PROPOSED ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING RULES

To amend HFS 119.07 (6) (b) to (d) and 119.15 (2) and (3) relating to operation of the health insurance risk-sharing plan (HIRSP).

RULE SUMMARY

Statutes interpreted: The rule interprets ss. 149.14 (5m), 149.142, 149.143, 149.144, 149.146, and 149.165, Stats.

Statutory authority: The department's authority to amend these rules is found in ss. 149.143 (2), 149.144, Stats., and 227.11 (2) Stats.

Explanation of agency authority: The Department is required to set HIRSP premium plan rates for the new year, insurer assessment rates and provider payment rates. HIRSP policyholder premium rates must fund sixty percent of plan costs. The remaining funding for HIRSP is to be provided by insurer assessments and adjustments to provider payment rates, in co-equal amounts of twenty percent each.

Related statute or rule: 149.14 (5m), 149.142, 149.143 (2), 149.144, 149.146, and 149.165, Stats.

Plain language analysis:

The State of Wisconsin in 1980 established a Health Insurance Risk-Sharing Plan (HIRSP). HIRSP provides major medical health insurance for persons who are covered under Medicare because they are disabled, persons who have tested positive for HIV, and persons who have been refused coverage or who cannot get coverage at an affordable price in the private health insurance market because of their mental or physical health conditions. Also eligible for coverage are persons who recently lost employer-sponsored insurance coverage if they meet certain criteria. According to state law, HIRSP policyholder premium rates must generally fund sixty percent of plan costs, except for costs associated with premium and deductible reductions. The remaining funding for HIRSP is to be provided by insurer assessments and adjustments to provider payment rates, in co-equal amounts.

HIRSP Plan 1 is for policyholders that do not have Medicare. Ninety-one percent of the 18,530 HIRSP policies in effect in February 2005 were enrolled in Plan 1. Plan 1 has Option A ($1,000 deductible) or Option B ($2,500 deductible). The rates for Plan 1 contained in this rulemaking order increase an average of 15.0% for policyholders not receiving a premium reduction. The average rate increase for policyholders receiving a premium reduction is 12.1%. Rate increases for individual policyholders within Plan 1 range from 7.0% to 16.8%, depending on a policyholder's age, gender, household income, deductible and zone of residence within Wisconsin. By law, Plan 1 rate increases reflect and take into account the increase in costs associated with Plan 1 claims.

HIRSP Plan 2 is for persons eligible for Medicare because of a disability or because they become age-eligible for Medicare while enrolled in HIRSP. Plan 2 has a $500 deductible. Nine percent of the 18,530 HIRSP policies in effect in February 2005 were enrolled in Plan 2. The rate increases for Plan 2 contained in this rulemaking order increase an average of 20.3% for policyholders not receiving a premium reduction. The average rate increase for

policyholders receiving a premium reduction is 17.3%. Rate increases for individual policyholders within Plan 2 range from 11.2% to 22.2%, depending on a policyholder's age, gender, household income and zone of residence within Wisconsin. Plan 2 premiums are set in accordance with the authority and requirements set out in s. 149.14 (5m), Stats.

Summary of, and comparison with, existing or proposed federal regulation:

There are no existing or proposed federal regulations that address rates or assessments for the HIRSP program.

Comparison with rules in adjacent states:

The State of Michigan does not have a plan or program similar to Wisconsin HIRSP. Illinois, Iowa and Minnesota have programs similar to Wisconsin HIRSP. The State of Illinois has the Comprehensive Health Insurance Program (CHIP). The State of Iowa has the Iowa Comprehensive Health Association (ICHA). The State of Minnesota has the Minnesota Comprehensive Health Association (MCHA). All three states establish premiums. All three states utilize premium income and ancillary funding, e.g., state general revenue and insurer assessments. However, unlike Wisconsin, none of the three states utilize state administrative rules to establish premiums, assessments or other fiscal adjustments to their programs. Rather, Illinois, Iowa and Minnesota all utilize prescriptive state statutes in order to establish premiums, assessments or other fiscal adjustments to their programs. The following provides additional information.

Illinois: Contact Illinois Comprehensive Health Insurance Plan @ www.chip.state.il.us or Thomas Jerkovitz @ 217-782-6333.

The State of Illinois Comprehensive Health Insurance Program (CHIP) is a state health benefits program governed by a 13-member Board of Directors. Premiums charged are currently set by statute between 125%-150% of the average rates charged individuals for comparable major medical coverage by five or more of the largest insurance companies in the individual health insurance market in Illinois. Each of CHIP's benefit plans offers individual deductible options of $500, $1,000, $1,500, $2,500 or $5,000. Family deductible options are $1,000, $2,000, $3,000, $5,000 or $10,000. About 16,000 Illinois citizens are insured by CHIP.

CHIP is funded partly by premiums paid by its participants and, to the extent that premiums do not meet anticipated expenses, CHIP may receive an appropriation from the State's General Revenue Fund. CHIP also assesses health insurers doing business in Illinois. Actuaries help determine the necessary premiums and assessments. Illinois's statutes are prescriptive and are used to determine CHIP premiums and assessments. Therefore, Illinois administrative rules are not used to determine CHIP premium and assessments. CHIP premiums vary depending on one's age, plan and deductible chosen.

Iowa: Contact the Iowa Comprehensive Health Association @ www.hipiowa.com or Patrick Carmody @ (402) 351-5620.

Iowa maintains a high-risk pool, called the Iowa Comprehensive Health Association (ICHA) to provide insurance for people with expensive health conditions. ICHA is governed by a 14-member Board of Directors. To buy ICHA coverage, one cannot be eligible to buy a standard or basic individual health plan, Medicare, or Medicaid or have terminated ICHA coverage within the last 12 months. The annual deductible options are $500, $1,000, $1,500 and

$2,000. In addition, a person is responsible for a coinsurance charge each time care is received, subject to an out-of-pocket maximum. Benefits are not payable for any pre-existing injury or sickness for the first six months following the policy date. About 130 Iowa citizens are insured by ICHA.

ICHA premiums are statutorily set at 150 percent of the average rate charged for comparable coverage by the five insurance companies with the largest health insurance premiums or payment volumes doing business in Iowa. ICHA losses in excess of premiums received are reimbursed by insurers. Iowa statutes are prescriptive and are used to determine ICHA premium and assessments. Therefore, Iowa administrative rules are not used to determine ICHA premiums and assessments. ICHA premiums vary depending on one's age, plan and deductible chosen.

Michigan:

The State of Michigan does not have a plan or program similar to HIRSP.

Minnesota: Contact Minnesota Comprehensive Health Association @ www.mchamn.com or Ms. Lynn Gruber @ 952-593-9609.

The Minnesota Comprehensive Health Association (MCHA) was established in 1976 to offer individual health insurance policies to Minnesota residents who have been turned down for health insurance by the private market, due to pre-existing health conditions. MCHA is sometimes referred to as Minnesota's "high-risk pool" for health insurance, or health insurance of last resort. About 34,000 Minnesota citizens are insured by MCHA.

MCHA is a non-profit Minnesota corporation organized under Chapter 317 of Minnesota law. MCHA is not a state agency. The Minnesota Department of Commerce regulates it. An 11-member board of directors provides policy direction to MCHA. The annual deductible plan options are $500, $1,000, $2,000, $5,000 and $10,000. An option for a basic or an extended basic Medicare supplement plan is also available. By law, MCHA premiums are statutorily set between 101%-125% of the weighted average for comparable policies in the marketplace. MCHA losses in excess of premiums are reimbursed by insurers in proportion to their share of total health insurance premiums received. Minnesota statutes are prescriptive and are used to determine MCHA premium and assessments. Therefore, MCHA premiums and assessments are not determined by administrative rules of the State of Minnesota. MCHA premiums vary depending on one's age, plan and deductible chosen.

Summary of factual data and analytical methodologies:

The Department through this order amends ch. HFS 119 in order to update HIRSP premium rates in accordance with the authority and requirements set out in s. 149.143 (2), Stats. The fiscal adjustments contained in this order were developed by an independent actuarial firm on behalf of HIRSP. These fiscal adjustments have been reviewed by Department staff and approved by the HIRSP Board of Governors. By law, the Board is a diverse body composed of consumers, insurers, health care providers, small business and other affected parties.

The Department is required to set premium rates by rule. HIRSP premium rates must be calculated in accordance with generally accepted actuarial principles. The Department through this order is also adjusting total HIRSP insurer assessments and provider payment rates, in accordance with the authority and requirements set out in ss. 149.143 (2) (a) 3. and 4., and 149.144, Stats. With the approval of the HIRSP Board of Governors and as required

by statute, the Department reconciled total costs for the HIRSP program for calendar year 2004. The Board of Governors approved a methodology that reconciles the most recent calendar year actual HIRSP program costs, policyholder premiums, insurance assessments and health care provider contributions collected with the statutorily required funding formula.

By statute, the adjustments for the most recent calendar year are to be applied to the next plan year budget beginning July 1, 2005. On April 22, 2005, the HIRSP Board of Governors approved the calendar year 2004 reconciliation process. On April 22, 2005, the Board approved the HIRSP budget for the plan year July 1, 2005 through June 30, 2006.

Analysis and supporting documents used to determine effect on small business or in preparation of economic impact report:

HIRSP program statutes require an assessment of insurers and an adjustment to provider payment rates in order to help finance HIRSP. No assessed insurer is a small business as defined in s. 227.114 (1) (a), Stats. However, some health care providers are small businesses. Provider rate adjustments are implemented via a reduced payment to providers for HIRSP services rendered. HIRSP affects small business health care providers by providing them with additional customers and guaranteed payment, including provider payments that are marginally discounted as a result of statutorily required HIRSP adjustments. The net fiscal impact of HIRSP on these small business health care providers is unknown.

Anticipated costs incurred by private sector:

The specific entities affected by this rule are HIRSP policyholders, Wisconsin's health insurers, and health care providers who serve HIRSP policyholders. As required by law, policyholder premium rates generally fund sixty percent of HIRSP program costs. Insurer assessments and adjustments to provider payment rates are intended to fund HIRSP in co-equal twenty percent amounts, plus half of the costs associated with premium and deductible reductions. These various policyholder premiums, assessments and adjustments are the amounts duly estimated for the next fiscal year.

However, actual fiscal results are never the same as original estimates. Therefore the law also requires a retrospective HIRSP fiscal reconciliation in order to maintain the proper allocated funding requirements for insurers, providers and policyholders. The results of this retroactive reconciliation process must also, by law, be factored into the HIRSP budget for the next year.

The HIRSP amounts for any given year are thus an actuarial combination of the prospective amounts needed for the next fiscal year and retrospective adjustments for the prior year. The combined total amount for the insurer assessments and the adjustments to the provider payment rates will not be identical for next year, although parity will be maintained over the longer term as required by law.

For State Fiscal Year (SFY) 2006, the required HIRSP insurer assessment is $38,879,512, an increase of $6,433,230 from SFY 2005. For SFY 2006, the required HIRSP provider contribution is $43,830,996, an increase of $9,708,019 from SFY 2005. For SFY 2006, the HIRSP policyholders' projected premium contribution is $116,104,392, an increase of $13,291,514 from SFY 2005. The rule's fiscal estimate contains additional financial information regarding the HIRSP program.

HIRSP offers health insurance to high medically at-risk citizens, at rates subsidized by health care insurers and providers of service. HIRSP has about 18,530 policyholders, or 0.3% of Wisconsin's population of 5.5 million. HIRSP increases the number of Wisconsin citizens with health insurance. Wisconsin citizens are helped because they can obtain otherwise unavailable health insurance coverage. This allows them to improve their health status. Health care insurers find themselves unable to serve this marketplace niche and health care providers receive additional customers. Many states have similar health insurance programs including our neighboring states of Illinois, Iowa and Minnesota.

Effect on small business:

HIRSP statutes require an assessment of insurers and an adjustment to provider payment rates in order to help finance HIRSP. The rule changes do not affect health insurers as none are small businesses as "small business" is defined in s. 227.114 (1) (a), Stats. The rules changes may affect some health care providers that are small businesses. The net fiscal impact of HIRSP on these small health care providers is unknown.

Agency contact person:

Randy McElhose, HIRSP Administrative Rules
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1 W. Wilson St.
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mcelhrf@dhfs.state.wi.us
Phone: (608) 267-7127
Fax: (608) 264-7720

Place where comments are to be submitted and deadline for submission:

A public hearing will be held:

1:00 p.m. to 3:00 p.m.
on Monday, July 11, 2005

at 1 W. Wilson St., Room B272
Madison, WI 53702-0001

Written comments regarding the proposed rules can be directed to:

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mcelhrf@dhfs.state.wi.us
Phone: (608) 267-7127
Fax: (608) 264-7720

The deadline for submitting comments is **4:30 p.m. on Monday, July 18, 2005.**

These proposed rules are identical to emergency rules issued by the Department that became effective July 1, 2005.

RULE TEXT

SECTION 1. HFS 119.07 (6) (b) to (d) are amended to read:

HFS 119.07 (6) (b) Annual *premiums for major medical plan policies with standard deductible*. The schedule of annual premiums beginning ~~July 1, 2004~~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	~~$2,472~~2,736	~~$2,232~~2,460	~~$1,980~~2,184
19-24	~~2,472~~2,736	~~2,232~~2,460	~~1,980~~2,184
25-29	~~2,604~~2,880	~~2,340~~2,580	~~2,088~~2,292
30-34	~~2,940~~3,252	~~2,652~~2,928	~~2,352~~2,604
35-39	~~3,444~~3,828	~~3,108~~3,444	~~2,760~~3,072
40-44	~~4,128~~4,656	~~3,708~~4,188	~~3,312~~3,720
45-49	~~5,328~~6,096	~~4,800~~5,496	~~4,272~~4,872
50-54	~~7,128~~8,256	~~6,420~~7,428	~~5,700~~6,600
55-59	~~9,396~~10,956	~~8,448~~9,852	~~7,512~~8,772
60+	~~12,084~~13,884	~~10,872~~12,492	~~9,660~~11,112

MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$2,472~~2,736	~~$2,232~~2,460	~~$1,980~~2,184
19-24	~~3,144~~3,552	~~2,820~~3,192	~~2,520~~2,844
25-29	~~3,516~~3,984	~~3,156~~3,588	~~2,820~~3,192
30-34	~~3,936~~4,476	~~3,528~~4,032	~~3,144~~3,588
35-39	~~4,500~~5,136	~~4,044~~4,632	~~3,600~~4,116
40-44	~~5,172~~6,012	~~4,656~~5,412	~~4,128~~4,812
45-49	~~6,096~~7,104	~~5,496~~6,396	~~4,872~~5,688
50-54	~~7,296~~8,484	~~6,564~~7,620	~~5,844~~6,768
55-59	~~8,520~~9,876	~~7,656~~8,892	~~6,816~~7,896
60+	~~9,984~~11,376	~~8,988~~10,236	~~7,992~~9,096

MEDICARE PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$2,004~~2,304	~~$1,800~~2,088	~~$1,596~~1,848
19-24	~~2,004~~2,304	~~1,800~~2,088	~~1,596~~1,848
25-29	~~2,100~~2,424	~~1,884~~2,184	~~1,680~~1,932
30-34	~~2,364~~2,736	~~2,136~~2,460	~~1,896~~2,184
35-39	~~2,772~~3,228	~~2,508~~2,916	~~2,220~~2,580
40-44	~~3,324~~3,924	~~2,988~~3,528	~~2,676~~3,132
45-49	~~4,296~~5,148	~~3,876~~4,632	~~3,444~~4,116
50-54	~~5,748~~6,960	~~5,172~~6,276	~~4,584~~5,568
55-59	~~7,572~~9,240	~~6,816~~8,328	~~6,048~~7,392

60+	~~9,744~~11,712	~~8,772~~10,548	~~7,800~~9,372

MEDICARE PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~2,004~~2,304	$~~1,800~~2,088	$~~1,596~~1,848
19-24	~~2,532~~3,000	~~2,268~~2,688	~~2,028~~2,400
25-29	~~2,844~~3,360	~~2,556~~3,012	~~2,268~~2,688
30-34	~~3,180~~3,768	~~2,844~~3,396	~~2,532~~3,012
35-39	~~3,624~~4,320	~~3,264~~3,912	~~2,904~~3,480
40-44	~~4,164~~5,064	~~3,744~~4,572	~~3,324~~4,044
45-49	~~4,920~~6,000	~~4,440~~5,388	~~3,936~~4,788
50-54	~~5,880~~7,152	~~5,292~~6,432	~~4,716~~5,724
55-59	~~6,876~~8,328	~~6,180~~7,500	~~5,496~~6,648
60+	~~8,052~~9,600	~~7,236~~8,628	~~6,456~~7,668

HFS 119.07 (6) (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, 2004~~July 1, 2005:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,764~~1,908	$~~1,596~~1,716	$~~1,416~~1,524
19-24	~~1,764~~1,908	~~1,596~~1,716	~~1,416~~1,524
25-29	~~1,860~~2,004	~~1,668~~1,800	~~1,488~~1,596
30-34	~~2,100~~2,268	~~1,896~~2,040	~~1,680~~1,812
35-39	~~2,460~~2,664	~~2,220~~2,400	~~1,968~~2,136
40-44	~~2,952~~3,240	~~2,652~~2,916	~~2,364~~2,592
45-49	~~3,804~~4,248	~~3,432~~3,828	~~3,048~~3,396
50-54	~~5,088~~5,748	~~4,584~~5,172	~~4,068~~4,596
55-59	~~6,708~~7,632	~~6,036~~6,864	~~5,364~~6,108
60+	~~8,628~~9,672	~~7,764~~8,700	~~6,900~~7,740

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,764~~1,908	$~~1,596~~1,716	$~~1,416~~1,524
19-24	~~2,244~~2,472	~~2,016~~2,220	~~1,800~~1,980
25-29	~~2,508~~2,772	~~2,256~~2,496	~~2,016~~2,220
30-34	~~2,808~~3,120	~~2,520~~2,808	~~2,244~~2,496
35-39	~~3,216~~3,576	~~2,892~~3,228	~~2,568~~2,868
40-44	~~3,696~~4,188	~~3,324~~3,768	~~2,952~~3,348
45-49	~~4,356~~4,944	~~3,924~~4,452	~~3,480~~3,960
50-54	~~5,208~~5,904	~~4,692~~5,304	~~4,176~~4,716
55-59	~~6,084~~6,876	~~5,472~~6,192	~~4,872~~5,496
60+	~~7,128~~7,920	~~6,420~~7,128	~~5,712~~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, 2004~~July 1, 2005:

MEDICARE PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,428~~1,608	~~$1,284~~1,452	~~$1,140~~1,284
19-24	~~1,428~~1,608	~~1,284~~1,452	~~1,140~~1,284
25-29	~~1,500~~1,692	~~1,344~~1,524	~~1,200~~1,344
30-34	~~1,692~~1,908	~~1,524~~1,716	~~1,356~~1,524
35-39	~~1,980~~2,244	~~1,788~~2,028	~~1,584~~1,800
40-44	~~2,376~~2,736	~~2,136~~2,460	~~1,908~~2,184
45-49	~~3,072~~3,588	~~2,772~~3,228	~~2,460~~2,868
50-54	~~4,104~~4,848	~~3,696~~4,368	~~3,276~~3,876
55-59	~~5,412~~6,432	~~4,872~~5,796	~~4,320~~5,148
60+	~~6,960~~8,160	~~6,264~~7,344	~~5,568~~6,528

MEDICARE PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,428~~1,608	~~$1,284~~1,452	~~$1,140~~1,284
19-24	~~1,812~~2,088	~~1,620~~1,872	~~1,452~~1,668
25-29	~~2,028~~2,340	~~1,824~~2,100	~~1,620~~1,872
30-34	~~2,268~~2,628	~~2,028~~2,364	~~1,812~~2,100
35-39	~~2,592~~3,012	~~2,328~~2,724	~~2,076~~2,424
40-44	~~2,976~~3,528	~~2,676~~3,180	~~2,376~~2,820
45-49	~~3,516~~4,176	~~3,168~~3,756	~~2,808~~3,336
50-54	~~4,200~~4,980	~~3,780~~4,476	~~3,372~~3,984
55-59	~~4,908~~5,796	~~4,416~~5,220	~~3,924~~4,632
60+	~~5,748~~6,684	~~5,172~~6,012	~~4,608~~5,340

HFS 119.07 (6) (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, 2004~~July 1, 2005:

ALTERNATIVE MAJOR MEDICAL PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,776~~1,968	~~$1,608~~1,776	~~$1,428~~1,572
19-24	~~1,776~~1,968	~~1,608~~1,776	~~1,428~~1,572
25-29	~~1,872~~2,076	~~1,680~~1,860	~~1,500~~1,656
30-34	~~2,112~~2,340	~~1,908~~2,112	~~1,692~~1,872

35-39	~~2,484~~2,760	~~2,232~~2,484	~~1,992~~2,208
40-44	~~2,976~~3,348	~~2,664~~3,012	~~2,388~~2,676
45-49	~~3,840~~4,392	~~3,456~~3,960	~~3,072~~3,504
50-54	~~5,136~~5,940	~~4,620~~5,352	~~4,104~~4,752
55-59	~~6,768~~7,884	~~6,084~~7,092	~~5,412~~6,312
60+	~~8,700~~9,996	~~7,824~~9,000	~~6,960~~8,004

ALTERNATIVE MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,776~~1,968	$~~1,608~~1,776	$~~1,428~~1,572
19-24	~~2,268~~2,556	~~2,028~~2,304	~~1,812~~2,052
25-29	~~2,532~~2,868	~~2,268~~2,580	~~2,028~~2,304
30-34	~~2,832~~3,228	~~2,544~~2,904	~~2,268~~2,580
35-39	~~3,240~~3,696	~~2,916~~3,336	~~2,592~~2,964
40-44	~~3,720~~4,332	~~3,348~~3,900	~~2,976~~3,468
45-49	~~4,392~~5,112	~~3,960~~4,608	~~3,504~~4,092
50-54	~~5,256~~6,108	~~4,728~~5,484	~~4,212~~4,872
55-59	~~6,132~~7,116	~~5,508~~6,408	~~4,908~~5,688
60+	~~7,188~~8,196	~~6,468~~7,368	~~5,760~~6,552

SECTION 2. HFS 119.15 (2) and (3) are amended to read:

(2) INSURER ASSESSMENTS. The insurer assessments for the time period ~~July 1, 2004 through June 30, 2005 total $32,446,282.~~ 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, 2004 through June 30, 2005 is $34,122,977.~~ 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 ~~61.32%~~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 ~~40.4%~~43.2% enhancement under s. 149.142 (1) (a), Stats.

SECTION 3. EFFECTIVE DATE: The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin administrative register, as provided in s. 227.22 (2), Stats.

Wisconsin Department of Health and Family Services

Dated: September 9, 2005

By: _____
Helene Nelson
Secretary

SEAL: