

1981 Assembly Bill 669

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CHAPTER 83 , Laws of 1981

AN ACT to repeal 619.14 (3) (f); to amend 619.13 (1) (a) and (b), 619.14 (1) (b), (2) (a), (3) (intro.), (b), (e), (p) and (q), (4) (k) and (5), 619.15 (1) and 632.785 (1) (intro.); to repeal and recreate 619.14 (3) (c) and 631.36 (7); and to create 619.15 (7) of the statutes, relating to changes to the mandatory health insurance risk sharing plan and granting rule-making authority.

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

SECTION 2. 619.13 (1) (a) and (b) of the statutes are amended to read:

619.13 (1) (a) Every insurer shall participate in the cost of administering the plan, except the commissioner may by rule exempt as a class those insurers whose share as determined under par. (b) would be so minimal as to not exceed the estimated cost of levying the assessment.

(b) 1. Except as provided in subd. 2, every participating insurer shall share in the operating and administrative expenses of the plan in proportion to the ratio of the insurer's total cost of premium, subscriber contract charges and health maintenance organization charges on business written in this state on behalf of residents during the preceding calendar year to the aggregate cost of premium, subscriber contract charges, health maintenance organization charges, self-insurance and medical reimbursement charges received by all participating insurers for health insurance written in this state on behalf of residents during the preceding calendar year, as determined by the commissioner.

2. If the participating insurer is a self-insurer or a provider of health insurance coverage under a medical reimbursement plan, the participating insurer's share in the operating and administrative expenses of the plan shall be proportional to the ratio of the sum of the total benefits paid and the total administrative costs incurred during the preceding calendar year to residents to the aggregate cost of premium, subscriber contract and health maintenance organization charges, and self-insurance and medicare reimbursement charges received by all participating insurers on health insurance business written in this state on behalf of residents during the preceding calendar year, as determined by the commissioner.

SECTION 3. 619.14 (1) (b), (2) (a) and (3) (intro.) and (b) of the statutes are amended to read:

619.14 (1) (b) If ~~any~~ an individual ~~whose coverage under terminates~~ terminates medical assistance ~~is terminated for any reason other than failure to pay any required contribution coverage and applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 619.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of the previous medical assistance coverage.~~

(2) (a) The plan shall provide every eligible person who is not eligible for medicare with major medical expense coverage. Major medical expense coverage offered under the plan shall pay an eligible person's covered expenses, subject to ~~limits on outpatient benefits under~~ sub. (3) ~~(c)~~ and deductible and coinsurance payments authorized under sub. (5), up to a lifetime limit of \$250,000 per covered individual. The maximum limit under this paragraph shall not be altered by the board, and no actuarially equivalent benefit may be substituted by the board.

(3) COVERED EXPENSES. (intro.) Covered expenses shall be the usual and customary charges for the services provided by persons licensed under ch. 446. Covered expenses shall also be the usual and customary charges for the following services and articles when prescribed by a physician licensed under ch. 448 or in another state:

(b) Basic medical-surgical services, including both in-hospital and out-of-hospital medical and surgical services, diagnostic services, anesthesia services and consultation services ~~and in-hospital and outpatient services as defined by s. 632.89 (1) (d) for alcoholism, drug abuse and mental and nervous disorders provided by a physician or under the supervision, at the direction of or on referral from a physician, subject to the limitations in this subsection.~~

SECTION 4. 619.14 (3) (c) of the statutes is repealed and recreated to read:

619.14 (3) (c) 1. Inpatient treatment in a hospital as defined in s. 632.89 (1) (b) or in a medical facility in another state approved by the board, for up to 30 days' confinement per calendar year due to alcoholism or drug abuse and up to 60 days' confinement per calendar year for nervous and mental disorders.

2. Outpatient services as defined in s. 632.89 (1) (d) for alcoholism, drug abuse or nervous and mental disorders, as follows:

a. The first \$500 of covered expenses per calendar year; and

b. An additional \$2,500 of covered expenses per calendar year, after satisfaction of the deductible and coinsurance requirements under sub. (5).

SECTION 5. 619.14 (3) (e) of the statutes is amended to read:

619.14 (3) (e) Services of a licensed skilled nursing facility for eligible persons eligible for medicare, to the extent required by s. 632.78 (4) and for not more than an aggregate 120 days during a policy calendar year, if the services are of the type which would qualify as reimbursable services under medicare. Coverage under this paragraph which is

not required by s. 632.78 (4) is subject to the deductible and coinsurance requirements under sub. (5).

SECTION 6. 619.14 (3) (f) of the statutes is repealed.

SECTION 7. 619.14 (3) (p) and (q), (4) (k) and (5) of the statutes are amended to read:

(3) (p) Services ~~For persons not eligible for medicare, services~~ of a licensed skilled nursing facility, only to the extent required by s. 632.78 (4).

(q) Any other health insurance coverage, only to the extent required under subch. VI of ch. 632.

(4) (k) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy calendar year.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) The plan shall offer a \$1,000 ~~annual~~ 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. 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 and deductibles shall be promulgated by rule by the commissioner. The rating plan shall be designed to be self-sufficient, except that for the first 3 years of its operation, the rating plan shall not provide for rates greater than 130% of the rate which a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under this section.

(b) Except as provided in par. (c), if the covered costs incurred by the eligible person exceed the deductible for major medical expense coverage ~~selected by the person~~ in a policy calendar year, the plan shall pay at least 80% of any additional covered costs incurred by the person during the policy calendar year.

(c) If the aggregate of the covered costs not paid by the plan under par. (b) and the deductible ~~selected by the eligible person covered under a major medical expense policy issued by the plan~~ exceeds \$500 for an eligible person receiving medicare, \$1,500 for any other eligible person during a policy calendar year or \$3,000 for all eligible persons in a family, the plan shall pay 100% of all covered costs incurred by the eligible person during the policy calendar year after the payment ceilings under this paragraph are exceeded.

SECTION 8. 619.15 (1) of the statutes is amended to read:

619.15 (1) The plan shall operate subject to the supervision and approval of a board consisting of representatives of 2 participating insurers which are nonprofit corporations, 2 other participating insurers, and 3 public members, ~~at least 2 of whom are members of the population covered by the plan and who are not professionally affiliated with the practice of medicine, a hospital or an insurance company or association,~~ appointed by the commissioner for staggered 3-year terms. In addition, a representative of the health policy council and the commissioner or a designated representative from the office of the commissioner shall be members of the board. The public members shall not be professionally affiliated with the practice of medicine, a hospital or an insurer. At least 2 of the public members shall be individuals reasonably expected to qualify for coverage under the plan or the parent or spouse of such an individual. The commissioner or the commissioner's representative shall be the chairperson of the board. Board members, except the commissioner or the commissioner's representative, shall be compensated at the rate of \$50 per diem plus actual and necessary expenses.

SECTION 9. 619.15 (7) of the statutes is created to read:

619.15 (7) (a) The board is not liable for any obligation of the plan.

(b) Members of the board are state officers for purposes of s. 895.46.

SECTION 10. 631.36 (7) of the statutes is repealed and recreated to read:

631.36 (7) CANCELLATION OR NONRENEWAL NOTICE. Notice of cancellation or non-renewal required under sub. (2) (b) or (4) is not effective:

(a) Unless the notice contains the notice required under s. 632.785, if applicable; and

(b) Unless the notice contains adequate instructions to the policyholder for applying for insurance through a risk sharing plan under subch. I of ch. 619, if a risk sharing plan exists under subch. I of ch. 619 for the kind of coverage being canceled or nonrenewed.

SECTION 11. 632.785 (1) (intro.) of the statutes is amended to read:

632.785 (1) (intro.) If an insurer issues one or more of the following or takes any other action based wholly or partially on medical underwriting considerations which is likely to render any person eligible under s. 619.12 for coverage under subch. II of ch. 619, the insurer shall notify all persons ~~covered or to be covered by the policy~~ affected of the existence of the mandatory health insurance risk sharing plan under subch. II of ch. 619, as well as the eligibility requirements and method of applying for coverage under the plan:
