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August 2006

An Audit

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

2005-2006 Joint Legislative Audit Committee Members

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August 10, 2006

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

Dear Senator Roessler and Representative Jeskewitz:

At the request of the Department of Health and Family Services (DHFS), we have completed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 2004-05. HIRSP provides medical and prescription drug insurance for almost 19,000 policyholders who are unable to obtain coverage in the private market or who have lost employer-sponsored group health insurance. We have provided an unqualified opinion on HIRSP's financial statements.

Enrollment has begun to moderate following years of double-digit increases. It increased 5.4 percent during FY 2004-05, then decreased slightly during FY 2005-06. However, net claims costs increased 25.5 percent during FY 2004-05, to a total $130.4 million. That size of increase was unexpected and contributed to a $7.1 million decrease in HIRSP's accounting balance, which showed a small deficit of $300,000 as of June 30, 2005. The deficit appears to have been addressed in FY 2005-06.

DHFS and HIRSP's Board of Governors increased the usual and customary discounts applied to medical bills for the period from January 1, 2004 through June 30, 2005. However, we found another change to the discounts mistakenly was not implemented July 1, 2005. If uncorrected, this oversight would have materially affected HIRSP's financial statements for FY 2005-06, and corresponding funding levels. In May 2006, DHFS took steps to address this oversight.

2005 Wisconsin Act 74 made significant changes to HIRSP. Among the most significant is the creation of the HIRSP Authority, which assumed oversight responsibility from DHFS on July 1, 2006. Other significant changes include simplifying HIRSP's complex funding formula, providing increased flexibility for plan design, and establishing income tax credits for insurers that pay assessments for HIRSP. Under Act 74, the Audit Bureau will continue to conduct annual financial audits of HIRSP.

We appreciate the courtesy and cooperation extended to us by DHFS and the plan administrator for HIRSP.

Respectfully submitted,

Janice Mueller
State Auditor

JM/DA/ss

Report Highlights ■

HIRSP has maintained a sound financial position since FY 2002-03.

Although policyholder enrollment has begun to moderate, net claims costs increased 25.5 percent in FY 2004-05.

A change in the discount rate applied to medical bills mistakenly was not implemented until the end of FY 2005-06.

2005 Wisconsin Act 74 made several significant changes to HIRSP.

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

Program costs are shared by policyholders, health insurance companies that do business in Wisconsin, and health care providers. During fiscal year (FY) 2004-05, HIRSP also received $2.2 million in federal funds designated for high-risk health insurance pools.

HIRSP offers eligible applicants three plans:

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

At the request of the Department of Health and Family Services (DHFS), we completed a financial audit of HIRSP. Our audit report contains our unqualified opinion on HIRSP's financial statements and related notes for the fiscal years ending June 30, 2005 and 2004.

Financial Status

Beginning with FY 2001-02, DHFS and HIRSP's Board of Governors implemented an accrual-based funding approach to address an accounting deficit. As a result, HIRSP's accounting balance, as represented by its unrestricted net assets, improved to $6.8 million as of June 30, 2004. However, as shown in Table 1, the balance decreased $7.1 million during FY 2004-05, resulting in a small deficit of $300,000 as of June 30, 2005.

Table 1

Unrestricted Net Assets
(In Millions)

Date	Amount
June 30, 2001	$(8.2)
June 30, 2002	(6.0)
June 30, 2003	(0.9)
June 30, 2004	6.8
June 30, 2005	(0.3)

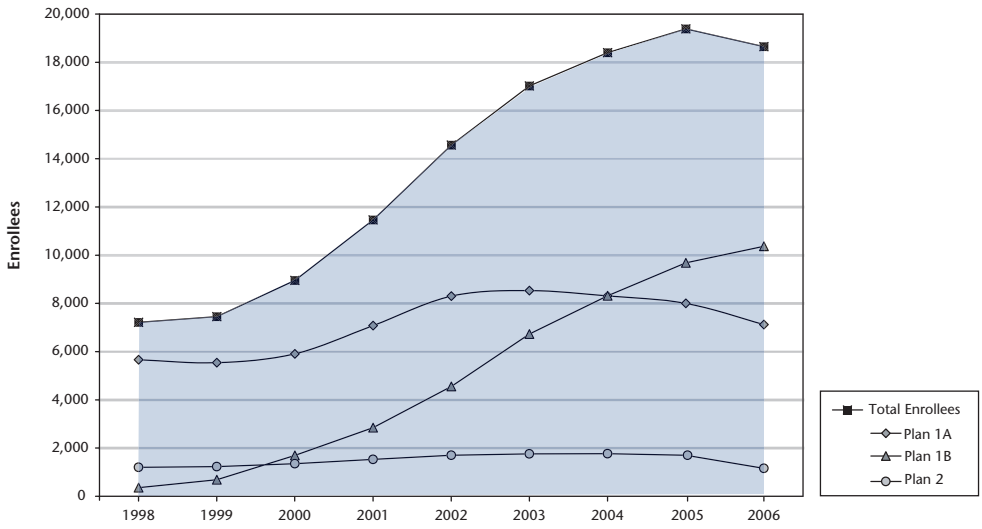
At least a portion of the decrease in the balance was expected in response to the Board's decision to apply $3.9 million in accumulated insurers' and providers' balances toward FY 2004-05 expenses. However, an unexpectedly large increase in claims costs contributed to a larger decrease than expected and to the small deficit. The deficit appears to have been addressed in FY 2005-06.

Enrollment and Claims Costs

Although HIRSP experienced double-digit enrollment growth for several years, total enrollment increased 5.4 percent during FY 2004-05. There were 19,385 policyholders as of June 30, 2005. During FY 2005-06, enrollment decreased slightly to reach 18,650 on June 30, 2006. Enrollment trends are shown in Figure 1.

Figure 1

HIRSP Enrollment by Plan
As of June 30



In contrast to moderating enrollment, claims costs continue to increase significantly, as shown in Table 2. Net of health care providers' contributions, claims costs increased $76.3 million over the past five years.

Table 2

Net Claims Costs[1]
(In Millions)

Fiscal Year	Amount	Change
2000-01	$ 54.1	–
2001-02	67.2	24.2%
2002-03	85.8	27.7
2003-04	103.9	21.1
2004-05	130.4	25.5

[1] Net of health care providers' contributions

Claims costs have been affected by increases in prescription drug and medical costs that are similar to those experienced by other payers. HIRSP's contracted actuary cites increased utilization of services by policyholders as another contributing factor.

Changes in Costs and Contributions

Health care providers help to fund HIRSP through reduced reimbursements for billed services. Their share of program funding is calculated by subtracting "allowable charges," which are generally a percentage of Medicaid reimbursement rates, from "usual and customary" charges.

Usual and customary charges are intended to reflect the range of fees that most health care providers in a given area charge for a given procedure. They are common to the health insurance industry and are established annually by most insurers as discounts to billed charges. HIRSP, however, maintained the same discount—approximately 20 percent, in aggregate, of billed charges—from 1998 through 2004. Because providers' billing rates increased during that period, maintaining the "usual and customary" discount caused HIRSP's claims costs and provider contributions to increase more than was expected.

In response, DHFS and HIRSP's Board of Governors increased the discounts applied to claims from January 1, 2004 through June 30, 2005 to approximately 30 percent of billed charges, which DHFS and the Board believed was more representative of industry averages. As a result, shared program costs for the 18-month period decreased by $25.5 million.

After additional research and analysis, the discount rates were adjusted to 28.5 percent effective July 1, 2005. However, this change was mistakenly not implemented. As a result, program costs and provider contributions were calculated at an estimated $3.6 million less than they should have been for the first nine months of FY 2005-06. If uncorrected, the miscalculation would have materially misstated the financial statements.

After we informed DHFS of the oversight, DHFS requested that the plan administrator implement the 28.5 percent discount rate and make the necessary adjustments to ensure program costs and provider contributions were properly calculated in FY 2005-06. DHFS also requested that HIRSP's contracted actuary assess the effect of the miscalculation on the FY 2006-07 budget projections. HIRSP's Board of Governors subsequently voted to amend the original budget and to increase provider payment rates for FY 2006-07 by 4.5 percent.

Program Changes

2005 Wisconsin Act 74 created the HIRSP Authority, which assumed responsibility for HIRSP on July 1, 2006. The HIRSP Authority is not a state agency and is not subject to the State's budgeting process, but some level of public accountability is retained through open records and open meetings requirements. The Audit Bureau also is required to continue auditing HIRSP on an annual basis.

Act 74 also made several other significant changes to HIRSP, including:

- simplifying the complex funding formula;
- providing the HIRSP Authority further flexibility in establishing plan design;
- tightening eligibility requirements; and
- establishing tax credits for the insurers that help to fund HIRSP.

■■■■

Introduction ■

At the request of DHFS, which had oversight responsibility for HIRSP through June 30, 2006, we completed a financial audit for FY 2004-05 that reviewed HIRSP's control procedures, assessed the fair presentation of the FY 2004-05 financial statements, and reviewed compliance with statutory provisions. During the period we audited, two private firms functioned as the plan administrator. Electronic Data Services (EDS), which also administers the State's Medicaid program, administered HIRSP through March 2005. Wisconsin Physicians Service Insurance Corporation (WPS) became the plan administrator in April 2005.

The HIRSP Authority created under 2005 Wisconsin Act 74 assumed responsibility for HIRSP on July 1, 2006. As required by Act 74, WPS continues to serve as the plan administrator under a contract with the HIRSP Authority.

Plan Provisions

Three plans are available to policyholders.

HIRSP offers eligible applicants three plans:

- Plan 1A is available for Wisconsin residents who have received a notice of rejection, cancellation, reduction of coverage, or substantial premium increase by an insurer; who have tested positive for the virus that causes AIDS; or who have lost employer-sponsored group health insurance and meet other specified criteria.

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

- Plan 2 is available to Wisconsin residents under the age of 65 who participate in the federal Medicare program because of a disability. Persons with coverage when they reach the age of 65 may continue in the plan. Effective May 15, 2006, plan 2 is available only to policyholders who are also enrolled in Medicare Parts A, B, and D.

Plan Funding

In FY 2004-05, HIRSP received $2.2 million in federal grant funds designated for high-risk health insurance pools.

In FY 2004-05, HIRSP received $2.2 million from the federal Centers for Medicare and Medicaid Services. These federal grant funds were available to qualified high-risk health insurance pools that met certain criteria and, as required under the grant agreement, were used for operating costs. HIRSP also received a $2.5 million federal high-risk pool grant in FY 2005-06.

However, HIRSP is funded primarily through policyholder premiums, financial assessments on health insurance companies that do business in Wisconsin, and reduced reimbursements to health care providers. Statues require that policyholder premiums fund 60 percent of HIRSP's estimated operating and administrative costs. In addition to annual premiums, policyholders are required to share in the costs of covered services through:

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

- medical coinsurance payments of 20 percent up to $1,000 annually, which must be paid by policyholders in plans 1A and 1B— but not plan 2—after their annual deductible requirements have been satisfied; and

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

The remaining 40 percent of program costs are to be funded equally by the insurers and health care providers, who also are equally responsible for premium, deductible, and drug co-insurance subsidies available to low-income policyholders. Insurers fund their share of HIRSP's annual operating and administrative costs through annual assessments that are proportionately based on their annual health insurance premium revenue. Health care providers contribute through reduced reimbursements for billed services.

By statute, HIRSP covers only those medical services that policyholders obtain through Medicaid-certified providers. These providers submit bills for services rendered, but they are paid by HIRSP at set rates that are known as "allowable charges." Allowable charges are generally a percentage of Medicaid reimbursement rates.

Providers' contributions reflect the difference between HIRSP's "usual and customary" rate and its allowable charges.

To calculate the providers' share of program funding, HIRSP also relies on a discount rate—the "usual and customary" discount rate—that is applied to billed charges from health care providers. The difference between HIRSP's higher "usual and customary" rate and its lower "allowable charges" rate represents the providers' contributions to HIRSP's funding.

Policyholder Premiums

Premium rates for each of HIRSP's three plans differ on the basis of policyholders' gender, age, and geographic location and may not exceed 200 percent of average industry rates for standard-risk individuals. During our audit period, premium rates were also required to be at least 140 percent of the average industry rates.

Rate increases for both plan 1A and plan 1B have been generally comparable to those that private insurers charge for individual standard-risk policies that provide substantially the same coverage and deductibles. However, FY 2006-07 premiums for these plans increased by just 5.0 percent because HIRSP's Board of Governors decided to apply $8.7 million of an accumulated balance of policyholder premiums toward the policyholders' share of costs during that year. Moreover, as shown in Table 3, premium rates for plan 2, which is available for certain Medicare participants, decreased 21.5 percent on July 1, 2006.

Table 3

Composite Premium Rate Changes

Effective Date	Plans 1A and 1B	Plan 2
July 1, 1998	11.4% Increase	24.0% Increase
January 1, 1999	No Change	10.0% Increase
July 1, 1999	No Change	4.0% Increase
July 1, 2000	12.4% Increase	18.2% Increase
July 1, 2001	3.4% Increase	3.4% Increase
July 1, 2002	25.4% Increase	30.8% Increase
July 1, 2003	10.6% Increase	15.6% Increase
July 1, 2004	12.2% Increase	18.4% Increase
July 1, 2005	15.0% Increase	20.3% Increase
July 1, 2006	5.0 % Increase	21.5% Decrease

Plan 2 typically experienced larger rate increases than plans 1A and 1B to more closely reflect that plan's claims costs. However, since May 15, 2006, plan 2 policyholders have been required to enroll in Medicare Part D, which will be the first payer of their pharmacy costs. HIRSP's FY 2006-07 costs will therefore be reduced for plan 2 participants. Examples of annual premiums effective July 1, 2006, for policyholders living in Milwaukee, where the rates are the highest, are shown in Table 4.

In FY 2004-05, 20.0 percent of HIRSP policyholders received subsidies, at a cost of $5.0 million.

Plan 1A and plan 2 policyholders who have annual household incomes below $25,000 are eligible for premium subsidies. Plan 1A policyholders with annual household incomes below $20,000 are also eligible for deductible and drug coinsurance subsidies. Plan 1B policyholders are not eligible for any of the subsidies. In FY 2004-05, 20.0 percent of HIRSP policyholders received subsidies from the program, at a cost of $5.0 million.

Table 4

Examples of Annual Premiums for Policyholders Living in Milwaukee
Rates Effective July 1, 2006

Plan Type	Male Ages 0-24	Male Ages 60-64	Female Ages 0-18	Female Ages 60-64
Plan 1A	$2,952	$14,424	$2,952	$11,976
Plan 1B	2,124	10,380	2,124	8,628
Plan 2	1,761	7,939	1,761	7,355

Program Changes

2005 Wisconsin Act 74 made several significant changes to HIRSP.

In December 2005, 2005 Wisconsin Act 74 created a quasi-public authority that assumed oversight responsibility for HIRSP on July 1, 2006. The HIRSP Authority is governed by a Board of Directors, which consists of 13 voting members appointed by the Governor with the advice and consent of the Senate. Act 74 required the board to include representatives of insurers, health care providers, and small businesses; HIRSP policyholders; and a professional consumer advocate. The Commissioner of Insurance or a designee also serves as a nonvoting member.

Because the HIRSP Authority is not a state agency, its operating budget is not subject to approval by the Legislature and a fund outside of the State's control was established for payment of HIRSP's operating and administrative expenses. However, the HIRSP Authority is a public body corporate and politic that is subject to open records, open meetings, and competitive bidding requirements, and its records will be available to the Department of Administration and the Legislative Fiscal Bureau. The law requires annual financial audits to continue to be conducted by the Audit Bureau. In addition:

- HIRSP's complex funding formula has been simplified, although policyholder premiums will continue to fund 60 percent of costs, and insurers and providers will each continue to fund 20 percent of costs. However, subsidy costs are first to be paid from any federal funds received and then to be equally funded by insurers and providers.

- The HIRSP Authority is allowed to establish the plan design on or after January 1, 2007. Certain services specified by statutes must be covered, but the HIRSP Authority may change benefit levels, deductibles, copayment and coinsurance requirements, exclusions, and limitations that it determines generally reflect and are commensurate with comprehensive health insurance coverage offered in the private individual market in Wisconsin.

- HIRSP applicants must reside in Wisconsin for three months, instead of the 30 days required under prior law, and they must have been rejected by two insurers instead of one within nine months.

- An income and franchise tax credit and a license fee credit were established to help offset the costs of insurers that pay HIRSP assessments. The amount of credit for all insurers cannot exceed $5.0 million annually.

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Program Management ■

Although claims costs continued to increase during FY 2004-05, enrollment began to moderate and HIRSP maintained a sound financial position. DHFS and the Board of Governors implemented a change in the calculation of program costs and provider contributions for FY 2005-06, but because of an oversight the change was not implemented until the end of the fiscal year.

Financial Status of the Plan

HIRSP has maintained a sound financial position since FY 2002-03.

As shown in Table 5, HIRSP has maintained a sound financial position since FY 2002-03. At the end of FY 2000-01, under its original cash-based funding approach, HIRSP had unrestricted net assets of -$8.2 million, which represented a significant accounting deficit. Beginning with FY 2001-02, an accrual-based funding approach was adopted to account for the full costs associated with events that occur during a plan year, including actuarial cost estimates for incurred claims that may not be filed until after the plan year. The change to an accrual-based approach required funding to eliminate the accumulated accounting deficit and funding for newly incurred costs, but it contributed to significant improvements in HIRSP's accounting balance, which was $6.8 million at the end of FY 2003-04.

Table 5

Accounting Balances
(In Millions)

Date	Total Net Assets	Restricted for Excess Policyholder Premiums[1]	Unrestricted Net Assets[2]
June 30, 2001	$(6.1)	$ 2.1	$(8.2)
June 30, 2002	(3.0)	3.0	(6.0)
June 30, 2003	9.5	10.4	(0.9)
June 30, 2004	16.9	10.1	6.8
June 30, 2005	9.2	9.5	(0.3)

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

In FY 2004-05, HIRSP's unrestricted net asset balance declined $7.1 million, to a deficit of $300,000 at June 30, 2005. At least a portion of the decrease was expected in response to a Board of Governor's decision to apply $3.9 million in accumulated insurers' and providers' balances toward FY 2004-05 expenses. However, an unexpectedly large increase in claims costs contributed to a larger decrease than expected and to the small deficit. The deficit balance was considered in establishing funding requirements for FY 2005-06, and preliminary financial information indicates that HIRSP will likely end FY 2005-06 with a positive accounting balance. Consequently, we do not believe the small deficit balance at the end of FY 2004-05 represents a significant concern.

During our audit period, statutes required a separate accounting of premiums received in excess of the amount needed to cover policyholders' 60 percent share of HIRSP's costs. Statutes restricted the use of these premiums to the following purposes:

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

Because the statutory floor for premium rates was typically greater than the premiums needed to fund 60 percent of HIRSP's costs, and because actual claims costs were less than costs assumed in HIRSP's FY 2002-03 budget, the excess policyholder premium account balance increased significantly during FY 2002-03. The balance decreased slightly since then, to $9.5 million as of June 30, 2005. In February 2006, HIRSP's Board of Governors decided to apply $8.7 million of the excess premium balance toward the policyholders' share of costs in FY 2006-07, to limit the level of increases in premium rates during that year.

2005 Wisconsin Act 74 simplifies HIRSP's complex funding formula.

Simplifications to HIRSP's complex funding formula that were enacted in 2005 Wisconsin Act 74 will remove both the statutory floor for premium rates and the requirement for a separate accounting of the difference between premiums received and the amount necessary to cover 60 percent of plan costs. Beginning July 1, 2006, net assets will not be statutorily restricted for excess policyholder premiums. Further, the elimination of the statutory premium floor may provide the HIRSP Authority additional flexibility in establishing premium rates that more closely correlate to policyholders' share of costs.

Enrollment and Claims Costs

The policyholder enrollment level has begun to moderate.

HIRSP's increasing enrollment and claims costs have presented management and funding challenges for several years, although enrollment growth slowed in FY 2004-05. As shown in Table 6, 19,385 policyholders were enrolled in the three available plans as of June 30, 2005. However, the 5.4 percent enrollment increase for all plans is significantly less than the increases reported in five preceding years. Further, HIRSP's total enrollment decreased slightly during FY 2005-06 and was 18,650 as of June 30, 2006.

Table 6

HIRSP Enrollment

Date	Plan 1A	Plan 1B	Plan 2	Total Policyholders	Percentage Change
June 30, 1998	5,660[1]	354[1]	1,204[1]	7,218	–
June 30, 1999	5,540	683	1,231	7,454	3.3%
June 30, 2000	5,909	1,692	1,348	8,949	20.1
June 30, 2001	7,081	2,849	1,530	11,460	28.1
June 30, 2002	8,302	4,558	1,703	14,563	27.1
June 30, 2003	8,532	6,729	1,756	17,017	16.9
June 30, 2004	8,312	8,319	1,764	18,395	8.1
June 30, 2005	8,000	9,683	1,702	19,385	5.4
June 30, 2006	7,125	10,368	1,157	18,650	(3.8)

[1] Estimated

FY 2004-05 enrollment in plans 1A and 2 decreased slightly, but enrollment in plan 1B increased by 16.4 percent. Increasing numbers of participants have shifted from plan 1A to plan 1B in recent years; DHFS and HIRSP's Board of Governors attribute the shift to lower premiums in that plan.

Net claims costs increased $76.3 million from FY 2000-01 to FY 2004-05.

In contrast to moderating enrollment, claims costs are increasing, as shown in Table 7. Net claims costs, which represent the amount actually paid by HIRSP, increased 141.0 percent, or $76.3 million, from FY 2000-01 through FY 2004-05. A portion of these increases can be explained by the 69.2 percent increase in enrollment over the same period. Claims costs have also been affected by prescription drug and medical cost increases similar to those experienced by other payers. HIRSP's contracted actuary cites increased utilization of services by policyholders as another contributing factor.

Table 7

Net Claims Costs[1]
(In Millions)

Fiscal Year	Net Claims Costs[1]	Percentage Change
2000-01	$ 54.1	–
2001-02	67.2	24.2%
2002-03	85.8	27.7
2003-04	103.9	21.1
2004-05	130.4	25.5

[1] Net of health care providers' contributions

Changes in Program Costs and Provider Contributions

As noted, the usual and customary charges that are used in calculating the providers' share of HIRSP funding are intended to reflect the range of fees that most health care providers in a given area charge for a given procedure. They are common to the health insurance industry and are established annually by most insurers as discounts to billed charges. HIRSP, however, maintained the same discount—approximately 20 percent, in aggregate, of billed charges—from 1998 through 2004. Because providers' billing rates increased during that period, maintaining the "usual and customary" discount caused HIRSP's claims costs and provider contributions to increase more than was expected.

The Board increased the usual and customary discount to address unexpected increases in program costs and provider contribution levels.

In January 2005, with the help of a contracted actuary, DHFS and the Board of Governors decided to better reflect industry averages by increasing HIRSP's usual and customary discount rate to approximately 30 percent, in aggregate, of billed charges from January 1, 2004 through June 30, 2005. As a result of this change, claims costs were reduced by $25.5 million for the 18-month period. The change also reduced the level of provider contributions calculated for this period by the same amount.

HIRSP's Board of Governors convened its actuarial advisory subcommittee to provide advice on establishing a market-based benchmark for determining usual and customary charges after FY 2004-05. As part of this process, commercial insurance companies

were surveyed by HIRSP's contracted actuary to obtain information regarding their current discount levels. On the advice of the actuary, the Board of Governors subsequently approved a slightly smaller usual and customary discount of 28.5 percent for all providers for FY 2005-06. The actuarial advisory subcommittee also concluded that provider reimbursement rates were not keeping pace with inflation. In response, a 2.0 percent increase to provider payment rates was approved for FY 2005-06.

The approved usual and customary discount rate mistakenly had not been implemented for FY 2005-06.

Although HIRSP's Board of Governors approved a usual and customary discount of 28.5 percent for all providers during FY 2005-06, we found the change had not been implemented by DHFS and the plan administrator. As a result, both provider contributions and program costs were calculated incorrectly: both were an estimated $3.6 million less than they should have been for the first nine months of FY 2005-06. If uncorrected, this error would have materially misstated HIRSP's financial statements and affected its funding levels.

After we informed DHFS of the oversight, DHFS requested that the plan administrator implement the 28.5 percent discount rate and make the necessary adjustments to ensure program costs are properly reported and providers appropriately credited for their contributions in FY 2005-06. Because the FY 2006-07 budget projections developed by the contracted actuary, and approved by the Board of Governors in February 2006, were based on incorrectly calculated provider contributions and program costs for the first half of FY 2005-06, DHFS requested that the actuary assess whether changes were necessary to the budget before its implementation on July 1, 2006.

The actuary recommended and the Board of Governors approved an increase in provider reimbursement rates of 4.5 percent at the start of FY 2006-07. We will continue to monitor usual and customary discount rates in the future to ensure that approved rates are appropriately implemented.

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Audit Opinion ■

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

We have audited the accompanying financial statements of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP) as of and for the years ended June 30, 2005 and 2004. These financial statements are the responsibility of the Department of Health and Family Services' management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

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

In our opinion, the financial statements referred to in the first paragraph present fairly, in all material respects, the financial position of HIRSP as of June 30, 2005 and 2004, and the changes in its financial position and its cash flows for the years then ended in conformity with accounting principles generally accepted in the United States of America.

Our audits were conducted for the purpose of forming an opinion on the financial statements of HIRSP. The supplementary information included as Management's Discussion and Analysis on pages 23 through 29 is presented for purposes of additional analysis and is not a required part of the financial statements referred to in the first paragraph. We have applied certain limited procedures, which consisted principally of inquiries of management regarding the methods of measurement and presentation of the supplementary information. However, we did not audit the information and express no opinion on it.

In accordance with *Government Auditing Standards*, we have also issued a report dated August 1, 2006, on our consideration of HIRSP's internal control over financial reporting and on our tests of its compliance with certain provisions of laws, regulations, contracts, and other matters. The purpose of that report is to describe the scope of our testing of internal control over financial reporting and compliance and the results of that testing, and not to provide an opinion on internal control over financial reporting or on compliance. That report is an integral part of an audit performed in accordance with *Government Auditing Standards* and should be considered in assessing the results of our audit.

LEGISLATIVE AUDIT BUREAU

August 1, 2006

Diann Allsen
Audit Director

Management's Discussion and Analysis ■

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

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

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

Overview of Financial Statements

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

HIRSP's financial statements comprise two components: 1) the financial statements, and 2) notes to the financial statements.

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

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

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

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

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

A fund is a grouping of related accounts that is used to maintain control over resources that have been segregated for specific activities or objectives. HIRSP uses fund accounting to ensure and demonstrate compliance with finance-related legal requirements. During FY 2004-05, the plan had two funding types: program revenue in the form of segregated (SEG) funds, and federal grant funds.

Program revenue is received by HIRSP from policyholders and insurers. Health care providers, except pharmacies, contribute to HIRSP by accepting a reduction in fees for their services. Section 149.143, Wis. Stats., prescribes a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers, except pharmacies, to share in plan costs. Pharmacies are specifically exempt from contributing to HIRSP as provided by s. 149.142(1)(b), Wis. Stats.

Premiums, which are statutorily required to be at least 140 percent of standard risk rates, are to fund 60 percent of estimated program costs as long as the necessary premium rates do not exceed 200 percent of standard risk rates. Private health insurers doing business in Wisconsin and health care providers (except pharmacies) providing medical services to HIRSP policyholders are to share equally in:

- costs remaining after the deduction of the policyholders' share of the costs;

- premium, deductible, and drug coinsurance subsidy costs; and

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

Since FY 1997-98, the highest HIRSP premium rates occurred in FY 2001-02, when they were 161.9 percent of the standard risk rates at that time.

Financial Analysis of HIRSP

In this discussion and analysis, the reasons for the changes in financial activity between FY 2004-05 and FY 2003-04 are reviewed. Net assets may serve over time as a useful indicator of the financial position of HIRSP. In the case of HIRSP, assets exceeded liabilities by $9,248,546 at the close of the fiscal year ending June 30, 2005, a decline of $7,649,828 in net assets since June 30, 2004.

Condensed Financial Information

	June 30, 2005	June 30, 2004	Percentage Change
Total Assets	$50,953,750	$51,820,029	(1.7%)
Total Liabilities	41,705,204	34,921,655	19.4
Net Assets:			
Restricted	9,542,625	10,106,007	(5.6)
Unrestricted	(294,079)	6,792,367	(104.3)
Total Net Assets	**$ 9,248,546**	**$16,898,374**	

	FY 2004-05	FY 2003-04	Percentage Change
Operating Revenues	$125,172,464	$116,000,161	7.9%
Operating Expenses	(136,023,918)	(109,033,117)	24.8
Nonoperating Revenues and Expenses	3,201,626	400,809	698.8
Change in Net Assets	**$ (7,649,828)**	**$ 7,367,853**	

The largest portion of HIRSP's total assets, 95.3 percent, is in the form of cash and cash equivalents. HIRSP uses cash to pay current operating expenses. Cash in excess of immediate needs is invested in short-term investments with the State of Wisconsin Investment Board.

The largest area of HIRSP's liabilities, 57.0 percent, is unpaid loss liabilities. Unpaid loss liabilities represent the accumulation of unpaid medical and pharmaceutical claims, net of health care provider contributions, that were reported but not paid prior to the close of the accounting period, and an actuarial estimate of claims incurred prior to June 30 but not reported. Consequently, cash is reserved for payment of these future claims.

Unearned premiums comprise the second largest liability, accounting for 40.3 percent of liabilities. Unearned premiums are premiums paid in advance of the period of HIRSP coverage.

HIRSP's revenues consist of policyholder premiums, insurer assessments, and federal grant funds. HIRSP uses these revenues to pay operating expenses. HIRSP's revenues, combined with reduced payments to health care providers (provider contributions), were insufficient to cover all operating expenses of the program during FY 2004-05. Therefore, HIRSP's net assets decreased by $7,649,828 during the fiscal year.

Financial Highlights

- Plan enrollment as of June 30, 2005, was 19,385, an increase of 5.4 percent over June 30, 2004 enrollment of 18,395. However, enrollment has declined since June 30, 2005, and as of June 30, 2006, it was 18,650.

- As a result of the FY 2004-05 enrollment increase and unsubsidized policyholder premium rate increases of 12.2 percent for plans 1A and 1B and 18.4 percent for plan 2, premium revenues increased 15.1 percent.

- Insurer assessment revenue decreased 8.3 percent during FY 2004-05 due to the use of $2.8 million of the insurers' net asset balance carried forward from the prior calendar year. Under s. 149.143(5)(a), Wis. Stats., assessments must be adjusted based on the results of the prior year's reconciliation of HIRSP costs to funding provided by the three funding parties. Net asset balances or deficits determined during the reconciliation are carried forward to future periods.

- For the first time, federal grant funds became available for states that had established qualified high-risk pools that incurred losses (defined as premium revenue less operating expenses), restrict premiums charged to no more than 200 percent of premiums for standard risk rates, offer a choice of two or more coverage options, and have a mechanism in effect to reasonably ensure continued funding of losses incurred in connection with operation of the pool after June 30, 2003. HIRSP received $2.2 million in federal grant funds during FY 2004-05.

- Investment income increased from $406,299 in FY 2003-04 to $983,259 in FY 2004-05, due to an increased investment balance and a steady increase in interest rates.

- Total claims expenses (net of health care providers' contributions) increased 25.5 percent during FY 2004-05 due to increases in medical and pharmacy costs, utilization of services, and enrollment. Correspondingly, unpaid loss liabilities increased by 25.2 percent.

- Plan operations are conducted by DHFS staff, as well as a third-party contract administrator.

  - Total administrative costs for FY 2004-05 were $5,509,742, or 4.1 percent of total plan cost for FY 2004-05, continuing a three-year trend of decreasing administrative costs as a percentage of total plan costs.

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

Cost Summary on a per Member per Month (PMPM) Basis
FY 2003-04 and FY 2004-05

Description	FY 2004-05	FY 2003-04	FY 2004-05 PMPM	FY 2003-04 PMPM	Percentage Change PMPM
Member Months (Total Members Enrolled in Each Month of Fiscal Year)	224,905	213,195	–	–	5.49%
Gross Claims (Costs before Provider Contributions Are Deducted)	$162,056,142	$135,523,775	$720.55	$635.68	13.35%
Administrative Expenses	$5,509,742	$5,060,142	$24.50	$23.73	3.22%

- HIRSP's net assets decreased during FY 2004-05. The change in net assets for FY 2004-05 was ($7,649,828), while the change in net assets for FY 2003-04 was $7,367,853. The decrease in FY 2004-05 was primarily the result of HIRSP expenses being $3.1 million greater than budgeted and the use of $3.9 million of insurer and provider carryover asset balances to fund current costs, as required by s. 149.143(5)(a), Wis. Stats.

- Net assets were also affected by a Board of Governor's decision in January 2005 to increase the usual and customary discount percentage to approximately 30 percent of billed charges for an 18-month period through June 30, 2005. The decision was based on the belief that HIRSP discounts were lower than the industry average. The increase in the discount percentage reduced gross medical losses by $17.0 million in total for FY 2004-05 and was shared by the three funding parties. However, the reduction in costs due to the change was offset by increasing claims costs. If the change in the discount percentage had not been made, net assets would have decreased by an additional $17.0 million.

- Net assets are split between restricted and unrestricted.

  - Restricted net assets, which represent policyholder premiums received in excess of their share of plan costs, decreased slightly from $10,106,007 to $9,542,625 because of higher than budgeted expenses that were greater than the reduction in costs associated with the change in the usual and customary discount percentage.

  - The restricted net assets are statutorily required under s. 149.143(2m)(b), Wis. Stats., to be used 1) to reduce policyholder premiums to a floor of 140 percent of standard risk rates when premiums exceed the policyholders' share of plan costs; 2) for other needs of eligible persons, with the approval of the Board of Governors; or 3) for distribution to eligible persons.

  - Unrestricted net assets, which represent the insurers' and providers' portion of fund balance, decreased from $6,792,367 to ($294,079). A number of factors contributed to the decrease, including higher than estimated expenses, the use of insurer and provider carryover balances, and the change in the usual and customary discount percentage. Although the change in the usual and customary discount percentage reduced costs for the three funding parties, including insurers and providers, it also reduced provider contributions.

Other Known Facts

2005 Wisconsin Act 74, enacted in December 2005, makes numerous changes to HIRSP, including the transfer of responsibility from DHFS to a newly created HIRSP Authority beginning July 1, 2006. Unencumbered balances in the DHFS appropriation accounts for HIRSP as of July 1, 2006, must be transferred to the HIRSP Authority. Under Act 74, the Authority must continue to contract with the

current HIRSP plan administrator under contract with DHFS. The Authority's Board of Directors was appointed and has been working with DHFS and the plan administrator on transition-related tasks. The Authority's Board of Directors selected and approved the hiring of a HIRSP director in June 2006. After assisting in the transition of HIRSP to the Authority, DHFS will no longer be responsible for HIRSP. For additional details of the changes required by Act 74, see Note 12 of the financial statement notes.

Contacting the Plan's Financial Management

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

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

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

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Financial Statements ■

Balance Sheet
June 30, 2005 and 2004

	June 30, 2005	June 30, 2004
ASSETS		
Cash and Cash Equivalents (Note 2)	$ 48,557,364	$ 49,824,628
Drug Rebates Receivable (Note 3)	1,586,548	941,241
Premiums Receivable (Note 3)	528,125	153,969
Claims Receivable (Note 3)	192,835	35,951
Assessments Receivable (Note 3)	85,013	90,547
Prepaid Items	3,585	31,013
Due from the State of Wisconsin (Note 3)	280	742,680
TOTAL ASSETS	**$ 50,953,750**	**$ 51,820,029**
LIABILITIES AND NET ASSETS		
Liabilities:		
Unpaid medical loss liabilities (Note 4)	$ 20,085,992	$ 15,294,266
Unpaid pharmacy loss liabilities (Note 4)	1,293,902	1,644,708
Unpaid loss adjustment expenses (Note 4)	660,000	660,000
Unearned premiums (Note 1F)	16,817,952	16,565,409
Payments to providers (Note 3)	1,739,431	0
Miscellaneous Payables	571,695	418,476
Accrued Administrative Expenses	536,232	338,796
Total Liabilities	**41,705,204**	**34,921,655**
Net Assets:		
Restricted for excess policyholder premiums (Note 5)	9,542,625	10,106,007
Unrestricted	(294,079)	6,792,367
Total Net Assets	**9,248,546**	**16,898,374**
TOTAL LIABILITIES AND NET ASSETS	**$ 50,953,750**	**$ 51,820,029**

The accompanying notes are an integral part of this statement.

Statement of Revenues, Expenses, and Changes in Net Assets for the Years Ended June 30, 2005 and 2004

	For the Year Ended June 30, 2005	For the Year Ended June 30, 2004
OPERATING REVENUES		
Premiums (Note 1F)	$ 92,726,195	$ 80,582,808
Insurers' Assessments (Note 6)	32,446,269	35,417,353
Total Operating Revenues	**125,172,464**	**116,000,161**
OPERATING EXPENSES		
Losses:		
Gross medical losses	109,839,286	93,468,035
Provider contributions (Note 10)	(31,626,631)	(31,642,500)
Increase (Decrease) in unpaid medical losses (Note 4)	6,436,550	2,601,429
Total medical losses	84,649,205	64,426,964
Gross pharmacy losses	46,131,112	39,188,171
Increase (Decrease) in unpaid pharmacy losses (Note 4)	(350,806)	266,140
Total pharmacy losses	45,780,306	39,454,311
Total Losses	**130,429,511**	**103,881,275**
General and Administrative Expenses (Note 9)	5,509,742	5,060,142
Referral Fees (Note 1G)	84,665	91,700
Total Operating Expenses	**136,023,918**	**109,033,117**
OPERATING INCOME	**(10,851,454)**	**6,967,044**
NONOPERATING REVENUES AND EXPENSES		
Federal Grant Revenue (Note 11)	2,222,903	0
Investment Income	983,259	406,299
Transfer to the General Fund	(4,536)	(5,490)
Total Nonoperating Income	**3,201,626**	**400,809**
CHANGE IN NET ASSETS	**(7,649,828)**	**7,367,853**
NET ASSETS		
Total Net Assets—Beginning of the Year	16,898,374	9,530,521
Total Net Assets—End of the Year	**$ 9,248,546**	**$ 16,898,374**

The accompanying notes are an integral part of this statement.

Statement of Cash Flows for the Years Ended June 30, 2005 and 2004

	For the Year Ended June 30, 2005	For the Year Ended June 30, 2004
CASH FLOWS FROM OPERATING ACTIVITIES		
Cash Received for Premiums	$ 93,329,519	$ 83,170,109
Cash Received for Assessments	32,451,804	35,493,841
Cash Received for Federal Grant	2,222,903	0
Cash Payments for Medical Losses	(79,896,477)	(64,253,874)
Cash Payments for Pharmacy Losses	(45,036,987)	(39,557,869)
Cash Payments for Other Expenses	(5,321,285)	(5,698,763)
Net Cash Provided by Operating Activities	**(2,250,523)**	**9,153,444**
CASH FLOWS FROM INVESTING ACTIVITIES		
Investment Income	983,259	406,299
Net Cash Provided by Investing Activities	**983,259**	**406,299**
NET INCREASE IN CASH AND CASH EQUIVALENTS	**(1,267,264)**	**9,559,743**
Cash and Cash Equivalents, Beginning of Year	49,824,628	40,264,885
Cash and Cash Equivalents, End of Year	$ 48,557,364	$ 49,824,628
RECONCILIATION OF NET OPERATING INCOME TO NET CASH PROVIDED BY OPERATING ACTIVITIES		
Net Operating Income	$ (10,851,454)	$ 6,967,044
Adjustments to Reconcile Net Operating Income to Net Cash Provided by Operating Activities:		
Federal grant revenue reported as nonoperating revenue	2,222,903	0
Changes in assets and liabilities:		
Decrease (Increase) in receivables	(428,412)	(254,053)
Decrease (Increase) in prepaids	27,428	52,027
Increase (Decrease) in liability for premium overpayments	0	(471,488)
Increase (Decrease) in accounts payable	350,656	(2,142,218)
Increase (Decrease) in unearned premiums	252,542	2,955,843
Increase (Decrease) in medical loss liabilities	4,791,725	1,785,639
Increase (Decrease) in pharmacy loss liabilities	1,388,625	266,140
Other adjustments	(4,536)	(5,490)
Total Adjustments	8,600,931	2,186,400
Net Cash Provided by Operating Activities	**$ (2,250,523)**	**$ 9,153,444**

The accompanying notes are an integral part of this statement.

Notes to the Financial Statements ■

1. Summary of Significant Accounting Policies

A. Description of the Fund

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

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

Section 149.143, Wis. Stats., prescribes a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers to share in estimated costs. Plan 1A and 1B premiums, which are statutorily required to be at least 140 percent of standard risk rates, are to fund 60 percent of these estimated costs, as long as the necessary premium rates do not exceed 200 percent of standard risk rates. Plan 2 premiums are established using criteria outlined in s. 149.14 5(m), Wis. Stats.: 1) comparison of cost per capita for plans 1A and 2 in the previous calendar year; 2) enrollment levels of eligible persons in plans 1A and 2; and 3) economic factors DHFS and the HIRSP Board of Governors consider relevant.

Private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders are to share equally in:

- costs remaining after the deduction of the policyholders' share of the costs;
- premium, deductible, and drug coinsurance subsidy costs; and
- excess costs when premium rates needed to fund 60 percent of costs exceed 200 percent of premium rates for standard risks.

B. Basis of Presentation and Accounting

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

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

Operating revenues and expenses are directly related to the ongoing medical insurance activities of HIRSP. Nonoperating revenues, such as investment income and federal grants, and nonoperating expenses are indirectly related to the ongoing medical insurance activities of HIRSP.

C. Accounting Estimates

The preparation of financial statements requires management to make estimates and assumptions that affect the amounts reported in the financial statements and accompanying notes. Actual results may differ from those estimates. Estimates that are particularly susceptible to significant change are the unpaid loss liabilities as described in Notes 1E and 4 and the health care provider contributions as described in Note 10. In estimating these items, management used the methodologies discussed in the applicable notes.

D. Cash and Cash Equivalents

Cash and cash equivalents reported on the Balance Sheet and the Statement of Cash Flows include a demand deposit account at a commercial financial institution and cash deposited with the State of Wisconsin, where available balances beyond immediate needs are pooled in the State Investment Fund for short-term investment purposes. Balances pooled are restricted to legally stipulated investments. These investments are valued consistent with GASB Statement Number 31, *Accounting and Financial Reporting for Investments and for External Investment Pools.*

E. Unpaid Loss Liabilities

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

F. Premium and Assessment Revenue

Premiums are recognized as revenue over the terms of the insurance policies, and a liability for unearned premiums is established to reflect premiums received applicable to subsequent accounting periods. Participating insurers are assessed every six months, and revenue is recognized over the period covered by the assessment. Insurer assessments are determined annually during the budgeting process and split into two installments.

G. Policy Acquisition Costs

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

H. Change in Presentation of Losses

Beginning with FY 2004-05, DHFS and the Board of Governors decided to separately present medical and pharmacy losses and their related liabilities in the financial statements. The prior-year financial statements have been reclassified in order to be consistent with the current year's presentation.

2. DEPOSITS

HIRSP's cash balances are maintained primarily with the State of Wisconsin Investment Board. General depository and claims checking accounts are also maintained with a commercial financial institution. Cash is transferred between the commercial accounts and the state account as necessary. The carrying amount of the commercial accounts was $1,031,054 at June 30, 2005, and $897,099 at June 30, 2004. The bank balance was $1,033,870 at June 30, 2005, and $2,294,505 at June 30, 2004.

Custodial credit risk related to deposits is the risk that, in the event of the failure of a depository financial institution, HIRSP will not be able to recover deposits that are in possession of an outside party. DHFS does not have a deposit policy specifically for custodial credit risk related to HIRSP. The Federal Deposit Insurance Corporation and the Wisconsin State Deposit Guarantee Fund (s. 34.08, Wis. Stats.) insure state deposits up to $500,000. Therefore, $533,870 of the bank balance was uninsured and uncollateralized at June 30, 2005, and $1,794,505 was uninsured and uncollateralized at June 30, 2004.

Cash deposited with the State of Wisconsin is invested in the State Investment Fund, which is a short-term pool of state and local funds managed by the State of Wisconsin Investment Board with oversight by its Board of Trustees. The carrying amount of shares in the State Investment Fund, which is presented at fair value, was $46,370,607 as of June 30, 2005, and $48,667,920 as of June 30, 2004. Cash on deposit with the State but not yet invested in the State Investment Fund was $1,155,703 as of June 30, 2005, and $259,609 as of June 30, 2004.

The various types of securities in which the State Investment Fund may invest are enumerated in ss. 25.17(3)(b), (ba), and (bd), Wis. Stats., and include direct obligations of the United States and Canada, securities guaranteed by the United States, securities of federally chartered corporations, unsecured notes of financial and industrial issuers, Yankee/Euro issues, certificates of deposit issued by banks in the United States and solvent financial institutions in this state, and bankers' acceptances. The State of Wisconsin Investment Board's trustees may approve other prudent investments and have granted derivatives authority, subject to review and approval by the State of Wisconsin Investment Board's Investment Committee, limited to positions in finance futures, options, and swaps and only if the purpose is to hedge existing positions, adjust portfolio duration within statutory guidelines, or reduce the interest rate risk. The State Investment Fund is not registered with the Securities and Exchange Commission.

3. RECEIVABLES AND PAYABLES

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

Of the $528,125 in premium receivables as of June 30, 2005, $204,344 is due from the plan administrator for premium payments made by credit card but not yet transferred to HIRSP. The remaining balance of $323,781 is for unreserved premium payments due for the July 2005 premium period.

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

As of June 30, 2005 the balance of unreserved claims receivables is $192,835, all of which is less than one year old.

A large payable to providers existed at June 30, 2005, because of the timing of the last June bimonthly pharmacy claims payment. In FY 2003-04, the last June claims payments were processed and paid before fiscal year-end. The remaining outstanding claims are included in the unpaid loss liabilities account (see Note 4).

4. LIABILITY FOR UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES

The following represents changes in the combined medical and pharmacy unpaid loss liabilities and unpaid loss adjustment expense liability account balances for FYs 2004-05 and 2003-04 (in thousands):

	FY 2004-05	FY 2003-04
Balance—Beginning of the Year	$ 17,599	$ 15,547
Incurred Claims:		
Provision for insured events of the current fiscal year	134,979	108,873
Changes in provision for insured events of prior fiscal years	(1,092)	(2,746)
Total Incurred	133,887	106,127
Payments:		
Claims attributable to insured events of the fiscal year	113,955	92,174
Claims attributable to insured events of prior fiscal years	15,491	11,901
Total Paid	129,446	104,075
Balance—End of the Year	$ 22,040	$ 17,599

5. NET ASSETS RESTRICTED FOR EXCESS POLICYHOLDER PREMIUMS

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

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

In April 2004, the Board of Governors voted to use $2,151,879 of the excess policyholder premium account to reduce the unfunded deductible and drug coinsurance subsidies balance as of March 31, 2004. An additional unfunded deductible and coinsurance subsidies balance of $1,100,225 had accumulated through June 30, 2005. In July 2005, the Board of Governors voted to use $1,100,225 of the excess policyholder premium account to reduce the balance as of June 30, 2005. 2005 Wisconsin Act 74 simplified the funding formula in HIRSP statutes and addressed this technical statutory provision.

6. INSURERS' ASSESSMENTS

Statutes prescribe that participating insurers contribute 20 percent of general HIRSP costs and 50 percent of the subsidy costs. 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.

7. DRUG COINSURANCE ANNUAL OUT-OF-POCKET MAXIMUMS

The drug coinsurance benefit has an annual out-of-pocket maximum, which varies by plan and option. Once the drug coinsurance out-of-pocket maximum is reached, HIRSP pays 100 percent of the allowed amount for the remainder of the calendar year. Plan 1A policyholders who qualify for deductible reductions also qualify for reductions in drug coinsurance out-of-pocket maximums. The reduced drug coinsurance out-of-pocket maximum will be based on the reduced medical deductible for which the policyholder qualifies. The table that follows provides details. Note 8 further discusses the drug coinsurance subsidies provided in FY 2004-05 and FY 2003-04.

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

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

8. PREMIUM, DEDUCTIBLE, AND DRUG COINSURANCE SUBSIDIES

HIRSP provides a premium, deductible, and drug coinsurance subsidy program to reduce premiums, deductible levels, and out-of-pocket costs for prescription drugs for low-income policyholders. This program varies by plan and option. HIRSP policyholders enrolled in plan 1A or plan 2 who have annual household incomes below $25,000 are eligible for a premium subsidy. No premium subsidy is available for policyholders enrolled in plan 1B. Policyholders enrolled in plan 1A with incomes below $20,000 are also eligible for a deductible subsidy. No deductible subsidy is available for policyholders enrolled in plan 1B or plan 2. Note 7 further discusses the drug coinsurance subsidies that are also provided to plan 1A policyholders.

HIRSP premiums for plan 1A and 1B are based on standard risk rates; that is, the rates private insurers would charge for individual insurance policies providing substantially the same coverage and deductibles as provided under HIRSP. Policyholders not eligible for a premium subsidy have generally been paying 140 to 150 percent of the rate a standard risk individual would pay in recent years, although premiums can be increased to 200 percent of standard risk if necessary to meet requirements of the funding formula. In FY 2004-05, premium rates for the primary plan were set at 140 percent of the rate a standard risk individual would pay.

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

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

Twenty percent of HIRSP policyholders received premium, deductible, and drug coinsurance subsidies totaling $5,018,627 in FY 2004-05, and $4,743,866 in FY 2003-04. The following table summarizes the amounts provided for each subsidy type during these years.

Subsidy Type	FY 2004-05	FY 2003-04
Premium	$4,142,096	$3,980,244
Deductible	660,248	602,320
Drug Coinsurance	216,283	161,302
Total	$5,018,627	$4,743,866

Premium, deductible, and drug co-insurance subsidy costs were shared equally by health insurers and health care providers, with each contributing $2,509,314 in FY 2004-05, and $2,371,933 in FY 2003-04. Pharmacies are statutorily exempt from contributing toward these costs.

9. GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses include the following:

	FY 2004-05	FY 2003-04
Plan Administrator Fees	$4,826,220	$3,915,253
State Administrative Costs	483,072	471,448
HIPAA Implementation	0	451,582
Postage	150,576	193,034
Other Expenses	49,874	28,825
Total	$5,509,742	$5,060,142

DHFS, in consultation with HIRSP's Board of Governors, selected a new HIRSP plan administrator through a competitive procurement process. The new plan administrator, Wisconsin Physicians Service (WPS), has subcontracted with Navitus Health Solutions for pharmacy benefit management services and with Milliman USA for consulting actuarial services. The plan administrator operations period began April 1, 2005, and

ends April 1, 2008, with three one-year renewals possible. Plan administrator fees for FY 2004-05 include one-time transition costs of $199,000. Beginning April 1, 2005, postage costs are included in plan administrator fees. Therefore, only nine months of postage expense is included in the amount presented for FY 2004-05.

10. HEALTH CARE PROVIDERS' CONTRIBUTIONS

Statutes prescribe that health care providers, except pharmacies, contribute 20 percent of general HIRSP costs and 50 percent of the subsidy costs. Provider contributions are obtained by reducing the amount health care providers are reimbursed for billed services. The health care provider contributions are not reported as revenue in the financial statements, but rather are reflected as a reduction to gross losses.

The basis for calculating HIRSP's program costs is usual and customary charges, which are reported as medical losses in the financial statements. The usual and customary charges are determined by applying percentage discounts to billed charges. From 1998 until 2004, the discounts used were based on reimbursement levels under the HIRSP program prior to 1998. The provider contribution represents the difference between usual and customary charges and allowed charges, which are amounts based on Medicaid reimbursement rates plus an add-on percentage.

In 2004, usual and customary charges, the provider contribution balance, and program costs began to grow considerably. An actuarial analysis determined the cause to be an increase in billed charges and provider reimbursement rates not keeping pace with inflation. The HIRSP discount in place since 1998 was believed to be approximately 10 percent lower than the industry average. Based on the difference between HIRSP discounts and estimated industry averages, the Board of Governors decided in January 2005 to increase the discounts applied to billed charges for the period January 1, 2004 through June 30, 2005 to be more reflective of industry averages. On an aggregate basis, the discounts were increased from approximately 20 percent to approximately 30 percent. The revised discounts are reflected in the medical losses reported for the last six months of FY 2003-04 and all of FY 2004-05. The revised discounts decreased program costs that are shared by the different funding groups but did not affect the net losses paid.

To further analyze growing provider contributions and program costs, the Board convened its actuarial advisory subcommittee to provide advice on establishing a market-based benchmark for determining usual and customary charges in the future. After obtaining input from the HIRSP contracted actuary and the subcommittee, the Board also concluded that the increasing provider contributions and program costs were the result of several factors, including increasing charges billed by providers and provider rates not keeping pace with inflation. The Board approved a 28.5 percent discount rate

to billed charges for all non-pharmacy providers beginning July 1, 2005. In addition, provider reimbursement rates were increased 2.0 percent beginning July 1, 2005.

Although management believes the results of the estimates are materially correct, due to uncertainties inherent in estimates the actual provider contribution may be in excess or less than the amounts estimated.

11. FEDERAL GRANT REVENUE

DHFS applied for and received a federal grant of $2,222,903 designated specifically for high-risk health insurance pools. The grant funds, which were first available to HIRSP in FY 2004-05, were used to pay HIRSP claims and reduced program costs for the three funding parties. DHFS applied for the same grant for FY 2005-06 and was awarded grant funds of $2,500,578. These funds will be reflected in the FY 2005-06 financial statements.

12. SUBSEQUENT EVENTS

2005 Wisconsin Act 74, which was enacted December 21, 2005, makes significant changes to HIRSP. It creates the HIRSP Authority and transfers administrative authority from DHFS to the new Authority and its Board of Directors effective July 1, 2006. An Authority is a public body, created by law, with a board of directors but is not a state agency. Act 74 specifies the composition of the Board of Directors and defines the duties and powers of the Authority, which is subject to open records and open meetings requirements of Chapter 19 of the statues. The Authority is to adopt policies to administer HIRSP according to Chapter 149 of Wisconsin Statutes and to contract with the current plan administrator for HIRSP. Under Act 74, unencumbered balances in the DHFS appropriation accounts for HIRSP as of July 1, 2006, must be transferred to the HIRSP Authority.

2005 Wisconsin Act 74 also:

- eliminates the complex funding formula under prior law, but retains the same basic funding system that premiums must pay 60 percent of costs, excluding subsidies, and insurers and providers must each pay 20 percent of costs excluding subsidies;

- requires that subsidy costs be paid first from any federal funds received and then equally by insurers and providers;

- requires the Legislative Audit Bureau to annually conduct a financial audit of HIRSP;

- continues HIRSP benefits under prior law through December 31, 2006. Beginning January 1, 2007, HIRSP benefits may be changed, subject to the requirement that certain services specified in statutes be covered;

- requires that HIRSP applicants be domiciled in Wisconsin for three months instead of 30 days, as under prior law;

- requires applicants be rejected by two insurers instead of one insurer within nine months;

- retains prior law provisions that persons with low household incomes receive premium subsidies as established by the Authority;

- requires the Authority to design and administer a qualified health plan under the federal Trade Adjustment Assistance Reform Act of 2002; and

- creates an income and franchise tax credit and a license fee credit for insurers that pay assessments for HIRSP.

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Report on Internal Control and Compliance ■

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

We have audited the financial statements of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP) as of and for the years ended June 30, 2005, and June 30, 2004, and have issued our report thereon dated August 1, 2006. We conducted our audits in accordance with auditing standards generally accepted in the United States of America and the standards applicable to financial audits contained in *Government Auditing Standards*, issued by the Comptroller General of the United States.

Internal Control over Financial Reporting

In planning and performing our audit, we considered the Department of Health and Family Services' internal control over HIRSP's financial reporting in order to determine our auditing procedures for the purpose of expressing our opinion on the financial statements, and not to provide an opinion on the internal control over financial reporting. 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 was the failure by the Department and the plan administrator to implement Board of Governors-approved changes to usual and customary discounts to billed medical claims that were to take effect July 1, 2005. As a result, program costs and provider contributions were not being properly calculated during FY 2005-06. The Department subsequently took steps to address this oversight. Further discussion of the reportable condition can be found in the section titled "Changes in Program Costs and Provider Contributions."

A material weakness is a reportable condition in which the design or operation of one or more of the internal control components does not reduce to a relatively low level the risk that misstatements caused by error or fraud in amounts that would be material in relation to the basic financial statements being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions. Our consideration of the internal control over financial reporting would not necessarily disclose all matters in the internal control that might be reportable conditions and, accordingly, would not necessarily disclose all reportable conditions that are also considered to be material weaknesses. However, we consider the reportable condition related to the failure to implement changes to usual and customary discounts to be a material weakness.

COMPLIANCE AND OTHER MATTERS

As part of obtaining reasonable assurance about whether HIRSP's financial statements are free of material misstatement, we performed tests of its compliance with certain provisions of laws, regulations, contracts, and grant agreements noncompliance with which could have a direct and material effect on the determination of financial statement amounts. However, providing an opinion on compliance with those provisions was not an objective of our audit and, accordingly, we do not express such an opinion. The results of our tests disclosed no instances of noncompliance or other matters that are required to be reported under *Government Auditing Standards.*

However, we noted a certain additional matter, pertaining to the resolution and reporting of claims errors by the plan administrator, that we reported to the Department of Health and Family Services in a separate memorandum dated June 14, 2006.

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

LEGISLATIVE AUDIT BUREAU

August 1, 2006

Diann Allsen
Audit Director