AN AUDIT

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

99-6

April 1999

1999-2000 Joint Legislative Audit Committee Members

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State Auditor - Janice Mueller

Editor of Publications - Jeanne Thieme

Audit Prepared by

Diann Allsen, Director and Contact Person
Elizabeth Frueh
Mary Frickelton
Jodi Miller

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APPENDIX - RESPONSE FROM THE DEPARTMENT OF HEALTH AND FAMILY SERVICES

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State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
STATE AUDITOR

SUITE 402
131 WEST WILSON STREET
MADISON, WISCONSIN 53703
(608) 266-2818
FAX (608) 267-0410

April 26, 1999

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 performed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 1997-98. HIRSP provides medical insurance for individuals unable to obtain private coverage. During our audit period, 1997 Wisconsin Act 27 transferred oversight responsibility for HIRSP from the Office of the Commissioner of Insurance to DHFS, modified the plan in response to new federal requirements, and required responsibility for its daily operations to be transferred to the State's fiscal agent for Medicaid. Act 27 also made significant changes to plan funding, including providing $17.9 million in general purpose revenue for the 1997-99 biennium and increasing health care providers' responsibility for HIRSP funding.

DHFS had less than three months to prepare for its new program oversight responsibility, and implementation of funding and other program changes has been more complex than expected. As a result, ensuring that HIRSP is funded in accordance with statutory provisions has been difficult; efforts to implement Medicaid cost-containment and reimbursement practices are resulting in operational and administrative problems; and higher-than-anticipated plan administration costs are being incurred. We qualify our opinion for the FY 1997-98 financial statements because DHFS cannot accurately determine and disclose health care providers' actual contributions to HIRSP.

DHFS is taking steps to address these concerns, including proposing significant changes to HIRSP as part of the 1999-2001 biennial budget. These changes would clarify plan operations and facilitate Medicaid cost-containment efforts. As it considers this proposal or any other proposed changes to HIRSP, the Legislature may also wish to require that DHFS take steps to improve financial management of HIRSP by funding it on the same basis used for financial reporting, monitoring claim liabilities, and improving cash management.

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

Respectfully submitted,

Janice Mueller
State Auditor

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SUMMARY

At the request of the Department of Health and Family Services (DHFS), we performed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 1997-98. HIRSP was established in 1980 to provide major medical insurance and Medicare supplemental insurance for individuals who cannot obtain private coverage because of the severity of their health conditions. At the end of 1998, 7,068 policyholders were enrolled in the plan.

During the period of this audit, 1997 Wisconsin Act 27 transferred oversight responsibility for HIRSP from the Office of the Commissioner of Insurance (OCI) to 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. 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. To address a declining participant population's concerns about program affordability, as well as insurers' concerns about increasing annual assessments to fund program costs, Act 27 authorized additional funding sources beginning on January 1, 1998, when HIRSP was transferred from OCI to DHFS. Effective that date, the Legislature provided $6.0 million in general purpose revenue (GPR) to offset costs in FY 1997-98, and $11.9 million to offset costs in FY 1998-99, and increased health care providers' responsibility for funding HIRSP by requiring them to share equally with insurers in program costs that were not covered by premiums and GPR.

DHFS had limited time after the October 1997 passage of Act 27 to prepare for either the program oversight responsibilities it assumed on January 1, 1998, or the transfer of daily program operations to a new plan administrator on July 1, 1998. Furthermore, implementation of the new HIRSP funding system and other program changes were more complex than expected. As a result:

- for the period January 1, 1998 through June 30, 1998, DHFS cannot determine whether HIRSP was funded in accordance with statutory provisions that require participants, insurers, and providers to share program costs;

- differences between HIRSP's funding approach and the presentation of information for financial reporting results in confusion for parties interested in the plan's operation;

- efforts to implement Medicaid cost-containment and reimbursement practices have resulted in payment problems for health care providers and service concerns for participants; and

- higher-than-anticipated plan administration costs have been incurred.

Act 27 includes a series of statutory provisions that directed DHFS to estimate, monitor, and revise premium rates, insurer assessments, and provider contributions to ensure that all parties participate in their appropriate share of HIRSP's costs for each plan year. While the new statutory formula was considered when initial program funding rates were established, neither DHFS nor the past or current plan administrator had systems in place to ensure compliance with the new provisions when they took effect. As a result, health care providers' contributions—which were required to increase significantly under the new formula—were not recorded, monitored, or reconciled with statutory provisions that providers and insurers share equally in program costs for the period January 1, 1998 through June 30, 1998. For this reason, we qualify our auditor's report on the FY 1997-98 financial statements and note concerns in our report on compliance and internal control.

The plan administrator's ability to determine the extent to which providers were contributing to HIRSP become more complicated on July 1, 1998, when the new plan administrator began to process claims using a Medicaid-based system. Under Medicaid, fee-for-service providers are paid for their services according to set rates. Services are identified by codes, and reimbursement rates correspond to these service codes. For HIRSP, Medicaid rates are adjusted so that providers and insurers share equally in program costs that are not covered by GPR and premiums. For FY 1998-99, DHFS estimated the providers' share of HIRSP's costs would be covered if provider reimbursement rates were 41 percent greater than standard Medicaid rates. However, DHFS did not recognize the need to record the provider reimbursement information for FY 1998-99 until September 1998. Subsequently, DHFS has been working with the new plan administrator to develop a process for recording the information and monitoring funding levels.

DHFS is determining and monitoring HIRSP's funding on a cash basis, while financial reporting is done on an accrual basis, which takes into account actuarial cost estimates for claims that have occurred but may not be filed until after the plan year. As a result of this difference, HIRSP's financial statements show a cash balance of $4.1 million but negative retained earnings of $9.8 million as of June 30, 1998. While HIRSP

currently has sufficient cash on hand and the ability to assess future parties to pay these estimated claims as they become due, the ability to pay these claims if HIRSP were to cease operations is less certain.

The transition of oversight responsibility from OCI to DHFS and the implementation of funding changes in the middle of a fiscal year also contributed to confusion in understanding HIRSP's financial activity and each agency's responsibility for that activity during FY 1997-98. For example, OCI did not report negative retained earnings in prior years because any deficit could be recouped from insurers: $6.6 million represented the amount insurers would be assessed to cover a deficit at June 30, 1997. However, the addition of other funding sources to share HIRSP's costs and the inability to adjust rates retroactively for deficits make it difficult to similarly account for HIRSP under the current statutory provisions.

Changing HIRSP's cash-based funding approach to an approach that includes estimates of future claims costs would eliminate confusion about differences that now exist between the funding approach and financial reporting. In addition, such a change would make HIRSP's financial position more secure and would increase the possibility that future claims could be paid even if the plan ceased operations. Furthermore, such a change would more equitably match the burden of paying for claims and the policyholders who incurred them, and it would limit the possibility of manipulating the funding process in ways that may be possible under a cash-based system. Statutes do not specify the basis under which plan costs should be funded.

Although Act 27 required that the plan administrator be the State's fiscal agent for the Medicaid program, it did not require HIRSP claims to be paid at or on the basis of Medicaid rates. Instead, the newly mandated program-funding requirements—which reflect a legislative compromise to balance the concerns of various parties with funding responsibility—more closely resemble the system in effect before January 1, 1998, in which submitted claims were discounted. As a result of seemingly conflicting direction provided by statutes, DHFS and the plan administrator have had difficulty in reconciling provider funding requirements with provider reimbursement rates under a Medicaid-based system, as well as in explaining inconsistencies between statutes and the Medicaid-based system currently being used to process HIRSP claims. Providers and others have expressed concern about how provider payment rates are determined.

In addition, the transition to a Medicaid-based system has affected service delivery under HIRSP. It has been DHFS's intention that coverage under HIRSP would remain the same, but that HIRSP would adopt Medicaid cost-containment, billing, and reimbursement practices. However, policyholders and providers have experienced problems during

the transition period for several reasons, including limited availability of documentation concerning the practices and the coverage provided under the prior administrator, and an underestimation of the effort required for the transition. Problems include confusion about the new cost-containment provisions, denial and delays in claims, and difficulty in receiving responses to their inquiries. At one point, the new plan administrator indicated that 95 percent of claims were not submitted electronically and required manual processing, and that, on average, 2,300 calls per month were not answered before the callers hung up. DHFS is taking steps to address these concerns and believes service has improved.

Because DHFS has given priority to addressing service needs first, it has been delayed in providing program oversight in several administrative and management areas, including financial and management reporting, monitoring of claim liabilities, cash management, and resolving audit findings related to subsidies for policyholders with annual household incomes below $20,000. While we agree that DHFS needs to place priority on ensuring that program services are being properly provided, administrative and management issues also need to be addressed to ensure the program is being operated as intended.

Some problems can be expected whenever major program changes are implemented. However, implementation of the new statutory funding requirements and other program changes are resulting in both DHFS and the new plan administrator committing more resources to HIRSP than originally expected. DHFS is currently committing more staff resources to HIRSP than the 1.5 full-time equivalent staff authorized by Act 27. A current estimate of the plan administrator's monthly costs of $261,446 for ongoing plan administration services is 50 percent higher than agreed to one year earlier, and 80 percent higher than monthly administrative costs paid to the former plan administrator.

A need for additional resources—at least initially—might have been suggested by the more complex program funding structure introduced in 1997 Wisconsin Act 27, DHFS's limited experience in administering an insurance program, and the challenge of merging HIRSP with Medicaid cost-containment provisions. Further, the Governor recognized in his veto message the difficulty of achieving an implementation date of January 1, 1998, because of the complexity added to HIRSP by the Legislature. However, part of the administrative cost difference may also be associated with the fact that the contract with the former plan administrator had been competitively negotiated, while a competitive process was not possible for the current contract because of the statutory requirement that the State's fiscal agent for Medicaid become the HIRSP plan administrator. Without the cost-control benefits of a competitive process, it is especially important for DHFS to have a disciplined approach to maintaining accountability, justifying changes, and controlling costs. This could involve developing specific funding

requirements, standards and measures of quality, and penalties for nonperformance of the plan administrator's responsibilities.

The Governor's 1999-2001 biennial budget proposal includes further changes to HIRSP service provisions and an annual reduction of $2.0 million in GPR funding. DHFS is developing a proposal that would make significant changes to HIRSP that it believes will clarify program administration and take full advantage of Medicaid cost-containment provisions. For example, DHFS proposes creating HIRSP-specific rates for hospital reimbursement. In considering this proposal and any other proposed changes to HIRSP, the Legislature may also wish to consider requiring DHFS to take other steps to ensure sound financial management, such as funding HIRSP on the same basis that is used for financial reporting, establishing a mechanism to monitor and report claim liabilities, and instituting sound cash management practices that would ensure cash balances are invested and adequately protected.

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INTRODUCTION

At the request of the Department of Health and Family Services (DHFS), we performed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 1997-98. HIRSP was established in 1980 to provide major medical insurance and Medicare supplemental insurance for individuals who cannot obtain private coverage because of the severity of their health conditions. During the period of this audit, 1997 Wisconsin Act 27 transferred oversight responsibility for HIRSP from the Office of the Commissioner of Insurance (OCI) to DHFS, modified HIRSP in response to the federal Health Insurance Portability and Accountability Act of 1996, changed the extent to which health care providers are required to fund HIRSP costs, and required responsibility for daily program operations to be transferred to a new plan administer that is also the State's fiscal agent for Medicaid.

Our audit opinion on the program's financial statements is qualified.

Although the changes required DHFS to account for provider funding and to reconcile actual funding with statutory funding requirements, DHFS did not have systems in place to accumulate information that allowed it to readily and accurately do so during our financial audit period. Therefore, after reviewing HIRSP's control procedures, assessing the fair presentation of its financial statements, and reviewing compliance with statutory provisions, we issued a qualified opinion on the financial statements for FY 1997-98.

We also reviewed issues that have developed since responsibility for HIRSP was transferred from OCI to DHFS. These issues are related to:

- plan design, including efforts to adopt Medicaid-based cost controls, as well as their effects on HIRSP policyholders and service providers;

- efforts by DHFS to implement a Medicaid-based system and to control the plan administrator's costs; and

- proposals by the Governor and by DHFS to reduce program costs and simplify administration of HIRSP in the future.

Plan Modifications Under 1997 Wisconsin Act 27

Enrollment in HIRSP, which peaked at 12,707 in 1992, had declined by almost half at the end of 1998. Premium rates increased significantly over the same period. In an effort to address decreasing HIRSP enrollments and increasing claim costs, policyholder premiums, and assessments to the health insurers doing business in Wisconsin, the Legislature began to seek an alternative to HIRSP earlier in this decade. 1995 Wisconsin Act 463 provided HIRSP with $1.5 million in general purpose revenue (GPR) to mitigate a premium rate increase and reduce premiums for certain individuals, and it directed DHFS and OCI to report to the Legislature by February 1, 1997, on a more efficient program for providing health care to high-cost individuals.

Meanwhile, in August 1996, the federal government enacted the Health Insurance Portability and Accountability Act to improve the availability of health insurance to working parents and their children. This federal law requires states to choose among several reform options in the individual health insurance market or be subject to federal regulations. Both DHFS and OCI recommended that HIRSP be modified to comply with provisions of the new federal law, and that it adopt cost-containment measures used in the Medicaid program.

Oversight and funding responsibilities for HIRSP changed under 1997 Wisconsin Act 27.

1997 Wisconsin Act 27 not only transferred oversight responsibility for HIRSP from OCI to DHFS, it also:

- required that the State's fiscal agent for administration of the Medicaid program be designated the plan administrator;
- modified plan provisions to enable HIRSP to fulfill federal requirements; and
- modified plan financing, including $17.9 million in GPR to help support program costs in the FY 1997-99 biennium, as well as a statutory formula for cost sharing among participants, insurers, and service providers.

These and other changes required under Act 27 are summarized in Table 1.

Table 1

Changes Required by Act 27

	Prior to Act 27	Subsequent to Act 27
Responsible agency	OCI	DHFS as of January 1, 1998
Board responsibilities	HIRSP is subject to the supervision and approval of the Board	Reduced to advisory role
Entity responsible for management of the plan	Board of Governors	DHFS
Plan administrator	Competitive negotiation process	Medicaid fiscal agent as of July 1, 1998
Approved providers	Licensed by the State	Licensed by the State and certified as Medicaid providers
Provider contribution	Payment reduced to 10% less than usual and customary, and any additional discounts negotiated by contract	Payment reduced to 10% less than usual and customary, plus an additional discount sufficient to match funding provided by insurers
GPR	Premium and discount subsidy for lower-income participants	Premium and discount subsidy and $6 million program subsidy for January to June 1998, and $11.9 million for FY 1998-99
Payment of plan costs	Participants paid 60% of costs and insurers paid 40% of costs	After GPR, participants pay 60% of costs; the remaining 40% is split equally between insurers and providers
Treatment and funding of deficit	Deficit covered by insurer assessments	Deficit covered by adjusting premiums, assessments, and provider discounts for next plan year

Modifications to Plan Administration

Act 27 requires the State's fiscal agent for Medicaid to administer HIRSP's daily operations.

The transfer of HIRSP from OCI to DHFS was intended to bring administration of all state-sponsored medical programs under one agency. The statutory requirement that the State's fiscal agent for Medicaid be designated the HIRSP plan administrator was intended to allow HIRSP to take advantage of cost-containment provisions associated with Medicaid. In recognition of the complexity of the program and late passage of Act 27, the Governor vetoed the required transfer to the Medicaid fiscal agent on January 1, 1998. As a result, Blue Cross & Blue Shield United of Wisconsin, which was under contract with OCI for plan administration services, continued serving as plan administrator until July 1, 1998, when Electronic Data System (EDS), the State's Medicaid fiscal agent, became the plan administrator for HIRSP.

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.

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 insurers' assessments and penalty payment amounts; and
- adjust the provider payment rates as necessary.

Some of these responsibilities had previously been assigned to the HIRSP Board of Governors, which became primarily advisory under Act 27. DHFS has been authorized 1.5 segregated positions and $94,600 annually to oversee all HIRSP operations and policy, as well as to provide administrative support to the 12-member advisory Board that consists of:

- the Secretary of DHFS (or a designee), who serves as chair;

- the Commissioner of Insurance (or a designee); and

- ten members appointed by the Secretary for staggered three-year terms, including two participating insurers representing nonprofit organizations, two other participating insurers, three health care providers, and three public members.

Although the Board's role is now largely advisory, it retains responsibility for establishing grievance procedures, developing and implementing a program to publicize HIRSP, and advising DHFS on the choice of coverage provided by each of three plans currently offered, as well as the annual program budget.

Modifications to Plan Provisions

Since January 1, 1998, three plans have been available to policyholders.

As a result of statutory changes that took effect on January 1, 1998, 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 programs because of a disability.

- A third plan became available in January 1998 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 premiums, but requires policyholders to pay a higher deductible before HIRSP begins paying claims.

Participants must receive services through Medicaid-certified providers.

As of December 31, 1998, 7,068 policyholders were enrolled in one of these three plans. All HIRSP participants are required by statute to receive medical services under the plans through Medicaid-certified providers. In addition, each plan requires its participants 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 third plan, which enrollees must personally pay before insurance benefits will be available; and

- coinsurance, which for the primary and third plans is up to $1,000 each year that the enrollee must personally pay after satisfying the annual deductible requirements. There is no coinsurance for the Medicare supplement plan.

To fulfill federal Health Insurance Portability and Accountability Act requirements, the exclusion for preexisting conditions was eliminated from HIRSP for individuals who met certain conditions, and premiums were capped at 200 percent of the rate that would be charged under an individual policy providing substantially the same coverage and deductibles as provided under HIRSP. Eligibility laws were also modified to ensure that individuals eligible for coverage under the federal law were eligible for coverage under HIRSP, and the lifetime maximum benefit per covered individual was increased to $1 million.

Modifications to Plan Funding

Before January 1, 1998, policyholders and insurance companies funded most program costs.

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. In addition, health care providers helped to fund HIRSP through reduced reimbursements for services provided—which amounted to 10 percent less than usual and customary fees—and insurers and the State funded premium and deductible subsidy programs intended to reduce the financial burden on participants with household incomes below $20,000 annually.

Act 27 authorizes additional funding from GPR and provider contributions.

To address a declining participant population's concerns about program affordability, as well as insurers' concerns about increasing annual assessments to fund program costs, 1997 Wisconsin Act 27 authorized additional funding sources beginning on January 1, 1998, when responsibility for HIRSP was transferred from OCI to DHFS. Effective that date, the Legislature:

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

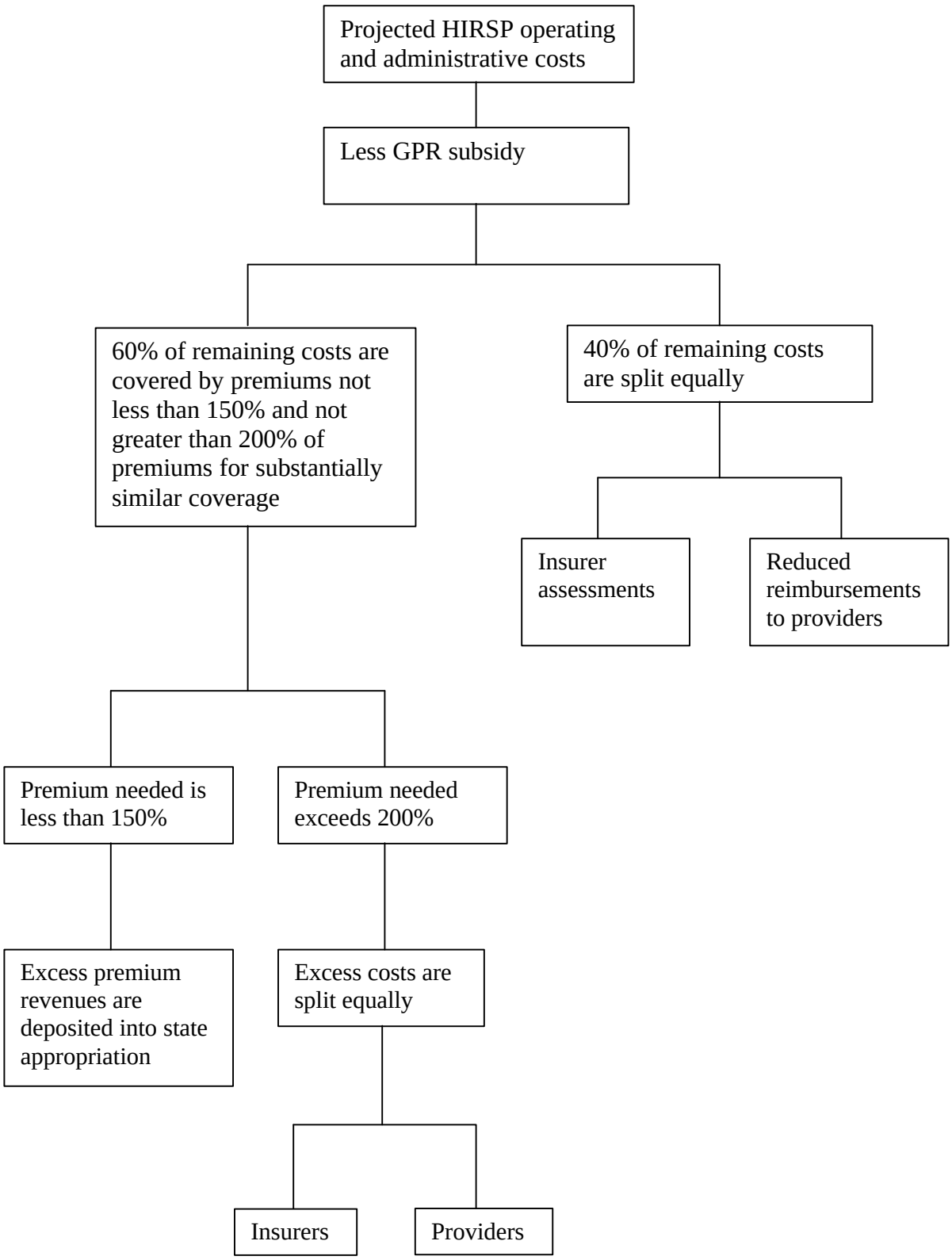
- increased health care providers' responsibility for funding HIRSP by requiring them to share equally with insurers in program costs that were not covered by premiums and GPR.

Providers and insurers must share their portion of HIRSP costs equally.

This change in HIRSP's funding requirements caused provider contributions to increase significantly. As shown in Figure 1, premium rates are expected to cover 60 percent of costs after GPR funds have been deducted, with the remaining 40 percent of operating and administrative costs expected to be shared equally by health insurers and providers. Furthermore, Act 27 does not allow premium rates to exceed 200 percent of the rate that would be charged under an individual policy that provides substantially the same coverage and deductibles as are provided under HIRSP. If a premium of more than 200 percent of the standard rate would be required to fund 60 percent of HIRSP's estimated costs after deduction of the GPR subsidy, then both provider payment rates and insurer assessments must be adjusted so that excess costs would be shared equally by providers and insurers. (If a premium of less than 150 percent of the standard rate would be required to fund 60 percent of HIRSP's estimated costs after deduction of the GPR subsidy, the premium rate would nonetheless be set at 150 percent of the standard rate, and excess funds would be set aside to reduce rates in years that would otherwise require higher premiums.)

Figure 1

Payment of Plan Costs



The premium rates established January 1, 1998 were, on average, set at the lowest rates allowed and represented an average decrease of 17 percent for the primary plan. The 1999 rates established on July 1, 1998 were again, on average, 150 percent of the standard rate, but represented an average increase of 9.6 percent from the 1998 rate for the primary plan. Premium rates for each of the three HIRSP plans differ on the basis of the gender, age, and geographic location of the insured. Examples of 1998 annual premium rates for a policyholder living in Milwaukee, where rates are highest, are shown in Table 2.

Table 2

Examples of Annual Premiums for a Policyholder Living in Milwaukee
Rates effective January 1, 1998

Plan Type	Male Ages 0 - 24	Male Ages 60 - 64	Female Ages 0 - 18	Female Ages 60 - 64
Primary Plan	$1,428	$5,712	$1,428	$4,776
Medicare Supplement	$ 720	$2,868	$ 720	$2,376
Alternate Primary Plan	$1,020	$4,104	$1,020	$3,432

As noted, premium and deductible subsidy programs exist to reduce the financial burden on participants with annual household incomes below $20,000. Until January 1, 1998, these programs were funded by GPR and insurer contributions. 1997 Wisconsin Act 27 required that providers and insurers share equally in subsidy program costs that are not covered by GPR.

Providers and insurers were required to fund $2.6 million in premium and deductible subsidies for FY 1997-98.

Annual premium subsidies range from $408 to $2,160, while deductible subsidies range from $200 to $500. Subsidies in FY 1997-98 totaled approximately $3.5 million, and the GPR appropriation for that period was $858,700. Therefore, insurers and health care providers were required to fund an additional $2.6 million in subsidy costs during our audit period.

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IMPLEMENTATION ISSUES

The new HIRSP program was more complex to administer than expected.

DHFS had limited time to prepare for either the program oversight responsibilities it assumed at the midpoint of our audit period or the transfer of daily program operations to a new plan administrator. DHFS assumed oversight responsibilities on January 1, 1998, less than three months after 1997 Wisconsin Act 27 was enacted. The new plan administrator assumed responsibility for daily operations under a new program funding system six months later, on July 1, 1998. Furthermore, implementation of the new HIRSP funding system, as well as other program changes, was more complex than expected. As a result:

- for the period January 1, 1998 through June 30, 1998, DHFS cannot determine whether HIRSP was funded in accordance with statutory provisions that require participants, insurers, and providers to share program costs;

- differences between HIRSP's funding approach and the accounting basis used for financial reporting results in confusion for parties interested in the operation of HIRSP;

- efforts to apply Medicaid-based cost-containment, billing, and reimbursement practices beginning July 1, 1998, have resulted in payment problems for health care providers and service problems for participants; and

- higher-than-anticipated plan administration costs have been incurred.

Meeting Statutory Funding Requirements

DHFS cannot determine whether statutory funding requirements were met for FY 1997-98.

1997 Wisconsin Act 27 directs DHFS to estimate, monitor, and revise premium rates, insurer assessments, and provider reimbursement rates so that each party funds its appropriate share of HIRSP's costs for each plan year. While the new statutory formula was considered when initial program funding rates were established, neither DHFS nor the past or current plan administrator had systems in place to ensure compliance with the new provisions when they took effect. As a result, health care providers' contributions—which were required to increase significantly under the new formula—were not properly monitored.

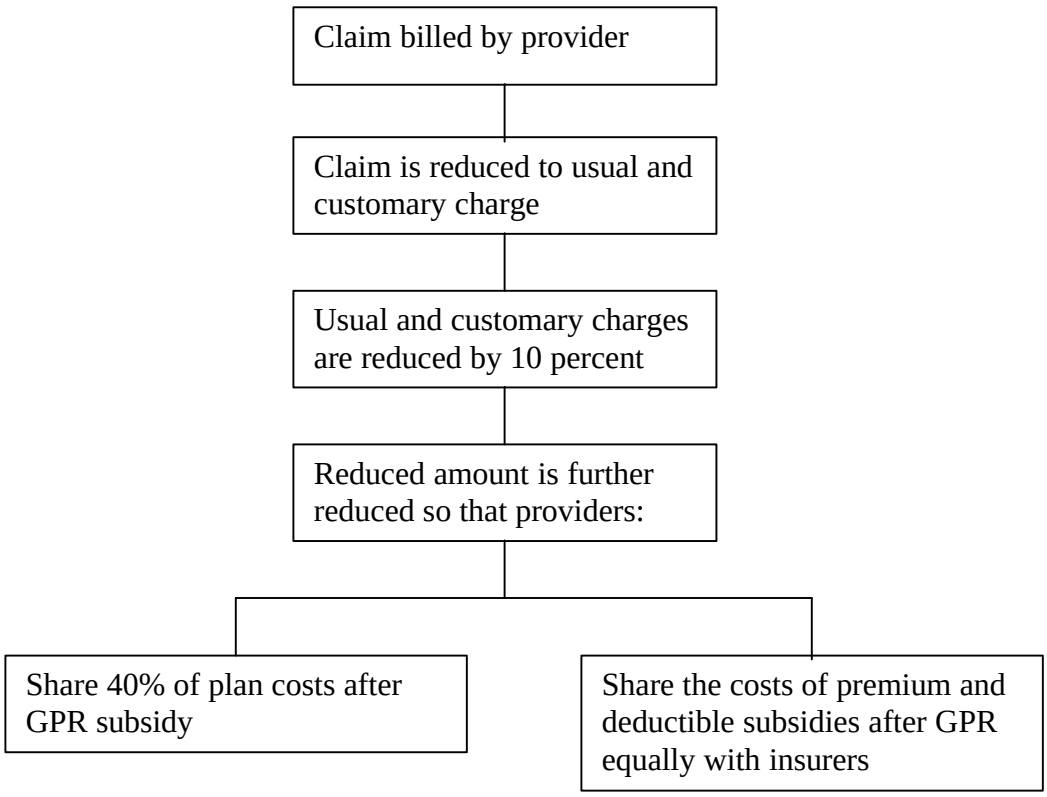
Although Act 27 requires the plan administrator to be the State's fiscal agent for Medicaid, it does not require HIRSP claims to be paid at Medicaid rates. Under Medicaid, fee-for-service providers are paid for their services according to set rates, which are typically lower than actual costs or usual and customary charges. Services are identified by codes, which must appear on claims that are submitted for reimbursement, and reimbursement rates correspond to these service codes.

Act 27 requires providers to fund their portion of HIRSP costs through discounted claims.

In contrast, 1997 Wisconsin Act 27 describes the provider contribution requirement in terms of discounts to submitted claims. As shown in Figure 2, claim amounts are first to be reduced to usual and customary charges. Usual and customary charges are then to be reduced by 10 percent, and this reduced amount is to be reduced further so that providers and insurers each assume 20 percent of program costs after GPR subsidies and share equally in subsidizing program costs for low-income participants.

Figure 2

Health Care Provider Contributions



To implement the new provider contribution requirement when it took effect on January 1, 1998, Blue Cross & Blue Shield United of Wisconsin—which was the plan administrator through the end of the period covered by our financial audit—negotiated additional provider payment discounts. However, neither DHFS nor Blue Cross & Blue Shield recognized the need to record information that could be used to readily determine whether additional provider payment discounts met the statutory requirement for provider funding levels. Blue Cross & Blue Shield recorded claims net of all discounts, including the reduction of allowable charges to usual and customary and the initial 10 percent discount. Therefore, health care provider contributions were not accounted for in a way that would allow them to be readily and accurately reported and reconciled with the statutory provisions for providers and insurers to share equally in program costs. For this reason, we qualified our auditor's opinion on HIRSP's FY 1997-98 financial statements.

Use of adjusted Medicaid rates further complicates accounting for provider contributions.

The plan administrator's ability to determine the extent to which providers were contributing to HIRSP became more complicated on July 1, 1998, when EDS became the plan administrator and began to process claims using a Medicaid-based system. Medicaid rates are to be adjusted so that providers and insurers will share equally in program costs that are not covered by GPR and premiums. For FY 1998-99, DHFS estimated the providers' share of HIRSP's costs would be covered if provider reimbursement rates were 41 percent greater than standard Medicaid rates. However, upon transfer of the program to EDS on July 1, 1998, neither DHFS nor EDS recognized the need to record provider reimbursement information in a way that would allow it to be monitored, reported, and reconciled with the statutory cost-sharing provisions, and no fiscal monitoring process was developed for doing so.

By September 1998, DHFS recognized it needed to take steps to ensure that statutory funding provisions were being met. DHFS therefore sought a method for reconstructing actual provider funding since January 1, 1998 and reconciling it with statutory funding requirements, and for creating a system to account for and monitor future program funding. Assistance has been provided since October 1998 by a committee that is part of the HIRSP Board of Governors and includes two members who represent insurers, three independent actuaries, one representative of health care providers, and representatives from both EDS and DHFS.

DHFS estimates that providers may have contributed less than statutes require.

In November 1998, DHFS proposed that for the period January 1 through June 30, 1998, provider contributions be estimated on the basis of prior experience; that is, claims paid from January through June 1997 would be analyzed and compared to claims paid from January through June 1998, and differences would be presumed to represent additional provider contributions required to meet the new statutory requirements. Members of the committee expressed varying levels of confidence in the reasonableness of such estimates, which do not consider inflationary

effects, the mix of types of services provided, the effects of unusually large claims, or other factors that may contribute to differences between periods. However, there appeared to be a general acceptance of the proposed methodology because the anticipated value of a more detailed and accurate analysis did not warrant the cost and time to complete it. Based on imprecise estimates of provider contributions determined through this methodology, DHFS estimates that from January 1, 1998 through June 30, 1998, insurers and HIRSP participants have contributed more to fund HIRSP—and providers have contributed less—than required by 1997 Wisconsin Act 27.

DHFS is in the process of completing its 1998 reconciliation of actual and statutorily prescribed funding levels and adjusting future provider contributions, insurer assessments, and participant premium rates based on variances from the statutory funding formula. Recently, EDS developed monthly financial reports that identify the level of funding provided by each funding source, including the amount of provider contributions. This information will assist DHFS in monitoring funding in the future.

Understanding the Plan's Financial Position

Differences between HIRSP's funding approach and the accounting basis used for financial reporting can be confusing to parties interested in HIRSP's operation and financial condition. Statutory changes could help to clarify funding requirements and better ensure a financially sound plan.

Differences Between the Funding Approach and Accounting Basis

DHFS funds HIRSP on a cash basis, which is based on estimated cash disbursements and has 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 a plan year, including actuarial cost estimates for claims that may not be filed until after the plan year.

HIRSP had a cash balance of $4.1 million, but negative retained earnings of $9.8 million as of June 30, 1998.

As a result of this difference, HIRSP's financial statements show a cash balance of $4.1 million, but negative retained earnings of $9.8 million as of June 30, 1998. The negative retained earnings largely represent estimated claims for which funding will need to be assessed and collected in future periods. HIRSP currently has sufficient cash on hand and the ability to assess future parties to pay these estimated claims as they become due. However, if HIRSP were to cease operations, the ability to pay future claims for which an obligation had already been incurred would be less certain.

Further complicating an assessment of HIRSP's financial activity for FY 1997-98 has been a change in the financial presentation of retained earnings, which resulted from changes in the statutory funding provisions. In prior years, retained earnings were reported at zero at the end of each fiscal year because OCI recognized additional assessment revenues and established a receivable for an amount that otherwise was a deficit. This receivable was developed in consultation with an outside public accounting firm and reflected the statutory requirement that any deficit incurred under the plan be recouped by insurer assessments. For example, HIRSP's FY 1996-97 financial statements included a receivable of $6.6 million that represented the amount insurers would be assessed to cover excess claims and expenses at June 30, 1997.

During the period OCI administered HIRSP, only insurers were responsible for funding a deficit after policyholder premiums, and HIRSP appeared to have a legally enforceable claim to collect deficit amounts from insurers even if the plan ceased operations. However, two changes reduce the acceptability of continuing OCI's treatment of the deficit for financial reporting purposes: 1) the addition of other funding sources to share HIRSP's costs, and 2) statutory provisions that require future funding rates be adjusted so that required funding proportions are met. We believe that if OCI's treatment of the deficit for financial reporting purposes were used now by DHFS, the financial statements would indicate that any deficit could be recouped from all parties responsible for funding HIRSP, including policyholders who received insurance coverage during the period it was incurred, those who provided services during that period, and insurers.

While the Legislature allows DHFS to adjust rates during the year to ensure plan costs are covered, it is not clear whether the Legislature intended for DHFS to adjust rates retroactively and collect additional funds from the various responsible parties to recoup a deficit. The ability to legally enforce and collect additional funds unless specifically required under statutes is uncertain. In the case of policyholders, a provision for retroactive adjustment also would likely need to be included in policy terms. Furthermore, the cash-based approach currently being used to establish funding levels in accordance with the statutory formula would appear to limit support for retroactively adjusting rates based on an accrual basis.

The transition of oversight responsibility from OCI to DHFS in the middle of the fiscal year also contributed to confusion in understanding HIRSP's financial activity and each agency's related responsibility for it during FY 1997-98. In anticipation of the transfer and the addition of GPR on January 1, 1998, OCI reduced HIRSP's cash balance by limiting insurer assessments. In addition, working with DHFS staff, OCI determined and the Board approved assessments in December 1997 for the period January 1998 through June 1998. Neither agency analyzed how best to account for financial activity during the transition.

Need for Full-Cost Funding Basis

A full-cost funding method would provide a more secure financial position.

While HIRSP is currently solvent and able to pay claims as they come due on a cash basis, a change to a funding basis that considers estimated incurred claims would provide a more secure financial position that would better ensure HIRSP could pay claims in the future, even in the event it were to cease operations. In addition, current funding of claims that have been incurred but not yet paid would establish the payment burden more equitably, because it would require policyholders to pay premiums that were established with the goal of funding claims that this same group of policyholders incurred. On a cash basis, policyholders are, in part, paying for the claims experience of prior policyholders. Because it is impossible to estimate exactly the ultimate claim amounts that will be paid, future rate levels would need to be adjusted to treat differences between actual and expected claim experience.

Another advantage to funding HIRSP on the same basis used for financial reporting is that doing so limits the possibility of manipulating the funding process in ways that may be possible under a cash-based system, such as by delaying payments into the next period. This is especially important to ensure that GPR is not funding claims that should have been paid by the other funding sources. Finally, a full-cost funding (or accrual-based) approach is commonly used to fund other state insurance programs, such as insurance programs for state employes.

The initial result of changing to an accrual-based funding approach would likely be increases in funding levels to eliminate the negative retained earnings. However, DHFS believes retained earnings have improved since June 30, 1998, which would reduce the effect on rates paid by insurers, providers, and policyholders. In addition, efforts to eliminate the existing negative retained earnings and build cash and investment balances to pay claims that have been incurred but not yet paid could be phased in so that the effect on rates could be realized over a period of time. Although statutes do not specify the basis under which plan costs should be funded, DHFS believes some would oppose any change unless statutes are clarified to require it.

Implementation of Medicaid-Based Program Requirements

An important goal of the program changes included in 1997 Wisconsin Act 27 was reducing program costs. DHFS and OCI had estimated that if HIRSP paid claims using Medicaid rates and adopted Medicaid cost-containment systems, annual cost savings would have been $8.7 million. HIRSP service providers were therefore required by Act 27 to be Medicaid-certified. However, Act 27 did not require HIRSP claims to be paid at or on the basis of Medicaid rates. Instead, the newly mandated program-funding requirements—which reflect a legislative compromise to balance the concerns of various parties with funding responsibility—

more closely resemble the system in effect before January 1, 1998, in which submitted claims were discounted.

Statutes provide conflicting direction for implementation of HIRSP changes.

As a result of seemingly conflicting direction in statutes regarding the use of a Medicaid-based system, DHFS and the plan administrator have had difficulty not only in reconciling provider funding requirements with provider reimbursement rates under a Medicaid-based system, but also in explaining inconsistencies between statutes and the Medicaid-based system currently being used to process HIRSP claims. Providers and others have expressed concern about how provider payment rates are determined. For example:

- Statutes define provider reimbursement rates in terms of reductions to usual and customary charges; however, in FY 1998-99, providers are being reimbursed at Medicaid rates plus 41 percent because DHFS has estimated that rate will cover their statutory share of HIRSP's costs.

- Statutes refer to the provider payment rates specified in the most recent provider contracts that are in effect; however, EDS does not have provider contracts for HIRSP.

- Under Medicaid, drug purchases are discounted at the wholesale level rather than at the pharmacy; however, statutes governing HIRSP require the same discounts that apply to other medical services to be applied to drug purchases.

Transition to a Medicaid-based system has affected service delivery.

In addition, transition to a Medicaid-based system has affected service delivery under HIRSP. It has been DHFS's intention that coverage under HIRSP would remain the same, but that HIRSP would adopt Medicaid cost-containment, billing, and reimbursement practices. However, policyholders and providers have experienced problems during the transition period for several reasons, including limited availability of documentation concerning the practices and the coverage provided under the prior administrator, and an underestimation of the effort required for the transition. Problems include:

- confusion about the new cost-containment provisions, such as a 34-day limit on drug supplies and the requirement that independent laboratories perform and bill for tests required by a physician's office;

- denial of claims because local procedures codes are not compatible with the Medicaid codes required by the new plan administrator;

- delays in the processing and payment of claims; and
- difficulty in receiving responses to their inquiries.

At one point the new plan administrator indicated that 95 percent of claims were not submitted electronically and required manual processing, which has resulted in approximately 400 overtime hours per month, and that, on average, 2,300 calls per month were not answered before the callers hung up.

DHFS is taking steps to improve service.

DHFS is taking steps to address these concerns and believes that service has improved. In addition, DHFS is in the process of providing additional information to help policyholders and providers better understand HIRSP's operations and comply with policies. For example, DHFS recently issued its first edition of a quarterly newsletter to policyholders and is finalizing drafts of a provider handbook and a plan document outlining coverage.

Several important administrative and management oversight measures have been delayed.

Because DHFS has given priority to addressing service needs first, it has been delayed in providing program oversight in several administrative and management areas, including:

- creation of monthly and quarterly management reports, including financial reports, enrollment reports, and reports that track customer service performance;
- regular monitoring and reporting of the value of claim liabilities HIRSP may be required to pay, which will become especially critical for financial reporting at fiscal year-end;
- improvements to cash management, including analysis to determine whether higher-yield options may be available for cash being kept in an interest-bearing checking account, and steps to ensure that cash balances are properly insured or otherwise protected; and
- resolution of findings from a DHFS audit of the premium and deductible subsidy, which indicated that 28 applicants' reported incomes did not match their tax records. DHFS has not yet taken steps to determine whether subsidy payments were made in error or to begin collecting any amounts that were inappropriately awarded.

Administrative Issues

Implementation and administrative costs are higher than anticipated.

While major program changes often come with some unanticipated difficulties, implementation of the new statutory funding requirements and other program changes have been more complex than expected. As a result, both DHFS and EDS now are committing more resources to HIRSP than originally expected. The staffing and funding resources that 1997 Act 27 appropriated to DHFS for oversight of HIRSP during the last six months of FY 1997-98 did not differ significantly from those budgeted under OCI. However, DHFS is currently committing more staff resources to HIRSP than the 1.5 full-time equivalent (FTE) staff authorized by Act 27.

In October 1997, DHFS and EDS developed a description of the implementation and ongoing administrative activities EDS would perform as HIRSP's plan administrator. Based on this document, DHFS authorized a resource estimate, prepared by EDS, that included implementation costs of $1.3 million and annual administrative costs of approximately $2.1 million. This resource estimate, which was dated March 6, 1998, was less than an estimated $4.0 million that EDS originally proposed, but greater than both DHFS's goal of spending no more than $1.0 million for implementation costs and its goal of maintaining administrative costs similar to those under Blue Cross & Blue Shield, which had been approximately $1.8 million annually.

Estimated staffing needs and costs doubled in one year.

DHFS subsequently agreed to increase EDS's staffing and funding resources significantly when the new plan administrator did not accomplish many of the activities it had originally agreed to perform. The most recent resource estimate, signed on March 11, 1999, indicates monthly ongoing administrative costs of $261,446 through December 1999 will be 50 percent higher than agreed to one year earlier. In addition, the most recent estimate includes an authorized staffing level of 50.8 FTE, which almost doubles the level of 25.9 FTE authorized in March 1998. The most significant increases in staffing were for additional customer service representatives, claim entry staff, computer programmers, and computer analysts. The March 1999 estimate of costs for ongoing plan administration services under EDS will be almost 80 percent higher than monthly administrative costs paid to Blue Cross & Blue Shield.

A need for additional resources—at least initially—might have been suggested by the more complex program funding structure introduced in 1997 Wisconsin Act 27, by the agency's own limited experience with an insurance program, and by the challenge of merging HIRSP with Medicaid cost containment provisions. Furthermore, the Governor's veto message noted that the complexity added to HIRSP by the Legislature made an implementation date of January 1, 1998, difficult to achieve. However, part of the administrative cost difference may also be associated with the fact that the contract with Blue Cross & Blue Shield

had been competitively negotiated, while a competitive process was not possible for the EDS contract because of the statutory requirement that the State's fiscal agent for Medicaid become the HIRSP plan administrator.

Without the cost-control benefits of a competitive process, it is especially important for DHFS to take other steps to manage costs and establish performance requirements. DHFS did not enter into a separate contract with EDS for implementation and administration of HIRSP, but instead relies on the existing Medicaid contract to cover these services. Under a separate contract, DHFS could have established explicit and controllable contract requirements for HIRSP, including deliverables, service quality measures, due dates, costs, and penalties if requirements are not met in a timely and appropriate manner. Both the document that describes the functions EDS is to perform as HIRSP plan administrator and the resource estimate documents provide some of the information that would be expected in a contract; however, as written, they do not appear to hold EDS accountable for expected deliverables, due dates, and cost estimates. For example, these documents explicitly state that the listed functions and activities are targets and are not enforceable deliverables. In addition, EDS stated in its initial resource estimate that proposed funding and staffing levels may not be adequate to support either current or desired service levels.

In the absence of a separate contract, it will be important for DHFS to have a disciplined approach for maintaining accountability, justifying changes, and controlling costs. This could involve developing specific funding requirements, standards and measures of quality, incentives for performance, and penalties for nonperformance of EDS's responsibilities as plan administrator.

Future Considerations

Both the Governor and DHFS have proposed changes to HIRSP.

The Governor's 1999-2001 biennial budget proposal includes further changes to HIRSP service provisions, further limits to the HIRSP Board's responsibilities, and an annual reduction of $2.0 million in GPR funding. DHFS is also developing a proposal that would make significant changes to HIRSP, which it believes will meet the Governor's proposed reduction in GPR funding, clarify program administration, and take advantage of Medicaid cost-containment provisions. Specific components of DHFS's proposal, which was presented at the April 14, 1999 Board of Governor's meeting, include:

- creating HIRSP-specific rates for hospital reimbursement;

- paying pharmacists Medicaid rates for dispensing fees and drug products;

- establishing other provider payment rates at Medicaid rates plus an additional 41 percent, which is similar to the rates currently being applied during FY 1998-99;

- eliminating coinsurance and deductibles for prescription drugs obtained by HIRSP policyholders, and instead instituting a $10 co-payment for prescription drugs;

- establishing a maximum annual amount for deductibles, coinsurance, and prescription drug co-payments;

- clarifying that the requirement to reconcile actual and statutorily prescribed funding be on a calendar year basis with adjustments effective July 1 of the next plan year;

- eliminating the program revenue appropriation designated for excess premiums when premium rates set at 150 percent of standard rates provide more than 60 percent of costs, and broadening the use of these excess premiums for other purposes in addition to future premium rate reductions;

- creating appropriations to allow all HIRSP revenues and expenditures to be recorded in the State's records and to allow excess funds to be invested as part of the State Investment Fund; and

- providing authority for an additional 3.5 positions within DHFS, funded by HIRSP, to oversee all HIRSP operations and policy.

In considering this proposal and any other proposed changes to HIRSP, the Legislature may also wish to consider requiring DHFS to take other steps to ensure sound financial management, including:

- funding HIRSP on the same basis used for financial reporting, which is an accrual basis that accounts for claim liabilities when medical services are provided rather than when claims are paid;

- creating reports that will improve both program management and agency communication with other interested parties;

- establishing a mechanism to monitor and report claim liabilities;

- instituting sound cash management practices that ensure cash balances are adequately protected and invested, which would be assisted by the DHFS proposal to maintain HIRSP's revenues and expenditures on the state records; and

- establishing specific funding requirements, standards and measures of quality, and penalties for nonperformance of responsibilities by the plan administrator.

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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, 1998, and the related statements of revenues, expenses, and changes in retained earnings and of cash flows for the year 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 audit.

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. 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 audit 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 4, 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 were 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.

In our opinion, except for the omission of the information discussed in the preceding paragraph, 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, 1998, and the

results of its operations and the cash flows for the year then ended in conformity with generally accepted accounting principles.

In accordance with *Government Auditing Standards*, we have also issued a report dated April 12, 1999, 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.

The Year 2000 Supplementary Information on pages 45-46 is not a required part of the basic financial statements but is supplementary information required by the Governmental Accounting Standards Board. 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 do not express an opinion on it. In addition, we do not provide assurance that the Health Insurance Risk-Sharing Plan is or will become year 2000 compliant, that the Plan's year 2000 remediation efforts will be successful in whole or in part, or that parties with which the Plan does business are or will become year 2000 compliant.

LEGISLATIVE AUDIT BUREAU

April 12, 1999 by

Diann Allsen
Audit Director

Statement 1

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

	June 30, 1998
Assets	
Cash and cash equivalents (note 2)	$4,076,409
State premium and deductible subsidy receivable	435,600
Other receivables	709,918
Prepaid items	1,227
Total Assets	$5,223,154
Liabilities and Fund Equity	
Liabilities:	
Unpaid loss liabilities (note 6)	$10,119,489
Unpaid loss adjustment expenses (note 6)	341,484
Unearned premiums	3,237,219
Accounts payable and other accrued liabilities	1,371,966
Total Liabilities	15,070,158
Fund Equity:	
Retained earnings (note 7)	(9,847,004)
Total Liabilities and Fund Equity	$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 Year Ended June 30, 1998

	For the Year Ended June 30, 1998
Operating Revenues	
Premiums	$19,490,562
State subsidy premiums	2,867,171
Revenue from the State of Wisconsin	6,000,000
Insurers' assessments (note 3)	3,940,576
Total Operating Revenues	32,298,309
Operating Expenses	
Losses:	
Losses paid or approved for payment	36,246,815
State deductible recoveries	(598,648)
Increase (decrease) in unpaid losses	3,581,000
Total Losses	39,229,167
Loss adjustment expenses (note 5)	1,085,791
General and administrative expenses (note 5)	1,974,527
Total Operating Expenses	42,289,485
Net Operating Income (Loss)	(9,991,176)
Non-Operating Revenues (Expenses)	
Investment income	143,215
Loss on disposal of fixed assets	(4,828)
Total Nonoperating Revenues (Expenses)	138,387
Net Income (Loss)	(9,852,789)
Retained Earnings	
Retained Earnings, Beginning of Year (note 1)	5,785
Retained Earnings, End of Year (note 7)	($9,847,004)

The accompanying notes are an integral part of this statement.

Wisconsin Health Insurance Risk-Sharing Plan
Statement of Cash Flows
for the Year Ended June 30, 1998

	June 30, 1998
Cash Flows from Operating Activities	
Cash received for premiums	$21,404,912
Cash received for assessments	9,612,624
Cash received from State of Wisconsin	6,000,000
Cash payments for losses	(36,578,045)
Cash payments for loss adjustment expenses	(1,086,154)
Cash payments for other expenses	(848,205)
Net Cash Used by Operating Activities	(1,494,868)
Cash Flows from Investing Activities	
Cash received from sale of treasury bills	11,939,713
Cash paid for purchase of treasury bills	(6,973,043)
Investment Income	143,215
Net Cash Provided by Investing Activities	5,109,885
Net Increase in Cash and Cash Equivalents	3,615,017
Cash and Cash Equivalents, Beginning of Year	461,392
Cash and Cash Equivalents, End of Year	$4,076,409

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

Net Operating Loss	($9,991,176)
Adjustments to Reconcile Net Operating Loss to Net Cash Provided By Operating Activities:	
Changes In Assets and Liabilities:	
Decrease (increase) in receivables	7,148,390
Decrease (increase) in prepaids	(532)
Increase (decrease) in accounts payable	(104,603)
Increase (decrease) in deferred revenue	(1,709,728)
Increase (decrease) in future benefits and loss liabilities	3,162,781
Total Adjustments	8,496,308
Net Cash Used by Operating Activities	($1,494,868)

The accompanying notes are an integral part of this statement.

1. Summary of Significant Accounting Policies

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 149.13, 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 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 in the insurance industry. Private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders are to share equally in:

- estimated costs remaining after the deduction of amounts projected to be 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 estimated costs exceed 200 percent of premium rates for standard risks.

HIRSP also includes a premium and variable deductible subsidy program to reduce premium and deductible levels that would otherwise be paid by low-income policyholders. Individuals with household incomes below $20,000 are eligible for the subsidy program. The subsidy program is funded by GPR appropriated under s. 20.435(5)(ah), Wis. Stats., assessments made on participating insurers, and adjustments to provider payment rates.

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.

Accounting and Presentation Changes

Prior 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 GAAP 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. Had the change been implemented during FY 1996-97, reported net income would have increased by $14,765.

The financial statement presentation of HIRSP's retained earnings balance represents a change from prior years because of statutory changes prescribing plan funding. Previously, retained earnings were reported at zero at the end of the fiscal year because the Office of the Commissioner of Insurance, in consultation with an outside public accounting firm, interpreted that a state statute provision requires any deficit incurred under the plan be recouped by insurer assessments. This allowed HIRSP to recognize additional assessment revenues and establish an additional receivable if policyholder premiums, investment income, and billed insurer assessments were less than the amount needed to cover claims and expenses. HIRSP's FY 1996-97 financial statements included a receivable of $6,578,264, entitled 'Assessments receivable – unbilled,' in its assets that represented the

amount of insurer assessments needed to cover excess claims and expenses at June 30, 1997.

In response to statutory changes effective January 1, 1998, that prescribe a funding formula in which policyholders, health insurers, and health care providers share in HIRSP's estimated costs in accordance with a prescribed funding formula, additional revenues are not recognized and receivables are not established to cover the deficit, as was done in prior years. As a result of the change in statement presentation, the June 30, 1998 retained earnings balance was negative $9,847,004. If financial presentation had not changed in response to the statutory changes, the retained earnings for FY 1997-98 would have been $0. Had the statutory changes been implemented during FY 1996-97, reported net income would have decreased by $6,578,264.

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.*

Premiums and Assessments

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.

Unpaid Losses

Unpaid losses 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 liability for unpaid losses is established by an actuary employed by the plan administrator and is 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 liability 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.

Policy Acquisition Costs

Since HIRSP has no marketing staff and incurs no sales commissions, policy acquisition costs are minimal and expensed as incurred.

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:

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

HIRSP's cash balances are primarily maintained in an interest-bearing checking account with a commercial financial institution. At year-end, the carrying amount of the demand deposits with the financial institution was $4,020,385, and the bank balance was $4,559,040. 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, $400,000 was insured and classified in risk category 1, and $4,159,040 was uninsured and uncollateralized and was classified in risk category 3.

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 $56,000. 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. 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.

4. 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 through additional discounts after payments had been reduced to usual and customary fees and then by 10 percent be sufficient to share equally with insurers in the cost of the program. 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.

5. General and Administrative Expenses

General and administrative expenses include:

Plan administrator fees	$ 670,062
State administrative fees	47,256
Implementation costs	984,752
Other expenses	272,457
Total	$ 1,974,527

Plan administrator fees do not include the fees paid to the plan administrator for expenses to adjudicate claims, which are classified as loss adjustment expenses. Implementation costs include costs incurred by the plan administrator to implement statutory changes effective January 1, 1998, and costs incurred to transfer administration of the program to Electronic Data Services (EDS) on July 1, 1998.

6. 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 1996-97 and 1997-98 (in thousands):

	FY 1996-97	FY 1997-98
Balance, beginning of year	$ 8,503	$7,298
Incurred related to:		
Current year	40,999	41,682
Prior years	(3,076)	(768)
Total Incurred	37,923	40,914
Paid related to:		
Current year	33,839	31,304
Prior years	5,289	6,447
Total Paid	39,128	37,751
Balance, end of year	$ 7,298	$10,461

The Unpaid Loss Adjustment Expense Liability account represents estimated future payment of costs to settle claims.

7. Negative Retained Earnings

HIRSP is funded on a cash basis, in which funding levels are based on estimated cash disbursements, rather than estimated incurred costs, in order to limit an accumulation of cash beyond current cash flow needs. HIRSP's negative retained earnings of $9,847,004 as of June 30, 1998, therefore, largely represents a GAAP-required 'unpaid loss liabilities' entry defined as the estimated costs to settle claims for services provided in FY 1997-98 that had not been paid during the fiscal year. The day to day operating basis and the basis on which premiums, assessments, and discounts are calculated for HIRSP is reflected in the Statement of Cash Flows and as summarized below.

	For the Year Ended June 30, 1998
Cash received for premiums, assessments, and from the State of Wisconsin	$37,017,536
Cash payments for claims and expenses	(38,512,404)
Net cash used by operating activities	(1,494,868)
Net cash provided by matured and sold investments	5,109,885
Net increase in cash	3,615,017
Cash, beginning of year	461,392
Cash, end of year	$ 4,076,409

The financial statement presentation of HIRSP's retained earnings balance represents a change from prior years because of statutory changes prescribing plan funding. Previously, retained earnings had been reported at zero at the end of the fiscal year because the Office of the Commissioner of Insurance interpreted that a state statute provision requires any deficit incurred under the plan be recouped by insurer assessments. This allowed HIRSP to recognize additional assessment revenues and establish an additional receivable if policyholder premiums, investment income, and billed insurer assessments were less than the amount needed to cover claims and expenses. HIRSP's FY 1996-97 financial statements included a receivable of $6,578,264, entitled 'Assessments receivable – unbilled,' in its assets that represented the amount of insurer assessments needed to cover excess claims and expenses at June 30, 1997.

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REQUIRED SUPPLEMENTARY INFORMATION—YEAR 2000

The Department has a year 2000 plan that oversees year 2000 issues related to all organizations within the Department, including HIRSP. The year 2000 issue refers to the many computer programs that use only the last two digits to refer to a year. Therefore, both 1900 and 2000 would be referred to as "00." Computer programs have to be adjusted to recognize the difference between those two years or the program will fail or create errors. The year 2000 issue could also affect electronic equipment containing computer chips that have date-recognition features.

The Department has made a commitment to be able to seamlessly deliver services to the citizens of Wisconsin through and beyond January 1, 2000. To this end, it is engaged in a comprehensive program to provide the maximum possible confidence that all items are "year 2000 compliant." Based on monthly reporting, as of January 1999, the following information is available:

Hardware and Operating Software – It is estimated that the Department has completed approximately 95 percent of the network upgrades, with the remainder to be completed by mid-1999. Of the approximately 3,800 PCs managed by the Department, it is estimated that approximately 5 percent may not be compliant. The Department is currently on a replacement and modification schedule that will allow all PCs to be compliant by mid-1999.

Software Applications — All modifications and testing to mainframe applications have been completed. Inventory and testing of PC-based applications is now being completed. Communications with vendor-supported software is continuing, and progress is being monitored. All data-exchange agreements are being reviewed.

Other Equipment — All institutions and office equipment have been inventoried. Analysis is currently being performed to determine year 2000 compliance. All facility equipment is being reviewed statewide for all State of Wisconsin facilities by the Wisconsin Department of Administration.

The Department is reviewing contractual arrangements with partners and suppliers, and contingency plans.

HIRSP relies on software developed and maintained by its fiscal agent, EDS. EDS has completed an assessment of its client systems. The Department has approved EDS's plan to modify and implement

HIRSP systems changes. It is projected that the HIRSP systems will be year 2000 compliant by the end of September 1999.

The Department has not, to date, identified any significant year 2000 consequences or unbudgeted costs to make the critical business applications year 2000 compliant. The costs to the Department to become year 2000 compliant have been and will continue to be absorbed within the base operating budgets, because most year 2000 compliance work is being completed by the Department as part of ongoing maintenance and upgrades previously identified and budgeted for by the Department.

In addition, the Department of Administration, which has the overall responsibility for the coordination of information technology in state government, is coordinating the State's year 2000 compliance issues. The Department of Administration has created an interagency task force to advise on ways to coordinate year 2000 compliance oversight activities. This approach allows the State to focus on the highest priority year 2000 compliance issues.

The State of Wisconsin cannot provide absolute assurances that all year 2000 problems will be corrected by January 1, 2000, or that all information technology systems will continue to work efficiently on January 1, 2000. There remains a possibility that some year 2000 problems will not be identified or corrected by January 1, 2000. Contingency plans are being developed to address these situations. The many actions that the State of Wisconsin is currently completing will minimize such potential problems, especially for critical business applications.

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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 Health Insurance Risk-Sharing Plan as of and for the year ended June 30, 1998, and have issued our report thereon dated April 12, 1999, which was qualified for the omission of information on health care providers' contributions. 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," 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.

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 a certain matter involving the internal control over financial reporting and its operation that we consider to be a reportable condition. 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. The reportable condition noted involves the lack of adequate systems to account for health care provider contributions and to

reconcile actual funding to statutorily prescribed funding levels, as further discussed in the accompanying report section, "Meeting Statutory Funding Requirements."

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 employes 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 systems to account for health care provider contributions to be a material weakness.

This report is intended for the information 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 matter of public record and its distribution is not limited.

LEGISLATIVE AUDIT BUREAU

April 12, 1999

by

Diann Allsen
Audit Director

APPENDIX - RESPONSE FROM THE DEPARTMENT OF HEALTH AND FAMILY SERVICES

April 22, 1999

Janice L. Mueller
State Auditor
Legislative Audit Bureau
131 W. Wilson Street, Rm. 402
Madison, WI 53703

Dear Ms. Mueller:

I am writing in response to the audit of the Health Insurance Risk Sharing Plan (HIRSP) performed by the Legislative Audit Bureau (LAB).

I appreciate the time and effort the LAB devoted to this audit, particularly LAB's staff preparation of the financial statements for this audit. Further, I appreciate the difficulty associated with this audit, particularly because the audit period (SFY 98) spanned the year in which the administration of HIRSP was transferred from the Office of the Commissioner of Insurance (OCI) to the Department of Health and Family Services (DHFS). The LAB auditors worked hard along with DHFS staff and several members of the HIRSP Board of Governors to interpret the statutory intent for reconciling the new funding formula.

In summary, the audit does note issues that arose during the early stages of transitioning HIRSP from OCI to the Department. Some difficulties still exist because of statutory provisions that impede cost effective administration of the program. However, HIRSP today is in much better shape than it was in July of 1998. Most claims are being processed in less than 15 days. Year end 1998 enrollment statistics show no significant decline in enrollment for the first time since 1994. We have held policyholder premiums to the lowest level permitted by law. The Department has developed a legislative package to address some of the difficulties that still exist. By making the statutory changes proposed by the Department, the Legislature would be taking important steps to strengthen the HIRSP program even more.

In order to understand the context of some of the points in the LAB audit and our response, we feel it is important to provide some background about HIRSP.

Prior to the transfer to DHFS, HIRSP was a much simpler self-funded insurance program. The plan was administered much like a private insurance plan under OCI's general oversight. HIRSP was funded through a straightforward 60/40 split of policyholder premiums and assessments on insurance companies. When the budgeted funding was not sufficient to fund the plan for the budget year, insurers were assessed to cover the shortfall.

However, HIRSP was in trouble. For the nine-year period from SFY 1989 until the year HIRSP was transferred from OCI to DHFS in SFY 1998, average policyholder premiums increased by 156 percent from $1,540 to $3,936. Insurance assessments went from $3.7 million to $13 million. Average claims costs per policyholder increased from $1,700 to almost $6,000 per year. HIRSP enrollment declined dramatically from a high of 12,707 in 1992 to 7,318 in 1997, the year before HIRSP transferred to DHFS.

There was growing concern within the Legislature that HIRSP would become insolvent. In fact, HIRSP faced a severe financial crisis in the months just before the transfer from OCI to DHFS. The plan had run out of cash. At that time, the HIRSP Board of Governors approved a $1.8 million emergency assessment on insurers. HIRSP claims were held for four months until insurer assessments and policyholder premiums generated enough cash to cover the claims being held.

While we are aware that the transition of HIRSP has not been without difficulty, the DHFS has worked very hard to fulfill legislative intent. Admittedly, this has not been easy. The statutory language given to us by the legislature to operate HIRSP is, in many respects, confusing and contradictory.

The LAB report suggests that DHFS did not recognize until September 1998 the need to record information that could be used readily to determine whether additional payment discounts met the statutory requirement for provider funding levels. In fact, DHFS was fully aware early in the program about the challenge of documenting payment discounts. At the time it assumed responsibility for HIRSP, DHFS instructed the prior plan administrator, Blue Cross Blue Shield (BCBS), to not modify existing reports or create new reports to track the provider contributions. This decision was made because the modification or creation of reports can be costly and time consuming. DHFS recognized that BCBS would only administer the plan until June 30, 1998, and on July 1, 1998, the entire payment system would change with the transition to the new plan administrator, EDS. It did not make sense to invest resources in developing reports that would be produced only for that six-month period. Additionally, since BCBS would have all of the information necessary to calculate the provider contribution in its claims system, DHFS decided that the most efficient and effective way to approach the calculation of the provider discount was to perform a retrospective analysis of claims. That is, in fact, what we did.

The report suggests that DHFS cannot determine whether HIRSP was funded in accordance with statutory provisions that require policyholders, insurers, and providers to share program costs for the period January 1, 1998, through June 30, 1998. However, we believe we have complied with the law. We have made a reasonable estimate of providers' contribution, attested by two actuaries. On April 14, 1999, the Board of Governors voted to accept a compromise reconciliation amount for that six-month period of $2 million. With the Board's consultation, the Department has complied with HIRSP statutory requirements to reconcile the funding requirements of policyholders, insurers, and providers for the January through June 1998 period.

While DHFS did not invest resources to produce reports for the January 1998 to June 1998 six-month period, we did fully recognize our statutory obligations and we complied. For the period July 1998 forward, the Department has implemented a monthly report that tracks provider, policyholder, and insurers' contributions to HIRSP. In addition, we will recommend statutory clarifications to make the HIRSP reconciliation process more efficient and less controversial.

The LAB audit report shows a $9.8 million negative retained earnings as of June 30, 1998. This figure is based upon the estimated value of HIRSP's loss reserve, i.e., claims that have been incurred but have not yet been received by HIRSP. Since this amount is a year-end figure, it incorporates the approximate $8 million negative retained earnings (unaudited) DHFS inherited on January 1, 1998. While OCI had the statutory authority to assess insurers to fund the loss reserves, the plan was funded largely on a cash basis. Insurers did not want to be assessed for HIRSP to have a multi-million cash reserve in the bank. The situation is more complicated now. The only way DHFS can, by current law, fund the loss reserves is to increase policyholder premiums, increase insurer assessments and reduce payments to providers.

While we understand the significance of the loss reserve concept, we have not yet determined the most prudent approach to building a sufficient reserve. This change in how HIRSP is funded would represent a fundamental departure from past practices. For the first time in HIRSP's history, policyholders, insurers and providers would have to absorb millions of dollars in future claims cost. In our view, such a fundamental change would require legislative action to provide the Department with sufficient authority to accumulate and retain reserves adequate to cover incurred claims.

The LAB audit report suggests that administrative costs are higher than anticipated. The DHFS has taken a very deliberate approach to controlling administrative expenditures for HIRSP. At the time HIRSP was transferred, we took every possible step to work within the expectation that administrative costs would not be increased significantly. Even though the Legislature had created a much more complex HIRSP for DHFS to administer, the Legislature did not provide any increase in funding levels to administer the new HIRSP. We scrutinized the estimated HIRSP implementation and ongoing costs of the Medicaid fiscal agent budget and negotiated those costs to a level consistent with the costs associated with the previous plan administrator.

We were forced to prioritize implementation tasks which resulted in delays in completing of some aspects of implementation. We made every effort not to increase administrative costs. However, when it became clear that the new HIRSP required additional resources, we acted promptly to provide additional resources to support HIRSP. Currently, even with the additional administrative costs we have approved to support HIRSP, our administrative costs are less than 10 percent of benefits. We believe this is consistent with the industry average to administer insurance plans.

The report suggests that competitively bidding for HIRSP specifically would have yielded better results and lower costs. EDS was awarded the fiscal agent contract through a rigorous competitive bid process and HIRSP takes advantage of the rates negotiated for the Medicaid Management

Information System. Competitive bids of the magnitude needed for HIRSP would take years to develop and award. In the year 2000 environment, it would have been nearly impossible to find qualified bidders at a reasonable price.

We continue to work toward improving HIRSP. The LAB made several recommendations that we agree will improve HIRSP administration. Some of these recommendations we have already initiated. For example, we have already begun to develop HIRSP-specific funding requirements, standards and measures of quality, and penalties for non-performance of responsibilities of the plan administrator.

Additionally, we have developed a legislative agenda to address points raised in the LAB audit report and to simplify HIRSP for providers, policyholders and insurers. Our legislative agenda will:

- Retain the reconciliation process but clarify that the Department will reconcile the 60/20/20 percent share of HIRSP annually and prospectively on a calendar year basis for the subsequent plan year. The reconciliation will be completed by April 30 with needed changes in premiums, insurer assessments, and provider rates effective July 1. Further, we will clarify that providers' 20 percent share is an approximate percentage across all provider groups calculated once annually.

- Keep expenditures as low as possible by controlling claims costs, and by assuring that only medically necessary and appropriate services are covered, according to state insurance law and the HIRSP policyholder contract.

- Eliminate coinsurance and deductibles on prescription drugs, and instead, charge copayments for each prescription drug to be included in the calculation of the policyholder's annual maximum out-of-pocket limit. This change would eliminate most policyholder billing. Therefore, we will fund this change with no increase in policyholder premiums.

- Expand uses designated for excess policyholder premiums when premium rates at 150 percent of standard rates provide more than 60 percent of costs, so that in addition to relief of future policyholder premiums, these funds could be used for other policyholder needs such as subsidizing copayment for pharmacy, or other uses.

- Improve the state's ability in all areas of HIRSP financial management by creating, for the first time, state appropriations for all HIRSP funds. This will provide DHFS with authority to have the State of Wisconsin Investment Board handle HIRSP investments and improve our cash management practices.

- Strengthen overall administration of HIRSP through the creation of a dedicated HIRSP Section within DHFS. The new HIRSP Section would include a contract monitor who will have responsibility to monitor all aspects of plan administrator performance.

We are committed to continued improvements in HIRSP administration. We appreciate the time and efforts extended by LAB staff to perform this audit, understand the complexities of HIRSP, and offer recommendations for improvement.

Sincerely,

Joe Leean
Secretary