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☞ Details: Legislative Audit Bureau Report 05-9: An Audit: Health Insurance Risk-Sharing Plan, Department of Health and Family Services

(FORM UPDATED: 08/11/2010)

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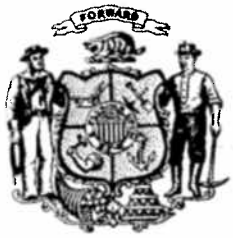

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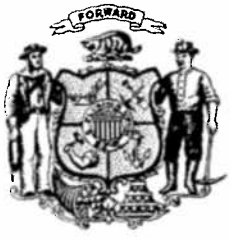

STATE OF WISCONSIN
Legislative Audit Bureau

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Janice Mueller
State Auditor

DATE: May 16, 2005

TO: Karen Asbjornson and Pamela Matthews
Committee Clerks to the Joint Legislative Audit Committee

FROM: Diann Allsen
Financial Audit Director

SUBJECT: Report 05-9: An Audit of the Health Insurance Risk-Sharing Plan

At the request of the Department of Health and Family Services (DHFS), we performed an audit of the financial statements of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 2003-04. HIRSP provides medical insurance for individuals unable to obtain private coverage. Almost 19,000 policyholders are enrolled in the plan. We are able to provide an unqualified opinion on HIRSP's financial statements.

HIRSP's financial position continued to improve during FY 2003-04. After several years of accounting deficits, the program had a positive accounting balance on June 30, 2004. Enrollment and claims costs continued to increase during FY 2003-04, although current statistics suggest that enrollment may be beginning to slow. DHFS and HIRSP's Board of Governors increased the usual and customary discounts applied to billed medical bills, which has the effect of reducing the amount of program costs shared by policyholders, insurers, and health care providers.

We identified two types of claims processing errors during our audit. First, pharmacy claims totaling $210,689 were inappropriately paid for cancelled policyholders. DHFS has already responded to this error and has withheld payment from the former plan administrator. Second, the former plan administrator was not properly applying deductibles in accordance with statutes, which resulted in 1,582 policyholders overpaying their deductibles. The Department agrees with our recommendation to provide refunds to the affected policyholders and indicates it will work with the Board to decide on the best course of action. We will follow up on the resolution of these claims issues during our next financial audit of HIRSP.

Finally, we again note a technical issue in HIRSP's statutory funding formula that results in policyholders being over-credited for subsidies they did not fund. Proposed statutory changes in the 2005-07 biennial budget bill, 2005 Assembly Bill 100 would correct this issue.

We expect the report to be released on Tuesday, May 17, at 9:00 a.m. Please let us know if you have any questions.

DA/bm

Enclosures

Report 05-9
May 2005

An Audit

Health Insurance Risk-Sharing Plan

Department of Health and Family Services

2005-2006 Joint Legislative Audit Committee Members

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State Auditor - Janice Mueller

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Payment of HIRSP Operating and Administrative Costs

Response

From the Department of Health and Family Services

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Janice Mueller
State Auditor

May 17, 2005

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

Dear Senator Roessler and Representative Jeskewitz:

At the request of the Department of Health and Family Services (DHFS), we have completed a financial audit of the Health Insurance Risk-Sharing Plan (HIRSP) for fiscal year (FY) 2003-04. HIRSP provides medical and prescription drug insurance for almost 19,000 policyholders who are unable to obtain coverage in the private market or who lost employer-sponsored group health insurance. We have provided an unqualified opinion on HIRSP's financial statements.

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

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

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

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

Respectfully submitted,

Janice Mueller
State Auditor

JM/DA/ss

Report Highlights ■

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

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

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

Pharmacy claims were inappropriately paid for cancelled policyholders.

Policyholder deductibles were not properly carried forward between years.

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

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

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

HIRSP offers eligible applicants three plans:

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

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

Financial Status of the Plan

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

Table 1

Unrestricted Net Assets
(In Millions)

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

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

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

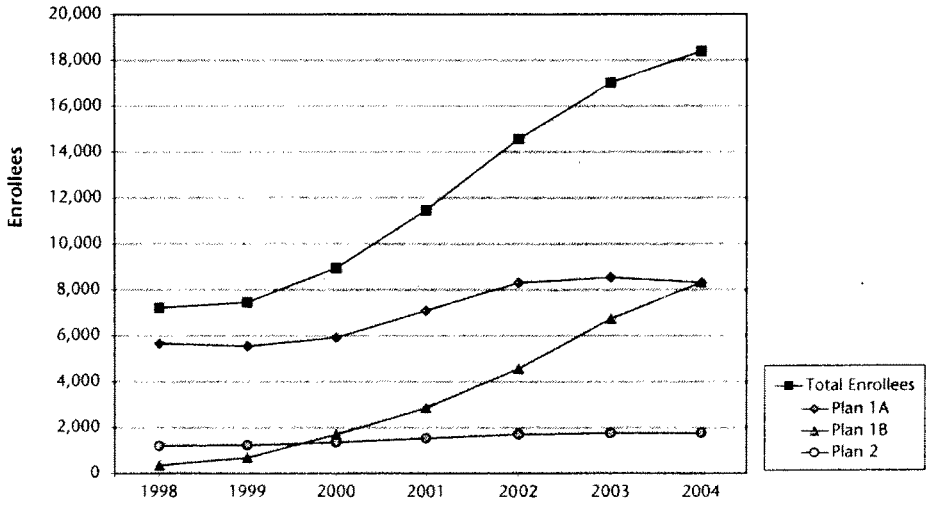
policyholder balance decreased slightly in FY 2003-04, to $10.1 million at June 30, 2004. The use of these funds is statutorily restricted to reduce policyholder premiums to the statutory minimum; for distribution to eligible persons; or for other needs of eligible persons, with the approval of the Board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

Enrollment and Claims Costs

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

Figure 1

HIRSP Enrollment by Plan
As of June 30



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

Table 2

Net Claims Costs[1]
(In Millions)

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

[1] Net of health care providers' discounts.

Determination of Program Costs

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

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

Claims Management Issues

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

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

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

Technical Statutory Issue

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

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

Recommendations

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

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

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

■ ■ ■ ■


FORWARD
E PLURIBUS UNUM

June 20, 2005

To: Wisconsin Legislators
Governor James Doyle

From: Dianne Greenley
Annette Stebbins
Public Members of the HIRSP Board of Governors

Re: Joint Committee on Finance Motion to Restructure HIRSP

We are writing to express our grave concern about the motion to restructure HIRSP. Unfortunately, this motion was developed and passed without our knowledge; it was not brought before the Board of Governors, nor were there any public hearings or other opportunities for public input. Thus, plan participants will be significantly impacted by decisions of which they are totally unaware. This is not the way to make public policy, especially when the health care of over 19,000 individuals is at stake. Thus, we ask that you take action to reverse this action. If changes are needed or desired for this program, there should be a public process and study to ensure that changes are reasonable and will not negatively impact plan participants.

Specifically we are concerned about the following changes in the program. The Joint Committee on Finance motion to change HIRSP:

- Removes HIRSP from the Department of Health and Family Services and recreates it as a private nonprofit organization with a 13 member board, 9 of whom represent insurers, providers, and small business; DHFS and the Office of Insurance Commissioner are removed from the board. This means that public members, who represent plan participants will be limited to 4 members, even though plan participants must pay 60% of the program's cost, and there will be no representation from the two governmental agencies who are charged with protecting the public. There must be more representation of plan participants; specifically persons who are covered by the program should have greater representation on the board.

- Removes plan benefits, deductibles, copayments, out of pocket limits, and rate setting procedures from the statutes. These will all be determined by the new board. There is great potential for reducing benefit levels and increasing participant costs, with no meaningful government oversight. OCI will approve policies to determine if they are "comparable to a typical health insurance policy offered in the private sector". Such policies may not meet the needs of HIRSP participants who by definition have significant health care needs.

- Shifts deductible and premium subsidies for low income plan participants from insurers and providers to plan participants. Currently, costs associated with these subsidies are paid 50% each by insurers and providers. The motion will require plan participants to pay 60% of these costs with insurers and providers each paying 20%. This is a direct cost shift from those most able to pay to those least able to pay.

These are very significant changes in a program designed to provide health insurance for persons who cannot obtain coverage in the private market; this is a vulnerable group of persons. Program restructuring should not be done out of public view and should not have negative impacts on the people whom it is designed to serve.