WISCONSIN STATE LEGISLATURE COMMITTEE HEARING RECORDS

2005-06
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance (AC-In)

(Form Updated: 11/20/2008)

COMMITTEE NOTICES ...

➢ Committee Reports ... CR
**

➢ Executive Sessions ... ES
**

➢ Public Hearings ... PH
**

➢ Record of Comm. Proceedings ... RCP
**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL ...

➢ Appointments ... Appt
**

Name:

➢ Clearinghouse Rules ... CRule
**

➢ Hearing Records ... HR (bills and resolutions)
**

➢ Miscellaneous ... Misc

05hr_AC-In_Misc_pt64

(2006 documents)

ASP 2/14/2006 JH HEARINGS 1

- MED MAL: (02-22-2006) Jt MTG
- NW MUT wants tort DEAL

10:00 a ASM HEAR
ASM EXEC

11:30 a ASM/SEN HEAR

{ NEED TO HAVE AN ASM EXEC
{ Thurs Morn Early

AGENDA (Jt)
- ~~IMS / FIX-UP~~
- ~~SCE TECH~~ (?)
- ~~SPECIFICITY BILL~~ (?)
- ~~PASS ABT ASM COMTE~~ → { SEN AFTER [illegible]
- ~~CHG UNIFORM EMP MT~~ { DO THESE AFTER

MISC: ASM:

PREPARED BY	MSP
DATE	2/14/2006

JT HEARINGS

PAGE NO. 1

- NEED (NUMBER): 02-22-2006 JT MTGS

- NW NCHP WANTS TUE DEC

10:00 a ASM HEARS
ASM EXEC

11:30 a ASM/SEN HEARS

{ NEED TO MOVE ANY ASM EXEC THINGS NORTH EARLY

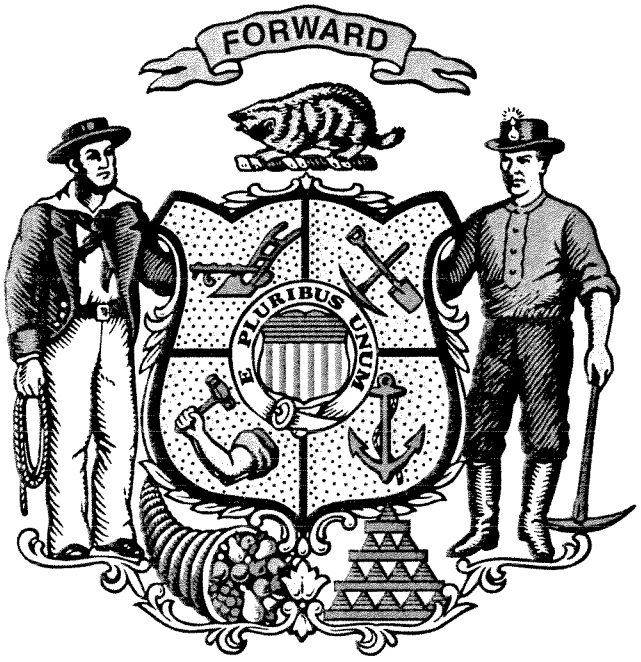
AGENDA (OT)
- INS 2 FIX-UP
- BCE TECH (?)
- STEERING BILL (?)
- Pass ADS ASM CONTE → { SEN MTE WELL DO HOSP ADS
- CHL-Uniform Emp Mtl

AGENDA: ASM:

Ann

I chair a hearing At 930 Am In room 328 NW. Have your staff come get me for the vote please.

Phil


FORWARD
E PLURIBUS UNUM

2005 FUNCTIONAL AND PROGRESS REPORT

The Injured Patients and Families Compensation Fund (Fund) was created in 1975 to provide excess medical malpractice insurance for Wisconsin health care providers. The Fund is governed by a 13-member Board of Governors (Board) which consists of three insurance industry representatives; a member named by the Wisconsin Academy of Trial Lawyers; a member named by the State Bar Association; two members named by the State Medical Society of Wisconsin; a member named by the Wisconsin Hospital Association; four public members appointed by the Governor; and the Commissioner of Insurance who serves as the chair.

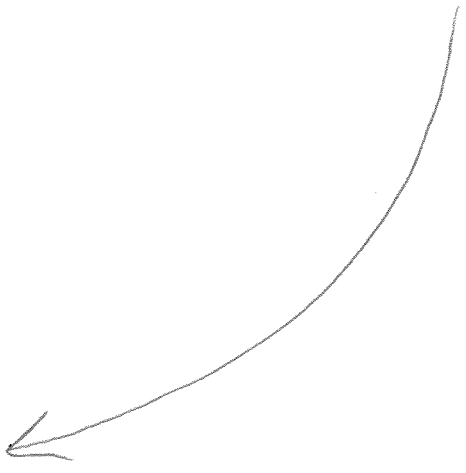
The Fund's Board is assisted in its governance function by the following committees: an Underwriting and Actuarial Committee, a Legal Committee, a Claims Committee, an Investment/Finance and Audit Committee, a Risk Management and Patient Safety Committee, and a Peer Review Council. The Board and committees meet quarterly.

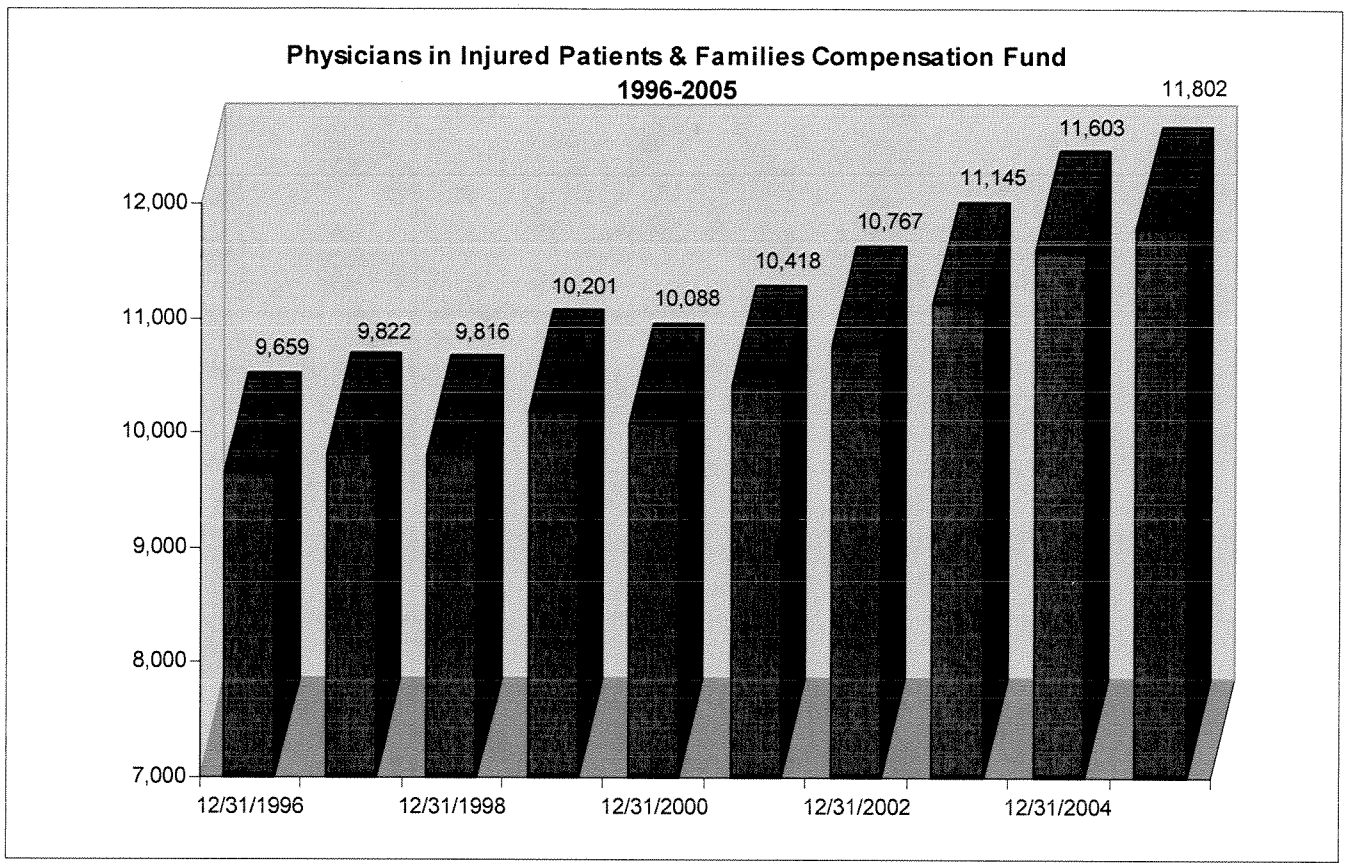
The Fund operates on a fiscal year basis; July 1 through June 30. Administrative costs, operating costs, and claim payments are funded through assessments on participating health care providers.

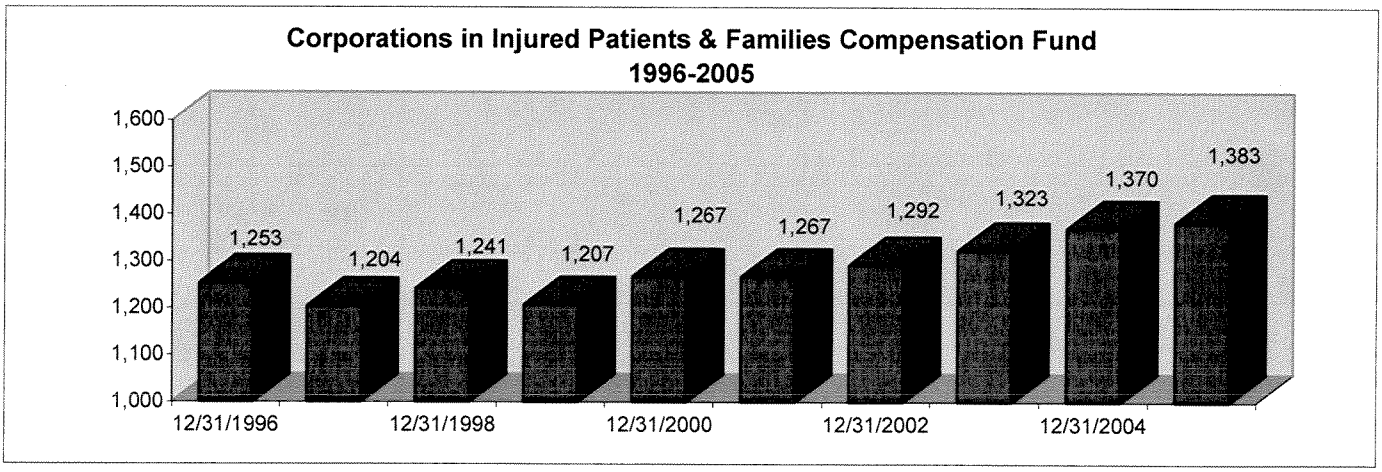
Fund Participants

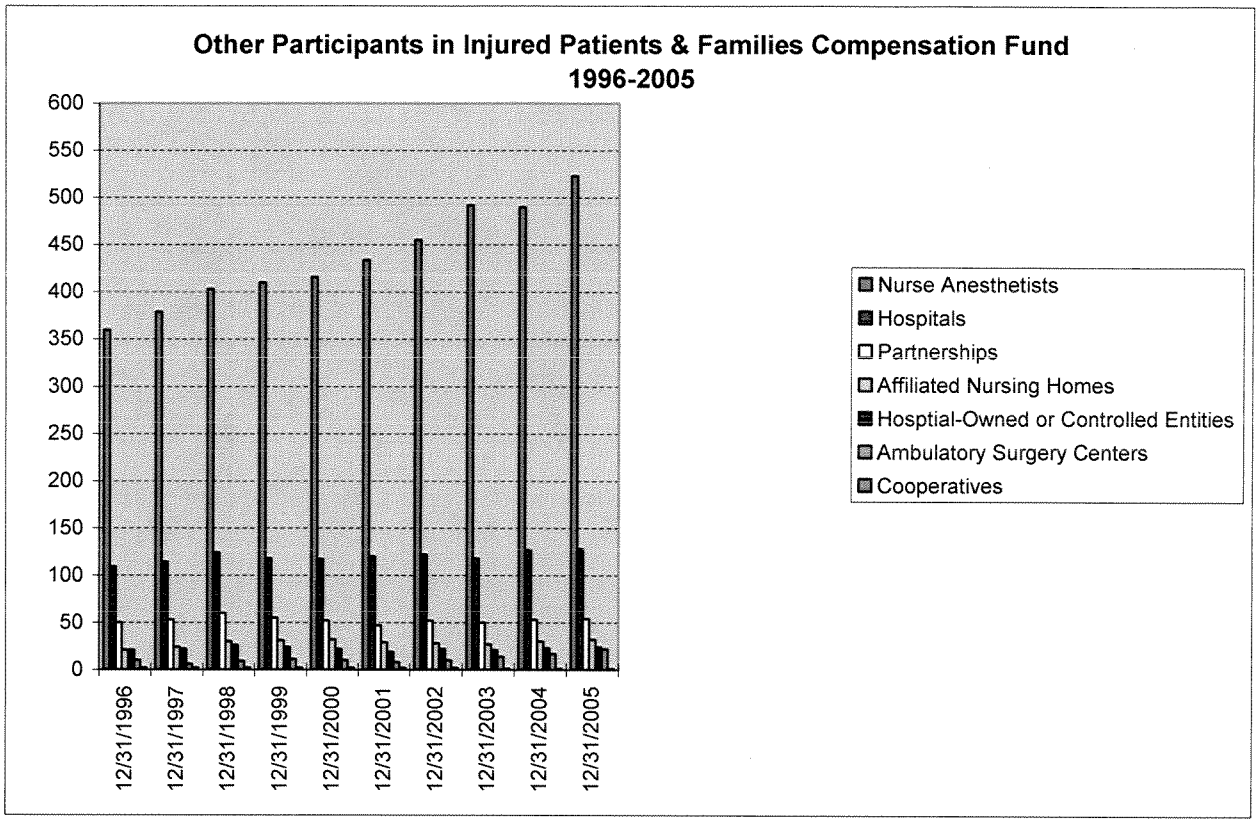
As of December 31, 2005, there were a total of 13,969 Fund participants comprised of 128 hospitals with 32 affiliated nursing homes, 11,802 physicians, 523 nurse anesthetists, 24 hospital-owned or controlled entities, 22 ambulatory surgery centers, one cooperative, 54 partnerships, and 1,383 corporations actively participating in the Fund.

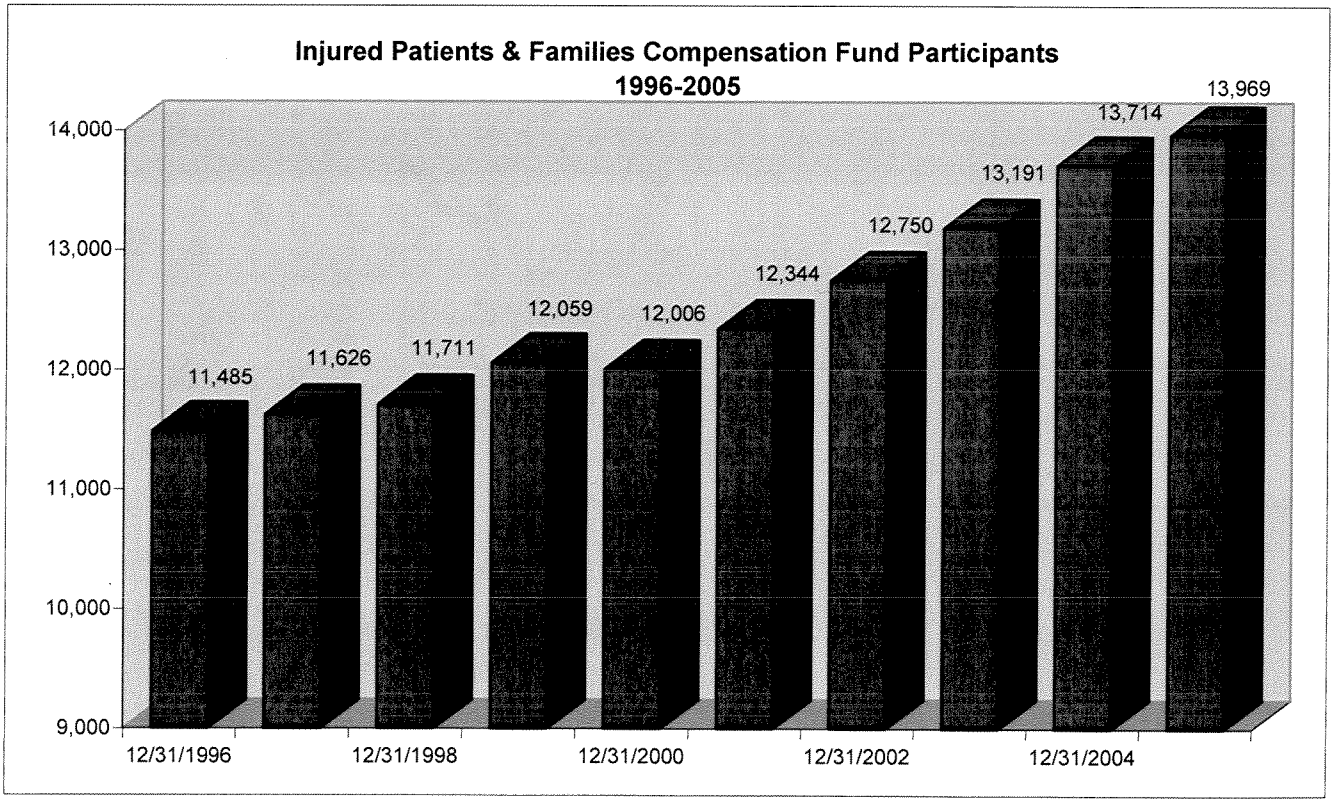
As of December 31, 2005, physicians comprised 84% of the Fund participants and corporations made up 10%. All other participants made up the remaining 6%.




Physicians in Injured Patients & Families Compensation Fund
1996-2005
12,000
11,000
10,000
9,000
8,000
7,000
9,659
9,822
9,816
10,201
10,088
10,418
10,767
11,145
11,603
11,802
12/31/1996
12/31/1998
12/31/2000
12/31/2002
12/31/2004


Corporations in Injured Patients & Families Compensation Fund
1996-2005
1,600
1,500
1,400
1,300
1,200
1,100
1,000
1,253
1,204
1,241
1,207
1,267
1,267
1,292
1,323
1,370
1,383
12/31/1996
12/31/1998
12/31/2000
12/31/2002
12/31/2004


Other Participants in Injured Patients & Families Compensation Fund
1996-2005
600
550
500
450
400
350
300
250
200
150
100
50
0
12/31/1996
12/31/1997
12/31/1998
12/31/1999
12/31/2000
12/31/2001
12/31/2002
12/31/2003
12/31/2004
12/31/2005
Nurse Anesthetists
Hospitals
Partnerships
Affiliated Nursing Homes
Hosptial-Owned or Controlled Entities
Ambulatory Surgery Centers
Cooperatives


Injured Patients & Families Compensation Fund Participants
1996-2005
14,000
13,000
12,000
11,000
10,000
9,000
11,485
11,626
11,711
12,059
12,006
12,344
12,750
13,191
13,714
13,969
12/31/1996
12/31/1998
12/31/2000
12/31/2002
12/31/2004

Claims Activity

From July 1, 1975, through December 31, 2005, 5,227 claims had been filed in which the Fund was named. During this period, the Fund's total number of paid claims increased to 627, totaling $596,253,376. Of the total number of claims in which the Fund has been named, 4,373 claims have been closed with no indemnity payment. Of the remaining open claims reported as of December 31, 2005, 34 cases carried aggregate case reserves of $59,087,852, while 193 cases had no reserves established.

Board Committees

Actuarial and Underwriting Committee

The Actuarial and Underwriting Committee advises the Board on actuarial and underwriting issues.

The Committee assisted the Board to promulgate the Fund Fee Rule for fiscal year 2005-2006 fees. Overall, there was a decrease of 30% in total fees for fiscal year 2005-2006. Mediation panel fees for physicians (excluding physicians in a residency program) were set at $34 per physician and $2 per hospital bed. This decrease was implemented prior to the July 2005 Wisconsin Supreme Court decision in which the Court declared the non-economic damages cap unconstitutional. This court decision contributed to the Board approving an increase in assessments for the 2006-2007 fiscal year of 25%. A rule is currently being promulgated to implement this increase effective July 1, 2006.

Under Act 473, various types of "health care professionals" may be shareholders in the same service corporation, regardless of the fact that they hold different licenses. "Health care professional" is defined to include anyone regulated by the Board of Nursing, Medical Examining Board, Optometry Examining Board, Pharmacy Examining Board, Psychology Examining Board and the Examining Board of Social Workers, Marriage and Family Therapists and Professional Counselors. Act 473 created s. 655.27(3)(a) 4, Wis. Stat., to require the Fund's Board, when setting annual fees for corporations, partnerships, and cooperative HMOs, to take into consideration risk factors and past and prospective loss and expense experience attributable to employes other than physicians and nurse anesthetists. As a result of Act 473, additional fees for corporations, partnerships and cooperative HMOs are included in the fiscal year 2006 annual fee rule and are anticipated to total $849,201 for the period.

Claims Committee

The responsibility of the Claims Committee (Committee) of the Board of Governors (Board) is to establish claims policies and procedures for the Patients Compensation Fund (Fund) and the Wisconsin Health Care Liability Insurance Plan (Plan).

The functions of the Claims Committee are the following:

- To establish guidelines for claims management by the contractor and OCI staff of the Fund and the Plan and to review claims to determine if the guidelines need to be revised.

- To provide for the evaluation of the claims contractor no less often than prior to the re-negotiation of each contract to assure that claims are being handled in an appropriate and expeditious manner.

- To review all claims involving alleged sexual misconduct, neurological impairment, quadriplegia, and those claims which the contractor has set reserves of $500,000 or more and provide settlement authorization and advise on those claims where settlement value exceeds $1 million or when the contractor has a claim management question.

- To monitor claims and claims administration costs and to make recommendations for possible savings to the board and the contractor.

- To establish guidelines for annuity purchases and to review such purchases periodically.

- To recommend to the board changes in the statutes or administrative rules that are needed to facilitate the claims policies and procedures of the Plan or Fund.

- To refer legal or other issues that come to the committee's attention to the appropriate committees.

- To prepare reports analyzing claims trends for risk management purposes.

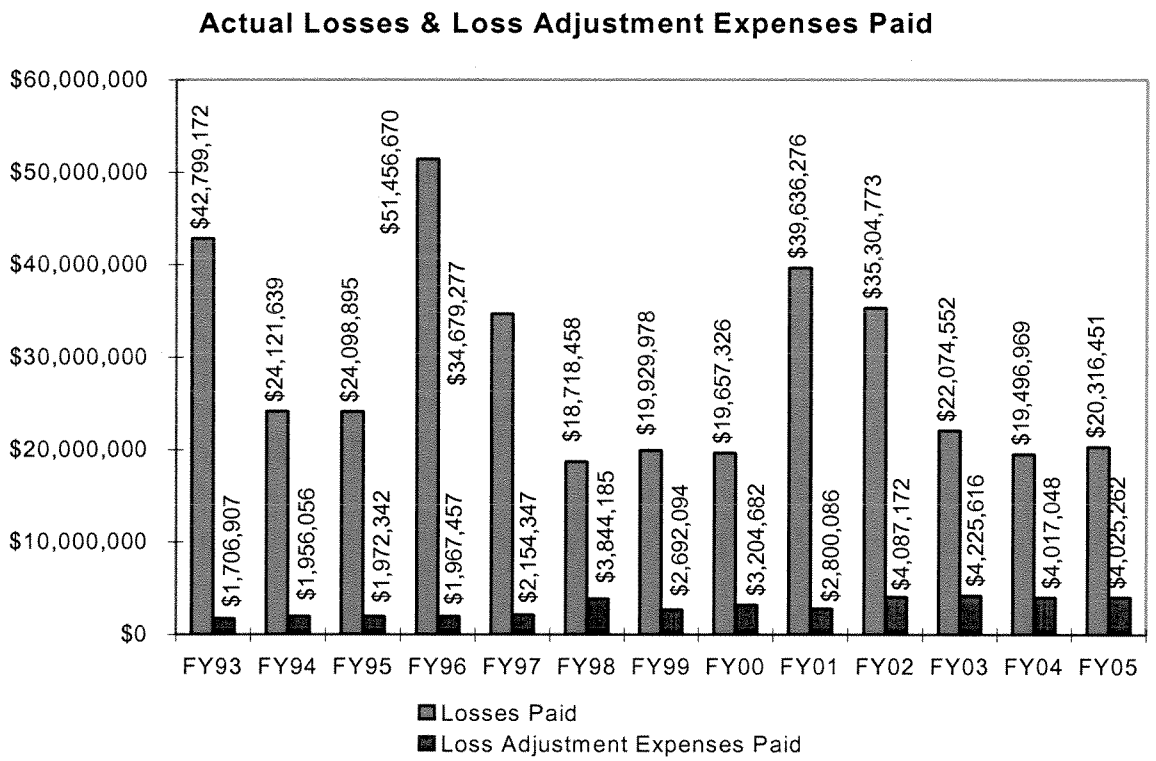
- To report to the board quarterly on the committee's activities.

Table 1, on the following page, summarizes quarterly loss payments by amount and number of claims paid, from fiscal 2001 through fiscal 2005. Chart 1 shows the range of annual Fund loss and loss expense payments, beginning with fiscal year 1993. The Fund's fiscal year runs from July 1 to June 30. The Fund made loss payments totaling approximately $20.3 million during fiscal 2005.

Table 1

AMOUNT AND NUMBER OF LOSSES PAID BY FISCAL YEAR

QUARTER ENDING	2000-2001 Amount #	2001-2002 Amount #	2002-2003 Amount #	2003-2004 Amount #	2004-2005 Amount #
Sept. 30	$29,365,577 8	$19,293,604 4	$8,738,481 3	$1,020,599 2	$2,076,297 1
Dec. 31	$2,161,785 5	$6,117,043 5	$8,800,092 3	$7,258,654 5	$8,938,812 2
March 31	$6,996,875 6	$4,000,671 3	$1,069,984 2	$2,662,968 2	$5,000,671 2
June 30	$1,112,039 3	$5,893,455 3	$3,465,995 3	$8,554,748 4	$4,300,671 1
TOTAL	$39,636,276 22	$35,304,773 15	$22,074,552 11	$19,496,969 13	$20,316,451 6

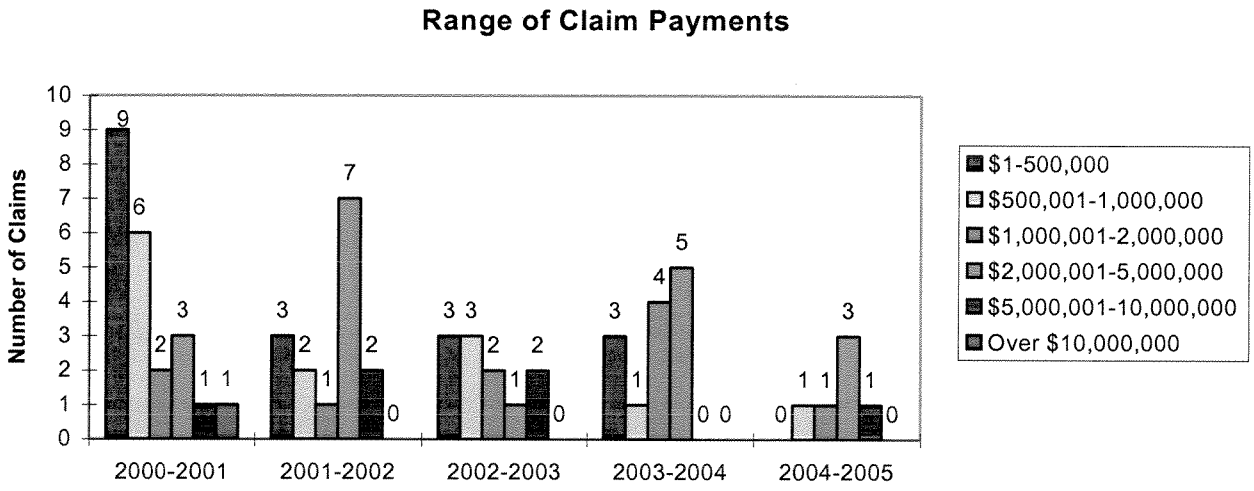


The range of Fund claim payments for the last five fiscal years is summarized below in table 2.

Table 2

RANGE OF FUND CLAIM PAYMENTS

Payment Range	2000-2001 # of Claims	2001-2002 # of Claims	2002-2003 # of Claims	2003-2004 # of Claims	2004-2005 # of Claims
$1-500,000	9	3	3	3	0
$500,001-1,000,000	6	2	3	1	1
$1,000,001-2,000,000	2	1	2	4	1
$2,000,001-5,000,000	3	7	1	5	3
$5,000,001-10,000,000	1	2	2	0	1
Over $10,000,000	1	0	0	0	0
Total Claims Paid	22	15	11	13	6



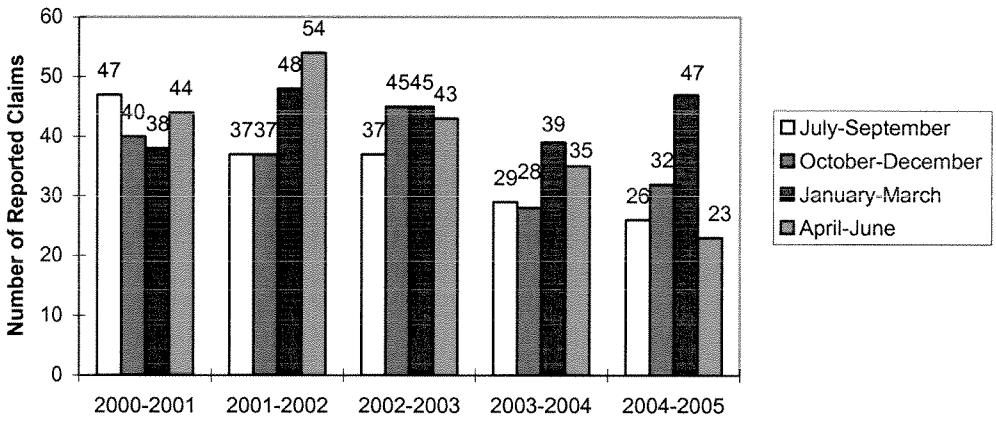
Fund claims reported by quarter by fiscal year are summarized in table 3 below. A total of 128 claims were opened during fiscal 2005.

Table 3

CLAIMS OPENED QUARTERLY BY FISCAL YEAR

Quarter	2000-2001	2001-2002	2002-2003	2003-2004	2004-2005
July 1-September 30	47	37	37	29	26
October 1-December 31	40	37	45	28	32
January 1-March 31	38	48	45	39	47
April 1-June 30	44	54	43	35	23
Totals	169	176	170	131	128

Claims Reported by Quarter by Fiscal Year



Finance/Investment/Audit Committee

The Finance/Investment/Audit Committee's responsibilities include establishing, monitoring, and amending as necessary, the investment strategy for the Fund to ensure obligations are met. The Committee periodically reviews investments for compliance with investment guidelines and evaluates cash flow liquidity needs. In addition, the committee oversees the financial reporting process. Responsibilities include review of financial position and results, as well as correspondence with auditors concerning audit scope, accounting issues, internal controls and management recommendations.

Legal Committee

The Legal Committee advises the Board on legal issues, including retroactive coverage requests, appeals, proposed statutory changes, administrative rule changes, and other issues that affect eligibility or Fund participation.

During 2005, the Committee reviewed 18 requests for retroactive coverage of which 17 were approved, and one was denied.

Peer Review Council

The Peer Review Council (Council) reviews physician claim records to determine whether a surcharge should be imposed against the Fund fee or Wisconsin Health Care Liability Insurance Plan (Plan) premium, if applicable. The surcharge is a percentage of a provider's Fund fee or Plan premium based on the number of closed medical liability claims reported, and the aggregate amount paid for those claims.

During the fiscal year from July 1, 2004, to June 30, 2005, 162 claims paid reports were filed. These included 66 for physicians or nurse anesthetists, 86 for hospitals, corporations or clinics, and 10 for other types of providers. One provider was subject to possible surcharge.

Since inception of the Council in 1986, 58 providers have been subject to possible surcharge. The status, or disposition, of those providers as of June 30, 2005, was as follows:

- Exemptions from participation in the Fund have been filed by 28 providers, resulting in suspension of the review for surcharge.
- No surcharge was warranted for 11 providers as a result of the Council's review or consultant opinions.
- Two providers have been surcharged for failure to respond to Council requests for information.
- Surcharge reviews will not be pursued for 16 providers, the reviews for which the Council determined were not conducted in a timely manner, in accordance with s. 655.275 (5) (a), Wis. Stat.
- The review for surcharge was pending for one provider.

Risk Management and Patient Safety Committee

The purpose of the Risk Management and Patient Safety Committee, created in June 1991, is to reduce patient/claimant compensable injuries, reduce Fund losses and associated expenses, improve the general quality of medical care, and reduce the premiums of participating health care providers.

Activities During 2005:

- Continued development of self-study programs for physicians.
- Publication of the quarterly risk management newsletter, *WiscRisk*. The newsletter is now available on the PCF website.
- Directed the risk management vendor to provide in-house risk management services to a group of hospitals insured by the Wisconsin Health Care Liability Insurance Plan (WHCLIP).

- Production and distribution of a 2006 risk management calendar.

In 2006, the committee will look to other risk management organizations/entities to collaborate on various risk management programs and training opportunities.

Other Fund Activities

In July 2005, the Wisconsin Supreme Court issued its ruling in the *Ferdon* case in which the court declared the cap on non-economic damages to be unconstitutional. This decision results in a potentially significant impact financially to the Fund. Due to the long tailed nature of medical malpractice, the actual effects of this decision will not be quantifiable for some time. It is expected that claim payments will increase. This ruling contributed to the Board's decision to increase fees by 25% for the 2006-2007 fiscal year. The effects of this decision will be closely monitored.

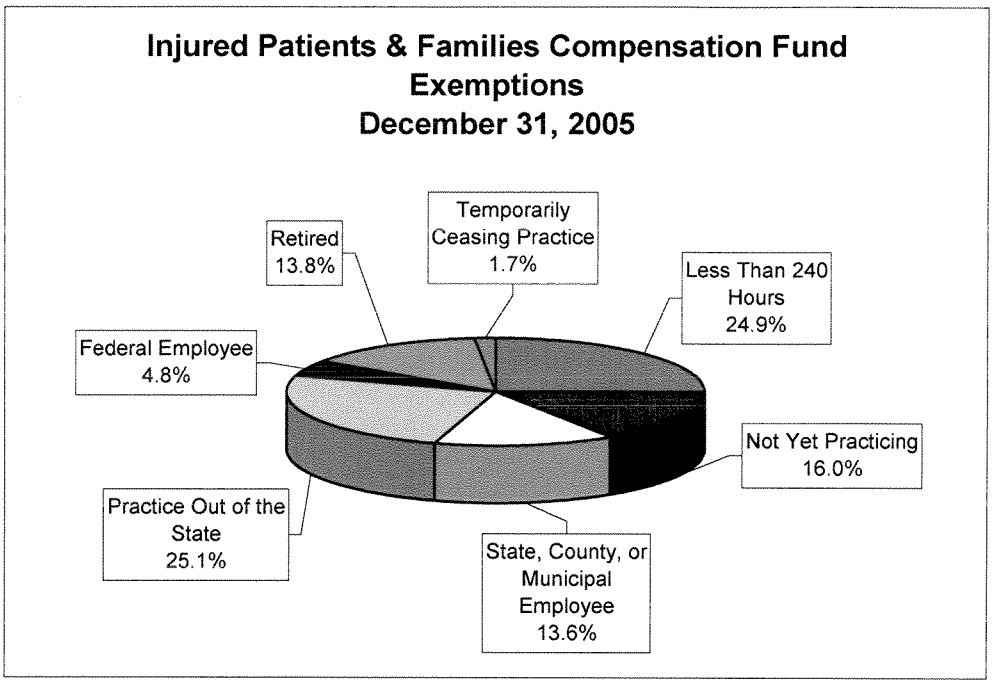
Fund administration, in conjunction with counsel, is also closely monitoring current challenges to the constitutionality of the wrongful death cap. The Supreme Court has accepted a case and oral arguments will take place in April 2006. These caps are currently at $350,000 for an adult and $500,000 for a child. In addition, the issue of awarding damages for pain and suffering in addition to damages for wrongful death is on appeal.

Fund administration closely monitors the use of outside counsel. Pursuant to a court decision in 2000, the Fund hires separate defense counsel on each claim. Fund staff monitors the claims and the use of this outside counsel to ensure that while the Fund receives the necessary representation, that legal fees are controlled.

Extensive work continued during 2005 to verify and process up-to-date exemption status for providers that held a license to practice in Wisconsin but for which a current exemption or certificate was not on file with the Fund. Providers that remain in noncompliance are referred to their respective licensing boards for appropriate enforcement action by that board.

As of December 31, 2005, there were 9,596 providers exempt from participation in the Fund. The exemptions are grouped as follows:

Less Than 240 Hours	2,392
Practice Out of Wisconsin	2,412
Retired	1,329
Not Yet Practicing or Never Practiced in Wisconsin	1,538
State, County, or Municipal Employee	1,308
Federal Employee	457
Temporarily Ceasing Practice	160

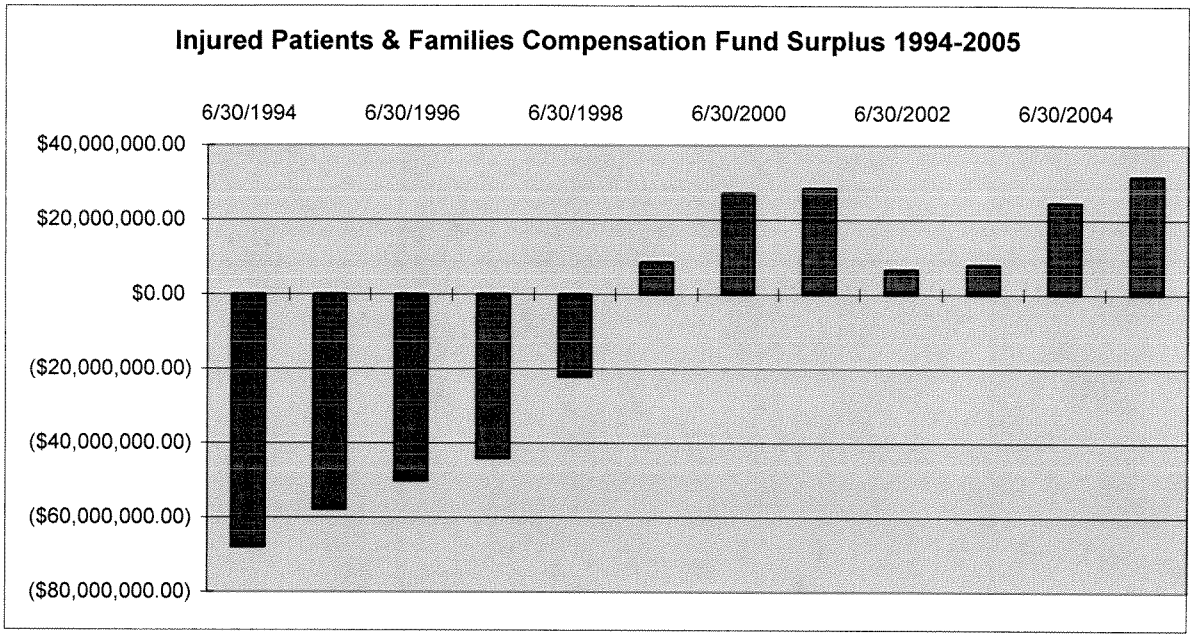


Financial Statistics

Attached as Exhibit 1 is the financial statement for the Fund for the fiscal year ending June 30, 2005.

The Fund reported a surplus of $31,706,181 as of June 30, 2005.

The following graph reflects the Fund's surplus (deficit) over the last twelve fiscal years.



This chart represents the reported surplus/deficit as of June 30 for each fiscal year 1994 through 2005. The surplus/deficit represents the balance of assets minus projected liabilities.

Medical malpractice with its extended reporting and settlement patterns is especially difficult to estimate and the ultimate claim payments will differ from the originally projected liabilities.

The Fund's next progress report, due March 1, 2007, will include an update on the Fund's activities during 2006.

Attachments

WISCONSIN INJURED PATIENTS AND FAMILIES COMPENSATION FUND
Statement of Net Equity
6/30/2005
Unaudited

ASSETS

Current Assets

Cash	$722,043
State Investment Fund Shares (market value)	$21,344,000
Short-term Investments	$49,489,535
Bond Investment Income Receivable	$8,597,928
State Shares Interest Receivable	$36,776
Assessments Receivable	$87,633
Less: Allowance for Uncollectible Accounts	($194)
Prepaid Items	$7,385
Office Supplies	$2,214
Other Receivables	$3,640,690
Total Current Assets	$83,928,010

Noncurrent Assets

Long-term Investments (market value)	$674,750,023
Capital assets, net of accumulated depreciation	$3,021
Total Noncurrent Assets	$674,753,044
TOTAL ASSETS	**$758,681,054**

LIABILITIES

Current Liabilities

Future Benefits and Loss Liabilities - Short Term	$55,250,000.00
Assessments Received in Advance	$5,399,716
Provider Refunds Payable	$312,217
Medical Mediation Panels Payable	$185,053
General & Administrative Expense Pay	$103,013
Vouchers Payable	$11,999
Compensated Absences	$15,069
Total Current Liabilities	$61,277,067

Noncurrent Liabilities	
Loss liabilities:	
Liability for IBNR	$815,316,991
Liability for Reported Losses	$21,614,068
Liability for LAE	$42,765,134
Estimated Loss Liabilities	$879,696,193
Less: Amount Representing Interest	$160,984,403
Discounted Loss Liabilities	$718,711,790
Liabilities for Future Medical Expenses	$1,811,396
Contributions Being Held	$400,000
Total Loss liabilities	$720,923,186
Less: Short Term Future Benefits & Loss Liabilities	$55,250,000
Noncurrent loss liabilities	$665,673,186
Compensated Absences - LT	$24,621
Total Noncurrent Liabilities	$665,697,807
TOTAL LIABILITIES	**$726,974,874**
NET EQUITY	
Net Equity:	
Invested in capital assets, net of related debt	$3,021
Premium deficiency reserve	$28,572,000
Restricted for injured patients and families	$3,131,160
TOTAL NET EQUITY	**$31,706,181**

WISCONSIN INJURED PATIENTS AND FAMILIES COMPENSATION FUND
Statement of Revenues, Expenses, and Changes in Fund Net Equity for the Fiscal Year Ended 6/30/2005
Unaudited

OPERATING REVENUES	
Assessments Levied (net of unearned)	$26,544,646
Administrative Fee Income	$41,991
Investment Income	$33,544,835
Unrealized gain (adjustment to mkt value)	$15,330,387
Change in Bond Premium (Discount)	$9,223,527
Other Income	($2,249)
Total Operating Revenues	**$84,683,137**
OPERATING EXPENSES	
Underwriting Expenses:	
Net Losses Paid	$19,879,534
Interest on Loss Payments	$136,918
LAE Paid	$4,025,262
Risk Mgt Exp	$32,308
Medical Expense Paid	$114,206
Change in Liability for IBNR	$13,343,856
Change in Liability for Reported Losses	($11,456,660)
Change in Liability for LAE	($2,635,513)
Change in Amount Representing Interest	$52,963,613
Change in Liability for Future Med Expenses	$222,524
Total Underwriting Expenses	$76,626,047
General and Administrative Expenses	$1,013,487
Depreciation Expense	$0
Total Operating Expenses	**$77,639,534**
OPERATING INCOME (LOSS)	**$7,043,604**
NONOPERATING REVENUES (EXPENSES)	
Assessment Interest Income	$46,253
Loss on Disposal of Fixed Assets	$0
Total Nonoperating Revenues (Expenses)	$46,253
CHANGE IN NET EQUITY	**$7,089,857**
NET EQUITY	
Net Equity--Beginning of the Period	$24,616,324
Net Equity--End of the Period	$31,706,181

Statement of Cash Flows for FY Ended June 30, 2005

Fund Name:		**IP&FCF**
Fund Type:		Enterprise
Cash Flows from Operating Activities:		
Cash Receipts from Customers	$	29,348,666.45
Cash Payments to Suppliers for Goods and Services		(253,411.35)
Cash Payments to Employees for Services		(493,824.52)
Cash Payments for Lottery Prizes		
Cash Payments for Loans Originated		
Collection of Loans		
Interest Income		
Cash Payments for Benefits		(24,188,226.94)
Other Operating Revenues		
Other Operating Expenses		
Other Sources of Cash		44,367.63
Other Uses of Cash		
Net Cash Provided (Used) by Operating Activities		4,457,571.27
Cash Flows from Noncapital Financing Activities:		
Operating Grants Receipts		
Grants for Loans to Governments		
Grants Disbursed		
Proceeds from Issuance of Long-term Debt		
Retirement of Long-term Debt		
Escrow Deposit		
Interest Payments		
Property Tax Credit Payments		
Noncapital Gifts and Grants		
Interfund Loans Received *(Lendee - s/b positive)*		
Interfund Loans Repaid *(Lendee - s/b negative)*		
Interfund Borrowings to Other Funds *(Lender - s/b negative)*		
Repayment of Interfund Borrowings *(Lender - s/b positive)*		
Interfund Advances Collected *(Lender - s/b positive)*		
Transfers In		
Transfers Out		(10,902.96)
Other Cash Inflows from Noncapital Financing Activities		
Other Cash Outflows from Noncapital Financing Activities		
Net Cash Provided (Used) by Noncapital Financing Activities		(10,902.96)
Cash Flows from Capital and Related Financing Activities:		
Proceeds from Issuance of Long-term Debt		
Capital Contributions		
Repayment of Long-term Debt		
Proceeds of Short-term Notes		
Interest Payments		
Interfund Advances Repaid *(Lendee - s/b negative)*		
Capital Lease Obligations		
Proceeds from Sale of Capital Assets		
Payments for Purchase of Capital Assets		
Other Cash Inflows from Capital Financing Activities		
Other Cash Outflows from Capital Financing Activities		
Net Cash Provided (Used) by Capital and Related Financing Activities		-
Cash Flows from Investing Activities:		
Proceeds from Sale and Maturities of Investment Securities		143,391,590.16
Purchase of Investment Securities		(182,771,024.24)
Cash Payments for Loans Originated		
Collection of Loans		
Investment and Interest Receipts		32,524,823.92
Net Cash Provided (Used) by Investing Activities		(6,854,610.16)
Net Increase (Decrease) in Cash and Cash Equivalents		(2,407,941.85)

Statement of Cash Flows for FY Ended June 30, 2005

Fund Name:		**IP&FCF**
Fund Type:		Enterprise
Net Increase (Decrease) in Cash and Cash Equivalents		(2,407,941.85)
Cash and Cash Equivalents, Beginning of Year		24,510,761.90
Cash and Cash Equivalents, End of Year	$	22,102,820.05
		-
Reconciliation of Operating Income (Loss) to Net Cash		
Provided by Operations:		
Operating Income (Loss)	$	7,056,527.74
Adjustments to Reconcile Operating Income (Loss) to Net Cash		
Provided (Used) by Operating Activities:		
Depreciation		
Amortization		
Provision for Uncollectible Accounts		(80.00)
Operating Income (Investment Income) Classified as Investing Activity		(58,102,432.62)
Operating Expense (Interest Expense) Classified as		
Noncapital Financing Activity		
Miscellaneous Nonoperating Income (Expense)		44,367.63
Changes in Assets and Liabilities:		
Decrease (Increase) in Receivables		40,090.86
Decrease (Increase) in Due from Other Funds		0.34
Decrease (Increase) in Due from Component Units		13,997.00
Decrease (Increase) in Due from Other Governments		
Decrease (Increase) in Inventories		(160.00)
Decrease (Increase) in Prepaid Items		(84.27)
Decrease (Increase) in Other Assets		
Decrease (Increase) in Deferred Charges		
Increase (Decrease) in Accounts Payable and		
Other Accrued Liabilities		155,349.03
Increase (Decrease) in Compensated Absences		8,944.60
Increase (Decrease) in Due to Other Funds		80,913.08
Increase (Decrease) in Due to Component Units		
Increase (Decrease) in Due to Other Governments		
Increase (Decrease) in Tax and Other Deposits		
Increase (Decrease) in Deferred Revenue		2,722,317.88
Increase (Decrease) in Interest Payable		
Increase (Decrease) in Future Benefits and Loss Liabilities		52,437,820.00
Total Adjustments		(2,598,956.47)
Net Cash Provided by Operating Activities	$	4,457,571.27
		0.00
Noncash Investing, Capital and Financing Activities:		
Capital Leases (Initial Year):		
Fair Market Value	$	
Current Year Cash Receipts (Payments)		
Contributions/Transfer In (Out) of Noncash Assets		
and Liabilities from/to Other Funds		
Lottery Prize Annuity Investment Assumption		
Lottery Prize Annuity Investment Liability		
Net Change in Unrealized Gains and Losses		(44,513,613.67)
Other		

Notes to the Financial Statements – 6/30/05

1. Description of the Fund

The Injured Patients and Families Compensation Fund is part of the State of Wisconsin's financial reporting entity and is reported as a major enterprise fund in the State's Comprehensive Annual Financial Report. The Fund, formerly known as the Patients Compensation Fund, was created in 1975 for the purpose of paying that portion of a medical malpractice claim exceeding the legal primary insurance limits prescribed in s. 655.23(4), Wis. Stats., or the maximum liability limit for which the health care provider is insured, whichever limit is greater. Most health care providers permanently practicing or operating in the State of Wisconsin are required to pay annual assessments.

Management of the Fund is vested with the 13-member Board of Governors, which is chaired by the Commissioner of Insurance. The Board has designated the Commissioner of Insurance as the administrator of the Fund. Similarly, under s. 655.27(2), Wis. Stats., the Commissioner shall either provide staff services necessary for the operation of the Fund or, with the approval of the Board, contract for all or part of these services. During FY 2004-05, the Board contracted for the Fund's actuarial, risk management, and claims administrative services.

2. Summary of Significant Accounting Policies

A. Fund Accounting and Basis of Presentation

The financial statements of the Injured Patients and Families Compensation Fund have been prepared in conformance with generally accepted accounting principles (GAAP) for proprietary funds. The accompanying financial statements were prepared based upon the flow of economic resources focus and full accrual basis of accounting, with revenues recognized when earned and expenses recognized when incurred.

The Statement of Revenues, Expenses, and Changes in Fund Net Assets classifies the Fund's fiscal year activity as either operating or nonoperating. Because the Fund is an enterprise fund, which is a type of proprietary fund, it accounts for operations in a manner similar to private businesses in which operating revenues are derived from exchange transactions. Assessments, which are received from health care providers in exchange for coverage under the Fund, represent a significant component of operating revenues. Investment income is also classified as operating revenues because it is considered a significant and integral source of revenue in the Fund's operations. Operating expenses include underwriting and administrative expenses.

Certain revenues and expenses that are not related to the Fund's primary purpose, such as gain or loss on the disposal of capital assets, are reported as nonoperating revenues and expenses.

The Fund applies all applicable Governmental Accounting Standards Board (GASB) pronouncements. Financial Accounting Standards Board (FASB) statements effective after November 30, 1989, are not applied in accounting for the operations of the Fund.

B. 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 could differ from those estimates. Estimates that are particularly susceptible to significant change in future years are the liabilities for unpaid losses and loss adjustment expenses. In estimating these liabilities, management uses the methodology discussed in Note 4 on ultimate and discounted loss liabilities.

C. Cash and Cash Equivalents

All cash is deposited with the State and is required to be invested in the State Investment Fund. The State Investment Fund 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. Since shares in the State Investment Fund are purchased in $1,000 increments, cash balances below $1,000 are deposited in the State's bank.

D. Investment Valuation

Investments of the Fund consist of high-grade fixed-income securities managed by the State of Wisconsin Investment Board, and shares in four equity index funds. Fixed-income obligations and index fund shares are reported at fair value consistent with the provisions of GASB Statement 31, *Accounting and Financial Reporting for Certain Investments and for External Investment Pools*. When available, fair value information is determined using quoted market prices. However, when quoted market prices for certain securities are not available, fair values are estimated.

E. Assessments

Assessments are billed and recognized as revenues on a fiscal year basis, which is also the policy year. Assessments received for the upcoming fiscal year are treated as deferred revenue and reported as assessments received in advance. Accounts of providers are automatically credited and reported as provider refunds payable when primary insurance lapses.

F. Loss Liabilities

Loss liabilities are estimated based on recommendations of a consulting actuary and are discounted to the extent that they are matched by cash and invested assets. The uncertainties inherent in projecting the frequency and severity of claims, the Fund's

unlimited liability coverage, and extended reporting and settlement periods make it likely that the amounts ultimately paid will differ from the recorded estimated liabilities.

G. Policy Acquisition Costs

Since the Fund has no marketing staff and incurs no sales commissions, acquisition costs are minimal and charged to operations as incurred.

H. Capital Assets

The Fund capitalizes all office furniture and equipment with a useful life of two or more years and a purchase price of $5,000 or more. Capital assets are depreciated under the straight-line method over the estimated useful lives of the assets. Accumulated depreciation as of June 30, 2005, was $27,182.

I. Employee Compensated Absences

The Fund's compensated absence liability consists of accumulated unpaid leave, compensatory time, personal holiday hours, and Saturday/legal holiday hours earned and vested as of June 30.

3. Deposits and Investments

A. Deposits

All cash is deposited with the State and is invested by the State of Wisconsin Investment Board through the State Investment Fund. The State Investment Fund is not registered with the Securities and Exchange Commission as an investment company. Shares in the State Investment Fund are reported as cash equivalents and are reported at fair value as of June 30. 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. Holdings of the State Investment Fund include certificates of deposit and investments consisting primarily of direct obligations of the federal government and the State, and unsecured notes of qualifying financial and industrial issuers. Interest income, gains, and losses of the State Investment Fund are allocated monthly.

The fair value of shares in the State Investment Fund was $21,344,000 (net of mark-to-market of $0) as of June 30, 2005. Shares in the State Investment Fund are not required to be categorized under GASB Statement 3.

B. Investments

The Fund's investments are managed by the Investment Board, whose objectives are to invest moneys held in the Fund in investments with maturities and liquidity that

are appropriate for the needs of the Fund. Permitted classes of investments include bonds of governmental units or of private corporations, loans secured by mortgages, preferred or common stock, real property, and other investments not specifically prohibited by statute. In FY 1999-2000, the Investment Board began investing a portion of the Fund's portfolio in equity index funds. The Fund's current investment guidelines limit equity investments to 20 percent of the total portfolio.

All of the Fund's fixed-income investments required to be categorized by GASB Statement 3 meet the criteria for risk category 1. Investments in risk category 1 are insured or registered, or are held by the State or its agent in the State's name. Shares in the equity index funds are not required to be categorized. The market values with accrued interest of the Fund's investments at year-end are as follows:

	June 30, 2005
Fixed Income:	
Government and Agency	$234,044,120
Industrial	245,048,544
Finance	59,659,952
Utilities	46,601,468
Yankees	20,890,788
Subtotal	606,244,872
Equities:	
Mid-cap B Lendable Non-Erisa	22,870,067
MSCI World Ex-US index	17,207,350
Russell 3000 Index Fund	49,253,309
Russell 2000 Index Fund	56,319,106
Subtotal	126,500,906
Total Investments	$732,745,778

4. Ultimate and Discounted Loss Liabilities

A. Loss Liabilities

Loss liabilities include individual case estimates for reported losses and estimates for losses that have been incurred but not reported (IBNR) based upon the projected ultimate losses recommended by a consulting actuary. Individual case estimates of the liability for reported losses and net losses paid from inception of the Fund are deducted from the projected ultimate loss liabilities to determine the liability for IBNR losses as follows:

	June 30, 2005
Projected Ultimate Loss Liability	$1,416,928,116
Less:	
Net Loss Paid from Inception	(579,997,057)
Liability for Reported Losses	(21,614,068)
Liability for IBNR Losses	$ 815,316,991

Loss liabilities also include a provision for the estimated future payment of costs to settle claims. These ultimate loss adjustment expenses (LAE), are estimated at 6.25 percent as of June 30, 2005, of the projected ultimate loss liabilities. The LAE paid from inception of the Fund are deducted from the projected ultimate LAE provision to determine the liability for LAE as follows:

	June 30, 2005
Projected Ultimate LAE Liability	$88,558,007
Less:	
Net LAE Paid from Inception	(45,792,873)
Liability for LAE	$42,765,134

B. Re-estimated Loss Liabilities

The loss liability and liability for LAE are continually reviewed as adjustments to these liabilities become necessary. Such adjustments are reflected in current operations. As of June 30, 2004, the actuary estimated that the liabilities for losses and LAE through June 30, 2003, would be $79.0 million (5.4 percent) less than the amount estimated for this period as of June 30, 2003. In a similar fashion, the total losses as of June 30, 2002 and June 30, 2001, were estimated one year later to be $32 million (3.9 percent) less and $32.5 million (2.7 percent) less, respectively, than originally estimated.

C. Discounted Loss Liabilities

Section Ins 17.27(3), Wis. Adm. Code, requires the liability for reported losses, liability for IBNR losses, and liability for LAE be maintained on a present-value basis, with the difference from full value being reported as a contra account to the loss reserve liabilities. The loss liabilities are discounted only to the extent that they are matched by cash and invested assets. However, beginning with FY 1998-99, the

Fund has held sufficient cash and invested assets to fully match the discounted loss liabilities. Therefore, the loss liabilities presented in the financial statements are fully discounted. The actuarially determined discount factor was 0.817 for FY 2004-05.

D. Loss Liabilities Balances and Activities

Loss Liabilities	July 1	Additions(net)	June 30	Current Portion
FY 2004-05	668,485,366	52,437,820	720,923,186	80,500,000

5. Future Medical Expense Liability

Section 655.015, Wis. Stats., requires accounts to be established for future medical expense awards in excess of $25,000 that were entered into or rendered before June 14, 1986, or in excess of $100,000 that were entered into or rendered on or after May 25, 1995.

6. Contributions Being Held Liability

A primary insurer may voluntarily present a nonrefundable payment to the Fund generally equal to the amount of primary coverage in effect for the related claim. This payment from the primary insurer is negotiable with the Fund in exchange for a release of payment for any future defense costs that may be incurred on the claim.

7. Medical Mediation Panel

Section Ins 17.27(3), Wis. Adm. Code, requires the fees collected for administration of the Medical Mediation Panel to be included in the Fund's financial reports, but that they should not be regarded as assets or liabilities or otherwise taken into consideration in determining assessment levels to pay claims. The Fund collected $222,888 in fees in FY 2004-05.

8. Assessment Interest Income

Fund participants choosing payment plans other than annually are assessed interest on the deferred assessment amounts. Section Ins 17.28(4), Wis. Adm. Code, prescribes the interest rate to be assessed on the deferred assessments as the average annualized rate earned by the Fund on its short-term funds for the first three quarters of the preceding fiscal year, as determined by the Investment Board. Interest was assessed at the rate of 1.025 percent for FY 2004-05.

9. Claim Annuities

The settlement of a claim may result in the purchase of an annuity. Under specific annuity arrangements, the Fund may have ultimate responsibility for annuity payments if the annuity company and the reassignment company default on annuity payments. One of the Fund's annuity providers defaulted on $89,449 in annuity payments through June 30, 2005, which the Fund subsequently paid. The annuity provider is currently making the majority of these annuity payments, but the Fund continues to make monthly annuity payments of $224 to cover defaulted payments. The Fund has received reimbursement for these payments, including interest, of $60,578 through June 30, 2005. It is unclear when the annuity provider will be able to make the remaining annuity payments and whether the Fund will be able to recover the remaining annuity payments made on the behalf of the annuity provider. The total estimated replacement value of the Fund's annuities as of June 30, 2005 was $145.7 million. The Fund reserves the right to pursue collection from state guarantee funds.

10. Employee Retirement Plan

Permanent full-time employees of the Patients Compensation Fund are participants in the Wisconsin Retirement System, a cost-sharing, multiple-employer, defined benefit plan governed by Chapter 40 of Wisconsin Statutes. State and local government public employees are entitled to an annual formula retirement benefit based on: 1) the employee's final average earnings; 2) years of creditable service; and 3) a formula factor. If an employee's contributions, matching employer's contributions, and interest credited to the employee's account exceed the value of the formula benefit, the retirement benefit may instead be calculated as a money purchase benefit. The Wisconsin Retirement System is considered part of the State of Wisconsin's financial reporting entity. Copies of the separately issued financial report that includes financial statements and required supplementary information may be obtained by writing to:

Department of Employee Trust Funds
P.O. Box 7931
Madison, WI 53707-7931

The report is also available on the Department of Employee Trust Funds' Web site, *http://etf.wi.gov*.

Generally, the State's policy is to fund retirement contributions on a level-percentage-of-payroll basis to meet normal and prior service costs of the retirement system. Prior service costs are amortized over 40 years, beginning January 1, 1990. However, in December 2003 the State issued bonds and subsequently fully liquidated its prior service liability balance as of January 2003. The liquidation of the State's prior service liability resulted in credits being granted to state agencies for amounts already paid in 2003. In addition, state agencies will be required to make future contributions to fund the bond payments.

The retirement plan requires employee contributions equal to specified percentages of qualified earnings based on the employee's classification, plus employer contributions at a rate determined annually. The Injured Patients and Families Compensation Fund's contributions to the plan were $45,973 for FY 2004-05. The relative position of the Injured Patients and Families Compensation Fund in the Wisconsin Retirement System is not available because the Wisconsin Retirement System is a statewide, multiple-employer plan.

11. Subsequent Events

In July 2005, the Wisconsin Supreme Court overturned the cap on non-economic damages that applies to claims brought about by living patients. The cap was established by 1995 Act 10 at $350,000 to be indexed annually. As of May, 2005, the cap had increased to $455,755. Based upon actuarial estimates, the undiscounted unpaid claim liabilities will increase by $172,995,690, resulting in a decrease in the Fund's surplus position of $139,996,364, which is equal to the discounted amount of the reserve increase. Future financial statements will reflect this increase in loss liabilities and a Fund deficit is expected to be reported.

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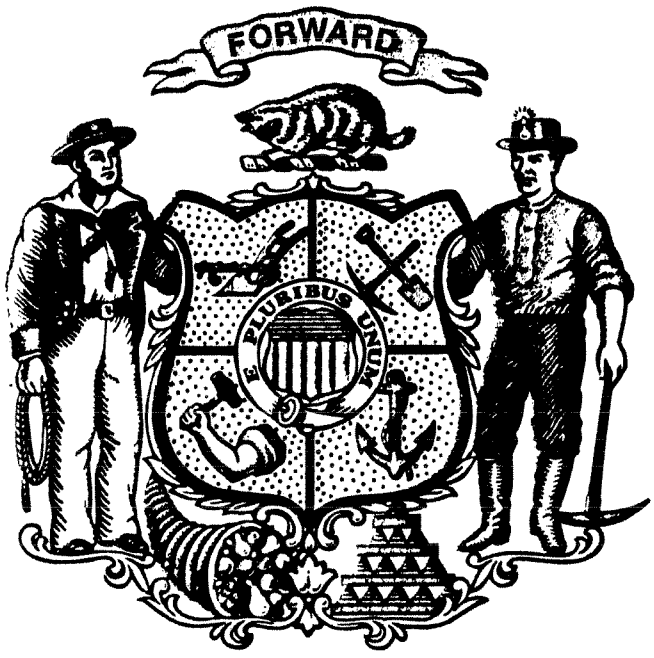
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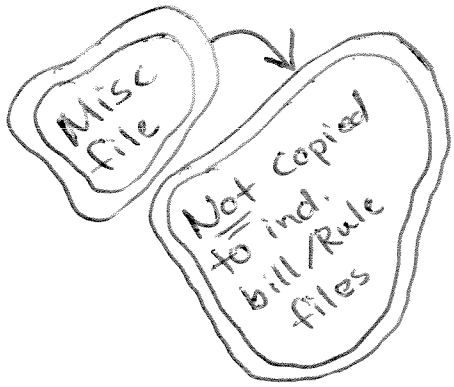


Committee Proposals
Items in committee
Committee on Insurance

01/07/2005 **Assembly Bill 1**
relating to: refunding public debt that is used to finance tax-supported or self-amortizing facilities and creating a nonrefundable individual income tax credit for certain amounts relating to health savings accounts that may be deducted from, or are exempt from, federal income taxes.

By Representatives Kaufert and Nischke.

03/10/2005 **Assembly Bill 199**
relating to: the purchase of health care coverage through the Group Insurance Board by individuals who are engaged in the business of farming, granting rule-making authority, and making an appropriation.

By Representatives Towns, Vruwink, Ainsworth, Pettis, Gronemus, M. Williams, Hubler, Musser, Kestell, Suder, Owens, Van Roy, Davis, Hines, Hahn, Freese, Pope-Roberts, Bies, Berceau, Gunderson, Kreibich, Wood, Seidel, Lamb, Petrowski, Nerison, Van Akkeren, Ott, Townsend, Albers and Ballweg; cosponsored by Senators Leibham, Decker, A. Lasee, Kapanke, Wirch, Breske, Hansen, Miller, Brown, Taylor, Zien and Lassa.

03/18/2005 **Assembly Bill 252**
relating to: increasing the limits for insurance coverage of nervous or mental health disorders or alcoholism or other drug abuse problems.

By Representatives Lehman, Benedict, Berceau, Black, Grigsby, Kreibich, Ott, Parisi, Pocan, Pope-Roberts, Shilling, Seidel, Sheridan and Zepnick; cosponsored by Senators Hansen, Miller, Risser, Stepp, Wirch, Harsdorf and Carpenter.

03/28/2005 **Assembly Bill 274**
relating to: allowing any provider to participate in a health care plan under the terms of the plan, requiring an annual period for providers to elect to participate in health care plans, and requiring notice to a provider of the reason for exclusion from a health care plan.

By Representatives Berceau, Musser, Lehman, Turner, Wasserman, Sherman, Sinicki and Schneider; cosponsored by Senator Risser.

04/22/2005 **Assembly Bill 351**
relating to: eligibility of certain persons for the Health Insurance Risk-Sharing Plan.

By Representatives Sheridan, Kaufert, Kreuser, Ainsworth, Berceau, Boyle, Fields, Lehman, McCormick, Molepske, Pocan, Richards, Seidel, Shilling, Sinicki, Staskunas, Turner, Van Akkeren and Zepnick; cosponsored by Senators Hansen, Ellis, Breske, Carpenter and Erpenbach.

04/22/2005 **Assembly Bill 352**
relating to: coverage under state employee health care coverage plan for certain qualifying individuals and making an appropriation.

By Representatives Sheridan, Kaufert, Kreuser, Ainsworth, Benedict, Berceau, Black, Boyle, Fields, McCormick, Molepske, Pocan, Richards, Seidel, Shilling, Sinicki, Staskunas, Turner, Van Akkeren and Zepnick; cosponsored by Senators Hansen, Ellis, Breske, Carpenter, Erpenbach and Robson.

04/22/2005 **Assembly Bill 363**
relating to: coverage under a liability insurance policy for owners of dogs.

By Representatives Lehman, Hahn and Mursau.

04/27/2005 **Assembly Bill 368**
relating to: requiring the group insurance board to offer prepaid legal services insurance benefits to state employees and granting rule-making authority.

By Representative Schneider.

04/27/2005 **Assembly Bill 391**
relating to: compulsory financial responsibility for the operation of motor vehicles, granting rule-making authority, and providing a penalty.

By Representatives Lehman, Black, Cullen, Gunderson, Krusick, Petrowski, Seidel, Sinicki, Van Akkeren and Toles; cosponsored by Senators Wirch, Carpenter and Roessler.

06/09/2005 **Assembly Bill 473**
relating to: health insurance coverage for wigs for cancer patients.

By Representative Schneider.

06/17/2005 **Assembly Bill 503**
relating to: defining marriage as between one man and one woman and establishing domestic partnership; providing coverage for domestic partners of University of Wisconsin System employees and annuitants under health care coverage plans and long-term care insurance policies offered by the Group Insurance Board.

By Representative Schneider.

07/07/2005 **Assembly Bill 553**
relating to: social and financial impact reports.

By Representatives Wieckert, Musser, Vos, Bies, Shilling, Pridemore, Gunderson, Davis, Lothian, Nass, Albers, Hines and McCormick; cosponsored by Senator Olsen.

10/06/2005 **Assembly Bill 737**
relating to: return of funds in excess of surplus and incurred liabilities.

By Representatives Gielow, Nischke, Ainsworth, Albers, Bies, Gunderson, Hahn, Hines, Hundertmark, McCormick, Nerison, Ott and Strachota; cosponsored by Senators Darling, Lassa and Roessler.

10/31/2005 **Assembly Bill 799**
relating to: health insurance coverage of smoking cessation treatment and medications.

By Representative Black.

11/09/2005 **Assembly Bill 816**
relating to: tax-exempt accounts for health care expenditures for an individual's parents.

By Representatives Townsend, Krawczyk, Vos, Hahn, McCormick, Hundertmark, Gunderson, Van Roy, Petrowski, Ainsworth, Nass and Suder; cosponsored by Senators Roessler and A. Lasee.

11/14/2005 **Assembly Bill 827**
relating to: prohibiting an insurer from requiring a certain vendor for repairing a motor vehicle.

By Representatives Shilling, Kerkman, Petrowski, Albers, Fields, Freese, Kreuser, Lehman, Lothian, Montgomery, Musser, Nelson, Owens, Sheridan, Sinicki, Van Roy, Vos and Zepnick; cosponsored by Senators Wirch, Brown, Breske, Erpenbach, Hansen, Jauch, A. Lasee and Miller.

12/08/2005 **Assembly Bill 862**
relating to: self-funded employer groups for providing health care coverage.

By Representatives Vos, Kerkman, Nischke, Bies, Hahn, Hines, Jensen, Jeskewitz, Kreibich, F. Lasee, Ott, Owens and Wood; cosponsored by Senators Stepp, Reynolds and Brown.

01/31/2006 **Assembly Bill 959**
relating to: health insurance coverage for children, extending the time limit for emergency rule procedures, providing an exemption from emergency rule procedures, requiring the exercise of rule-making authority, and making appropriations.

By Representatives Zepnick, Sinicki, Grigsby, Fields, Vruwink, Seidel, Cullen, Benedict, Turner, Parisi, Pocan, Pope-Roberts, Berceau, Boyle, Hebl and Black; cosponsored by Senators Miller, Coggs, Hansen, Erpenbach and Risser.

01/31/2006 **Assembly Bill 960**
relating to: recovery of noneconomic damages in medical malpractice cases.

By Representatives Owens, Schneider and Ziegelbauer.

02/07/2006 **Assembly Bill 997**
relating to: increasing the limit on policies issued by the state life insurance fund.

By Representatives Lehman, Hebl, Turner, Boyle, Berceau and Sherman; cosponsored by Senators Miller, Coggs and Risser.

02/20/2006 **Assembly Bill 1039**
relating to: persons to whom liability insurance claim settlement checks must be made payable; independent evaluations for insurance coverage of chiropractic treatment; current procedural terminology codes on health insurance claim forms; and direct payment to a chiropractor.

By Representatives Kestell, Freese, Kreibich, Montgomery, Albers, Loeffelholz, Musser, Towns, Ainsworth, Pettis, Krawczyk, Ott, Ballweg, Petrowski and Bies; cosponsored by Senators Schultz, Zien and Carpenter.

02/23/2006 **Assembly Bill 1071**
relating to: the time limit for a person under the age of 18 to bring action against a health care provider.

02/23/2006 **Assembly Bill 1072**
relating to: awards to persons suffering damages as the result of medical malpractice and evidence of ompensation for those damages.

02/23/2006 **Assembly Bill 1073**
relating to: recovery of noneconomicdamages in medical malpractice cases.

02/23/2006 **Assembly Bill 1074**
relating to: recovery of attorney fees in medical malpractice cases.

03/14/2006 **Assembly Bill 1120**
relating to: using accumulated unused sick leave credits and health insurance premium credits for the purchase of long-term care insurance for participants under the Wisconsin Retirement System.

By Representatives Petrowski, Ainsworth, Musser, Albers, Ott, Hahn, Owens and Townsend; cosponsored by Senator Roessler.

03/27/2006 **Assembly Bill 1148**
relating to: an assessment on large employers that reduce or eliminate health care coverage, providing an exemption from emergency rule procedures, requiring the exercise of rule-making authority, and providing a penalty.

By Representatives Berceau, Nelson, Seidel, Pocan, Parisi, Sheridan, Hebl, Schneider, Travis, Molepske, Colon, Pope-Roberts, Sinicki, Young, Vruwink, Sherman, Turner, Richards, Kreuser, Black, Grigsby and Fields; cosponsored by Senator Miller.

04/05/2006 **Assembly Bill 1171**
relating to: creating a Healthy Wisconsin Authority and requiring a study on a catastrophic reinsurance program for health care costs.

By Representatives Gielow, Albers, Benedict, Gronemus, Hebl, Hubler, Lehman, Nelson, Seidel and Zepnick; cosponsored by Senators Robson, Erpenbach and Hansen.

04/11/2006 **Assembly Bill 1178**
relating to: prohibiting the Office of the Commissioner of Insurance from promulgating certain rules related to limited-scope dental or vision plans and preferred provider plans.

By Joint Committee for Review of Administrative Rules.

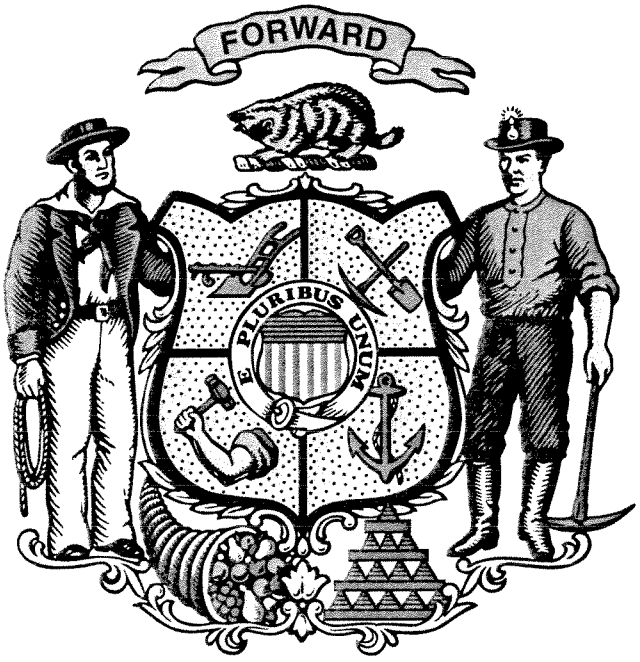
12/08/2005 **Clearinghouse Rule 05-099**
relating to small employer uniform employee application for group health insurance.

04/11/2006 **Clearinghouse Rule 05-111**
relating to agent licensing procedure changes which will affect small business.

02/28/2006 **Clearinghouse Rule 06-002**
relating to annual patients compensation fund and mediation fund fees for the fiscal year beginning July 1, 2006 and may have an effect on small businesses.

05/12/2005 **Education Seminar: Principles of Risk Management**
The Griffith Foundation for Insurance Education will conduct a special Education seminar entitled "The Basic Principles of Risk Management and Insurance." This seminar is designed to provide members with background information relevant to insurance topics. The Griffith Foundation for Insurance Education is a nonprofit

education foundation founded in 1947. Its mission is to promote the teaching of risk management and insurance by colleges and universities, to encourage student participation in these programs, and to offer education programs in these disciplines for public policymakers.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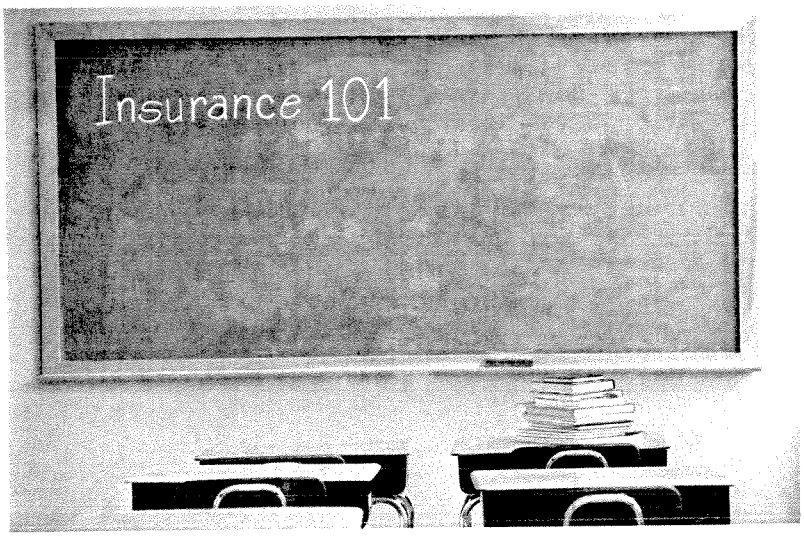
AIA ADVOCATE

Insurance 101: Property-Casualty Basics



Every day, individuals and businesses face a variety of potentially catastrophic risks. By creating tools to manage uncertainty and loss, property-casualty insurers are able to provide vital personal and professional protection. In addition, property-casualty insurance helps provide and maintain a reliable foundation for our economy. Despite these fundamental roles property-casualty insurance plays in the lives of virtually every American, relatively few people outside of the insurance industry understand how it works.

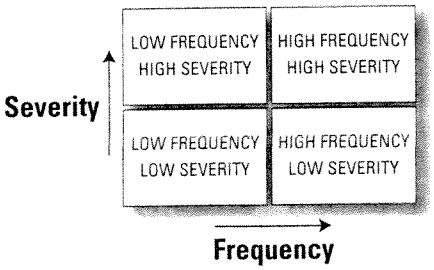
This issue of the ***AIA Advocate*** *looks at the basic concepts of property-casualty insurance, providing a plain-English primer on several key topics. The middle pullout page provides background on how insurance benefits our economy and society, as well as a glossary of common insurance terms.*

Insurance Helps People Manage Risk

Risk is inevitable in society; insurance helps address that reality. Insurance allows individuals or organizations to exchange the risk of a large loss for the certainty of smaller periodic payments, known as *premiums*. The exchange (or transfer) of risk is laid out in a legal contract called the insurance *policy*, which spells out the coverage, compensation, and/or other benefits.

Insurance takes on (or assumes) "pure" risk — the possibility of suffering harm or loss. (Insurance is not for "speculative" risks, like gambling, where financial gain is possible.) If a loss occurs, the policyholder simply is restored to the same condition as before the loss. Examples of risk covered by insurance include fire, theft, tornadoes, motor vehicle crashes, and being sued for causing harm to another person.

Risk has two key dimensions—frequency and severity—and both help determine insurability. "Frequency" relates to how often a loss occurs, i.e., whether the risk/event is common or relatively rare. "Severity" relates to how costly losses resulting from that risk could be, i.e., whether they could be relatively inexpensive or truly catastrophic in nature.



In the table above, insurance can be an appropriate method of risk transfer for low-frequency, high-severity losses (e.g., house fires or tornadoes), as well as for high-frequency, low-severity losses (e.g., motor vehicle crashes). However, insurance may not be the most appropriate method for treating all risks facing individuals and businesses. For example, insurance could be too expensive for certain risks (low-frequency, low-severity) or unavailable for other risks (such as high-frequency, high-severity risks, or risks whose frequency and/or severity is difficult to predict, such as terrorism). Additionally, insurance may be unable to fully compensate for a loss (e.g., the destruction of family photos, which have great emotional value but little financial value).

In taking on massive amounts of societal risk, the insurance industry relies on two fundamental tools: *pooling* and the *Law of Large Numbers*. An insurer can cover the risk of losses from a few policyholders by combining (pooling) together the premiums from a much larger group of policyholders. This also improves predictability, thanks to a statistical principle known as the Law of Large Numbers, which

states that the accuracy of loss prediction increases with the number of policyholders in the pool.

Insurance also handles risk by working to prevent losses to lives and property. Loss prevention (also known as loss control or mitigation) is a core function of the insurance business and has benefited society immeasurably. See "Two Functions of Property-Casualty Insurance" in the pullout section for some examples of how the property-casualty industry created and continues to support many important public safety systems and world-class safety organizations.

Property-Casualty Insurance: Origins and Types

Property-casualty insurance traces its modern history back to marine insurance in the late Middle Ages. With an increase in maritime trading, merchants and bankers became concerned about the safety of shipments due to piracy, storms, and other perils. The bankers provided guarantees against loss; in return, merchants paid the bankers a fee for this protection.

Fire insurance, and what became the modern insurance industry, developed primarily in England after the Great London Fire in 1666. The U.S. property-casualty insurance market evolved from British practices; the first U.S. fire insurer was started by Benjamin Franklin in 1752. By the early 1900s, many major types (or "lines") of insurance we know today had developed.

Today, this segment of the insurance industry provides protection from risk in two basic areas: protection for physical items, such as houses, personal possessions, cars, commercial buildings, and inventory (property), and protection against legal liability (casualty).

Property insurance is a "first-party" coverage for losses related to a policyholder's own person/property. Casualty (or liability) insurance is a "third-party" coverage for a policyholder's legal obligations against losses the policyholder may cause to others.

These two basic types of coverage are written for both individuals or families ("personal lines" policies) and businesses ("commercial lines" policies).

Personal lines policies include homeowners insurance, renters insurance, and vehicle coverage. For example, homeowners policies cover both fire damage to a house and/or contents, plus legal defense costs and liabilities should a person be injured on the policyholder's property.

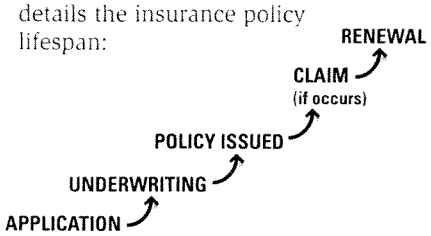
Commercial lines products are written for businesses and other organizations (churches, schools, cities, non-profits), and include packages such as "Business Owners Policies" as well as commercial general liability, workers' compensation, commercial property, and product liability insurance.

Commercial property policies cover buildings and the organization's property, and include a type of coverage known as "business interruption" designed to help a company continue operating if it is put out of its office/physical plant by a covered risk. Commercial liability policies protect policyholders against financial responsibility for injury or property damage resulting from a policyholder's premises, products, services, or other operations. One example of commercial casualty coverage is workers' compensation, which deals with lost earnings and medical expenses of employees injured on the job.

The specific scope and limits of coverage in all of these examples are spelled out by an individual insurance policy. The next section of this ***AIA Advocate*** examines this essential contract.

The Insurance Transaction

An insurance policy is a binding legal contract with very specific terms, conditions, and promises by both insurance company and policyholder. The policy describes in detail what is—and what is not—covered. The following diagram details the insurance policy lifespan:



Using the example of a typical homeowners insurance product, here is how the process works:

Application – The customer contacts an insurance agent or insurance company directly to inquire about the types of coverage available and costs related to coverage for a specific need (such as a new house). The customer fills out an application, which is then sent to an insurance company underwriter.

Underwriting – Through the underwriting process, the insurance company determines which customers to insure and what coverages to offer. The insurer considers the insurance agent's recommendation (if an agent is involved), the amount of coverage requested, the policyholder's loss and insurance history, as well as several other objective, actuarially derived factors. The insurance company will accept the application, reject the application, or accept the application with modifications. Except as limited by state law, these modifications can include higher deductibles, changes to the coverage limits or premium, or changes to the coverage by the use of "endorsements" (specific policy revisions that provide greater or lesser coverage than allowed under the standard/base policy form).

Continued on page 3

AIA ADVOCATE

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Continued from page 2

Issuing the Policy – The policy is then sent to the policyholder (also known as an "insured"). The policy includes the following: a "declarations page" (important information about the policyholder, exposures and coverage to be provided); an insuring agreement (the insurer's promise to pay for covered losses); modifications ("exclusions" eliminate coverage for certain property or situations, while "conditions" specify what is required of the policyholder and insurer to ensure that losses are covered); and endorsements. It is the policyholder's responsibility to read the policy and make sure the coverage provided is what was requested. At this time, the policyholder also is required to submit the premium payment.

Claims – Fortunately, most policyholders do not suffer losses that lead them to submit claims under their insurance policies. When a claim is made, how it is handled depends on the type of loss involved.

Property claim: In the event of loss, the policyholder calls their agent or company claims department to report the loss/file a claim. The claims representative (known as an "adjuster") will investigate the loss, including verifying coverage for the particular risk; they also will determine whether a policy is in force, and prepare a repair estimate.

Liability claim: If a third party makes a claim alleging that the policyholder is responsible for damage to/losses by the claimant (e.g., a guest falls down the policyholder's stairs and injures their back), the insurance company claims representative would assess the claim, verify insurance coverage, and interview the policyholder, claimant, and the claimant's medical doctor to determine the extent of injuries and negligence.

Liability claim costs generally are broken down into two categories: 1) special damages, which include the claimant's out-of-pocket expenses and lost wages; and, 2) general damages, which cover compensation for pain and suffering (often called non-economic damages).

The claim representative/adjuster has the responsibility to offer a fair settlement to the injured party (whether first- or third-party), but can offer only up to the dollar limits of the policy. Once the claimant and company agree on the amount of loss, the company pays that amount (less the amount of a deductible in first-party claims). If there is disagreement over the claim, the matter may go to arbitration, mediation, or court for resolution.

Renewal – Most policies (especially personal lines) run for either six months or 12 months and are renewed at the end of that period. However, policies also can be cancelled or non-renewed by either the policyholder or the insurer. The policyholder can choose to cancel the policy during the policy period or move to another insurer at the end of the policy period (non-renew). The insurer can decide to non-renew a policy if the insured has had an unacceptable number of claims, and can cancel a policy during the policy period for non-payment of premium or other specific reasons. State laws place restrictions on the ability of insurance companies to cancel or non-renew. Advance notice to the policyholder is required in both instances.

The Challenge of Determining Premiums

The lifespan of the insurance policy outlined above illustrates one of the fundamental differences between insurance products and other products. Issuing the policy (and thus collecting premiums) comes before paying out the claims, sometimes years or even decades before.

For most economic goods, the cost of the product to the business is known at the time the customer is given a price and the customer purchases the product/service. However, for insurance products, the actual cost of providing coverage is unknown to the insurer for some time. Nonetheless, the insurer remains obligated to pay claims in the face of this uncertainty, even if the premium it received turns out to be wholly inadequate.

Premiums are fundamentally derived from projected cost of claims (losses) and other expenses. While each insurance entity's operational expenses vary, they are relatively predictable. Claims costs, on the other hand, are not always predictable. Insurers use statistics and historical loss information to forecast an accurate estimate of the amount of losses to be paid in the future—sometimes the distant future—for a particular pool of risks. The accuracy of the estimate depends on the type of risk, policyholder characteristics, and the size of the pool.

The bottom line is that as the cost of the things insurance pays for rises or falls, the price policyholders pay for coverage typically rises or falls as well. This also means that when regulators, public policymakers, the courts, and/or the public want insurance companies to increase benefits under an insurance policy, the purchasers of that policy must pay more for coverage.

A more expansive discussion of how premiums are determined and where premium dollars are spent can be found in an upcoming ***AIA Advocate*** on insurer finance that will serve as a companion to this edition.

Insurance Regulation

Property-casualty insurance is heavily regulated at the state level; this is particularly true for personal lines and for workers' compensation. Generally speaking, state regulators have oversight of market conduct; insurance company and agent licensing; insurance rates; policy language; financial condition (solvency) of insurance companies; and, consumer protection in insurance transactions.

Ideally, regulators focus their resources on making sure that insurance rates are adequate to cover losses, so that claims can be paid in full. They also are responsible for making sure that rates are neither unreasonably high nor unfairly discriminatory. Another key regulatory duty is to make sure that insurers remain solvent, i.e., that

they maintain enough capital to pay policyholder losses as they come due.

States also have laws in place to protect insurance consumers, such as Unfair Trade Practices Acts (which prohibit coercion of consumers during the sales process) and Unfair Claims Practices Acts (which prohibit insurers from settling a claim for less than should be paid).

Regulators (whose titles range from commissioner to superintendent to director) in every state and in the District of Columbia administer insurance laws for their jurisdictions. The vast majority of insurance regulators are appointed; in about a dozen states, insurance regulators are elected to office.

All states provide mechanisms for relatively high-risk individuals who seek insurance from the private market, but are unable to find it; these individuals are known as the "residual market." For example, high-risk drivers who are required to carry liability insurance by state law, but cannot obtain auto insurance in the regular or "voluntary" market because of the high likelihood of costly losses (which insurers may not be able to reflect in rates due to government price controls) can go to their state's residual market mechanisms for coverage. All insurers licensed in the state must participate in these mechanisms for their particular lines of coverage, whether that is auto insurance, property insurance, or workers' compensation.

A few federal insurance programs either directly provide or enable private sector provision of property-casualty coverage. These include the National Flood Insurance Program (private insurers sell coverage and adjust claims; but coverage is underwritten and claims are paid wholly by the government); the Overseas Private Investment Corporation (provides political risk coverage for U.S. businesses with operations overseas); the Terrorism Risk Insurance Act program (a public-private risk-sharing mechanism for catastrophic terrorist attacks); and the Federal Crop Insurance Corporation (federally reinsured coverage against adverse weather, plant diseases, and insect infestations). ●

This basic primer is meant to provide a quick, relatively simple overview of the property-casualty insurance product and market. A companion issue will follow later this year covering the basics of insurer finance. For further information on any of the topics covered in this issue of the ***AIA Advocate****, please contact the American Insurance Association's Public Affairs Department at (202) 828-7100, or at webmaster@aiadc.org.*

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Brief Glossary of Key Property-Casualty Insurance Terms

Assigned Risk Plans (Automobile Insurance Plans): A mechanism used in some states to insure people who cannot obtain insurance in the voluntary market. There is one rate level and the individual policies are assigned to specific companies according to the percentage of the market they insure.

Combined (Loss/Expense) Ratio: An important measure of underwriting and profitability, this figure represents the percentage of each premium dollar that an insurer spends on claims and expenses (i.e., a combination of the "loss ratio" and "expense ratio"). A combined ratio of less than 100 percent indicates a profit; anything over 100 represents a loss.

Exclusion: A provision in an insurance policy that denies coverage for certain perils, persons, property, or location.

Expense Ratio: This figure represents the insurer's operating expenses divided by net premiums written (expenses include salaries, commissions, administrative expenses, losses, and loss adjustment expenses).

FAIR (Fair Access to Insurance Requirements) Plan: A facility, operating under a government-insurance industry cooperative program, to make fire insurance and other forms of property insurance readily available to people who have difficulty obtaining such coverage.

Loss Control: Methods to reduce the cost and/or frequency of risk through prevention and mitigation. Simple, common examples of risk management/loss control include wearing a seat belt, installing deadbolt locks or security systems, making factory workers wear safety goggles, and installing fire suppression systems.

Loss Ratio: Percentage of each premium dollar that an insurer spends on claims. Example: A loss ratio of 94 means that the insurer spends 94 percent of each $1 of premiums on claims.

Pool: An organization of insurers or reinsurers through which particular types of risks are underwritten with premiums, losses, and expenses shared in agreed ratios.

Reinsurance: Just as individuals purchase insurance to spread the risk of possible losses, primary insurers need a way to transfer some of these losses too, so they turn to "reinsurers." Reinsurance is an agreement between two property-casualty insurers to share financial consequences of a loss. The primary insurer buys reinsurance (essentially, insurance for insurance companies) in order to diversify and transfer risks, and to share potentially devastating losses.

Reserve: This term can apply to: 1) an amount representing actual or potential liabilities kept by an insurer to cover obligations to policyholders and third-party claimants; or, 2) an amount allocated for a special purpose. Note: A reserve is usually a liability and not an extra fund. On occasion, a reserve may be an asset, such as a reserve for taxes not yet due.

Residual Market: A general term describing the total of all consumers who have had difficulty purchasing insurance through normal channels. Automobile Insurance Plans, FAIR Plans, reinsurance facilities, and Joint Underwriting Associations all service this market.

Risk Retention: A term meaning that the policyholder pays for part or all of the losses associated with a particular risk. Retention can be deliberate or unintentional. Deliberate risk retention includes such things as: 1) agreeing to a particular level of "deductible" as part of purchasing an insurance policy; or 2) a business or individual covering the cost of low frequency-low severity events, or high frequency-low severity events (such as flat tires on cars, shoplifting at grocery stores, or damage to household possessions). Unintentional risk retention may result because an individual or business simply did not realize that some type of risk was not covered by their insurance policy.

Statutory Accounting Principles (SAP): State legal requirements that insurers must follow when submitting financial statements to the various state insurance departments. Such principles differ from Generally Accepted Accounting Principles (GAAP) in some important respects. For example, SAP requires that expenses must be recorded immediately and cannot be deferred to track with premiums as they are earned and taken into revenue.

Surplus Lines: Any risk or part thereof for which insurance is not available through a company licensed in the policyholder's state (licensed insurers are also known as "admitted" insurers). The business, therefore, is placed with "non-admitted" insurers (insurers not licensed in the state) in accordance with surplus or excess lines provisions of state insurance laws.

TYPES OF INSURERS

Stock Companies: Formed to make money for shareholders, who actually own the company. Also known as "public" companies, because their shares are publicly traded.

Mutual Companies: Owned by the policyholders; like shareholders at stock companies, policyholders of mutual companies receive dividends if operations are profitable.

Captives: Wholly owned subsidiary of a business organization or group of affiliated organizations that exists for a limited purpose: to provide all or part of the parent organization's insurance coverage.

Risk Retention Groups: Limited by law to providing product liability and other commercial liability insurance coverage for collections of similar entities with similar risk exposures.

Reciprocals: Unincorporated associations that provide insurance services only to their members, known as "subscribers." ●

How Insurance Benefits Society and the Economy

- **Improving consumer and worker safety:** Insurance makes businesses and individuals more aware of the risks they face and provides motivation to prevent losses. For example, insurers provide premium discounts to safe drivers and to businesses that implement effective worker safety programs.

- **Protecting consumer transactions:** Most consumers have to borrow money to buy homes and cars; lenders require insurance in order to secure the loans they make for these purchases. Without insurance, few people could obtain an auto loan or home mortgage.

- **Protecting business transactions:** Without insurance, most businesses would find that they could not operate. Insurance enables businesses of all sizes and types to manage the risks that are an inherent part of any business operation (e.g., signing contracts, financing and expanding operations, manufacturing and distributing products, providing services, hiring employees).

- **Providing recovery from catastrophes:** Hurricanes, winter storms, fires, and other disasters can cause tremendous, sudden loss to many people all at once. Insurance coverage enables businesses to replace inventories and rebuild buildings, and allows homeowners to repair and rebuild homes and replace property.

- **Providing trillions of dollars to the U.S. economy each year:**

  - The property-casualty insurance industry pays out more than $300 billion annually in policy benefits.

  - Property-casualty insurers doing business in the United States have more than $1 trillion invested in the economy, through stock, corporate and government bonds, and real estate mortgages. These investments finance building construction and provide other crucial support to economic development projects all across the country.

  - Property-casualty insurers are a major source of capital for state and local government in the United States. Insurers held a total of over $266.4 billion in state municipal bonds in 2004. This represents approximately 16 percent of the current outstanding state and local government debt. Insurers invest in a variety of public projects, such as airport, hospital, and highway construction. Insurers also purchase general obligation bonds used to finance ongoing government operations.

  - There are approximately 3,000 companies providing property-casualty insurance coverage in the United States. About 100 of these companies provide the majority of the property-casualty coverage.

  - About 1.3 million people are employed by the property-casualty industry, including insurance companies, agencies, and brokerages. ●

Two Functions of Property-Casualty Insurance

Preventing Losses

Property-casualty insurance is about preventing losses (injuries, deaths, and/or property damage) from occurring in the first place; through their everyday business practices, insurers are dedicated to reducing injuries, deaths, and property damage; in this way, the interests of insurers, their customers, and the general public are exactly in line.

Listed below are a few of the many public safety organizations that insurers have started throughout their history.

Insurance companies were the first firefighters. They started the fire service, and supported, improved, and standardized it. Fire brigades in the early days were run by insurance companies, and even after firefighting was undertaken by local governments, the industry still played an active role through the National Board of Fire Underwriters (NBFU), which was created in 1866. (AIA is descended from the NBFU).

NFPA®

Insurance companies created the National Fire Protection Association (NFPA) in 1896. The NFPA remains the world's leading advocate of fire prevention and public safety. The organization was the driving force behind building and electrical codes; and now NFPA codes influence every building, design, and installation in the United States as well as many across the world.

UL®

Insurers started the Underwriters Laboratories over a hundred years ago. The UL mark is among the most universally recognized and sought consumer product safety certifications.

INSURANCE INSTITUTE FOR HIGHWAY SAFETY

The Insurance Institute for Highway Safety (IIHS) was founded in 1969 for the specific purpose of conducting high-quality, independent research looking at motor vehicle technology and design, driver and occupant safety systems and behavior, and roadway engineering. IIHS research has led to safety innovations that have saved thousands of lives; its work has spread worldwide.

INSTITUTE FOR Business & Home Safety®

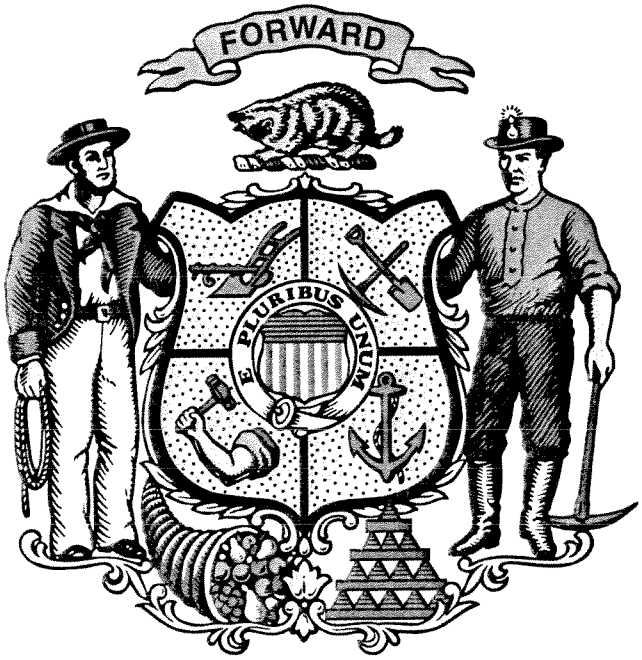
Individual homes and commercial buildings are made safer through the work of the Institute for Business & Home Safety (IBHS). IBHS was established by the insurance industry to reduce the social and economic effects of natural disasters and other property losses by conducting research and advocating improved construction, maintenance, and preparation practices.

Helping Recover from Loss

Property-casualty insurance is about facilitating recovery from losses suffered by individuals or businesses – whether those losses are relatively small (such as a fender bender) or truly catastrophic (such as a hurricane).

- Insurance helps individuals, businesses, and entire communities stay financially stable and recover from unanticipated – and potentially ruinous – losses. As a result, jobs are protected, taxes continue to be paid, and goods and services continue to be produced and provided.

- Insurance policies (contracts) provide protection against financial losses that occur as the result of certain specified causes. For example, if you are involved in an automobile crash, health insurance or auto insurance would pay your medical bills and those of your passengers; auto insurance would pay for repairs to your vehicle, and for losses your driving causes to other people or property. ●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STATE OF WISCONSIN

Report 06-10
August 2006

An Audit

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

Legislative Audit Bureau

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Health Insurance Risk-Sharing Plan

Department of Health and Family Services

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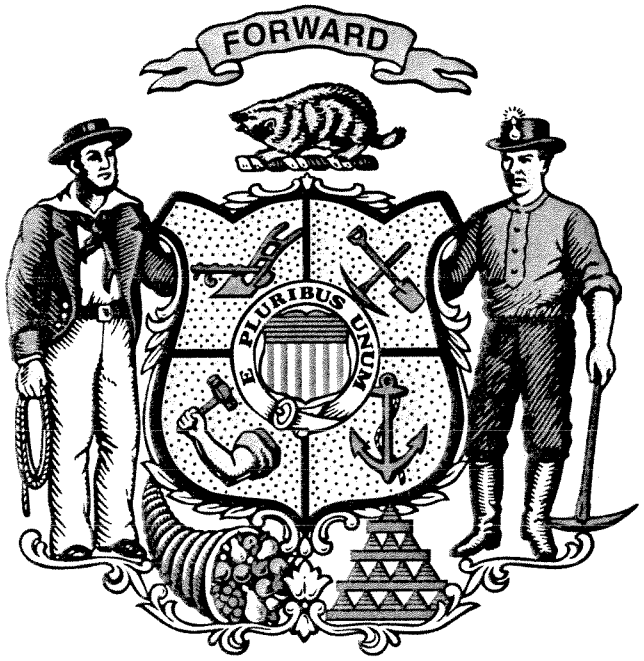
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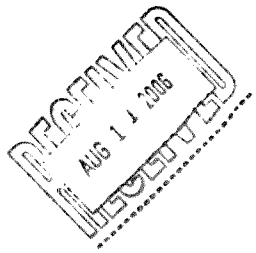
06-10



An Audit:

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

August 2006

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.

Key Facts and Findings

Almost 19,000 policyholders are enrolled in HIRSP.

HIRSP is funded through policyholder premiums, insurer assessments, and reduced reimbursements to health care providers.

We have issued an unqualified opinion on HIRSP's FY 2004-05 financial statements.

HIRSP's unrestricted net assets decreased by $7.1 million during FY 2004-05.

2005 Wisconsin Act 74 created the HIRSP Authority, which assumed responsibility for HIRSP on July 1, 2006.

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, the balance decreased $7.1 million during FY 2004-05, resulting in a small deficit of $300,000 as of June 30, 2005.

Unrestricted Net Assets (In Millions)

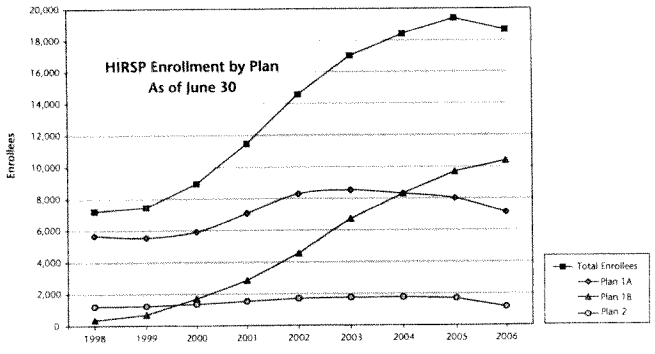
Date	Amount
June 30, 2001	$(8.2)
June 30, 2002	(6.0)
June 30, 2003	(0.9)
June 30, 2004	6.8
June 30, 2005	(0.3)

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.



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

Net Claims Costs[1] (In Millions)

Fiscal Year	Amount	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

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.