,648	$1,741,672
State administrative fees	104,979	47,256
Implementation costs	0	984,752
Other expenses	944,210	245,332
Total	$3,236,837	$3,019,012

8. Health Care Providers' Contribution

Statutes prescribe that health care providers contribute to their share of costs through discounted payment rates. Prior to January 1, 1998, provider payments were reduced to usual and customary fees reduced by an additional 10 percent, and further reduced by any additional discount negotiated by the plan administrator. Effective January 1, 1998, statutes required that providers' contributions be sufficient to share equally with insurers in the cost of the program. Claim losses are reported on the face of the financial statements as net of the discounts. However, disclosure of the discounts is important for full disclosure of HIRSP's funding sources and to demonstrate compliance with the statutory funding formula.

The Department could not determine and disclose the actual amount of provider contributions attributable to funding HIRSP for the period January 1, 1998 through June 30, 1998, because losses were recorded at the discounted payment amount, and the amount of discounts applied to provider payments during this period was not recorded. Therefore, systems were not in place to accumulate information needed to reconcile actual funding levels to those required by statutes for FY 1997-98.

The Department has since developed systems to measure the provider contribution amounts for claims paid after June 30,1998. Using actuarially developed estimates of reimbursement levels under the HIRSP program prior to January 1998, the Department estimates that the provider contributions attributable to funding HIRSP for the period July 1, 1998 through June 30, 1999 was $7,817,619. 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 estimated amount. The Department used this provider contribution to reconcile to actual funding levels required by statutes.

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 $10,375,501 as of June 30, 1998, 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.

10. Non-compliance with Statutory Provisions

Prior to the passage of 1999 Wisconsin Act 9, s. 149.143(2)(a)1.c, Wis. Stats., required the Department to deposit into a special appropriation account under s. 20.435 (5)(gh), Wis. Stats., the amount of excess premiums projected to be collected when premiums set at the minimum of 150 percent of standard risk exceed the projected policyholders' share of plan costs. The use of these excess funds is restricted to the reduction of premiums in future periods. Due to difficulties interpreting and implementing the funding requirements, the Department was not in compliance with these provisions for FYs 1997-98 and 1998-99.

Instead of using projected amounts as required by statute, the Department and the HIRSP Board of Governors used the final reconciliation of calendar year (CY) 1998 plan costs to determine the amount of excess premium revenue that was

actually generated. This is the same process used to determine if providers and insurers paid their required shares of plan funding. The Board reconciled the CY 1998 plan costs and determined that excess premium revenue actually totaled $3.8 million. The amount was deposited into the special appropriation in July 1999 and was available for the intended purpose of holding premiums at the lowest level permitted by law.

With the enactment of 1999 Wisconsin Act 9 on October 28, 1999, deposit of excess premiums into a separate appropriation is no longer required. Instead, a separate accounting of excess premiums, based on actual experience, is required and use of the excess premiums is broadened to include other needs of eligible persons with the approval of the Board.

11. Subsequent Event

Subsequent to the end of the fiscal period, it was determined that significant overpayments had been made on prescription drug claims. Initial estimates are that drug claims were overpaid by approximately $1.7 million during FY 1998-99. 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 may eventually be recovered.

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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, 1999 and June 30, 1998, and have issued our report thereon dated October 10, 2000, which was qualified for the effect of the omission of information on health care providers' contributions on the FY 1997-98 financial statements. We conducted our audit in accordance with generally accepted auditing standards 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 noncompliance that is required to be reported under *Government Auditing Standards.* As discussed in the accompanying report section titled "Meeting Statutory Funding Requirements" and Note 8 of the financial statements, the Department did not have adequate systems in place to ensure that the Health Insurance Risk-Sharing Plan was in compliance with statutory funding requirements for the period January 1, 1998 through June 30, 1998. In addition, as discussed in Note 10 of the financial statements, the Department had not fully complied with the statutory requirement to deposit excess premiums into a special appropriation during FY 1997-98 and FY 1998-99.

Internal Control Over Financial Reporting

In planning and performing our audit, we considered the 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. However, we noted certain matters involving the internal control over financial reporting and its operation that we consider to be reportable conditions. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control over financial reporting that, in our judgment, could adversely affect the Department's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements.

One reportable condition noted is the lack of adequate system controls to ensure proper payment of drug claims, which contributed to a significant overpayment of drug claims

during FY 1998-99, as discussed in the accompanying report section titled "Controlling Prescription Drug Claim Costs" and Note 11 of the financial statements. A second reportable condition was the lack of adequate systems to account for health care provider contributions and to reconcile actual funding to statutorily prescribed funding levels. However, as further discussed in the accompanying report section titled "Meeting Statutory Funding Requirements," the Department addressed this concern for the FY 1998-99 financial statements.

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. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. We consider the reportable condition on inadequate system controls for drug claims to be a material weakness for FY 1998-99 and the reportable condition on inadequate systems to account for health care provider contributions to be a material weakness for FY 1997-98.

This report is intended solely for the information and use of the Department's management and the Wisconsin Legislature's Joint Legislative Audit Committee. This restriction is not intended to limit the distribution of this report, which, upon submission to the Joint Legislative Audit Committee, is a public document. 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 or should not be used by anyone other than these specified parties.

LEGISLATIVE AUDIT BUREAU

October 10, 2000 by

Diann Allsen
Audit Director

APPENDIX

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

November 1, 2000

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

Dear Ms. Mueller:

I am writing in response to the fiscal year 1998-99 audit of the Health Insurance Risk Sharing Plan (HIRSP) performed by the Legislative Audit Bureau (LAB). On behalf of the Department and the HIRSP Board of Governors, I would like to thank you and LAB staff for conducting a thorough audit and providing constructive feedback about ways in which we can continue to strengthen HIRSP.

As the audit report points out, there have been many improvements in HIRSP over the last year. HIRSP is stronger and more stable than it was a year ago. More importantly perhaps, legislative changes, a dedicated Board of Governors, and the Department's administration of this program have largely achieved our collective goal of stabilizing a program that, only a few years ago, was in financial jeopardy. We all have a vested interest in a strong HIRSP, a critical safety net program that provides access to Wisconsin citizens who would otherwise have no health insurance.

As the audit points out, during fiscal year 1998-99, HIRSP had a net income of $6.6 million, a significant improvement in the plan's financial condition over recent years. We have reversed the previous trend of steadily declining enrollment from a high of 12,707 in 1992 to a low of 7,248 in 1998. Enrollment as of today is over 9,600, the highest level since 1994.

I would especially like to express my sincere appreciation to the members of the HIRSP Board of Governors for their steadfast commitment to HIRSP. It is with their guidance, expertise and support that we have been able to accomplish as much as we have since 1998. I look forward to the continued partnership between the Department and the Board to address issues raised in the audit report and to continue to make sound decisions that will result in an even stronger and more stable HIRSP.

While we are pleased with the degree to which HIRSP has been stabilized, we acknowledge that there are important issues we need to address, including the issues related to prescription drug claims processing and payments noted in the audit report. The Department and the HIRSP Board take these issues very seriously and we are implementing corrective measures. Our response to the LAB audit recommendations and the actions we are taking to implement corrective measures are explained in the remainder of this letter.

DHFS Review of Pharmacy Claims: The Department and the HIRSP Board have conducted a review of HIRSP pharmacy claims and have found that there appears to be widespread noncompliance with the billing instructions. At the direction of the HIRSP Board, the Department is proceeding as follows:

- We have had discussions with representatives of the Pharmacy Society of Wisconsin (PSW) and the Wisconsin Merchants' Foundation, which represents many chain pharmacies, to alert them to the results of our analysis and to inform them that the Department will initiate recoveries of overpayments.

- An "urgent notice" will be sent to all pharmacists this week alerting them to the results of our analysis, informing them that recoveries will be pursued and notifying them that pricing controls will be reinstituted.

- We have directed the plan administrator to reinstitute pricing and policy controls. These will prevent HIRSP from reimbursing more than the HIRSP allowed amount for prescription drugs and will enforce other HIRSP policies such as "brand medically necessary."

- We have developed updated billing instructions for pharmacists, including a "quick reference" guide related to HIRSP policyholders.

- We have developed notification to policyholders, including a "HIRSP pharmacy benefits" wallet card they can present to their pharmacy to remind the pharmacist about HIRSP billing instructions.

- Additionally, the HIRSP Board and the Department are exploring options for a point of sale or pharmacy benefits management system as referenced in the audit report.

We appreciate the work done by LAB in reviewing HIRSP pharmacy claims and we are working hard to take corrective action as quickly as possible, taking care to develop thorough notifications to providers and policyholders. Since the policies and procedures surrounding prescription drugs tend to have a significant impact directly on policyholders, we are proceeding in a very deliberate manner over the next few months to minimize disruption for policyholders.

We acknowledge the importance of obtaining pharmaceutical providers' contributions toward funding HIRSP. We concur with LAB's recommendation to submit a report to the Joint Legislative Audit Committee by January 31, 2001, on our progress in this area.

Separate Drug Copayment: We concur with LAB's recommendation to seek statutory authority to implement a separate drug copayment that is not tied to other plan deductibles or out-of-pocket maximums.

Determining Provider Discounts: The LAB also recommends that the Department seek statutory changes to clarify the process for determining provider discounts. We concur with this recommendation.

HIRSP Reports: Additionally, LAB recommends that we expand our current project to improve monthly reporting to include reliable premium and claim information segregated by plan type. The Department and the Financial Oversight Committee of the HIRSP Board have devoted considerable effort to improve HIRSP reports. The Financial Oversight Committee and the HIRSP Board have approved recent modifications to HIRSP reports and, to the best of our knowledge, the HIRSP Board is satisfied with the information provided in those reports.

Full-Cost Funding Approach: The LAB, in its audit report, also provides a discussion regarding possible advantages of converting HIRSP to a full-cost funding approach. The Department and the HIRSP Board are very interested in continuing to improve the financial position of HIRSP. I will raise this issue with the Board to determine if there is interest in having the Financial Oversight Committee of the Board review this matter and present recommendations to the full Board. I encourage LAB to participate in any discussions the Committee or Board hold on this matter.

Again, on behalf of the Department and the HIRSP Board, I would like to thank LAB for the time and effort they devoted to this audit and for their recommendations. The audit report acknowledges considerable improvement in several areas of HIRSP management and operations, and appropriately identifies issues that have yet to be addressed. I believe that both the Department and the HIRSP Board of Governors have demonstrated a strong commitment to improving the administration of HIRSP, and we will continue to work toward a stronger and more stable program.

Sincerely,

Joe Leean
Secretary