Chapter Ins 18

HEALTH INSURANCE RISK-SHARING PLAN

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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 written receipt from the plan applicant of evidence of any of the eligibility criteria set forth in s. 619.12 (1), Stats.

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

(b) For purposes of s. 619.12 (2) (b) 1, Stats., a person is considered to have voluntarily terminated coverage under the plan if the policy terminates because of failure to pay the premium.

(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 or deductible reductions under s. Ins 18.12 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; r. and recr. (1), am. (3), Register, February, 1989, No. 398, eff. 3-1-89; (2) renum. (2) (a), cr. (2) (b), Register, April, 1991, No. 424, eff. 5-1-91..

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:

emerg. r. & recr. 7-1-91

MAJOR MEDICAL PLAN

MALE

Age Group	Annual	Semiannual	Quarterly
	Zone 1		
0-18	$ 720	$ 360	$ 180
19-29	720	360	180
30-39	848	424	212
40-44	1,092	546	273
45-49	1,332	666	333
50-54	1,640	820	410
55-59	2,064	1,032	516
60-64	2,480	1,240	620
	Zone 2		
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	1,476	738	369
55-59	1,856	928	464
60-64	2,232	1,116	558
	Zone 3		
0-18	$ 576	$ 288	$ 144
19-29	576	288	144
30-39	700	350	175
40-44	872	436	218
45-49	1,064	532	266
50-54	1,312	656	328
55-59	1,652	826	413
60-64	1,984	992	496
	Zone 4		
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

FEMALE

Age Group	Annual	Semiannual	Quarterly
	Zone 1		
0-18	$ 720	$ 360	$ 180
19-29	1,212	606	303
30-39	1,368	684	342
40-44	1,552	776	388
45-49	1,668	834	417
50-54	1,796	898	449
55-59	1,924	962	481
60-64	2,104	1,052	526

	Zone 2		
0-18	$ 676	$ 338	$ 169
19-29	1,092	546	273
30-39	1,232	616	308
40-44	1,396	698	349
45-49	1,500	750	375
50-54	1,616	808	404
55-59	1,732	866	433
60-64	1,904	952	476
	Zone 3		
0-18	$ 576	$ 288	$ 144
19-29	968	484	242
30-39	1,096	548	274
40-44	1,240	620	310
45-49	1,336	668	334
50-54	1,436	718	359
55-59	1,540	770	385
60-64	1,684	842	421
	Zone 4		
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

MEDICARE PLAN

Age Group	Annual	Semiannual	Quarterly
	Zone 1		
All Policyholders	$ 1,136	$ 568	$ 284
	Zone 2		
All Policyholders	$ 1,136	$ 568	$ 284
	Zone 3		
All Policyholders	$ 1,024	$ 512	$ 256
	Zone 4		
All Policyholders	$ 1,136	$ 568	$ 284

2. For the purposes of par. (a), Zone 1 shall contain all of the Wisconsin postal zip code area in which the first 3 digits are 532. Zone 2 shall contain postal zip code areas in which the first 3 digits are 530, 531, 534 and 537. Zone 3 shall contain postal zip code areas not contained in Zones 1, 2 or 4. Zone 4 shall contain postal zip code areas in which the first 3 digits are 540 and 547.

(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; r. and recr. (5) (b) 1. and 2., Register, May, 1990, No. 413, eff. 5-1-90.

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

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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 Premium and deductible reductions for low-income policyholders. (1) PURPOSE. The purpose of this section is to interpret and implement ss. 619.14 (5) (a) and 619.165, Stats.

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

(3) SCHEDULE OF PREMIUM AND DEDUCTIBLE REDUCTIONS. The schedule of premium reductions is set forth in s. 619.165, Stats. The schedule of deductible reductions is set forth in s. 619.14 (5) (a), Stats. Premium and deductible reductions are based on these schedules and on the availability of funds as appropriated under s. 20.145 (7), Stats.

(4) APPLICATION FOR PREMIUM AND DEDUCTIBLE REDUCTIONS. An application for premium and deductible reduction is not complete until a Supplemental Application for Premium and Deductible Reduction form or a completed Wisconsin Homestead Credit Schedule H is submitted to the administrator of the plan. An application for the premium and deductible reduction shall be accompanied by or preceded by an application to the plan.

Note: A person may obtain the supplemental application for premium and deductible reduction 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 8116HIRSP APP SUPP.

(5) APPLICATION DEADLINES, EFFECTIVE DATES OF REDUCTIONS, RE-ESTABLISHING ELIGIBILITY. (a) New plan applicants may establish eligibility for the reductions:

1. At the time of plan application. In this case, for purposes of the premium reduction, the administering carrirer shall bill the applicant the reduced premium unless the first premium payment is submitted with the application. If the first premium payment is submitted with the application, the applicant shall recieve a refund of the reduced portion of the premium. Deductible reductions take effect upon issuance of the policy.

2. After eligibility for the plan is established. a. If eligibility for the premium reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive 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, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the renewal date on which it is to take effect, and the ad-

ministering carrier shall bill the policyholder the reduced premium beginning on the renewal date.

b. If eligibilty for the deductible reduction is established within 31 days after the effective date of the policy, the new policyholder shall receive a refund of a portion of the deductible paid by the policyholder prior to establishing eligibility. The amount of the refund shall be the difference between the deductible paid by the policyholder and the deductible as reduced by any reduction to which the policyholder is entitled. If eligibility is not established within 31 days after the effective date the policy, the policyholder shall receive no refund. In this case, the policyholder shall establish eligibility at least 60 days before the policy's renewal date, and the deductible reduction shall take effect on Janurary 1 of the year commencing after the ploicy's renewal date.

(b) Persons who are existing policyholders as of March 31 shall apply annually by May 1 in order to be eligible for the reductions for the year beginning on July 1. For premium reductions, 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. An existing policyholder who is first determined to be eligble for a premium reduction shall receive a refund on a pro rata basis for the time period between July 1 of each calendar year and the next renewal date. Deductible reductions under this paragraph take place on January 1 of the year following establishment of elgibility. Under this subsection, the administering carrier shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(c) Eligibility for the premium and deductible reductions 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; am. (1) to (5), cr. (5) (a) 2. b., Register, February, 1989, No. 398, eff. 3-1-89.

Ins 18.13 Cost containment services. (1) PURPOSE. This section implements and interprets s. 619.17 (4) (a), Stats., by establishing cost containment provisions for the Plan.

(2) DEFINITIONS. In this section:

(a) "Case management" means a review of the medical necessity and appropriateness of the treatment or procedures used in connection with specified medical conditions.

(b) "Preadmission and concurrent review of hospital admissions" means a review of the medical necessity and appropriateness of a hospital admission prior to and during a hospital stay.

(c) "Pretreatment and concurrent review of selected outpatient services" means a review of the medical necessity and appropriateness of a plan of treatment prior to and during the treatment.

(3) REQUIRED COST CONTAINMENT SERVICES. The Plan shall include the following cost containment services:

(a) Preadmission and concurrent review of hospital admissions;

(b) Pretreatment and concurrent review of selected outpatient services; and

(c) Case management.

(4) WRITTEN DESCRIPTION OF COST CONTAINMENT SERVICES. When a new policy is issued, a new policyholder shall receive a written description of the Plan's cost containment services and the procedures that the policyholder shall follow in order to comply with these cost containment services. Existing policyholders shall receive a written description of any change to the Plan's cost containment services or the procedures that policyholders shall follow in order to comply with these cost containment services. The existing policyholders shall receive this written description at least 30 days before the change takes effect.

History: Cr. Register, February, 1989, No. 398, eff. 3-1-89.