Report 05-9
May 2005

An Audit

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

2005-2006 Joint Legislative Audit Committee Members

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From the Department of Health and Family Services

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Janice Mueller
State Auditor

May 17, 2005

Senator Carol A. Roessler and
Representative Suzanne Jeskewitz, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Roessler and Representative Jeskewitz:

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 (FY) 2003-04. HIRSP provides medical and prescription drug insurance for almost 19,000 policyholders who are unable to obtain coverage in the private market or who lost employer-sponsored group health insurance. We have provided an unqualified opinion on HIRSP's financial statements.

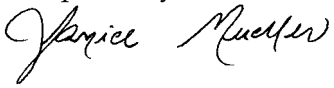
HIRSP's financial position continued to improve during FY 2003-04. After several years of accounting deficits, the program had a positive accounting balance at June 30, 2004. The program's unrestricted net asset balance was $6.8 million on June 30, 2004. Policyholder enrollment continued to increase during our audit period, with an increase of 8.1 percent. However, we note that growth in enrollment has slowed in the first nine months of FY 2004-05.

Net claims costs increased by 21.0 percent during FY 2003-04. In response to increasing program costs, DHFS and HIRSP's Board of Governors increased the usual and customary discounts applied to medical bills. This had the effect of reducing the amount of program costs shared by policyholders, insurers, and health care providers. Further, proposed statutory changes to address a technical issue in HIRSP's statutory funding formula are included in the 2005-07 biennial budget bill, 2005 Assembly Bill 100.

We identified two types of claims errors during our audit. First, pharmacy claims totaling $210,689 were inappropriately paid on behalf of 302 terminated policyholders. DHFS has withheld payment to the former plan administrator for the inappropriate payments. Second, policyholder deductibles were not consistently carried forward between calendar years, as required by statute. As a result, 1,582 policyholders overpaid their deductibles by a total of $327,699. We recommend that DHFS take steps to provide refunds to policyholders who have overpaid their deductibles and ensure that the new plan administrator that began administering HIRSP in April establishes procedures to properly apply deductibles between years.

We appreciate the courtesy and cooperation extended to us by DHFS and the plan administrator for HIRSP. A response from DHFS follows the appendix.

Respectfully submitted,



Janice Mueller
State Auditor

JM/DA/ss

Report Highlights ■

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

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

The usual and customary discounts applied to medical bills were increased beginning in 2004.

Pharmacy claims were inappropriately paid for cancelled policyholders.

Policyholder deductibles were not properly carried forward between years.

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

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

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

HIRSP offers eligible applicants three plans:

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

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

Financial Status of the Plan

Because of its cash-based funding approach, HIRSP had an accounting deficit of $8.2 million as of June 30, 2001. Beginning with fiscal year (FY) 2001-02, DHFS and HIRSP's Board of Governors implemented an accrual-based approach to funding HIRSP, which has contributed to a significant improvement in its financial position. HIRSP's unrestricted net asset balance was $6.8 million at June 30, 2004. The improvement in HIRSP's unrestricted net asset balance over the last four years is shown in Table 1.

Table 1

Unrestricted Net Assets
(In Millions)

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

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

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

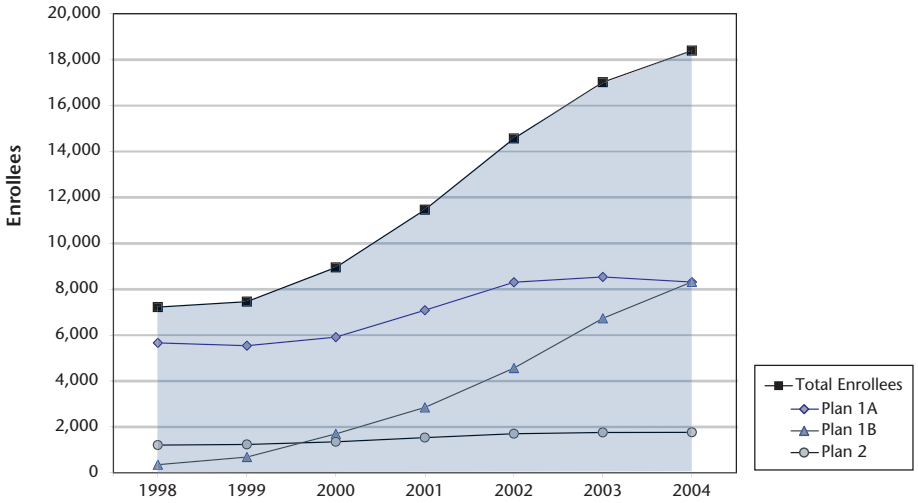
policyholder balance decreased slightly in FY 2003-04, to $10.1 million at June 30, 2004. The use of these funds is statutorily restricted to reduce policyholder premiums to the statutory minimum; for distribution to eligible persons; or for other needs of eligible persons, with the approval of the Board of Governors.

Enrollment and Claims Costs

Increasing enrollment and claims costs present continuing challenges to HIRSP's management and funding. HIRSP experienced double-digit enrollment growth for several years. Policyholder enrollment continued to increase during our audit period. In FY 2003-04, enrollment increased by 8.1 percent for a total of 18,395 policyholders as of June 30, 2004. However, growth has slowed in the first nine months of FY 2004-05, and enrollment was 18,725 at March 31, 2005. As shown in Figure 1, enrollment in plans 1A and 2 began to level in recent years, although enrollment in plan 1B continued to increase steadily.

Figure 1

HIRSP Enrollment by Plan
As of June 30



Like enrollment, claims costs have been increasing each year, as shown in Table 2. Net of health care providers' discounts, claims costs increased $67.5 million over the past five years.

Table 2

Net Claims Costs[1]
(In Millions)

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

[1] Net of health care providers' discounts.

Determination of Program Costs

Program costs shared by policyholders, insurers, and health care providers are billed medical charges that have been reduced by usual and customary discounts. These discounts have been based on reimbursement levels for the program since before 1998. In aggregate, the discounts have been approximately 20 percent of billed charges.

However, unexpected increases in program costs in 2004 caused DHFS and the Board of Governors to increase the discounts applied to billed medical claims from January 1, 2004 through June 30, 2005. On an aggregate basis, the discounts were increased to approximately 30 percent, which DHFS and the Board believed was more representative of industry averages. The amount of program costs shared by the funding groups decreased as a result of this change. DHFS and the Board are currently re-evaluating the discounts that will be applied for future periods.

Claims Management Issues

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

intends to refund the former administrator for any amounts collected from these individuals.

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

Technical Statutory Issue

DHFS and HIRSP's contracted actuary have identified a technical statutory issue that will require legislative action. Under current statutes, the method by which HIRSP's funding formula applies deductible and drug coinsurance subsidies for low-income policyholders results in policyholders being over-credited for subsidies they did not fund.

DHFS and the Board of Governors decided in 2001 that $1.5 million of the resulting unallocated costs associated with the deductible subsidy credit would be paid by policyholders, insurers, and health care providers based on the statutory funding split used for HIRSP costs. These costs had accumulated during 1998, 1999, and 2000. In April 2004, DHFS and the Board decided to reduce the excess policyholder premium account by $2.2 million for the balance of over-credited deductible subsidies that had subsequently accumulated through March 31, 2004. Proposed statutory changes to address this technical issue are included in the 2005-07 biennial budget bill, 2005 Assembly Bill 100.

Recommendations

We include a recommendation for the Department of Health and Family Services to:

- take steps to provide refunds to policyholders who have overpaid their deductibles; and

- ensure the new plan administrator establishes procedures to properly apply fourth-quarter deductibles to the following year's deductibles *(p. 20).*

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Introduction ■

DHFS has been responsible for overseeing HIRSP since 1998. The 13-member Board of Governors advises DHFS on HIRSP's operations and includes members representing insurers, health care providers, and the public. At least one member of the Board must be a HIRSP policyholder. While the Board fills an advisory and oversight role, DHFS retains program rule-making authority, establishes the annual budget, and contracts with a third-party vendor to administer HIRSP. Since July 1, 1998, DHFS had contracted with the State's Medicaid fiscal agent to administer HIRSP, as required by statute. However, 2003 Wisconsin Act 33 eliminated this requirement and DHFS recently conducted a competitive procurement process to select a new plan administrator, which began administering HIRSP in April 2005.

At the request of DHFS, we completed a financial audit of HIRSP for FY 2003-04. As necessary parts of the financial audit, we reviewed HIRSP's control procedures, assessed the fair presentation of the FY 2003-04 financial statements, and reviewed compliance with statutory provisions.

Plan Provisions

Three plans are available to policyholders.

HIRSP offers eligible applicants three plans:

- Plan 1A is available for Wisconsin residents who have received a notice of rejection, cancellation, reduction of coverage, or substantial premium increase by an insurer; who have tested positive

for the virus that causes AIDS; or who have lost employer-sponsored group health insurance and meet other specified criteria.

- Plan 1B is an alternative plan that was introduced in 1998 to comply with a federal HIPAA requirement to offer a choice of major medical expense coverage to the same individuals eligible for the primary plan.

- Plan 2 is available to Wisconsin residents under the age of 65 who participate in the federal Medicare program because of a disability. Persons with coverage when they reach the age of 65 may continue in the plan.

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

- annual medical deductibles of $1,000 for plan 1A, $2,500 for plan 1B, and $500 for plan 2, which must be paid by policyholders before insurance benefits will be available;

- medical coinsurance payments of 20 percent up to $1,000 per year for policyholders in plans 1A and 1B, which must be paid by the policyholders after their annual deductible requirements have been satisfied (there is no coinsurance requirement for plan 2); and

- drug coinsurance payments of 20 percent, or $25 maximum per drug, up to $750 for plan 1A, $1,000 for plan 1B, and $125 for plan 2.

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. 1997 Wisconsin Act 27 authorized additional funding sources that took effect when oversight responsibility was transferred to DHFS on January 1, 1998. At the time, the Legislature:

- made general purpose revenue (GPR) funding available to offset program costs; and

- required providers of covered health care items and services to share equally with insurers in program costs that were not covered by premiums and GPR. By statute, pharmacies have been excluded from the funding requirement for providers.

GPR support for HIRSP, which totaled $21.0 million in the 2001-03 biennium, has been eliminated.

Until FY 2003-04, the Legislature also provided GPR support to help fund premium and deductible subsidies for low-income policyholders. Insurers and health care providers shared equally in the subsidy costs that were not covered by GPR. GPR support for HIRSP totaled $21.0 million in the 2001-03 biennium, but all GPR support was eliminated beginning in FY 2003-04.

Under HIRSP's complex statutory funding formula, which is illustrated in the appendix, policyholder premiums are required to fund 60 percent of estimated operating and administrative costs. The remaining 40 percent are funded equally by private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders. The insurers and health care providers also are responsible for equally sharing costs of subsidies provided to low-income policyholders for premiums, deductibles, and drug co-insurance.

Premium rates for each of HIRSP's three plans differ on the basis of policyholders' gender, age, and geographic location and may range from not less than 140 percent to not more than 200 percent of average industry rates for standard risk individuals. On average, premium rates for the primary plan have been at the minimum level, although they were 161.9 percent of standard risk rates in FY 2001-02.

Rate increases for both plan 1A and plan 1B have been generally comparable to increases in the standard risk rates that private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP. Table 3 shows premium rate changes since 1998. Plan 2, which is available for certain Medicare participants, typically experienced larger rate increases to more closely reflect that plan's claims costs. In response to concerns about increases in premiums for plan 2, statutes allow DHFS to consider enrollment levels and other economic factors in addition to claims costs when establishing premium levels. The ultimate goal of DHFS and the Board of

Governors is to make the ratio of losses to premiums more consistent for all plans and to reduce the extent to which plans 1A and 1B are subsidizing plan 2.

Table 3

Premium Rate Changes

Effective Date	Plans 1A and 1B	Plan 2
July 1, 1998	11.4% Increase	24.0% Increase
January 1, 1999	No Change	10.0% Increase
July 1, 1999	No Change	4.0% Increase
July 1, 2000	12.4% Increase	18.2% Increase
July 1, 2001	3.4% Increase	3.4% Increase
July 1, 2002	25.4% Increase	30.8% Increase
July 1, 2003	10.6% Increase	15.6% Increase
July 1, 2004	12.2% Increase	18.4% Increase

Examples of annual premiums effective July 1, 2004, for policyholders living in Milwaukee, where the rates are the highest, are shown in Table 4.

In FY 2003-04, 22.0 percent of HIRSP policyholders received subsidies, at a cost of $4.7 million.

Policyholders who are enrolled in plan 1A or plan 2 and who have annual household incomes below $25,000 are eligible for premium subsidies. Policyholders enrolled in plan 1A with annual household incomes below $20,000 are also eligible for deductible and drug coinsurance subsidies. Policyholders enrolled in plan 1B are not eligible for any of the subsidies. In FY 2003-04, 22.0 percent of HIRSP policyholders received subsidies, at a cost of $4.7 million.

Table 4

Examples of Annual Premiums for a Policyholder Living in Milwaukee
Rates Effective July 1, 2004

Plan Type	Male Ages 0-24	Male Ages 60-64	Female Ages 0-18	Female Ages 60-64
Plan 1A	$2,472	$12,084	$2,472	$9,984
Plan 1B	1,776	8,700	1,776	7,188
Plan 2	2,004	9,744	2,004	8,052

DHFS and HIRSP's contracted actuary identified a technical issue relating to the treatment of deductible and drug coinsurance subsidies in the statutory funding formula. When the formula is applied, deductible and drug coinsurance subsidies are appropriately excluded from the costs that are allocated among all funding parties. The subsidies are then appropriately funded by insurers and providers. However, statutes also require that the subsidies be credited to policyholders when premiums are calculated. Therefore, deductible and drug coinsurance subsidy amounts are, in essence, double-counted under the statutory funding formula; policyholders are inappropriately credited for subsidies each year; and, as a result, a portion of HIRSP's annual costs is not allocated to any funding group.

DHFS and the Board of Governors decided in 2001 that $1.5 million of unallocated costs associated with the deductible subsidy credit would be paid by policyholders, insurers, and health care providers based on the statutory funding split used for HIRSP costs. These costs had accumulated during 1998, 1999, and 2000. In April 2004, DHFS and the Board decided to reduce the excess policyholder premium account by the amount of over-credited deductible subsidies that subsequently had accumulated to $2.2 million through March 31, 2004. Proposed statutory changes to address this technical issue are included in the 2005-07 biennial budget bill, 2005 Assembly Bill 100.

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Program Management ■

HIRSP's financial position has improved significantly over the past few years, despite increasing enrollment and claims costs. DHFS and the Board of Governors are currently changing their approach for determining program costs, which will affect future funding needs. In addition, claims management problems we noted suggest that DHFS needs to be diligent in ensuring that the new plan administrator properly implements HIRSP policies and procedures.

Financial Status of the Plan

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

Because of its cash-based funding approach, HIRSP had an accounting deficit of $8.2 million as of June 30, 2001, as represented by its unrestricted net asset balance. However, DHFS and HIRSP's Board of Governors implemented an accrual-based approach to funding HIRSP beginning with FY 2001-02. An accrual basis takes into account the full costs associated with events that occur during a plan year, including actuarial cost estimates for incurred claims that may not be filed until after the plan year. The change to an accrual-based approach required funding to eliminate the accounting deficit that had accumulated under the cash-based approach, as well as funding for newly incurred costs accounted for on an accrual basis. These actions contributed to a significant improvement in HIRSP's unrestricted net asset balance, which totaled $6.8 million as of June 30, 2004.

Statutes require policyholders to fund 60 percent of HIRSP's costs and establish a floor for policyholder premiums of at least 140 percent of standard risk rates. Statutes also require a separate

accounting of premiums received in excess of the amount needed to cover policyholders' 60 percent share of HIRSP's costs. The use of these funds is statutorily restricted for these purposes:

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

Because the statutory floor for premium rates has typically been greater than the premiums needed to fund 60 percent of HIRSP's costs, and because actual claims costs were less than costs assumed in HIRSP's FY 2002-03 budget, the excess policyholder premium account balance increased significantly during FY 2002-03. As shown in Table 5, it was $10.4 million as of June 30, 2003, compared to $3.0 million as of June 30, 2002. In FY 2003-04, the excess policyholder balance decreased to $10.1 million because of the April 2004 decision to use $2.2 million to cover over-credited deductible subsidies. DHFS and the Board have concluded this was an acceptable use of the excess premiums, based on the premise that maintaining a financially solvent plan benefited policyholders.

Table 5

Accounting Balances
(In Millions)

Date	Unrestricted Net Assets[1]	Restricted for Excess Policyholder Premiums[2]	Total Net Assets
June 30, 2001	$(8.2)	$ 2.1	$(6.1)
June 30, 2002	(6.0)	3.0	(3.0)
June 30, 2003	(0.9)	10.4	9.5
June 30, 2004	6.8	10.1	16.9

[1] The unrestricted net assets balance represents the net amount available for HIRSP's general operations. A negative balance represents the additional amount needed to pay covered expenses that were incurred but not yet paid as of that date.
[2] The balance of excess policyholder premiums is restricted for statutorily defined purposes.

Increasing Enrollment and Claims Costs

Policyholder enrollment continued to increase in FY 2003-04.

Increasing enrollment and claims costs present continuing management and funding challenges. As shown in Table 6, HIRSP experienced double-digit enrollment growth for several years. Policyholder enrollment continued to increase during our audit period. In FY 2003-04, enrollment increased by 8.1 percent for a total of 18,395 policyholders as of June 30, 2004. However, growth has slowed in the first nine months of FY 2004-05, and enrollment was 18,725 at March 31, 2005.

Table 6

HIRSP Enrollment

Date	Plan 1A	Plan 1B	Plan 2	Total Policyholders	Percentage Change
June 30, 1998	5,660[1]	354[1]	1,204[1]	7,218	–
June 30, 1999	5,540	683	1,231	7,454	3.3%
June 30, 2000	5,909	1,692	1,348	8,949	20.1
June 30, 2001	7,081	2,849	1,530	11,460	28.1
June 30, 2002	8,302	4,558	1,703	14,563	27.1
June 30, 2003	8,532	6,729	1,756	17,017	16.9
June 30, 2004	8,312	8,319	1,764	18,395	8.1

[1] Estimated

Enrollment in plans 1A and 2 began to level in recent years, although enrollment in plan 1B continued to increase steadily. Further, increasing numbers of participants have shifted from plan 1A to plan 1B in recent years.

Net claims costs increased $67.5 million over the past five years.

Like enrollment, claims costs have been increasing each year, as shown in Table 7. Net claims costs, which represent the amount paid by HIRSP, increased 185.4 percent, or $67.5 million, over the past five years. A large portion of these increases can be explained by the enrollment increases, although HIRSP claims costs also have been affected by prescription drug and medical cost increases similar to those experienced by other payers.

Table 7

Net Claims Costs[1]
(In Millions)

Fiscal Year	Net Claims Costs[1]	Percentage Change
1999-2000	$ 36.4	–
2000-01	54.1	48.6%
2001-02	67.2	24.2
2002-03	85.8	27.7
2003-04	103.9	21.1

[1] Net of health care providers' discounts

Determination of Program Costs

The difference between usual and customary charges and allowable charges represents the providers' contribution.

Health care providers are paid for allowable charges that are based on payment rates generally set as a percentage of Medicaid reimbursement rates. However, program costs that are shared by policyholders, insurers, and health care providers are based on billed medical costs that have been reduced by a discount to arrive at the usual and customary charges. The difference between usual and customary charges and allowable charges for medical claims represents the health care providers' contribution to funding HIRSP. The payment rates change as needed to provide the providers' estimated share of projected program costs.

The discounts used in determining usual and customary charges have been based on reimbursement levels that had been in place before HIRSP was transferred to DHFS in 1998. On an aggregate basis, the discounts have been approximately 20 percent of billed medical claims. However, DHFS noted in 2004 that usual and customary charges and provider contribution balances were increasing more rapidly than expected.

Providers' usual and customary discounts were increased to approximately 30 percent.

Working with HIRSP's contracted actuary, DHFS and the Board of Governors decided in January 2005 to increase the discounts applied to billed medical claims from January 2004 through June 30, 2005, which reduced usual and customary charges. On an aggregate basis, the discounts were increased to approximately 30 percent, which DHFS and the Board believed was more representative of industry averages. While the net claims paid by HIRSP remained unchanged,

the program costs shared by the funding groups decreased with this change. The Board reconvened its actuarial advisory subcommittee to provide advice on establishing a market-based benchmark for determining usual and customary charges in the future. As part of this process, commercial insurance companies have been surveyed to obtain information regarding their current discount levels. The Board concluded that the increasing provider contribution balance also resulted from other factors, which included increasing medical charges billed by providers and provider payment rates not keeping pace with inflation. It plans to increase non-pharmacy provider payment rates by 2.0 percent for FY 2005-06.

Claims Management Issues

More than $210,000 in pharmacy claims were inappropriately paid for 302 terminated policyholders.

During the course of our audit work, we identified two areas in which errors were made in the management of claims by HIRSP's former plan administrator. First, 4,016 pharmacy claims totaling $190,165 were paid on behalf of 203 individuals who were no longer policyholders. The inappropriate payments occurred because, from November 2001 until we identified the errors in August 2004, the former plan administrator had not reviewed a report developed to identify and communicate policy cancellations to the pharmacy benefit management company, which operated under the terms of a separate contract with the former plan administrator. Subsequently, the former plan administrator identified an additional $20,524 in inappropriate payments for another 99 cancelled policyholders.

The Board allowed the former plan administrator to collect the ineligible payments through written correspondence with individuals who inappropriately received coverage for pharmacy claims. However, the former plan administrator was instructed to not initiate collection actions or any other actions that would harm the credit records of these individuals. DHFS has withheld payments to the former plan administrator for the inappropriate payments and intends to refund the former administrator for any amounts collected from these individuals.

The second area of concern is that the former plan administrator had inadequate procedures in place to ensure that deductibles were carried forward between calendar years as required by statute. In accordance with s. 149.14 (5), Wis. Stats., "expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year." In our testing of medical claims, we identified three instances in which the former administrator had not properly applied the fourth-quarter deductible from the previous year.

Since 1998, 1,582 policyholders overpaid their deductibles by a total of $327,699.

The former plan administrator indicates that it adjusted the deductibles if a policyholder identified the error and contacted a customer service representative. However, it did not take any proactive steps to identify situations in which adjustments should have been made. In February 2005, the former plan administrator determined that, since 1998, 1,582 policyholders had overpaid their deductibles because the deductibles had not been properly carried forward. The overpayments, which ranged from less than $1 to $2,500, totaled $327,699.

In light of the length of time since some of the deductible overpayments were made, refunding all of the policyholders who had overpaid their deductibles will likely not be feasible, especially for those who are no longer policyholders. However, reasonable steps should be taken to locate and refund individuals affected by this error.

☑ Recommendation

We recommend the Department of Health and Family Services:

- *take steps to provide refunds to policyholders who have overpaid their deductibles; and*

- *ensure that the new plan administrator establishes procedures to properly apply fourth-quarter deductibles to the following year's deductibles.*

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Audit Opinion ■

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

We have audited the accompanying financial statements of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP) as of and for the years ended June 30, 2004 and 2003. These financial statements are the responsibility of the Department of Health and Family Services' management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

As discussed in Note 1, the financial statements referred to in the first paragraph present only HIRSP and do not purport to, and do not, present fairly the financial position of the State of Wisconsin and the changes in its financial position and its cash flows, where applicable, in conformity with accounting principles generally accepted in the United States of America.

In our opinion, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of HIRSP as of June 30, 2004 and 2003, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the financial statements of HIRSP. The supplementary information included as Management's Discussion and Analysis on pages 23 through 28 is presented for purposes of additional analysis and is not a required part of the financial statements referred to in the first paragraph. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued a report dated May 2, 2005, on our consideration of HIRSP's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

LEGISLATIVE AUDIT BUREAU

May 2, 2005

Diann Allsen
Audit Director

Management's Discussion and Analysis ■

Prepared by the Health Insurance Risk-Sharing Plan's Management

This section presents management's discussion and analysis of the financial performance of HIRSP. This discussion should be read in conjunction with the accompanying financial statements and notes. The financial statements, notes, and this discussion are the responsibility of HIRSP's management.

HIRSP was established in 1980. The purpose of HIRSP is to provide medical and prescription drug insurance for persons unable to obtain this insurance in the private market or who otherwise qualify for eligibility under s. 149.12, Wis. Stats.

Overview of Financial Statements

HIRSP prepares its financial statements in accordance with Governmental Accounting Standards Board (GASB) standards.

HIRSP's financial statements comprise two components: 1) the financial statements, and 2) notes to the financial statements that explain in more detail some of the information in the financial statements.

Following this section are the financial statements and notes as they relate to HIRSP.

- The Balance Sheet provides information on the types of assets and the liabilities of HIRSP, with the differences between the two reported as net assets. Over time, increases or decreases in net assets are an indicator of HIRSP's financial health.

- The Statement of Revenues, Expenses, and Changes in Net Assets presents the revenues earned and the expenses incurred during the year on an accrual basis.

- The Statement of Cash Flows presents information related to cash inflows and outflows summarized by operating, noncapital financing, and investing activities and helps measure HIRSP's ability to meet financial obligations as they mature.

- The notes to the financial statements provide additional information that is essential to a full understanding of the data provided in the financial statements.

A fund is a grouping of related accounts that is used to maintain control over resources that have been segregated for specific activities or objectives. HIRSP uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements. During FY 2003-04, the plan had one funding type: program revenue in the form of segregated (SEG) funds.

For fiscal years ending June 30, 1998 through June 30, 2003, GPR was received by HIRSP from the State of Wisconsin for general plan funding, as well as for premium and deductible subsidies for low-income policyholders. Prior to FY 1997-98, GPR funding was only available for premium and deductible subsidies. Starting in FY 2003-04, no GPR funding was appropriated for HIRSP for either general plan funding or premium and deductible subsidies for low-income policyholders.

Program revenue is received by HIRSP from policyholders and insurers. Health care providers, except pharmacies, contribute to HIRSP by accepting a reduction in fees for their services. Section 149.143, Wis. Stats., prescribes a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers, except pharmacies, to share in plan costs remaining after GPR appropriated (prior to FY 2003-04) under s. 20.435(4)(af), Wis. Stats., is deducted. Pharmacies are specifically exempt from contributing to HIRSP as provided by s. 149.142(1)(b), Wis. Stats.

Premiums, which are statutorily required to be at least 140 percent of standard risk rates, are to fund 60 percent of estimated program 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 (except pharmacies) providing medical services to HIRSP policyholders are to share equally in:

- costs remaining after any GPR appropriated (prior to FY 2003-04) under s. 20.435(4)(af), Wis. Stats., and after the deduction of the policyholders' share of the costs;

- premium, deductible, and drug coinsurance subsidy costs in excess of any GPR appropriated (prior to FY 2003-04) under s. 20.435(4)(ah), Wis. Stats., for that purpose; and

- excess costs when premium rates needed to fund 60 percent of costs exceed 200 percent of premium rates for standard risks. However, between FY 1997-98 and FY 2003-04, the highest HIRSP rates were 161.9 percent of the standard risk rates in FY 2001-02.

Financial Analysis of HIRSP

In this discussion and analysis, the reasons for the changes in financial activity between FY 2003-04 and FY 2002-03 are reviewed. Net assets may serve over time as a useful indicator of the financial position of HIRSP. In the case of HIRSP, assets exceeded liabilities by $16,898,374 at the close of the fiscal year ending June 30, 2004, an improvement of $7,367,853 over total net assets as of June 30, 2003.

Condensed Financial Information

	June 30, 2004	June 30, 2003	Percentage Change
Total Assets	$51,820,029	$42,058,260	23.2%
Total Liabilities	34,921,655	32,527,739	7.4
Net Assets:			
Restricted	10,106,007	10,418,274	(3.0)
Unrestricted	6,792,367	(887,753)	865.1
Total Net Assets	**$16,898,374**	**$9,530,521**	

	FY 2003-04	FY 2002-03	Percentage Change
Operating Revenues	$116,000,161	$92,371,493	25.6%
Operating Expenses	(109,033,117)	(90,462,180)	20.5
Nonoperating Revenues and Expenses	400,809	10,586,731	(96.2)
Change in Net Assets	**$ 7,367,853**	**$12,496,044**	

The largest portion of HIRSP's total assets, 96.1 percent, is in the form of cash and cash equivalents. HIRSP uses cash to pay current operating expenses. Cash in excess of immediate needs is invested in short-term investments with the State of Wisconsin Investment Board.

The largest area of HIRSP's liabilities is unpaid loss liabilities. Unpaid loss liabilities represent the accumulation of losses (unpaid medical or pharmaceutical claims), net of discounts to health care providers, that were reported but not paid prior to the close of the accounting period, and an actuarial estimate of claims incurred prior to June 30 but not reported. Consequently, cash is reserved for payment of these future claims.

HIRSP's net assets increased by $7,367,853 during FY 2003-04. HIRSP's revenues consist of policyholder premiums and insurer assessments. HIRSP uses these revenues to pay operating expenses. HIRSP's revenues, combined with reduced payments to health care providers, were sufficient to cover all operating expenses of the program during FY 2003-04.

Financial Highlights

- Plan enrollment as of June 30, 2004, was 18,395, an increase of 8.1 percent over June 30, 2003 enrollment of 17,017. For the first time since FY 1998-99, enrollment has not grown at a double-digit rate. Since the end of FY 2003-04, enrollment has continued to slow. As of December 31, 2004, enrollment was 18,341, a slight decrease since June 30, 2004. As a result of the enrollment increase during FY 2003-04:
  - Premium revenues increased.
  - Insurer assessments increased.
  - Claims expense (net of health care providers' discounts) increased.
- Revenue from the State of Wisconsin decreased 100.0 percent, as the result of the elimination of GPR support for HIRSP in FY 2003-04.
- Plan operations are conducted by DHFS staff, as well as a third-party contract administrator.
  - Total administrative costs for FY 2003-04 were $5,060,142, or 4.6 percent of program costs for FY 2003-04, a decrease from 4.9 percent of program costs for FY 2002-03 and 5.3 percent of program costs for FY 2001-02.

- The following chart shows plan costs for claims and administrative expenses on a per member per month (PMPM) basis:

Cost Summary on a per Member per Month (PMPM) Basis
FY 2002-03 and FY 2003-04

Description	FY 2003-04	FY 2002-03	FY 2003-04 PMPM	FY 2002-03 PMPM	Percentage Change PMPM
Member Months (Total Members Enrolled in Each Month of Fiscal Year)	213,195	192,654	–	–	10.7%
Gross Claims (Costs before Provider Contributions Were Deducted)	$135,523,775	$112,009,977	$635.68	$581.40	9.3 %
Administrative Expenses	$ 5,060,142	$ 4,460,955	$ 23.73	$ 23.16	2.5 %

- HIRSP's net assets increased during FY 2003-04.
  - The change in net assets for FY 2003-04 was $7,367,853, while the change in net assets for FY 2002-03 was $12,496,044. The change was smaller for FY 2003-04 as the result of actual claims expense being more than actuarial estimates at the time the FY 2003-04 budget was established.
  - Investment income increased from $349,551 in FY 2002-03 to $406,299 in FY 2003-04, due to an increased investment balance.
- Net assets are split between restricted and unrestricted.
  - Restricted net assets for excess policyholder premiums decreased slightly from $10,418,274 to $10,106,007. The restricted net assets are statutorily required under s. 149.143(2m)(b), Wis. Stats., to be used 1) to reduce policyholder premiums to a floor of 140 percent of standard risk rates when premiums exceed the policyholders' share of plan costs; 2) for other needs of eligible persons, with the approval of the Board of Governors; or 3) for distribution to eligible persons.

- Unrestricted net assets improved from ($887,753) to $6,792,367. A portion of this increase is related to a transfer from the excess policyholder premium account to eliminate an unfunded deductible subsidy balance of $2,151,879 as of March 31, 2004. The transfer was approved by the Board of Governors as a temporary remedy to a technical issue with the statutory funding provisions.

Contacting the Plan's Financial Management

The financial report is designed to provide a general overview of HIRSP finances for all those with an interest. Questions concerning any of the information provided in this report, or requests for additional information, should be addressed to:

Sally A. Acuff, Audit Liaison
Department of Health and Family Services
Room 655, 1 West Wilson Street
P.O. Box 7850
Madison, WI 53707-7850

General information relating to HIRSP can be found at the HIRSP Web site, *http://www.dhfs.wisconsin.gov/hirsp/index.htm.*

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Financial Statements ■

Balance Sheet
June 30, 2004 and 2003

	June 30, 2004	June 30, 2003
ASSETS		
Cash and Cash Equivalents (Note 2)	$ 49,824,628	$ 40,264,885
Drug Rebates Receivable (Note 3)	941,241	571,544
Due from the State of Wisconsin (Note 3)	742,680	418,324
Premiums Receivable	153,969	129,423
Assessments Receivable	90,547	167,035
Claims Receivable (Note 3)	35,951	424,009
Prepaid Items	31,013	83,040
TOTAL ASSETS	**$ 51,820,029**	**$ 42,058,260**
LIABILITIES AND NET ASSETS		
Liabilities:		
Unpaid net loss liabilities (Note 4)	$ 16,938,974	$ 14,887,195
Unpaid loss adjustment expenses (Note 4)	660,000	660,000
Unearned premiums	16,565,409	13,609,566
Liability for premium overpayments (Note 5)	0	471,488
Payments to providers (Note 3)	0	1,950,069
Accrued Administrative Expenses	338,796	759,030
Miscellaneous Payables	418,476	190,391
Total Liabilities	**34,921,655**	**32,527,739**
Net Assets:		
Restricted for excess policyholder premiums (Note 6)	10,106,007	10,418,274
Unrestricted	6,792,367	(887,753)
Total Net Assets	**16,898,374**	**9,530,521**
TOTAL LIABILITIES AND NET ASSETS	**$ 51,820,029**	**$ 42,058,260**

The accompanying notes are an integral part of this statement.

Statement of Revenues, Expenses, and Changes in Net Assets for the Years Ended June 30, 2004 and 2003

	For the Year Ended June 30, 2004	For the Year Ended June 30, 2003
OPERATING REVENUES		
Premiums	$ 80,582,808	$ 66,368,223
Insurer's Assessments (Note 7)	35,417,353	26,003,270
Total Operating Revenues	**116,000,161**	**92,371,493**
OPERATING EXPENSES		
Losses:		
Gross medical and pharmacy losses	132,656,206	110,443,938
Provider contributions on medical losses (Note 11)	(31,642,500)	(26,160,080)
Net medical and pharmacy losses paid or approved for payment	101,013,706	84,283,858
Increase in unpaid losses	2,867,569	1,566,039
Total Losses	**103,881,275**	**85,849,897**
Change in Unpaid Loss Adjustment Expenses	0	38,100
General and Administrative Expenses (Note 10)	5,060,142	4,460,955
Referral Fees	91,700	113,228
Total Operating Expenses	**109,033,117**	**90,462,180**
OPERATING INCOME	**6,967,044**	**1,909,313**
NONOPERATING REVENUES AND EXPENSES		
Revenue from the State of Wisconsin	0	9,500,000
State Premium and Deductible Subsidies (Note 9)	0	741,800
Investment Income	406,299	349,551
Transfer to the General Fund	(5,490)	(4,620)
Total Nonoperating Income	**400,809**	**10,586,731**
CHANGE IN NET ASSETS	**7,367,853**	**12,496,044**
NET ASSETS		
Total Net Assets—Beginning of the Year	9,530,521	(2,965,523)
Total Net Assets—End of the Year	**$ 16,898,374**	**$ 9,530,521**

The accompanying notes are an integral part of this statement.

Statement of Cash Flows for the Years Ended June 30, 2004 and 2003

	For the Year Ended June 30, 2004	For the Year Ended June 30, 2003
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash Received for Premiums	$ 83,170,109	$ 70,356,312
Cash Received for Assessments	35,493,841	26,114,337
Cash Payments for Losses	(103,811,743)	(87,071,251)
Cash Payments for Other Expenses	(5,698,763)	(4,684,838)
Net Cash Provided by Operating Activities	**9,153,444**	**4,714,560**
CASH FLOWS FROM NONCAPITAL FINANCING ACTIVITIES		
Cash Received from State of Wisconsin	0	10,241,800
Net Cash Provided by Noncapital Financing Activities	**0**	**10,241,800**
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income	406,299	349,551
Net Cash Provided by Investing Activities	**406,299**	**349,551**
NET INCREASE IN CASH AND CASH EQUIVALENTS	**9,559,743**	**15,305,911**
Cash and Cash Equivalents, Beginning of Year	40,264,885	24,958,974
Cash and Cash Equivalents, End of Year	$ 49,824,628	$ 40,264,885
RECONCILIATION OF NET OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Net Operating Income	$ 6,967,044	$ 1,909,313
Adjustments to Reconcile Net Operating Income to Net Cash Provided by Operating Activities:		
Changes in assets and liabilities:		
Decrease (Increase) in receivables	(254,053)	811,910
Decrease (Increase) in prepaids	52,027	(23,778)
Increase (Decrease) in liability for premium overpayments	(471,488)	0
Increase (Decrease) in accounts payable	(2,142,218)	(1,368,242)
Increase (Decrease) in unearned premiums	2,955,843	3,138,835
Increase (Decrease) in loss liabilities	2,051,779	251,142
Other adjustments	(5,490)	(4,620)
Total Adjustments	2,186,400	2,805,247
Net Cash Provided by Operating Activities	**$ 9,153,444**	**$ 4,714,560**

The accompanying notes are an integral part of this statement.

Notes to the Financial Statements ■

1. Summary of Significant Accounting Policies

A. Description of the Fund

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

Effective January 1, 1998, HIRSP was transferred from the State of Wisconsin Office of the Commissioner of Insurance to the State of Wisconsin Department of Health and Family Services (DHFS). DHFS uses independent third-party administrators to provide underwriting, claims settlement, actuarial, 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 any general purpose revenue (GPR) appropriated under s. 20.435(4)(af), Wis. Stats., is deducted. Plan 1A and 1B premiums, which are statutorily required to be at least 140 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. Plan 2 premiums are established using criteria outlined in s. 149.14 5(m), Wis. Stats.: 1) comparison of cost per capita for plans 1A and 2 in the previous

calendar year; 2) enrollment levels of eligible persons in plans 1A and 2; and 3) economic factors DHFS and the HIRSP Board of Governors consider relevant.

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 any GPR appropriated under s. 20.435(4)(af), Wis. Stats., and after the deduction of the policyholders' share of the costs ;

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

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

With the enactment of 2003 Wisconsin Act 33, the 2003-05 Biennial Budget Act, all GPR support for HIRSP program and subsidy costs was eliminated beginning in FY 2003-04.

B. Basis of Presentation and Accounting

The accompanying financial statements of HIRSP have been prepared in conformity with generally accepted accounting principles 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.

Operating revenues and expenses are directly related to the ongoing medical insurance activities of HIRSP. Nonoperating revenues and expenses are indirectly related to the ongoing medical insurance activities of HIRSP, such as investment income. Certain significant revenue streams relied upon by operations are reported as nonoperating revenue, as defined by GASB Statement Number 34, Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments, including state general appropriations.

C. Accounting Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results may differ from those estimates. Estimates that are particularly susceptible to significant change are the unpaid loss liabilities as described in Notes 1E and 4 and the health care provider contributions as described in Note 11. In estimating these items, management used the methodologies discussed in the applicable notes.

D. Cash and Cash Equivalents

Cash and cash equivalents reported on the Balance Sheet and the Statement of Cash Flows include a demand deposit account at a commercial financial institution and cash deposited with the State of Wisconsin, 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 Number 31, Accounting and Financial Reporting for Investments and for External Investment Pools.

E. Unpaid Loss Liabilities

Unpaid loss liabilities represent the accumulation of losses 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, which are reported net of estimated health care provider discounts, are established by an independent actuary and are based on historical patterns of claim payments. Such liabilities are necessarily based on estimates and, while management believes the results of the estimates are materially correct, the ultimate liabilities may be in excess or less than the amounts provided due to uncertainties inherent in the estimation process. The method and assumptions used in making such estimates are periodically reviewed and updated, with resulting adjustments to the liabilities reflected in current operations. The unpaid loss adjustment expense is the anticipated cost for processing claims related to the unpaid loss liabilities.

F. Premium and Assessment Revenue

Premiums are recognized as revenue 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 over the period covered by the assessment. Insurer assessments are determined annually during the budgeting process and split into two installments.

G. Policy Acquisition Costs

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

H. Change in Presentation of Losses

In prior years, net losses were presented on the face of the financial statements and the amount of provider contributions that reduced gross losses to the net amount was disclosed in the notes. Beginning with FY 2003-04, the gross losses and reduction for the amount of provider contributions are also reported on the face of the financial statements. The prior-year financial statements have been reclassified in order to be consistent with the current year's presentation.

2. DEPOSITS

GASB Statement Number 3 requires deposits with financial institutions to be categorized to indicate the level of risk assumed by the State at year-end. The risk categories for deposits are:

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

HIRSP's cash balances are maintained in a public funds checking account with a commercial financial institution and with the State of Wisconsin Investment Board. The carrying amount of the demand deposits with the financial institution was $897,099 at June 30, 2004, and $1,256,659 at June 30, 2003. The bank balance was $2,294,505 at June 30, 2004, and $1,252,504 at June 30, 2003. The Federal Deposit Insurance Corporation and the Wisconsin State Deposit Guarantee Fund (s. 34.08, Wis. Stats.) cover state deposits. Of the bank balance at June 30, 2004, and June 30, 2003, $500,000 was insured and classified in risk category 1; $1,794,505 at June 30, 2004, and $752,504 at June 30, 2003, was uninsured and uncollateralized and was classified in risk category 3.

The State of Wisconsin Investment Board, through the State Investment Fund, invests cash deposited with the State of Wisconsin. The carrying amount of shares in the State Investment Fund, which approximates market value, was $48,667,920 as of June 30, 2004, and $38,674,192 as of June 30, 2003.

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 Number 3. The State Investment Fund is not registered with the Securities and Exchange Commission.

3. RECEIVABLES AND PAYABLES

Unless otherwise noted, receivable balances are expected to be collected within the following year. While the plan expects to receive all drug rebates receivable, it typically takes more than one year for final settlement to occur.

The Due from the State of Wisconsin balance represents receipts that were not processed through the HIRSP lock box, but were deposited into the State's General Fund and need to be transferred to the HIRSP fund at June 30, 2004.

In order to improve program accounting, DHFS developed a schedule beginning with FY 2003-04 to estimate uncollectible claims receivables based on past recoupment history. Under the schedule, claims receivables older than three years have been reserved and expensed as uncollectible throughout the fiscal year. There is no unanticipated budgetary effect of this new schedule.

As of June 30, 2004, the balance of unreserved claims receivables is $35,951, of which $35,183 is less than one year old.

A large payable to providers existed at June 30, 2003, because of the timing of the check-writing process for the last week of June claim payments. In FY 2003-04, the last week of June claim payments were processed and paid before fiscal year-end. The remaining outstanding claims are included in the Unpaid Loss Liabilities Account (see Note 4).

4. LIABILITY FOR UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES

The following represents changes in the combined medical and pharmacy unpaid loss liabilities and unpaid loss adjustment expense liability account balances for FYs 2003-04 and 2002-03 (in thousands):

	FY 2003-04	FY 2002-03
Balance—Beginning of the Year	$15,547	$15,296
Incurred Claims:		
Provision for insured events of the current fiscal year	108,873	90,904
Changes in provision for insured events of prior fiscal years	(2,746)	(3,815)
Total Incurred	106,127	87,089

	FY 2003-04	FY 2002-03
Payments:		
Claims attributable to insured events of the fiscal year	$ 92,174	$ 76,344
Claims attributable to insured events of prior fiscal years	11,901	10,494
Total Paid	104,075	86,838
Balance—End of the Year	$ 17,599	$15,547

5. LIABILITY FOR PREMIUM OVERPAYMENTS

During the calculation of premium rates for FY 2001-02, an error caused subsidized policyholders to overpay $700,000 in premiums. (See Note 9 for a description of subsidies.) According to s. 149.165, Wis. Stats., premium rates for subsidized policyholders should be set at a specific percentage of the standard rate according to household income. Instead, the subsidized premium rates for FY 2001-02 were incorrectly increased at the same rate as the unsubsidized premium rates. The HIRSP Board of Governors voted on September 10, 2003, to issue a premium refund to policyholders who received a subsidy in FY 2001-02 and are currently active. This action resulted in an accrued liability of $471,488 on June 30, 2003. These refunds were paid in December 2003.

6. NET ASSETS RESTRICTED FOR EXCESS POLICYHOLDER PREMIUMS

Section 149.143(2m)(a), Wis. Stats., requires DHFS to keep a separate accounting of the difference between premiums received during a plan year and the amount of premiums necessary to cover policyholders' 60 percent share of plan costs for that plan year. The use of these funds is restricted under s. 149.143(2m)(b), Wis. Stats., as follows: 1) to reduce policyholder premiums to a floor of 140 percent of standard risk rates when the policyholders' share of costs would otherwise require a premium increase; 2) for other needs of eligible persons, with the approval of the HIRSP Board of Governors; or 3) for distribution to eligible persons.

Under current statutes, the method by which HIRSP's funding formula applies deductible and drug coinsurance subsidies for low-income policyholders results in policyholders being credited for subsidies that are not currently funded by policyholders nor insurers or providers.

In April 2004, the Board of Governors voted to use $2,151,879 of the excess policyholder premium account to reduce the unfunded deductible and drug coinsurance subsidies balance as of March 31, 2004. An additional unfunded deductible and coinsurance subsidies balance of $223,692 had accumulated through June 30, 2004. The 2005-07 biennial budget bill, 2005 Assembly Bill 100, proposes statutory changes to address this technical funding issue.

7. INSURERS' ASSESSMENTS

Statutes prescribe that participating insurers contribute 20 percent of general HIRSP costs and 50 percent of the subsidy costs not funded by GPR. 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.

8. DRUG COINSURANCE ANNUAL OUT-OF-POCKET MAXIMUMS

The drug coinsurance benefit has an annual out-of-pocket maximum, which varies by plan and option. Once the drug coinsurance out-of-pocket maximum is reached, HIRSP pays 100 percent of the allowed amount for the remainder of the calendar year. Plan 1A policyholders who qualify for deductible reductions also qualify for reductions in drug coinsurance out-of-pocket maximums. The reduced drug coinsurance out-of-pocket maximum will be based on the reduced medical deductible for which the policyholder qualifies. The table that follows provides details. Note 9 further discusses the drug coinsurance subsidies provided in FY 2003-04 and FY 2002-03.

Plan	Medical Deductible	Drug Coinsurance Out-of-Pocket Maximum
1A	$1,000	$ 750
	800	600
	700	525
	600	450
	500	375
1B	2,500	1,000
2	500	125

The amounts paid toward prescription drugs under this benefit do not apply to the medical deductible, medical coinsurance, or medical out-of-pocket maximums.

9. PREMIUM, DEDUCTIBLE, AND DRUG COINSURANCE SUBSIDIES

HIRSP provides a premium, deductible, and drug coinsurance subsidy program to reduce premiums, deductible levels, and out-of-pocket costs for prescription drugs for low-income policyholders. This program varies by plan and option. HIRSP policyholders enrolled in plan 1A or plan 2 who

have annual household incomes below $25,000 are eligible for a premium subsidy. No premium subsidy is available for policyholders enrolled in plan 1B. Policyholders enrolled in plan 1A with incomes below $20,000 are also eligible for a deductible subsidy. No deductible subsidy is available for policyholders enrolled in plan 1B or plan 2. Note 8 further discusses the drug coinsurance subsidies that are also provided to plan 1A policyholders.

HIRSP premiums for plan 1A and 1B are based on standard risk rates; that is, the rates private insurers would charge for individual insurance policies providing substantially the same coverage and deductibles as provided under HIRSP. Policyholders not eligible for a premium subsidy have generally been paying 140 to 150 percent of the rate a standard risk individual 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. In FY 2003-04, premium rates for the primary plan were set at 140 percent of the rate a standard risk individual would pay.

Policyholders enrolled in plan 1A or plan 2 who are eligible for the subsidy program pay premiums indexed to the standard risk rates, as shown in the following table.

Annual Household Income		Amount of Premium as Percentage of	Reduction in Deductible for
at Least	but Less Than	Standard Risk Rates	Plan 1A Participants
$ 0	$10,000	100.0%	$500
10,000	14,000	106.5	400
14,000	17,000	115.5	300
17,000	20,000	124.5	200
20,000	25,000	130.0	N/A

Twenty-two percent of HIRSP policyholders received premium, deductible, and drug coinsurance subsidies totaling $4,743,866 in FY 2003-04 and $4,634,397 in FY 2002-03. The following table summarizes the amounts provided for each subsidy type during these years.

Subsidy Type	FY 2003-04	FY 2002-03
Premium	$3,980,244	$3,974,005
Deductible	602,320	534,858
Drug Coinsurance	161,302	125,534
Total	$4,743,866	$4,634,397

GPR appropriated and spent for premium and deductible subsidies was $0 in FY 2003-04 and $741,800 in FY 2002-03. Costs in excess of GPR appropriated for this purpose were shared equally by health insurers and health care providers, with each contributing $2,371,933 in FY 2003-04 and $1,946,299 in FY 2002-03. Pharmacies are statutorily exempt from contributing toward these costs.

10. GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses include the following:

	FY 2003-04	FY 2002-03
Plan Administrator Fees	$3,915,253	$3,588,355
State Administrative Costs	471,448	388,715
HIPAA Implementation	451,582	290,075
Postage	193,034	175,984
Other Expenses	28,825	17,826
Total	$5,060,142	$4,460,955

11. HEALTH CARE PROVIDERS' CONTRIBUTIONS

Statutes prescribe that health care providers, except pharmacies, contribute 20 percent of general HIRSP costs and 50 percent of the subsidy costs not funded by GPR. Provider contributions are obtained by reducing the amount health care providers are reimbursed for billed services. The health care provider contributions are not reported as revenue in the financial statements, but rather are reflected as a reduction to gross losses. Separate disclosure of the health care provider contribution amount is important for full disclosure of HIRSP's funding sources and to demonstrate compliance with the statutory funding formula.

The basis for calculating HIRSP's program costs is the usual and customary charges, which are reported as medical losses in the financial statements. The usual and customary charges are determined by applying percentage discounts to billed charges. The discounts used were based on reimbursement levels under the HIRSP program prior to 1998. The provider contribution represents the difference between usual and customary charges and allowed charges, which are amounts based on Medicaid reimbursement rates plus an add-on percentage.

In 2004, usual and customary charges and the provider contribution balance began to grow considerably. As an interim step to respond to increasing program costs and provider contribution balance, the Board of Governors decided in January 2005 to increase the discounts applied to billed charges for the period January 1, 2004 through June 30, 2005 to be more reflective of industry averages. On an aggregate basis, the discounts were increased from approximately 20 percent to approximately 30 percent. The revised discounts are reflected in the medical losses reported for the last six months of FY 2003-04. The revised discounts decreased program costs that are shared by the different funding groups but did not affect the net losses paid.

To provide a prospective solution to growing program costs, the Board reconvened its actuarial advisory subcommittee to provide advice on

establishing a market-based benchmark for determining usual and customary charges in the future. The Board concluded that the increasing provider contribution balance was the result of several factors, including increasing charges billed by providers and provider rates not keeping pace with inflation. The Board plans to increase payment rates for FY 2005-06.

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 amounts estimated.

12. SUBSEQUENT EVENTS

During FY 2003-04, DHFS applied for and received a federal grant specifically for high-risk health insurance groups. The grant was awarded October 7, 2004, for $2,222,903. These funds were received in FY 2004-05 and will be reflected in the FY 2004-05 financial statements.

DHFS, in consultation with the HIRSP Board, selected a new HIRSP plan administrator through a competitive procurement process. The new plan administrator, Wisconsin Physicians Service (WPS), has subcontracted with Navitus Health Solutions for pharmacy benefit management services and with Milliman USA for consulting actuarial services. The new contract was effective on April 1, 2005.

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Report on Internal Control and Compliance ■

Independent Auditor's Report on Internal Control over Financial Reporting and on Compliance and Other Matters 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 (HIRSP) as of and for the years ended June 30, 2004, and June 30, 2003, and have issued our report thereon dated May 2, 2005. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control over Financial Reporting

In planning and performing our audit, we considered the Department of Health and Family Services' (DHFS's) internal control over HIRSP'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 an opinion on the internal control over financial reporting. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be material weaknesses. A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements in amounts that would be material in relation to the financial statements being audited may occur and not be detected within a timely period by employees in the normal course of

performing their assigned functions. We noted no matters involving the internal control over financial reporting and its operation that we consider to be material weaknesses.

COMPLIANCE AND OTHER MATTERS

As part of obtaining reasonable assurance about whether HIRSP'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 no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

However, we noted certain matters involving internal control other than a reportable condition and an immaterial instance of noncompliance, which we discuss in the report section titled "Claims Management Issues." First, we found that $210,689 in pharmacy claims were inappropriately paid to cancelled policyholders because the former plan administrator had not reviewed a report developed to identify and communicate policy cancellations to the pharmacy benefit management company. Second, we found that the plan administrator had inadequate steps in place to ensure that deductibles were carried forward between years as required by statute. As a result, since 1998, 1,582 policyholders have overpaid their deductibles by a total of $327,699.

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

LEGISLATIVE AUDIT BUREAU

May 2, 2005

Diann Allsen
Audit Director

Appendix

Payment of HIRSP Operating and Administrative Costs

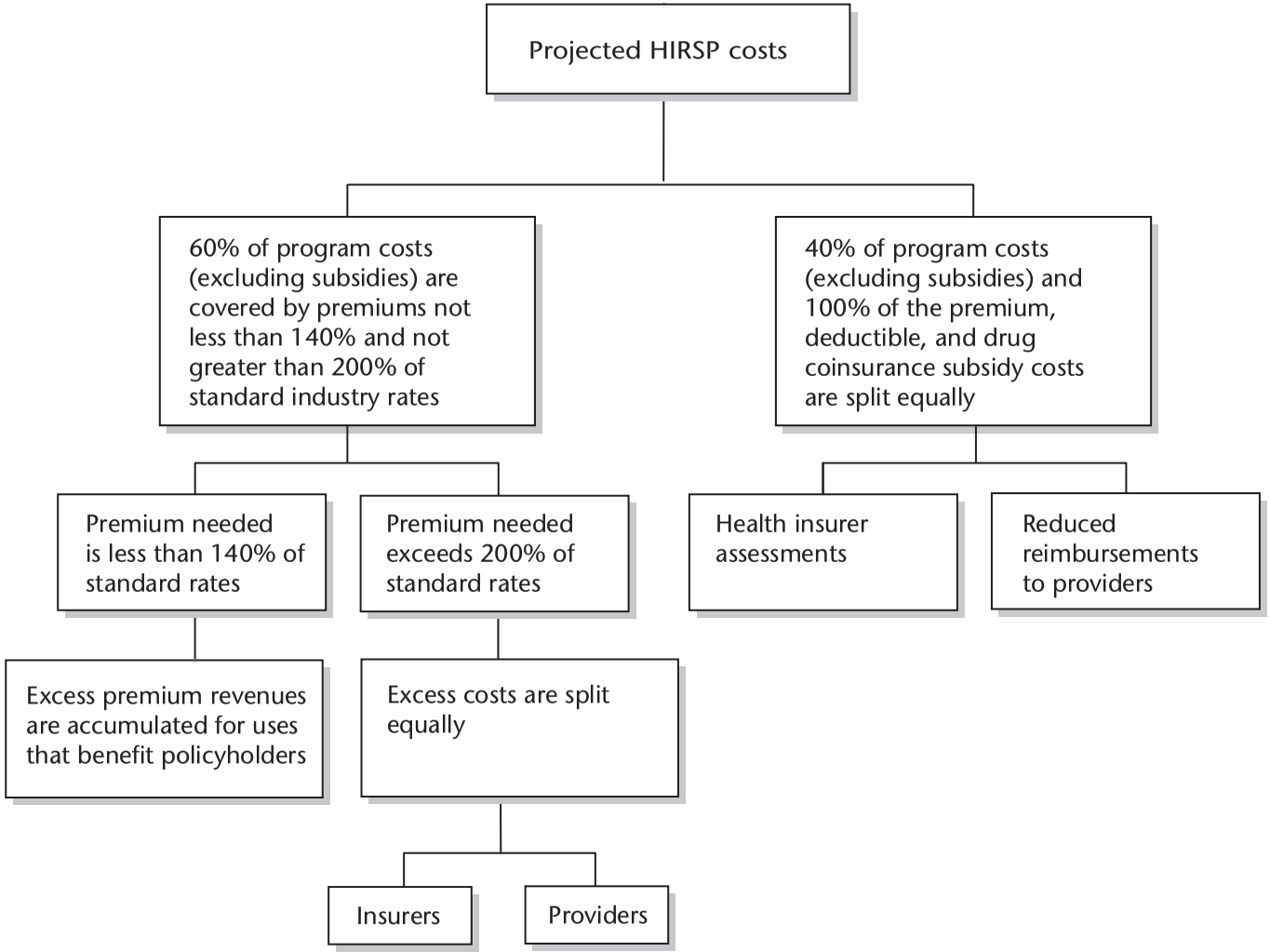
Statutes prescribe a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers to share in estimated operating and administrative costs. Policyholder premiums are expected to fund 60 percent of the estimated operating and administrative costs. Private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders are required to share equally in the remaining 40 percent of operating and administrative costs.

Premium rates are statutorily required to be at least 140 percent, but not in excess of 200 percent, of standard risk rates (that is, the rates that private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP).

If premiums of less than 140 percent of the standard rates were required to fund 60 percent of HIRSP's estimated costs, the premium rates would nonetheless be set at 140 percent of the standard rates in accordance with statutes, and excess funds would be set aside to reduce rates in years that would otherwise require higher premiums, or for other purposes that benefit policyholders. If premiums exceeding 200 percent of standard risk rates were required, any excess policyholder funds set aside in past years would be utilized, with insurers and health care providers sharing equally in the remaining costs in excess of 200 percent of standard risk rates.

Insurers and health care providers, except pharmacies, also share equally in the costs for premium, deductible, and drug coinsurance subsidies.

Payment of Operating and Administrative Costs
(As of June 30, 2004)



State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

May 4, 2005

Janice Mueller, State Auditor
Legislative Audit Bureau
22 W. Mifflin Street, Suite 500
Madison, WI 53704

Dear Ms. Mueller:

This letter is in response to the Legislative Audit Bureau's (LAB) audit report of the Health Insurance Risk Sharing Plan's (HIRSP) SFY 2003-04 Financial Statements.

On behalf of the Department of Health and Family Services (DHFS) and the HIRSP Board of Governors, I would like to thank you and the LAB audit staff for working with DHFS and the HIRSP plan administrator to conduct the audit.

We agree with the audit report. The audit report acknowledges that HIRSP's financial position continued to improve in SFY 2003-04. As noted in the report, there has been steady improvement in the plan's financial position over the past several years.

- As of June 30, 2004, HIRSP no longer has an accounting deficit. Since June 30, 2000, DHFS and the HIRSP Board have eliminated a $9.1 million accounting deficit.

- Total net assets increased by approximately $7.4 million in SFY 2003-04. As of June 30, 2004, HIRSP had a positive unrestricted net asset balance of $6.8 million.

- Average claims costs per policyholder increased by only 9.3% in SFY 2003-04. This increase is approximately 1.4% lower than medical cost increases for state employees and 7.1% lower than increases experienced by large employer plans.

- Total administrative costs, as a percent of total program costs, accounted for 4.6% of program costs in SFY 2003-04, down from the past two years (4.9% in SFY 2002-03 and 5.3% in SFY 2001-02).

The audit report identifies two situations in which HIRSP claims were not properly processed. The first relates to $210,689 in prescription drug claims payments made in error on behalf of 203 individuals who were no longer enrolled in HIRSP. This error was due to the former plan administrator's failure to review a monthly report that showed individuals who were no longer enrolled. As noted in the audit report, DHFS, with Board approval, has withheld administrative payments to the former plan administrator for the total amount of the erroneous payments.

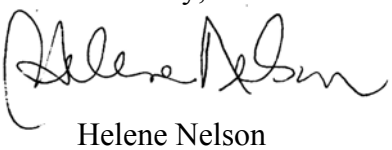
The second issue relates to inadequate plan administrator procedures to assure compliance with a statutory provision that requires that amounts applied to deductibles in the fourth quarter of the calendar year are also applied to the deductible of the following calendar year. We concur with LAB's recommendation that reasonable steps should be taken to issue refunds to the individuals affected by this error. We will be reviewing this matter and LAB's recommendation with the Board to determine a specific course of action.

We also agree with LAB's recommendation that the new plan administrator establish procedures to properly apply fourth-quarter deductibles to the following year's deductibles. We have been assured by the new plan administrator that those procedures are already in place. However, we will require that these procedures be clearly and thoroughly documented in its operations manual for HIRSP.

On behalf of DHFS and the HIRSP Board, we take very seriously our fiscal responsibility and we are very proud of the continued improvement in HIRSP's financial position.

We appreciate the time and effort extended by LAB staff to perform this audit.

Sincerely,



Helene Nelson
Secretary