Chapter HFS 119
HEALTH INSURANCE RISK–SHARING PLAN

Note: Chapter Ins 18 was renumbered ch. HFS 119 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, March, 1998, No. 507.

Note: An emergency rule repealed and recreated ch. HFS 119, eff. 7–1–98. An emergency rule amended s. HFS 119.07 (6) (b) (intro.) and tables and 119.15 effective January 1, 1999. Chapter HFS 119, as it existed January 31, 1999, was repealed and a new chapter HFS 119 was created, Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.01 Authority and purpose. This chapter is promulgated under the authority of ss. 149.11, 149.12 (3) (c), 149.143 (2) (a) 2., 3. and 4., (3) (a) and (4), 149.144, 149.146 (2) (b) (intro.), 149.15 (5) and 149.17 (4), Stats., to establish requirements and procedures for the operation of a plan of health insurance coverage for persons who qualify under s. 149.12, Stats., for coverage because they cannot otherwise obtain it. Every insurer in the state offering health insurance is required by s. 149.13, Stats., to share in the operating, administrative and subsidy expenses of the plan.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.02 Applicability. This chapter applies to the department, to the board of governors for the plan, to the plan administrator, to all insurers and to all eligible persons who receive health care coverage through the plan.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.03 Establishment of plan and title. In accordance with s. 149.11, Stats., a plan of health insurance coverage which meets the requirements of ch. 149, Stats., and s. 632.785, Stats., is established. The title of the plan shall be "Health Insurance Risk–Sharing Plan."

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.04 Definitions. In this chapter:

(1) "Board" means the HIRSP board of governors established under s. 149.15, Stats.

(2) "Coinsurance" means the percentage of the covered expenses for which the HIRSP policyholder is responsible.

(3) "Commissioner" means the commissioner of insurance.

(4) "Creditable coverage" has the meaning specified in s. 149.10 (2j), Stats.

(5) "Deductible" means the amount, exclusive of coinsurance, which HIRSP otherwise would pay, for which the HIRSP policyholder is responsible.

(6) "Department" means the department of health and family services.

(7) "HIRSP" means the health insurance risk–sharing plan under this chapter.

(8) "Insurer" has the meaning specified in s. 149.10 (5), Stats.

(9) "Managed care" means a program operated by an insurer to evaluate each patient's medical needs and to identify the appropriate treatments to meet those needs, with the primary goal of providing cost–effective health care without sacrificing quality of care or access.

(10) "Medical assistance" means the program operated by the department under ss. 49.43 to 49.497, Stats., and chs. HFS 101 to 108.

(11) "Medically necessary" has the meaning specified in s. HFS 101.03 (96m).

(12) "Medicare" means the health insurance program operated by the U.S. department of health and human services under 42 USC 1395 and 42 CFR subchapter B.

(13) "Plan" means HIRSP.

(14) "Plan administrator" means the fiscal agent under s. 49.45 (2) (b) 2., Stats.

(15) "Plan applicant" or "applicant" means a person who applies for coverage under the plan.

(16) "Policyholder" means a person who is covered under the plan.

(17) "Policy" means any document, other than a group certificate, used to describe in writing the terms of an insurance contract, including endorsements, riders and service contracts.

(18) "Premium" means any consideration for an insurance policy, and includes assessments, membership fees or other required contributions or consideration, however designated.

(19) "Resident" has the meaning specified in s. 149.10 (9), Stats.

(20) "Secretary" means the secretary of the department.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.05 Eligibility. The plan administrator shall determine an applicant's eligibility for coverage under the plan in accordance with s. 149.12, Stats., and as follows:

(1) CRITERIA. The plan administrator shall certify as eligible any resident upon written receipt from the plan applicant of evidence that he or she meets any of the eligibility criteria set forth in s. 149.12 (1), Stats.

(2) NON–ELIGIBILITY. (a) Exclusions from eligibility for the plan shall be as set forth in s. 149.12 (1m), (2) and (3), Stats.

(b) For purposes of s. 149.12 (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 unless the grievance committee of the board determines under s. HFS 119.14 (3) that the failure to pay was not intentional.

(3) SPECIAL ELIGIBILITY REQUIREMENTS. Section 149.12 (2) (e), Stats., does not preclude eligibility for coverage under the plan under any of the following conditions:

(a) When the health care benefits plan for which the person is eligible through his or her employer includes a rider excluding coverage for one or more of the person's conditions for more than 12 months or provides more limited coverage than the coverage available to others covered by the employer's plan.

(b) When the person has continued coverage under s. 632.897, Stats., or the federal consolidated omnibus budget reconciliation act of 1985, as amended, 29 USC 1161 to 1168 or 42 USC 300bb–1 to 300bb–8.

(4) REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the plan administrator is entitled to a review under s. HFS 119.14. A request for review does not stay termination of coverage.

(5) DATE OF ELIGIBILITY. Coverage for a person certified as eligible for the plan begins on the date the plan receives the person's complete application and full initial premium payment or, at the request of the applicant, within 60 days following that date or, as provided in s. 149.14 (1) (b), Stats., on the date of termination of medical assistance coverage. Any individual anticipating termi-

nation 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.

(6) CREDITABLE COVERAGE. Pursuant to s. Ins 3.70, the method of aggregating creditable coverage for purposes of s. 149.10 (2t) (a), Stats., shall comply with 45 CFR 146.113 (a) (3).

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.06 Participation of insurers. (1) Every insurer shall share in the expenses of the plan as provided in s. 149.13 (2), Stats. In setting premiums under s. HFS 119.07 (6), the department shall not include any subsidies for the reduction of the cost of premiums or of deductibles in the calculation of operating and administrative costs of the plan. The commissioner may waive the assessment for an insurer or any class of insurers for any year the department determines that the administrative costs of collecting the assessment would exceed the amount of the assessment.

(2) Every insurer shall file a copy of "Wisconsin health insurance risk–sharing plan assessment form," OCI 43–003, with its annual statement filed with the office of the commissioner of insurance.

Note: Copies of OCI 43–003 may be obtained from the HIRSP Program, Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701–0309.

(3) An insurer who makes an error in the insurer's assessment form that results in an underpayment of assessments to the plan may file a corrected assessment form with the office of the commissioner of insurance within 30 days after the error is discovered.

(4) An insurer that makes an error in an assessment form that results in an overpayment of assessments to the plan may, at any time, file a corrected assessment form with the office of the commissioner of insurance. If the overpayment resulted from an assessment form filed in the previous calendar year, the plan shall credit the insurer's next annual assessment under s. 149.13, Stats., for the amount of the overpayment. If the insurer does not owe any amount for the next annual assessment, the plan shall refund the amount of the overpayment. No credit or refund may be granted for an error in an assessment form filed in any year prior to the previous calendar year.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.07 Coverage. (1) REQUIREMENTS. The plan shall offer coverage that complies with ss. 149.14 and 149.146, Stats., and this section.

(2) LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Pursuant to s. 149.14 (1), Stats., if an eligible person is also eligible for medicare coverage, the plan shall not pay or reimburse the person for expenses paid by medicare. As required by s. 149.14 (2) (b), Stats., the plan offers under sub. (6) (b) and (c) an alternative for an individual eligible for medicare which reduces the benefits payable by the amounts paid under medicare.

(3) MAJOR MEDICAL EXPENSE COVERAGE. Major medical expense coverage shall comply with s. 149.14 (2), Stats.

(4) COVERED EXPENSES. Covered expenses shall be those services and articles enumerated in s. 149.14 (3), Stats., if the services are medically necessary, appropriate and cost effective, as determined by the plan administrator.

(5) EXCLUSIONS. Exclusions from coverage shall comply with s. 149.14 (4), Stats.

(6) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) *Compliance with statutes.* Premiums, deductibles and coinsurance shall be in compliance with ss. 149.14 (5), 149.146, 149.165 and 149.17, Stats.

(b) *Annual premiums for major medical plan policies with standard deductible.* The schedule of annual premiums beginning July 1, 2005, for persons not entitled to a premium reduction under s. 149.165, Stats., is as follows:

MAJOR MEDICAL PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0–18	$2,736	$2,460	$2,184
19–24	2,736	2,460	2,184
25–29	2,880	2,580	2,292
30–34	3,252	2,928	2,604
35–39	3,828	3,444	3,072
40–44	4,656	4,188	3,720
45–49	6,096	5,496	4,872
50–54	8,256	7,428	6,600
55–59	10,956	9,852	8,772
60+	13,884	12,492	11,112

MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0–18	$2,736	$2,460	$2,184
19–24	3,552	3,192	2,844
25–29	3,984	3,588	3,192
30–34	4,476	4,032	3,588
35–39	5,136	4,632	4,116
40–44	6,012	5,412	4,812
45–49	7,104	6,396	5,688
50–54	8,484	7,620	6,768
55–59	9,876	8,892	7,896
60+	11,376	10,236	9,096

MEDICARE PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0–18	$2,304	$2,088	$1,848
19–24	2,304	2,088	1,848
25–29	2,424	2,184	1,932
30–34	2,736	2,460	2,184
35–39	3,228	2,916	2,580
40–44	3,924	3,528	3,132
45–49	5,148	4,632	4,116
50–54	6,960	6,276	5,568
55–59	9,240	8,328	7,392
60+	11,712	10,548	9,372

MEDICARE PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0–18	$2,304	$2,088	$1,848
19–24	3,000	2,688	2,400
25–29	3,360	3,012	2,688
30–34	3,768	3,396	3,012
35–39	4,320	3,912	3,480
40–44	5,064	4,572	4,044
45–49	6,000	5,388	4,788
50–54	7,152	6,432	5,724
55–59	8,328	7,500	6,648
60+	9,600	8,628	7,668

(c) *Base rates for calculating premium reductions.* 1. The annual base rates for calculating premium reductions under s. HFS 119.12 that are applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's major medical plan are as follows beginning July 1, 2005:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0–18	$1,908	$1,716	$1,524
19–24	1,908	1,716	1,524
25–29	2,004	1,800	1,596
30–34	2,268	2,040	1,812
35–39	2,664	2,400	2,136
40–44	3,240	2,916	2,592
45–49	4,248	3,828	3,396
50–54	5,748	5,172	4,596
55–59	7,632	6,864	6,108
60+	9,672	8,700	7,740

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0–18	$1,908	$1,716	$1,524
19–24	2,472	2,220	1,980
25–29	2,772	2,496	2,220
30–34	3,120	2,808	2,496
35–39	3,576	3,228	2,868
40–44	4,188	3,768	3,348
45–49	4,944	4,452	3,960
50–54	5,904	5,304	4,716
55–59	6,876	6,192	5,496
60+	7,920	7,128	6,336

2. The annual base rates for calculating premium reductions under s. HFS 119.12 that are applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's medicare plan are as follows beginning July 1, 2005:

MEDICARE PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0–18	$1,608	$1,452	$1,284
19–24	1,608	1,452	1,284
25–29	1,692	1,524	1,344
30–34	1,908	1,716	1,524
35–39	2,244	2,028	1,800
40–44	2,736	2,460	2,184
45–49	3,588	3,228	2,868
50–54	4,848	4,368	3,876
55–59	6,432	5,796	5,148
60+	8,160	7,344	6,528

MEDICARE PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0–18	$1,608	$1,452	$1,284
19–24	2,088	1,872	1,668
25–29	2,340	2,100	1,872
30–34	2,628	2,364	2,100
35–39	3,012	2,724	2,424
40–44	3,528	3,180	2,820
45–49	4,176	3,756	3,336
50–54	4,980	4,476	3,984
55–59	5,796	5,220	4,632
60+	6,684	6,012	5,340

(d) *Annual premiums for major medical plan policies with a $2,500 deductible.* In accordance with s. 149.146, Stats., an alternative plan of health insurance involving major medical expense coverage is established with a $2,500 deductible. After the policyholder satisfies the annual $2,500 deductible, HIRSP will pay 80% of the covered expenses for the next $5,000 of covered expenses. Policyholders are required to pay the remaining 20% as coinsurance, up to an annual individual maximum of $1,000. The annual maximum amount a family with 2 or more alternative plans will be required to pay for covered expenses is $7,000. The schedule of annual premiums for coverage under the alternative plan with a $2,500 deductible is as follows beginning July 1, 2005:

ALTERNATIVE MAJOR MEDICAL PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0–18	$1,968	$1,776	$1,572
19–24	1,968	1,776	1,572
25–29	2,076	1,860	1,656
30–34	2,340	2,112	1,872
35–39	2,760	2,484	2,208
40–44	3,348	3,012	2,676
45–49	4,392	3,960	3,504
50–54	5,940	5,352	4,752
55–59	7,884	7,092	6,312
60+	9,996	9,000	8,004

ALTERNATIVE MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0–18	$1,968	$1,776	$1,572
19–24	2,556	2,304	2,052
25–29	2,868	2,580	2,304
30–34	3,228	2,904	2,580
35–39	3,696	3,336	2,964
40–44	4,332	3,900	3,468
45–49	5,112	4,608	4,092
50–54	6,108	5,484	4,872
55–59	7,116	6,408	5,688
60+	8,196	7,368	6,552

(e) *Zones.* For the purposes of pars. (b), (c) and (d), Zone 1 shall contain all of the Wisconsin zip code areas 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 or 537. Zone 3 shall contain postal zip code areas not contained in Zones 1 and 2.

(f) *Detailed description of how premium rates are set.* 1. The department shall have on file an actuarial report detailing the process by which rates were determined.

2. The annual report of the board to the chief clerk of each house of the legislature required by s. 149.15 (2), Stats., and s. HFS 119.08 (2) (a) 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. 149.15 (5), Stats., and s. HFS 119.08 (3) (d).

(6m) PRESCRIPTION DRUG COINSURANCE COVERAGE. (a) Effective January 1, 2002, a policyholder shall pay a 20% coinsurance, based on the HIRSP allowed amount for each prescription drug, up to a maximum of $25 per prescription.

(b) Effective January 1, 2002, a policyholder may not be required to pay more than the maximum out–of–pocket amount for each prescription cost specified in par. (a) or more than the policyholder's annual out–of–pocket limit specified in table HFS 119.07 (6m).

(c) Insulin and disposable medical supplies for the treatment of diabetes are subject to the coinsurance specified in pars. (a) and (b).

(d) This subsection does not apply to a policyholder for which HIRSP is a secondary payer.

(e) Any coinsurance paid under this subsection is separate from and does not count toward the deductible and covered costs not paid by the plan under ss. 149.14 (5) (a) to (c), and 149.146 (2) (am) 1. to 3., Stats.

Table HFS 119.07 (6m)
Policyholder's Drug Coinsurance Annual Out–of–Pocket Maximum

Plan	If Policy–Holder's Medical Deductible is:	Policy–Holder's Drug Coinsurance Annual Out–of–Pocket Maximum is:
PLAN 1, Option A	$1,000	$750
	$800	$600
	$700	$525
	$600	$450
	$500	$375
PLAN 1, Option B	$2,500	$1,000
PLAN 2	$500	$125

(7) PREEXISTING CONDITIONS. Preexisting conditions limitations shall conform with s. 149.14 (6), Stats. Determinations of what constitutes a preexisting condition shall be made by the plan administrator.

(8) COORDINATION OF BENEFITS. Benefits shall be coordinated as provided in s. 149.14 (7), Stats.

(9) RIGHT TO REVIEW. Any person whose claim is denied or reduced by the plan administrator is entitled to a review under s. HFS 119.14.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99; emerg. am. (6) (b) (intro.), (c) 2. (intro.), eff. 7–1–99; am. (6) (b) (intro.), Register, August, 1999, No. 524, eff. 9–1–99; am. (6) (b) (intro.) and Medicare Plan Tables, (c) 2. (intro.) and Tables, Register, February, 2000, No. 530, eff. 3–1–00; emerg. am. (6) (b) (intro.) and tables (c) (intro.), and 2. and tables, (d) (intro.) and tables, eff. 7–1–00; am. (6) (b) (intro.) and (d) (intro.), (c) 1. (intro.) and 2. (intro.) and Medicare Plan Tables, Register, December, 2000, No. 540, eff. 1–1–01; emerg. am. (6) (b) (intro.), tables, (c) 1. (intro.), tables, 2. (intro.), tables and (6) (d) (intro.) and tables, eff. 7–1–01; emerg. cr. (6m), eff. 1–1–02; CR 01–073: am. (6) (b) (intro.), tables, (c) 1. (intro.), tables, 2. (intro.), tables and (6) (d) (intro.) and tables, Register January 2002 No. 553, eff. 2–1–02; CR 01–148: cr. (6m) Register May 2002 No. 557, eff. 6–1–02; emerg. am. (6) (b) (intro.) and tables (1) (c) (intro.) and table 2. and (d) (intro.), eff. 7–1–02; CR 02–083: am. (6) (b) to (d), Register November 2002 No. 563, eff. 12–1–02; CR 03–048: am. (6) (b) to (d) Register October 2003 No. 574, eff. 11–1–03; CR 04–056: am. (6) (b) to (d) Register October 2004 No. 586, eff. 11–1–04; **emerg. am. (6) (b) to (d), eff. 7–1–05; CR 05–047: am. (6) (b) to (d) Register October 2005 No. 598, eff. 11–1–05.**

HFS 119.08 Board of governors. (1) APPOINTMENT OF MEMBERS. The board shall be appointed pursuant to s. 149.15, Stats.

(2) ANNUAL REPORTS. (a) The board shall make an annual report to plan participants and to appropriate standing committees of the legislature pursuant to s. 149.15 (2), Stats., which summarizes the activities of the plan in the preceding calendar year.

(b) The board shall submit an annual report on or before June 30 to the legislature and the governor pursuant to s. 149.15 (2m), Stats., on the operation of the plan, including any recommendations for changes to the plan.

(3) BOARD FUNCTIONS. (a) The board shall carry out the functions specified in s. 149.15 (3), Stats., and any other function specified for the board in this chapter.

(b) The board may carry out the functions authorized in s. 149.15 (4), Stats.

(c) The board may provide for agent commissions and require agents and insurers to provide assistance in filing applications.

(d) The board may establish subcommittees and appoint members who do not serve on the board to the subcommittees.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.09 Plan administrator. The plan administrator shall carry out the functions under s. 149.16 (3), Stats., and any other function of the plan administrator specified in this chapter.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.10 Notification by insurers of availability of HIRSP. (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 under ch. 880, Stats., of the existence of HIRSP, as well as the eligibility requirements and how to apply for coverage under the plan, as required by s. 632.785 (1), Stats.

(2) FORM OF NOTICE. An insurer who takes one or more of the actions under s. 632.785 (1), Stats., shall satisfy the notice requirement under sub. (1) by providing each person covered or to be covered by the policy with a copy of "Wisconsin Health Insurance Risk–Sharing Plan (HIRSP)," an informational pamphlet prepared by the department.

Note: Copies of the informational pamphlet may be obtained from Health Insurance Risk–Sharing Plan (HIRSP), P.O. Box 8961, Madison, Wisconsin 53708–8961 (phone 608–221–4551 or 1–800–828–4777).

(3) STATEMENT OF REASONS FOR REJECTING, TERMINATING OR CANCELING COVERAGE OR IMPOSING UNDERWRITING RESTRICTIONS. If an insurer rejects, terminates or cancels coverage or imposes underwriting restrictions under s. 632.785 (1), Stats., the insurer is obligated under s. 632.785 (2), Stats., to include in the notice required under sub. (1) a statement giving the specific medical reasons for the insurer's action.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.11 Confidentiality and access to records. (1) CONFIDENTIALITY. The plan administrator and the department shall keep information about plan applicants and policyholders confidential, unless disclosure is otherwise permitted by law.

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

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.12 Premium and deductible reductions for low–income policyholders. (1) PURPOSE. The purpose of this section is to interpret and implement ss. 149.14 (5) and 149.165, 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 for the reductions.

(3) CALCULATION OF PREMIUM AND DEDUCTIBLE REDUCTIONS. (a) The base rates for calculating premium reductions under s. 149.165 (1) and (2), Stats., are set forth in s. HFS 119.07 (6) (c).

(b) The schedule of deductible reductions is set forth in s. 149.14 (5) (a), Stats.

(c) The plan administrator may reassess the household income of an eligible person at any time during the term of the person's policy. If an eligible person's household income changes during a policy term, the plan administrator may, if appropriate under s. 149.165 (2), Stats., revise the premium for the person in conformity with s. 149.165 (2), Stats., and the deductible for the person under s. 149.14 (5) (a), Stats., for the remainder of the policy term. The revised premium and deductible shall take effect the first month beginning after the plan administrator's decision.

(d) The availability of premium and deductible reductions is based on the availability of funds appropriated under s. 20.435 (4) (v), Stats., including the provisions of s. 149.144, Stats.

(4) APPLICATION FOR PREMIUM AND DEDUCTIBLE REDUCTIONS. An application for premium and deductible reductions 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 plan administrator. A complete application for premium and deductible reduction shall also include a completed federal profit or loss from farming form, schedule F, if there was a profit or loss from farming. An applica-

tion 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 reductions at no charge from Health Insurance Risk–Sharing Plan (HIRSP), P.O. Box 8961, Madison, Wisconsin 53708–8961 (phone 608–221–4551 or 1–800–828–4777.)

(5) APPLICATION DEADLINES, EFFECTIVE DATES OF REDUCTIONS AND REESTABLISHMENT OF ELIGIBILITY. (a) *New plan applicants.* New plan applicants may request eligibility for the reductions at any of the following times:

1. At the time of plan application. In this case, for purposes of the premium reduction, the plan administrator shall make the appropriate adjustments regarding the applicant's initial premium payment submitted with the application. Deductible reductions take effect upon issuance of the policy.

2. After eligibility for the plan is established, in which case the following provisions apply:

a. If eligibility for the premium reduction is established within 31 days after the effective date of the policy, the new HIRSP 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 plan administrator shall bill the policyholder for the reduced premium beginning on the renewal date.

b. If eligibility for the deductible reduction is established within 31 days after the effective date of the policy, the new HIRSP 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 of 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 January 1 of the year commencing after the policy's renewal date.

(b) *Existing policy holders.* 1. 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.

2. 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 eligible 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.

3. Deductible reductions under this paragraph take place on January 1 of the year following establishment of eligibility.

(c) *Treatment as new policyholder.* Under this subsection, the plan administrator shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(d) *Reestablishment of eligibility.* Eligibility for the premium and deductible reductions shall be reestablished at least annually.

(6) RIGHT TO REVIEW. An applicant who is denied a premium or deductible reduction is entitled to a review under s. HFS 119.14.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99; correction in (3) (d) made under s. 13.93 (2m) (b) 7., Stats., Register January 2002 No. 553; **correction in (3) (d) made under s. 13.93 (2m) (b) 7., Stats., Register October 2005 No. 598.**

HFS 119.13 Cost containment provisions. HIRSP may use common, current methods employed by managed care programs and the medical assistance program to contain costs, including prior authorization and other limitations regarding health care utilization and reimbursement. When a new policy is issued, the plan administrator shall send the new policyholder a written description of the plan's cost containment provisions and the procedures that the policyholder shall follow in order to comply with these cost containment provisions. The plan administrator shall send existing policyholders a written description of any change to the plan's cost containment provisions or the procedures that policyholders shall follow in order to comply with these cost containment provisions. The existing policyholders shall receive this written description at least 60 days before the change takes effect.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.14 Grievance procedure. (1) PURPOSE. This section implements s. 149.17 (3), Stats.

(2) REVIEW BY PLAN ADMINISTRATOR. A person entitled under this chapter to a review of a determination by the plan administrator shall, within 60 days of the date of the letter of determination, submit a written request to the plan administrator that the determination be reviewed. Upon receipt of a request, the plan administrator shall review the original determination, either affirm, modify or rescind it and provide the requester with a written response which includes the plan administrator's final decision and the reason for it. The plan administrator shall have 10 days from receipt of a request for review to issue a letter of decision or a letter to the requester asking for additional information.

Note: To request a review by the plan administrator, write HIRSP, P.O. Box 8961, Madison, WI 53708–8961.

(3) REVIEW BY GRIEVANCE COMMITTEE OF THE BOARD. (a) If a decision under sub. (2) is adverse to an applicant or policyholder, the applicant or policyholder may request a review of the decision by the grievance committee of the board. A request for review under this subsection shall be made in writing to the board within 30 days of the date of the letter of decision under sub. (2) and shall clearly describe the reason the requester believes the plan administrator's decision is erroneous under ch. 149, Stats., this chapter or the terms of the plan policy.

Note: To request a review by the grievance committee of the board, write: HIRSP Board Grievance Committee, P.O. Box 309, Madison, WI 53701–0309.

(b) The board shall appoint a grievance committee of at least 5 persons, a majority of whom are not members of the board, to review decisions of the plan administrator that adversely affect applicants and policyholders entitled to review under this chapter. Upon the written request of an applicant for HIRSP or a policyholder, the grievance committee shall conduct a review based on written submissions by the plan administrator and the applicant or policyholder. No discovery is permitted. The grievance committee may invite or permit representatives of the plan administrator and the applicant or policyholder to appear and make oral statements during the review. The grievance committee shall, within 45 days from the receipt of the applicant's or policyholder's request for review, issue a written decision affirming, modifying or rescinding the decision of the plan administrator and stating the reason for its decision. The committee's decision shall be final, unless the secretary of the department determines that a different decision is in the best interests of the state of Wisconsin.

(c) The grievance committee shall file a quarterly report with the board on all actions taken under par. (b).

(4) RESPONSIBILITY OF PLAN ADMINISTRATOR. The plan administrator shall comply with the final decision of the board's grievance committee or the secretary.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.

HFS 119.15 Insurer assessments and provider payment rates. (1) PURPOSE. This section implements s. 149.143 (2) (a) 3. and 4., Stats.

(2) INSURER ASSESSMENTS. The insurer assessments for the time period July 1, 2005 through June 30, 2006 total $38,879,512.

(3) PROVIDER PAYMENT RATES. The total adjustment to the provider payment rates for the time period July 1, 2005 through June 30, 2006 is $43,830,996. HIRSP provider payment rates may not exceed charges. Payment rates for prescription drugs are set under s. 49.46 (2) (b) 6. h., Stats. Payment rates for hospital inpatient services utilize hospital–specific inpatient rates established under s. 49.46 (2) (b) 6. e., Stats., and HIRSP–specific weights for diagnostically related groups. Payment rates for hospital outpatient services may not exceed 62.55% of charges. Payment rates for

other professional services including physicians, labs and therapies are set under s. 49.46 (2) (b), Stats., including a 43.2% enhancement under s. 149.142 (1) (a), Stats.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99; emerg. am. eff. 7–1–99; am. Register, August, 1999, No. 524, eff. 9–1–99; am. (2) and (3), Register, February, 2000, No. 530, eff. 3–1–00; emerg. am. (2) and (3), eff. 7–1–00; am. (2) and (3), Register, December, 2000, No. 540, eff. 1–1–01; emerg. am. (2) and (3), eff. 7–1–01; CR 01–073: am. (2) and (3), Register January 2002 No. 553, eff. 2–1–02; emerg. am. (2) and (3), eff. 7–1–02; CR 02–083: am. (2) and (3), Register November 2002 No. 563, eff. 12–1–02; CR 03–048: am. (2) and (3) Register October 2003 No. 574, eff. 11–1–03: CR 04–056: am. (2) and (3) Register October 2004 No. 586, eff. 11–1–04; reprinted to correct errors in (2), Register December 2004 No. 588; **emerg. am. (2) and (3), eff. 7–1–05; CR 05–047: am. (2) and (3) Register October 2005 No. 598, eff. 11–1–05.**

HFS 119.16 Claim submission. (1) TIMELINE. To be considered for payment, a correct and complete claim or adjustment shall be received by the plan administrator from the health care provider or policyholder within 365 days after the date of the service. The health care provider or policyholder is responsible for providing complete and timely follow–up to each claim submission to verify that correct and complete payment was made, and to seek direct resolution of any disputed claims.

(2) CORRECTIVE ACTION. The department at any time may make a payment to comply with a court order or to carry out a hearing decision or department–initiated corrective action taken to resolve a dispute. To request payment, the health care provider or policyholder shall submit a correct and complete claim to the plan administrator within 90 days after mailing of a notice by the department or the court of the court order, hearing decision or corrective action to the health care provider or policyholder.

History: Cr. Register, January, 1999, No. 517, eff. 2–1–99.