State of Wisconsin
1995 - 1996 LEGISLATURE

LRB-5650/1
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# 1995 ASSEMBLY BILL 1056

March 21, 1996 - Introduced by Representatives ALBERS and UNDERHEIM. Referred to Committee on Insurance, Securities and Corporate Policy.

AN ACT ***to amend*** 619.13 (2), 619.135 (2) and 619.14 (5) (a); and ***to create*** 619.137, 619.14 (5) (e) and 619.14 (5) (f) of the statutes; **relating to:** limiting premiums and insurer assessments under the health insurance risk-sharing plan, requiring a study for a replacement for that plan and providing an exemption from rule-making procedures.

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***Analysis by the Legislative Reference Bureau***

The health insurance risk-sharing plan (HIRSP) under current law provides major medical health insurance coverage 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 coverage at an affordable price, in the private health insurance market because of their mental or physical health condition. A board of governors supervises HIRSP and manages the health insurance risk-sharing fund, which is made up of assessments paid by health insurers and out of which operating and administrative expenses, including claims in excess of premiums, are paid. Claims, other than those in excess of premiums, are paid by premiums collected from persons with coverage under HIRSP. The commissioner of insurance (commissioner) must determine and set out the schedule of premiums by administrative rule and must set the rates at 60% of the operating and administrative costs of HIRSP.

This bill sets a limit on the premium rates that may be charged to persons with coverage under HIRSP. If the average rate, when rates are set at 60% of the operating and administrative costs, would exceed 250% of what a standard risk would be charged for substantially the same coverage, the commissioner must apply to the joint committee on finance to supplement the appropriation out of which the operating and administrative costs are paid from premiums. The bill also sets a limit on the assessments that may be levied against insurers to make up for any deficit in

funding for HIRSP. If the assessments levied to make up for any deficit would exceed 0.8% of the aggregate of the insurers' health care coverage revenue (premiums or other charges received to pay for health care coverage) for residents of this state during the preceding calendar year, the commissioner must apply to the joint committee on finance to supplement the appropriations out of which the operating and administrative costs are paid from insurer assessments.

The bill also directs the commissioner and the department of health and social services to conduct a study on establishing a health care program to replace HIRSP. The health care program must use managed care, and a report of the study must be submitted to the legislature by March 1, 1997. The bill also authorizes the commissioner to determine the schedule of premiums for HIRSP by temporary rules in an expedited manner. The temporary rules would be replaced by permanent rules promulgated in the usual manner.

For further information see the ***state*** fiscal estimate, which will be printed as an appendix to this bill.

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***The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:***

**SECTION 1.** 619.13 (2) of the statutes is amended to read:

619.13 **(2)** ~~Any~~ Except as provided in s. 619.137, any deficit incurred under the plan shall be recouped by assessments apportioned under sub. (1) by the board among participating insurers, who may recover these amounts in the normal course of their respective businesses without time limitation.

**SECTION 2.** 619.135 (2) of the statutes is amended to read:

619.135 **(2)** ~~If~~ Except as provided in s. 619.137, if the moneys under s. 20.145 (7) (a) and (g) are insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), or the commissioner determines that the moneys under s. 20.145 (7) (a) and (g) will be insufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a), the commissioner shall, by rule, increase the amount of the assessment under sub. (1) (a) or levy an assessment against every

insurer, or a combination of both, sufficient to reimburse the plan for premium reductions under s. 619.165 and deductible reductions under s. 619.14 (5) (a).

**SECTION 3.** 619.137 of the statutes is created to read:

**619.137 Limit on, and supplementing, insurer assessments.** Total assessments imposed in any calendar year under ss. 619.13 (2) and 619.135 (2) may not exceed 0.8% of the aggregate health care coverage revenue of all participating insurers for residents of this state during the preceding calendar year. If the total specified assessments in any calendar year will exceed the specified amount, the commissioner shall request additional funding under s. 13.101 to supplement any of the appropriations under s. 20.145 (7) (a), (g) and (u). Notwithstanding s. 13.101 (3) (a) 1. and (4), the joint committee on finance may supplement any of the appropriations under s. 20.145 (7) (a), (g) and (u) from the appropriations under s. 20.865 (4) (a), (g) and (u) without finding that an emergency exists.

**SECTION 4.** 619.14 (5) (a) of the statutes is amended to read:

619.14 **(5)** (a) The plan shall offer a deductible in combination with appropriate premiums determined under this subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended. The deductible amounts for all other eligible persons shall be dependent upon household income as determined under s. 619.165. For eligible persons under s. 619.165 (1) (b) 1., the deductible shall be $500. For eligible persons under s. 619.165 (1) (b) 2., the deductible shall be $600. For eligible persons under s. 619.165 (1) (b) 3., the deductible shall be $700. For eligible persons under s. 619.165 (1) (b) 4., the deductible shall be $800. For all other eligible persons who are not eligible for

medicare, the deductible shall be $1,000. With respect to all eligible persons, expenses used to satisfy the deductible during the last 90 days of a calendar year shall also be applied to satisfy the deductible for the following calendar year. The schedule of premiums shall be promulgated by rule by the commissioner. The commissioner shall set rates at 60% of the operating and administrative costs of the plan, except that the average of those rates may not exceed 250% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan.

**SECTION 5.** 619.14 (5) (e) of the statutes is created to read:

619.14 **(5)** (e) Using the procedure under s. 227.24, the commissioner may promulgate rules under par. (a) for the schedule of premiums for the period before the effective date of any permanent rules promulgated under par. (a) for the schedule of premiums, but not to exceed the period authorized under s. 227.24 (1) (c) and (2). Notwithstanding s. 227.24 (1) and (3), the commissioner is not required to make a finding of emergency.

**SECTION 6.** 619.14 (5) (f) of the statutes is created to read:

619.14 **(5)** (f) If the average rate, when the rates are set as provided in par. (a), will exceed 250% of the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan, the commissioner shall request additional funding under s. 13.101 to supplement the appropriation under s. 20.145 (7) (u). Notwithstanding s. 13.101 (3) (a) 1. and (4), the joint committee on finance may supplement the appropriation under s. 20.145 (7) (u) from the appropriation under s. 20.865 (4) (u) without finding that an emergency exists.

**SECTION 7. Nonstatutory provisions.**

(1) STUDY ON REPLACEMENT FOR THE HEALTH INSURANCE RISK–SHARING PLAN. The office of the commissioner of insurance and the department of health and social services shall conduct a study on replacing the health insurance risk–sharing plan under subchapter II of chapter 619 of the statutes, as affected by this act, with a health care program that utilizes managed care. The office and the department shall submit a report of the study and their recommendations to the legislature in the manner provided under section 13.172 (2) of the statutes no later than March 1, 1997.

**(END)**