$109,195 of the insurers' assessments receivable balance is not expected to be collected within the following fiscal year. While the plan expects to receive all drug rebates receivable, it typically takes more than one year for final settlement to occur. $253,999 of the claims receivable balance is greater than two years old, and $228,600 is not expected to be collected in the following fiscal year. The remaining claims receivable balance of $170,010 is less than two years old, and $102,006 is not expected to be collected in the following fiscal year.

Significant payable and other accrued liability balances as of June 30, 2003, include the following:

Payments to Providers	$1,950,069
Accrued Administrative Expenses	759,030
Miscellaneous Payables	190,391
Total	$2,899,490

4. LIABILITY FOR UNPAID LOSSES AND LOSS ADJUSTMENT EXPENSES

The following represents changes in the combined unpaid loss liabilities and unpaid loss adjustment expense liability account balances for FYs 2002-03 and 2001-02 (in thousands):

	FY 2002-03	FY 2001-02
Balance, Beginning of Year	$15,296	$17,790
Incurred Claims:		
Provision for insured events of the current fiscal year	90,904	75,553
Changes in provision for insured events of prior fiscal years	(3,815)	(7,035)
Total Incurred	87,089	68,518
Payments:		
Claims attributable to insured events of the fiscal year	76,344	61,161
Claims attributable to insured events of prior fiscal years	10,494	9,851
Total Paid	86,838	71,012
Balance, End of Year	$15,547	$15,296

5. LIABILITY FOR PREMIUM OVERPAYMENTS

During the calculation of premium rates for FY 2001-02, an error caused subsidized policyholders to overpay $700,000 in premiums. (See Note 9 for a description of subsidies.) According to s. 149.165, Wis. Stats., premium rates for subsidized policyholders should be set at a specific percentage of the standard rate according to household income. Instead, the subsidized premium rates for FY 2001-02 were incorrectly increased at the same rate as the unsubsidized premium rates. The HIRSP Board of Governors voted on September 10, 2003, to issue a premium refund to policyholders who received a subsidy in FY 2001-02 and are currently active. This action resulted in an accrued liability of $471,488 on June 30, 2002 and 2003. These refunds were paid in December 2003.

6. NET ASSETS RESTRICTED FOR EXCESS POLICYHOLDER PREMIUMS

Section 149.143(2m)(a), Wis. Stats., requires DHFS to keep a separate accounting of the difference between premiums received during a plan year and the amount of premiums necessary to cover policyholders' 60 percent share of plan costs for that plan year. The use of these funds is restricted under s. 149.143(2m)(b), Wis. Stats., as follows: 1) to reduce policyholder premiums to a floor of 150 percent (140 percent effective July 30, 2002) 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.

7. INSURERS' ASSESSMENTS

Statutes prescribe that participating insurers contribute 20 percent of general HIRSP costs and 50 percent of the subsidy costs not funded by GPR. Each participating insurer shares in the costs of HIRSP in proportion to the ratio of the insurer's total health care coverage revenue for Wisconsin residents to the aggregate health care coverage revenue of all participating insurers for Wisconsin residents. Insurers writing health insurance in Wisconsin are required to report the annual amount of accident and health insurance premiums earned to the Commissioner of Insurance, and assessments based on percentages derived from these reports are made every six months.

8. DRUG COINSURANCE OUT-OF-POCKET MAXIMUMS

As of January 1, 2002, HIRSP prescription drug benefits changed. Under the new benefit program, policyholders are responsible for a 20 percent coinsurance payment up to a maximum of $25 per prescription. HIRSP will pay the remainder of the allowed amount directly to the pharmacy.

The drug coinsurance benefit also has an annual out-of-pocket maximum, which varies by plan and option. Once the drug coinsurance out-of-pocket maximum is reached, HIRSP pays 100 percent of the allowed amount for the remainder of the calendar year. Plan 1A policyholders who qualify for deductible reductions also qualify for reductions in drug coinsurance out-of-pocket maximums. The reduced drug coinsurance out-of-pocket maximum will be based on the reduced medical deductible for which the policyholder qualifies. The table that follows provides details. Note 9 further discusses the drug coinsurance subsidies provided in FY 2002-03 and FY 2001-02.

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

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

9. PREMIUM, DEDUCTIBLE, AND DRUG COINSURANCE SUBSIDIES

HIRSP provides a premium, deductible, and drug coinsurance subsidy program to reduce premiums, deductible levels, and out-of-pocket costs for prescription drugs for low-income policyholders. This program varies by plan and option. HIRSP policyholders enrolled in plan 1A or plan 2 who have annual household incomes below $25,000 are eligible for a premium subsidy. No premium subsidy is available for policyholders enrolled in plan 1B. Policyholders enrolled in plan 1A with incomes below $20,000 are also eligible for a deductible subsidy. No deductible subsidy is available for policyholders enrolled in plan 1B or plan 2. Note 8 further discusses the drug coinsurance subsidies that are also provided to plan 1A policyholders.

HIRSP premiums for plan 1A and 1B are based on standard risk rates; that is, the rates private insurers would charge for individual insurance policies providing substantially the same coverage and deductibles as provided under HIRSP. Individuals not eligible for a premium subsidy have generally been paying 150 percent of the rate a standard risk would pay in recent years, although premiums can be increased to 200 percent of standard risk if necessary to meet requirements of the funding formula. In FY 2002-03, premium rates for the primary plan were set at 150 percent of the rate a standard risk would pay.

Individuals enrolled in plan 1A or plan 2 who are eligible for the subsidy program pay premiums based on reduced percentages of standard risk, as shown in the following table.

Annual Household Income at Least	Annual Household Income 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-four percent of HIRSP policyholders received premium, deductible, and drug coinsurance subsidies totaling $4,634,397 in FY 2002-03 and $2,553,363 in FY 2001-02. The following table summarizes the amounts provided for each subsidy type during these years.

Subsidy Type	FY 2002-03	FY 2001-02
Premium	$3,974,005	$1,918,393
Deductible	534,858	624,910
Drug Coinsurance[1]	125,534	10,060
Total	$4,634,397	$2,553,363

[1]The FY 2001-02 amount is for the six months ending June 30, 2002.

GPR appropriated and spent for premium and deductible subsidies was $741,800 in FY 2002-03 and $780,800 in FY 2001-02. No GPR was specifically appropriated for drug coinsurance subsidies in either year. Prior to January 1, 2002, the HIRSP deductible applied to prescription drug and medical claims. Therefore, prescription drug claims were subsidized through the deductible reduction program. Costs in excess of GPR appropriated for this purpose were shared equally by health insurers and health care providers, with each contributing $1,946,299 in FY 2002-03 and $886,282 in FY 2001-02. Pharmacies are exempt from contributing toward these costs.

10. GENERAL AND ADMINISTRATIVE EXPENSES

General and administrative expenses include the following:

	FY 2002-03	FY 2001-02
Plan Administrator Fees	$3,588,355	$3,170,135
State Administrative Costs	388,715	358,460
Postage	175,984	180,291
HIPAA Implementation	290,075	0
Other Expenses	17,826	75,813
Total	$4,460,955	$3,784,699

In January 2002, the plan administrator rescinded administrative invoices totaling $447,081 that had been accrued as of June 30, 2001. As a result, the expense for plan administrator fees was reduced by $447,081 during FY 2001-02.

11. HEALTH CARE PROVIDERS' CONTRIBUTIONS

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

DHFS estimates the provider contributions attributable to funding HIRSP were $26,160,080 for FY 2002-03 and $15,757,717 for FY 2001-02. The contributions are based on actuarially developed estimates of reimbursement levels under the HIRSP program prior to January 1998. Although management believes the results of the estimates are materially correct, due to uncertainties inherent in estimates the actual provider contribution may be in excess or less than the amount estimated. DHFS and the Board of Governors used these provider contribution amounts to assess whether providers were providing their required level of funding for HIRSP.

12. NET ASSETS

Negative unrestricted net assets have resulted, in large part, because prior to FY 2001-02, HIRSP had been funded on a cash basis, in which funding levels were based on estimated cash disbursements and had the goal of providing sufficient revenues to pay claims as they were submitted, but limiting the accumulation of cash beyond current needs. Beginning in FY 2001-02, HIRSP's funding is on an accrual basis, which takes into account the total costs associated with events that occurred during the plan year, including actuarial cost estimates for claims that have been incurred but will not be paid until after the end of the plan year.

13. SUBSEQUENT EVENT

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

14. CHANGE IN ACCOUNTING PRINCIPLE

HIRSP implemented a new financial reporting model, as required by the provisions of GASB Statement Number 34, Basic Financial Statements—and Management's Discussion and Analysis—for State and Local Governments, as of June 30, 2002. This statement's requirements represent a significant change in the financial model used by state governments, including statement formats and changes in fund types.

Some of the major changes in HIRSP's financial presentation under GASB 34 included reclassifying revenues not related to HIRSP's primary purpose from operating to nonoperating, recording net assets as restricted or unrestricted, and adding management's discussion and analysis of HIRSP's financial operations.

15. PRIOR-PERIOD ADJUSTMENT

Due to the mistaken application of the premium overpayment liability discussed in Note 5, the FY 2001-02 net assets restricted for excess policyholder premiums was incorrectly reduced by the liability of $471,488. Instead, unrestricted net assets should have been reduced by this amount. The FY 2001-02 statements have been restated to reflect this correction.

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Report on Compliance and Control ■

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

We have audited the financial statements of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP) as of and for the years ended June 30, 2003, and June 30, 2002, and have issued our report thereon dated April 2, 2004. 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.

COMPLIANCE

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

INTERNAL CONTROL OVER FINANCIAL REPORTING

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

However, as noted during our prior audit (report 03-12), oversight of HIRSP could be improved if periodic reviews of the internal controls of the pharmacy benefit management company were completed. Entities such as claims processing organizations that provide similar services to several organizations often obtain special independent external reviews of their controls to fulfill the needs of the various user organizations they serve and the user organizations' auditors. These reviews, which are commonly referred to as "SAS 70" service organization audits, provide an in-depth audit of a service organization's control activities and their operating effectiveness. For example, HIRSP's plan administrator regularly obtains a SAS 70 report for its clients and their auditors to rely upon. However, the pharmacy benefit management company contracted by the HIRSP plan administrator to process prescription drug claims beginning in FY 2001-02 does not obtain, nor is required by DHFS or the plan administrator to obtain, an external SAS 70 review of its internal controls.

Because prescription drug claims, which were $23.1 million during FY 2001-02 and $32.4 million during FY 2002-03, represent a large portion of HIRSP's claims expenses, it is important that the internal controls in place at the pharmacy benefit management company are sound and working as intended. In response to recommendations made during the prior audit, DHFS plans to incorporate into its future contract for a plan administrator a requirement for a SAS 70 audit or alternative steps to provide independent reviews of controls over prescription drug claims. It specified the audits as a requirement in the Request for Vendors' Proposals, which will be used to award a new contract.

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

LEGISLATIVE AUDIT BUREAU

Diann Allsen

April 2, 2004

Diann Allsen
Audit Director

Appendix

Payment of HIRSP Operating and Administrative Costs

Statutes prescribe a funding formula for HIRSP that requires policyholders, private health insurers, and health care providers to share in estimated operating and administrative costs remaining after the GPR contribution has been deducted. Policyholder premiums are expected to fund 60 percent of the remaining estimated operating and administrative costs.

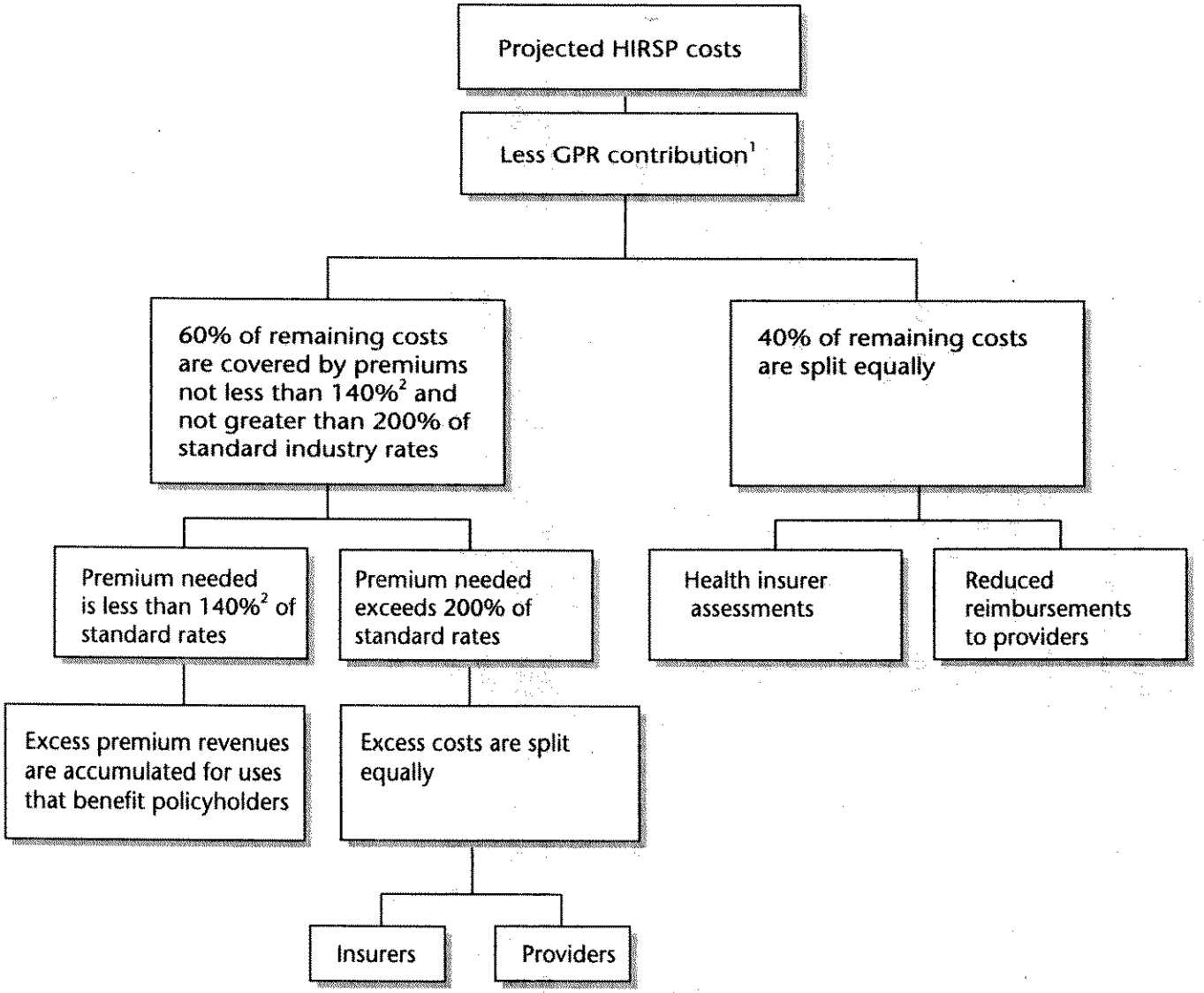
Prior to July 30, 2002, premium rates were statutorily required to be at least 150 percent, but not in excess of 200 percent, of standard risk rates (that is, the rates that private insurers would charge for individual insurance policies that provide substantially the same coverage and deductibles available under HIRSP). Private health insurers doing business in Wisconsin and health care providers providing medical services to HIRSP policyholders are required to share equally in the remaining 40 percent of operating and administrative costs.

In addition, insurers and health care providers share equally in the excess costs not funded by policyholder premiums when the premium rates needed to fund 60 percent of costs exceed 200 percent of standard risk rates. If premiums of less than 150 percent of the standard rates were required to fund 60 percent of HIRSP's estimated costs after the GPR contribution has been deducted, the premium rate would nonetheless be set at 150 percent of the standard rates in accordance with statutes, and excess funds would be set aside to reduce rates in years that would otherwise require higher premiums, or for other purposes that benefit policyholders.

To provide additional flexibility in establishing premium rates, 2001 Wisconsin Act 109 lowered the minimum premium level from 150 percent to 140 percent of the standard risk rate, effective July 30, 2002. Also, under 2003 Wisconsin Act 33, all GPR support for HIRSP is eliminated. Beginning in FY 2003-04, the other funding parties will be required to pay for costs previously funded through GPR. A diagram of HIRSP's funding provisions as of June 30, 2003, follows.

Payment of Operating and Administrative Costs

(As of June 30, 2003)



[1]All GPR support was eliminated beginning in FY 2003-04.
[2]150% before July 30, 2002.

State of Wisconsin
Department of Health and Family Services

Jim Doyle, Governor
Helene Nelson, Secretary

April 1, 2004

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

Dear Ms. Mueller:

This letter is in response to the Legislative Audit Bureau's (LAB) audit report of the Health Insurance Risk Sharing Plan's (HIRSP) State Fiscal Year (SFY) 2003 Financial Statements. On behalf of the Department of Health and Family Services (DHFS) and the HIRSP Board of Governors, I would like to thank you and the LAB audit staff for working with DHFS and the HIRSP plan administrator to conduct the audit.

We agree with the audit report. The audit report acknowledges that increasing enrollment presents continuing challenges to the management and funding of HIRSP. As cited in the audit, HIRSP experienced a 16.9 percent increase in enrollment during SFY 2003, although the rate of increase in enrollment appears to have tapered off in recent months.

Despite the challenges associated with growing enrollment, HIRSP's financial position continued to improve in SFY 2003. DHFS, together with the HIRSP Board, remain diligent in our administration of HIRSP. As a result:

- HIRSP's accounting deficit has decreased by another $5.1 million from SFY 2002 to SFY 2003 and, as of June 30, 2003, is less than $1 million. Since June 30, 2000, we have reduced the accounting deficit by more than $8 million.

- Net assets increased by approximately $12.5 million in SFY 2003.

- Total administrative costs, as a percent of total program costs, actually declined in SFY 2003 and account for only 4.9 percent of program costs (5.3 percent in SFY 2002).

- Average claims costs per policyholder increased by 10.7 percent in SFY 2003, which is approximately 3 percent lower than medical cost increases experienced for health care for commercial plans or for state employees.

The audit highlights two technical issues that the Department and Board are aware of and in the process of remedying. The report outlines a "technical statutory issue" regarding the manner which the state statutes treat policyholder deductible subsidies in the HIRSP funding formula. At the Board's direction, Department staff will submit 2005-07 Biennial Budget statutory language request that would resolve this technical issue.

Furthermore, the report identifies the need for the Department to increase its oversight of pharmacy claims through independent audits of the pharmacy benefits management company's controls. As the report mentions, the Department is currently procuring for a new HIRSP administrative services vendor and has included this independent audit requirement in its request for proposal for a new plan administrator.

On behalf of DHFS and the HIRSP Board, we are very proud of our accomplishments. HIRSP is more stable and in a better financial position than the prior year, even with the challenges associated with a growing health plan.

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

Sincerely,

Helene Nelson
Secretary

Legislative Audit Bureau

State of Wisconsin \ LEGISLATIVE AUDIT BUREAU

JANICE MUELLER
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September 29, 2004

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:

We have followed up on questions raised in a August 10, 2004, letter from Mr. George Potaracke, the Executive Director of the Board on Aging and Long Term Care, regarding the Health Insurance Risk-Sharing Plan (HIRSP). Mr. Potaracke questions HIRSP's authority to impose a six-month preexisting condition waiting period on applicants who have Medicare coverage and suggests that Medicare beneficiaries with certificates of creditable coverage should not be required to serve the preexisting waiting period.

Based on our review of applicable state statute sections and federal code sections, and explanations provided by the Department of Health and Family Services (DHFS), which is responsible for administering HIRSP, we believe HIRSP is complying with statutory requirements that impose a six-month preexisting condition waiting period for applicants with Medicare coverage. The policy is also consistent with related federal requirements. In this letter we provide further explanation of the issue and support for our conclusion. In addition, we offer some historical background on past practices and legislative action pertaining to this issue. We also offer a suggested letter you could send to Mr. Potaracke in response to his inquiry.

Current Requirements

In the late 1990s, HIRSP was designated as Wisconsin's plan to meet federal Health Insurance Portability and Accountability Act (HIPAA) regulations and to provide health insurance to those who lose employer-sponsored group health insurance and meet other specified criteria. HIPAA regulations set forth minimum requirements with which states are required to comply. One of the HIPAA requirements is that an individual who meets specific criteria and is considered an "eligible individual" is not subject to a waiting period for coverage of services related to a preexisting condition. HIPAA regulations (42 U.S.C. 300gg-41) define an eligible individual as an individual for whom all of the following apply:

- the aggregate of the individual's periods of creditable coverage is 18 months or more;
- the individual's most recent period of creditable coverage was under a group health plan, governmental plan, church plan, or under any health insurance offered in connection with any of those plans;

- the individual is not eligible for coverage under a group health plan, *part A or part B of title XVIII of the federal Social Security Act (Medicare)*, or a state plan under title XIX of the federal Social Security Act (Medicaid), or any successor program, and does not have any other health insurance coverage; [emphasis added]

- the individual's most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or failure to pay premiums; and

- if offered the option of continuation coverage under a federal continuation provision (COBRA) or similar state program, the individual elected and has exhausted the continuation coverage.

In s.149.10(2t), Wis. Stats., the definition of an eligible individual who is not subject to HIRSP's preexisting condition exclusion, as provided in s. 149.14(6)(b), Wis. Stats., parallels the federal requirements. Consequently, under current statutes, a HIRSP applicant with Medicare coverage does not qualify as an eligible individual and, therefore, must serve the six-month preexisting condition waiting period.

History of State Provisions

In discussing the current imposition of the preexisting condition waiting period for applicants with Medicare coverage, DHFS provided some historical perspective on changes that have occurred regarding this provision. The Office of the Commissioner of Insurance (OCI), which administered HIRSP prior to January 1, 1998, had waived the six-month waiting period for HIRSP applicants who were under 65, on Medicare, and able to submit a certificate of creditable coverage, based on its interpretation that federal law allowed less stringent criteria. However, DHFS noted that, in spring 1998, it questioned whether OCI's practice was in compliance with state statutes.

In 1997 Wisconsin Act 237, the Legislature apparently attempted to waive the preexisting waiting period for individuals who had Medicare coverage by defining eligible individuals in the preexisting statute section. Act 237 created a definition of an eligible individual in s. 149.14(6)(b)(1), Wis. Stats., that included all the criteria listed in s. 149.10(2t), Wis. Stats., except for the requirement that the individual not be eligible for Medicare. At that time, DHFS concluded that 149.14(6)(b)1 allowed HIRSP to waive the preexisting condition waiting period for individuals who had Medicare coverage and met all of the other criteria.

However, upon subsequent review of relevant statute sections, DHFS concluded that the inconsistency in the definition of an eligible individual in ss. 149(10)(2t) and 149.14(6)(b)1, Wis. Stats., affected its authority to waive the waiting period for individuals with Medicare coverage. In response, DHFS sought legislative action to eliminate the inconsistency in ch. 149, Wis. Stats., which resulted in the repeal of s. 149.14(6)(b)(1), Wis. Stats., as part of 2001 Wisconsin Act 16. DHFS subsequently instructed its plan administrator that individuals who have Medicare coverage must meet the preexisting condition waiting period.

States apparently can establish less stringent eligibility requirements than those specified by the HIPAA regulations. Consequently, if the Legislature wishes to waive the preexisting condition waiting period for applicants with Medicare coverage and a certificate of creditable coverage, it could change the definition of eligible individuals in s. 149.10(2t), Wis. Stats. However, such a change would be a policy question that would need further evaluation, including a calculation of the fiscal effect of the change on the program.

I hope this information is helpful in responding to Mr. Potaracke. Please let me know if we can be of any further assistance.

Sincerely,

Janice Mueller
State Auditor

JM/DA/bm

Enclosure

WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Carol Roessler
State Representative Suzanne Jeskewitz

October 1, 2004

Mr. George Potaracke, Executive Director
State of Wisconsin Board on Aging and Long Term Care
1402 Pankratz Street, Suite 111
Madison, Wisconsin 53704-4001

Dear Mr. Potaracke:

Thank you for your August 10, 2004, letter regarding the Health Insurance Risk-Sharing Plan (HIRSP). In your letter, you questioned the authority of HIRSP to impose a preexisting condition waiting period on applicants who have Medicare coverage and a certificate of creditable coverage. We asked the Legislative Audit Bureau to follow up on the questions you raised in your letter. In its review of applicable state and federal law, and explanations provided by the Department of Health and Family Services (DHFS), the Audit Bureau believes that HIRSP is complying with statutory requirements that impose a six-month preexisting condition waiting period for applicants who have Medicare coverage. This policy is also consistent with related federal requirements.

As you note in your letter, the federal Health Insurance Portability and Accountability Act (HIPAA) regulations prohibit the imposition of a preexisting condition waiting period for individuals who have lost employer-sponsored group health insurance. HIPAA establishes such a prohibition for "eligible individuals," who are defined in 42 U.S.C. 300gg-41 as individuals for whom all of the following apply:

- the aggregate of the individual's periods of creditable coverage is 18 months or more;
- the individual's most recent period of creditable coverage was under a group health plan, governmental plan, church plan, or under any health insurance offered in connection with any of those plans;
- the individual is not eligible for coverage under a group health plan, *part A or part B of title XVIII of the federal Social Security Act (Medicare)*, or a state plan under title XIX of the federal Social Security Act (Medicaid), or any successor program, and does not have any other health insurance coverage; [emphasis added]
- the individual's most recent period of creditable coverage was not terminated for any reason related to fraud or intentional misrepresentation of material fact or failure to pay premiums; and
- if offered the option of continuation coverage under a federal continuation provision (COBRA) or similar state program, the individual elected and has exhausted the continuation coverage.

SENATOR ROESSLER
P.O. Box 7882 • Madison, WI 53707-7882
(608) 266-5300 • Fax (608) 266-0423

REPRESENTATIVE JESKEWITZ
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(608) 266-3796 • Fax (608) 282-3624

Please note that one of the requirements for being an eligible individual is that the individual is not eligible for part A or part B of title XVIII of the federal Social Security Act, which is the Medicare program.

In s.149.10(2t), Wis. Stats., the definition of an eligible individual who is not subject to HIRSP's preexisting condition waiting period, as provided in s. 149.14(6)(b), Wis. Stats., parallels the federal requirements. Consequently, under current statutes, a HIRSP applicant with Medicare does not qualify as an eligible individual and, therefore, must serve the six-month preexisting condition waiting period.

As you note in your letter, the Office of the Commissioner (OCI), which administered HIRSP prior to January 1, 1998, had waived the six-month preexisting condition waiting period for HIRSP applicants with Medicare coverage who submitted certificates of creditable coverage. DHFS indicates that, upon taking over the program in 1998, it concluded such a practice was not in compliance with state statutes.

We hope this information is helpful in understanding DHFS's current practice of requiring a preexisting condition waiting period for individuals with Medicare coverage. We appreciate your interest in this issue and empathize with the difficulties the preexisting condition waiting period can impose on individuals with Medicare coverage.

Please let us know if we can be of further assistance.

Sincerely,

Senator Carol A. Roessler, Co-chair
Joint Legislative Audit Committee

Representative Suzanne Jeskewitz, Co-chair
Joint Legislative Audit Committee

cc: Janice Mueller
State Auditor

AUG 1 2 2004

STATE OF WISCONSIN
BOARD ON AGING AND LONG TERM CARE
1402 Pankratz Street, Suite 111
Madison, WI 53704-4001
(608) 246-7013
Ombudsman Program (800) 815-0015
Medigap Helpline (800) 242-1060
Fax (608) 246-7001
http://longtermcare.state.wi.us

10 Aug 2004

Sen. Carol Roessler
Rep. Suzanne Jeskewitz
Co-Chairs, Legislative Joint
Committee on Audit
Wisconsin State Capitol
Madison, Wi. 53708

Dear Co-Chairs Roessler and Jeskewitz,

The Board on Aging and Long Term Care is concerned about a procedural determination that has been reached by the HIRSP administration within DHFS. The problem appears when a Medicare beneficiary with a certificate of creditable coverage applies for coverage under HIRSP due to losing their employer group insurance benefits. When people call HIRSP, the HIRSP employee on the telephone tells the person that they first have to exhaust their COBRA benefit coverage before they can enroll in HIRSP. Most people do that, then apply for coverage. It is at that point in time, that HIRSP tells the person that they now have to serve a six-month pre-existing condition waiting period if they join the plan. HIRSP is the HIPAA plan for Wisconsin. As the HIPAA plan, HIRSP is prohibited from imposing a pre-existing condition waiting period upon a person who has a certificate of creditable coverage from their former employer group insurance plan.

As a result of this HIRSP practice, persons with pre-existing medical conditions who would otherwise smoothly transition from group insurance coverage into HIRSP without a break in coverage, are subjected to a six month break in coverage for conditions that were fully covered under their prior insurance and that should be protected by the certificate of creditable coverage. HIRSP forces Medicare beneficiaries with certificates of creditable coverage to serve a pre-existing condition waiting period before being eligible for full coverage.

The following citizens are Medicare beneficiaries of the state of Wisconsin and have given their permission for their names and stories to be shared with you to illustrate the impact on the lives of real people that this prohibited practice of HIRSP has as well as the additional expense and burden it places on families and individuals trying desperately to keep insurance coverage in force. For them, it is as much a quality of life issue as it is a financial issue.

- #497/#2523 Connie Kimmel, age 54. She lost COBRA coverage on 4/30/04. She has letter of creditable coverage which was denied by HIRSP. She had to purchase additional insurance because of the imposition of the six month pre-existing condition waiting period by HIRSP. She is currently paying the HIRSP premium and the premium for the second insurance coverage until the six months are up.

- #4200/#2689 Sandra Terry, age 42. Her COBRA coverage ended on 12/31/03. Her HIRSP effective date is 1/26/04. She has a certificate of creditable coverage which HIRSP denied. She has incurred medical bills which she had to pay out of pocket concurrently with the HIRSP premiums because of the six month pre-existing condition waiting period.

- #599/#2685 Kathy Hnath, age 56. She exhausted disability/COBRA health coverage thru employer group on 3/31/04. She enrolled in HIRSP immediately. HIRSP imposed a six month pre-existing condition waiting period. In addition to HIRSP, Kathy has had to pick up a medicare supplemental policy to cover costs incurred because of pre-existing medical conditions. This will cost her $225 per month which is a total of $1,350 over the 6 month pre-existing waiting period, in addition to her HIRSP premium.

- Angela Kaczecka, age 63. On 12/31/04, she lost COBRA health coverage through her employer group. She has a certificate of creditable coverage which HIRSP denied. Her HIRSP coverage became effective 01/01/04. She has had to pay the expenses of medical care during the six month pre-existing condition waiting period which ended June 30, 2004. Angela told me she was glad to contribute to this letter, have someone call her, or whatever else she can do to help put an end to this practice. In a strained, tired voice, she added, "they'd better get to me quick.....I'm not expected to live too long with this disease and its already been eight months since we tried to get them to listen."

By its actions, the Department has asserted that the federal HIPAA law requires (or, perhaps, permits) imposition of such a pre-existing condition exclusionary period. We have been unable to determine which provision of HIPAA has this effect. In fact, HIPAA, when describing the nature of a state's "Acceptable Alternative Mechanism" for assuring accessibility to insurance coverage, requires (at § 2744(a)(1)(B) of P.L. 104-191) that the state's alternative plan must "not impose any preexisting condition exclusion with respect to such coverage."

It is an interesting fact that, prior to the transfer of responsibility for HIRSP from the Office of the Commissioner of Insurance to DHFS, this prohibition on consideration of preexisting conditions was observed. An opinion memo was issued by OCI in 1997 stating that HIRSP applicants on Medicare who submit certificates of creditable coverage will be waived from serving the six month preexisting condition waiting period.. From the time of the issuance of that memo until the transfer of HIRSP to DHFS, OCI ensured that HIRSP followed this policy. HIPAA was in effect during that time and it was the apparent position of OCI, as it is of this agency, that HIPAA does allow a Medicare beneficiary who has a certificate of creditable coverage to be considered eligible for immediate HIRSP coverage without serving a six month pre-existing condition waiting period.

We respectfully request that the Audit Committee, as part of your next examination of the DHFS administration of HIRSP, inquire as to the specific rationale for imposition of this improper pre-existing condition exclusion.

Please feel free to contact my staff person, Donna Bryant, our lead Medigap Counselor at 246.7016 for further information and perspective.

Sincerely,

George F. Potaracke
Executive Director

6-24-04

HIRSP

Audit Bureau
- Submitted written testimony / power pt.
- Report is done annually.

Mark Moody - DHFS
- Submitted written
- HIRSP financials are the best they have ever been.
- 33 high risk pools nationwide: WI 4th in total enrollment.
- Board approved budget that is $7 million less than SFY 2004 budget.
- Premiums are at 140% of std rate — lowest allowed by law.
- As of June '03 deficit down to >$1.0 million
- RFP for new plan administrator issued.
- Expect new contract in July '04.
- Growth in enrollment is a challenge.
- HIRSP is working — not in need of major reform.

Kelly Rosatti – Submitted written (after she testified)
- HIRSP working so well because it has 2 bottomless pits of money: health plans + provider rates.
- To help inequities in program – worked on bill last session.
Large self funded employers don't fund
no state funding
no pharm. co. funding. (in CR bill)

- ASSOL has created a special HIRSP committee. Process is ongoing. Develops a proposal to make changes different + sep. from bill intro. last session.
Even the bill didn't pass, they realize a new approach is needed.
Look at cost containment issues.
-

Alice OConnor – reg. in favor – not speaking
- Did submit testimony.