Chapter Ins 18

HEALTH INSURANCE RISK-SHARING PLAN

Ins 18.01 Purpose. This chapter is intended to implement and interpret subch. II of ch. 619, Stats., and s. 632.785, Stats., for the purpose of establishing procedures and requirements for a health insurance risk-sharing plan, in accordance with ss. 619.11 and 601.41 (3), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.02 Creation of plan and title. In accordance with ss. 619.11 and 601.41 (3), Stats., a plan of health insurance coverage which meets the requirements of subch. II of ch. 619, Stats., and s. 632.785, Stats., is established. The title of the plan shall be "Health Insurance Risk-Sharing Plan", and shall be referred to in this chapter as the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.03 Scope. This chapter shall apply to all insurers as defined in s. 619.10 (5), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.04 Definitions. For the purpose of this chapter, the definition of terms used shall be those definitions set forth in s. 619.10, Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.05 Eligibility. Eligibility shall be determined in accordance with s. 619.12, Stats.

(1) CRITERIA. The administering carrier shall certify as eligible any resident as defined in s. 619.10 (9), Stats., upon receipt from the plan applicant of any of the following, as set forth in s. 619.12 (1), Stats., based wholly or partially on medical underwriting considerations within 6 months prior to making application for coverage by the plan:

(a) A notice of rejection or cancellation of health insurance coverage from 2 or more insurers.

(b) A notice of reduction or limitation of health insurance coverage, including restrictive riders, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considering a standard risk for the type of coverage provided by the plan. A denial of coverage for any of the covered expenses enumerated in s. 619.14 (3), Stats., shall constitute a substantial reduction in coverage, if the same policy offered to standard risks includes such coverage. A denial of coverage for a particular medical condition shall constitute a substantial reduction in coverage if the same

policy offered to standard risks includes such coverage, and such coverage is available under the plan.

(c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies for the same coverage then in effect in Wisconsin.

(d) A notice of premium for a major medical or medicare supplement policy not yet in effect from 2 or more insurers which exceeds the premium applicable to a person considered a standard risk by 50% or more.

(2) NON-ELIGIBILITY. Exclusions from eligibility for the plan shall be as set forth in s. 619.12 (2), Stats.

(3) BOARD REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the administering carrier is entitled to a review by the board under the grievance procedures established by the board under s. 619.15 (3) (a), Stats. Persons denied the premium reductions under Ins 18.13 are entitled to a review under this section.

(4) DATE OF ELIGIBILITY. Except as provided in s. 619.14 (1) (b), Stats., persons certified as eligible for the plan shall be deemed eligible for coverage from the date of application for coverage by the plan. Any individual anticipating termination under an individual plan or group health insurance policy or any other plan providing coverage similar to that under a health insurance policy, including medical assistance, may seek to establish eligibility for the plan prior to termination of existing coverage, in order to maintain continuous coverage to the greatest extent possible.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. (3), Register, August, 1986, No. 368, eff. 9-1-86.

Ins 18.06 Participation of insurers. Every insurer shall participate in the cost of administering the plan in accordance with the formula established in s. 619.13 (1) (b), Stats. The commissioner shall have the authority to waive assessments for insurers or any class of insurers for any year when it is determined that the administrative costs would exceed the amount of the assessment.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.07 Coverage. Coverage shall conform with s. 619.14, Stats.

(1) LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Limitations on coverage offered shall conform with s. 619.14 (1), Stats. In accordance with s. 619.14 (2) (b), the plan shall offer an alternative to the major medical policy for individuals who are eligible for the plan and also eligible for medicare.

(2) MAJOR MEDICAL EXPENSE COVERAGE. Major medical expense coverage shall conform with s. 619.14 (2), Stats.

(3) COVERED EXPENSES. Covered expenses shall be those services and articles enumerated in s. 619.14 (3), Stats. The formula for determining usual and customary charges shall be developed by the administering carrier and approved by the board.

(4) EXCLUSIONS. Exclusions from coverage shall conform with s. 619.14 (4), Stats.

(a) The formula for determining the prevailing charge in the locality where the service is provided shall be developed by the administering carrier and approved by the board.

(b) The medical necessity of the service shall be determined by the administering carrier and shall be subject to board review under the grievance procedures established by the board under s. 619.15 (3) (a), Stats.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) Premiums, deductibles and coinsurance shall conform with ss. 619.14 (5) and 619.17, Stats.

(b) 1. The schedule of premiums, based on data compiled from the health insurance industry, shall be as follows:

MAJOR MEDICAL PLAN

MALE

Age Group	Annual	Semiannual	Quarterly
	Zone 1		
0-18	$ 676	$ 338	$169
19-29	676	338	169
30-39	820	410	205
40-44	996	498	249
45-49	1,216	608	304
50-54	1,468	734	367
55-59	1,784	892	446
60-64	2,140	1,070	535
	Zone 2		
0-18	$ 576	$288	$144
19-29	576	288	144
30-39	700	350	175
40-44	848	424	212
45-49	1,036	518	259
50-54	1,248	624	312
55-59	1,516	758	379
60-64	1,810	910	455

FEMALE

Age Group	Annual	Semiannual	Quarterly
	Zone 1		
0-18	$ 676	$338	$169
19-29	1,040	520	260
30-39	1,192	596	298
40-44	1,320	660	330
45-49	1,420	710	355
50-54	1,540	770	385
55-59	1,660	830	415
60-64	1,904	952	476

	Zone 2		
0-18	$ 576	$288	$144
19-29	884	442	221
30-39	1,012	506	253
40-44	1,120	560	280
45-49	1,208	604	302
50-54	1,312	656	328
55-59	1,412	706	353
60-64	1,620	810	405

MEDICARE PLAN

	Annual	Semiannual	Quarterly
	Zone 1		
All Policyholders	$1,135	$568	$284
	Zone 2		
All Policyholders	$964	$482	$241

2. For the purposes of this paragraph, Zone 1 shall contain all of the Wisconsin postal zip codes whose first 3 digits are: 530, 531, 532, 534, 537, 540 and 547. Zone 2 shall contain all other Wisconsin postal zip code areas.

(c) Premiums shall be set by rule by the commissioner, based on all available data, including industry experience and actual plan experience. The commissioner shall have on file an actuarial report detailing the process whereby rates were determined.

(d) The annual report of the board to standing committees of the legislature required by s. 619.15 (2), Stats., and Ins 18.08 (2) shall include a section describing premium rate setting in detail. In order to fulfill this requirement, the board may appoint an actuarial committee under the powers granted to the board in s. 619.15 (5) and Ins 18.08 (3) (d) and (e).

(6) PRE-EXISTING CONDITIONS. Pre-existing conditions limitations shall conform with s. 619.14 (6), Stats. Determinations of what constitutes a pre-existing condition shall be made by the administering carrier and shall be subject to board review under the grievance procedures established by the board under s. 619.15 (3) (a), Stats.

(7) COORDINATION OF BENEFITS. There shall be coordination of benefits as provided in s. 619.14 (7), Stats.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.; r. and recr. (5) (b), Register, June, 1982, No. 318, eff. 7-1-82; r. and recr. (5) (b), Register, December, 1983, No. 336, eff. 1-1-84; r. and recr. (5) (b) 1., Register, December, 1984, No. 348, eff. 1-1-85; am. (5) (b) 1., Register, December, 1985, No. 360, eff. 1-1-86; r. and recr. (5) (b) 1., Register, December, 1986, No. 372, eff. 1-1-87.

Ins 18.08 Board of governors. The board shall be appointed and shall operate pursuant to s. 619.15, Stats.

(1) BOARD APPOINTMENTS. The board shall be appointed pursuant to s. 619.15 (1), Stats.

(2) ANNUAL REPORT. The board shall make an annual report to the members of the plan and to standing committees on health and insurance in each house of the legislature pursuant to s. 619.15 (2), Stats.

(3) BOARD FUNCTIONS. Board functions shall conform with ss. 619.15 (3), (4) and (5), Stats.

(a) The board shall carry out the functions required in s. 619.15 (3), Stats.

(b) The board may carry out the functions authorized in s. 619.15 (4), Stats.

(c) The board may provide for agent commissions and require agents and companies to provide assistance in filing applications under the powers granted in s. 619.15 (5), Stats.

(d) The board may establish subcommittees and appoint members who do not serve on the board to these subcommittees in order to carry out its functions under s. 619.15, Stats.

(e) The board may hire consultants in order to carry out its functions under s. 619.15, Stats.

(f) The board shall contract with the administering carrier of the plan to provide those services enumerated in s. 619.16 (3), Stats., as well as any other functions enumerated in the contract between the board and the administering carrier, in order to carry out its functions under s. 619.15, Stats.

(g) The board may defer payment of administrative expenses to the administering carrier, in accordance with the terms set forth in the contract between the board and the administering carrier.

(h) The board shall develop a detailed written policy regarding confidentiality of records.

(i) The board may adopt and amend from time to time reasonable operating procedures which are not inconsistent with the statutory requirements and ch. Ins 18, for the management and operation of the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; am. (1), Register, December, 1983, No. 336, eff. 1-1-84.

Ins 18.09 Administering carrier. The selection, term and functions of the administering carrier shall conform with s. 619.16, Stats.

(1) SELECTION. The board shall select an insurer through a competitive bidding process to administer the plan based on criteria established by the board which shall conform with the requirements of s. 619.16 (1), Stats.

(2) TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS. The term served by the administering carrier and the selection of the administering carrier for succeeding periods shall conform with s. 619.16 (2), Stats.

(3) FUNCTIONS. The administering carrier shall perform the functions enumerated in s. 619.16 (3), Stats., and any other functions agreed to in the contract between the board and the administering carrier.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.10 Notice of mandatory risk-sharing plan. Notice of the plan shall conform with s. 632.785, Stats.

(1) WHEN NOTICE REQUIRED. If an insurer takes one or more of the actions enumerated in s. 632.785 (1), Stats., the insurer shall notify all persons covered or to be covered by the policy, including parents and guardians in cases involving minor children and individuals adjudged incompetent, of the existence of the plan, as well as the eligibility requirements and the method of applying for coverage under the plan, in accordance with s. 632.785 (1), Stats.

(2) FORM OF NOTICE REQUIRED. "Health Insurance Risk-Sharing Plan", an informational pamphlet prepared by and available through the Office of the Commissioner of Insurance and endorsed by the board, shall satisfy the notice requirements set forth in s. 632.785 (1), Stats. Any other notice given in accordance with s. 632.785 (1), Stats., shall substantially conform to this pamphlet in type size and readability and shall be subject to the prior approval of the commissioner of insurance.

(3) STATEMENT OF REASONS FOR REJECTION, TERMINATION, CANCELLATION OR IMPOSITION OF UNDERWRITING RESTRICTIONS. The insurer's rejection, termination, cancellation or imposition of underwriting restrictions under s. 632.785 (1) shall, pursuant to s. 632.785 (2), state the specific medical reason for the insurer's action.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.11 Confidentiality and access to records. (1) CONFIDENTIALITY. Information regarding plan applicants and plan participants shall be kept confidential by the administering carrier and the board. A detailed written policy regarding confidentiality shall be developed by the board pursuant to s. 619.15 (5), Stats., and Ins 18.08 (3) (h).

(2) ACCESS TO RECORDS BY PLAN APPLICANTS AND PARTICPANTS. Plan applicants and participants shall have access to all of their medical records held by the plan.

History: Cr. Register, December, 1980, No. 300, eff. 1-1-81.

Ins 18.12 Effective date. History: Cr. Register, December, 1980, No. 300, eff. 1-1-81; r. Register, August, 1986, No. 368, eff. 9-1-86.

Ins 18.12 Premium reduction for low income policyholders. (1) PURPOSE. The purpose of this section is to interpret and implement s. 619.165, Stats.

(2) ELIGIBILITY. Applicants for coverage under the plan may apply for the premium reduction under this section. Persons covered under the plan shall reapply annually.

(3) SCHEDULE OF PREMIUM REDUCTIONS. The schedule of premium reductions is set forth in s. 619.165, Stats. Premium reductions are based on that schedule and on the availability of funds as appropriated under s. 20.145 (7), Stats.

(4) APPLICATION. An application for premium reduction is not complete until a Supplemental Application for Premium Reduction form or a completed Wisconsin Homestead Credit Schedule H is submitted to the administrator of the plan. If the month of application is January through June, then the Supplemental Application for Premium Reduction or Schedule H shall be based on financial information from the second prior

calendar year. If application is made during the months from July through December financial information from the prior calendar year shall be used. An application for the premium reduction shall be accompanied by or preceded by an application to the plan.

Note: The supplemental application for premium reduction may be obtained at no charge either at the Office of the Commissioner of Insurance, P.O. Box 7873, Madison, Wisconsin 53707, 123 West Washington Avenue, or at Mutual of Omaha Insurance Company, P.O. Box 31746, Omaha, Nebraska 68131 (1-800-228-7044). The form is numbered Form 8116H1RSP APP SUPP.

(5) APPLICATION DEADLINES. (a) New plan applicants may establish eligibility for the premium reduction:

1. At the time of plan application. In this case the applicant shall be billed the reduced premium unless the first premium payment is submitted with the application. Then a refund of the reduced portion of the premium shall be issued.

2. After eligibility for the plan is established. If eligibility for premium reduction is established within 31 days after the effective date of the policy, the new policyholder shall be issued a refund of the reduced portion of the premium retroactive to the effective date of the policy. If eligibility for the reduced premium is not established within 31 days after the effective date of the policy, it shall be established at least 60 days before the renewal date on which it is to take effect.

(b) Persons who are existing policyholders as of March 31 shall apply annually by May 1 in order to be eligible for the premium reduction for the year beginning on July 1. If the application is not postmarked by May 1, then the application shall be postmarked at least 60 days prior to the policyholder's next policy renewal date in order for the corresponding premium notice to reflect the reduced premium. Any individual who becomes a policyholder after March 31 shall be treated under sub. (5) as a new policyholder.

(c) Eligibility for premium reduction shall be reestablished annually. Once eligibility is established, it is effective until the following July 1 at which time eligibility for the following year, from July 1 to June 30, shall have been established.

History: Cr. Register, August, 1986, No. 368, eff. 9-1-86.