50-192

ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING RULES

Section 149.143 (4), Stats., permits the Department to promulgate rules required under s. 149.143(2) and (3), Stats. by using emergency rulemaking procedures, except that the Department is specifically exempted from the requirement under s. 227.24(1) and (3), Stats., that it make a finding of emergency. These are the rules. Department staff consulted with the HIRSP Board of Governors on April 30, 1999 on the proposed rules, as required by s. 149.20, Stats.

Analysis Prepared by the Department of Health and Family Services

The State of Wisconsin in 1981 established a Health Insurance Risk-Sharing Plan (HIRSP) for the purpose of making health insurance coverage available to medically uninsured residents of the state. One type of coverage provided by HIRSP is supplemental coverage for persons eligible for Medicare. This coverage is called Plan 2. Medicare (Plan 2) has a $500 deductible. Approximately 17% of the 7,291 HIRSP policies in effect on March 31, 1999 were of the Plan 2 type.

The Department through this rulemaking order is amending ch. HFS 119 in order to update HIRSP Plan 2 premium rates in accordance with the authority and requirements set out in s. 149.143 (2) (a) 2., Stats. The Department is required to set premium rates by rule. These rates must be calculated in accordance with generally accepted actuarial principles. Policyholders are to pay 60% of the costs of HIRSP.

There are separate sets of tables in ch. HFS 119 that show unsubsidized and subsidized Plan 2 premium rates. Both sets of tables are amended by this order to increase the premium rates because Plan 2 costs, which historically have been running about 50% less than Plan 1 costs, began to increase several years ago and now are running at about 67% of Plan 1 costs. The Plan 2 premium rates need to be increased to cover increased costs of treatment for individuals enrolled under Plan 2. The order increases these premium rates by about 18%.

In January 1999, the Department published an emergency rule order to increase HIRSP unsubsidized Plan 2 premium rates by about 10%, with the intention of increasing those rates again in July 1999 to the level provided for in this order. However, in May 1999 the Legislature's Joint Committee for the Review of Administrative Rules (JCRAR) refused to extend the effective period of that part of the January 1999 emergency rule order relating to premium rate increases, with the result that effective May 31, 1999, the rates reverted back to the rates in effect before January 1, 1999. Consequently, to increase rates effective July 1, 1999, the Department through this rulemaking order has based the increased rates on the rates in effect prior to January 1, 1999.

The Department through this order is also adjusting the total HIRSP insurer assessments and provider payment rates in accordance with the authority and requirements set out in s. 149.143 (2)(a)3. and 4., 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 1998. The Board of Governors approved a reconciliation 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 calendar year are to be applied to the next plan year budget beginning July 1, 1999.

The result of this reconciliation process for calendar year 1998 indicated that insurance assessments collected were greater than the 20% of costs (net of the GPR contribution from appropriation s. 20.435(5)(af), Stats.), required of insurers. Also, the calendar year 1998 reconciliation process showed that an insufficient amount was collected from health care providers. As a result of this reconciliation, the insurer assessments for the time periods July 1, 1999 through December 31, 1999 and January 1, 2000 through June 30, 2000, are reduced to offset the overpayment in 1998. The total adjustments to the provider payment rates for the same time periods are sharply increased in order to recoup the provider contribution that was not collected in calendar year 1998. The budget for the plan year ending June 30, 2000 and the calendar year 1998 reconciliation process were approved by the HIRSP Board of Governors in April 1999.

ORDER

Pursuant to authority vested in the Department of Health and Family Services by s. 149.143(2)(a) 2., 3. and 4., (3) and (4), Stats., the Department of Health and Family Services hereby amends rules interpreting s. 149.143, Stats., as follows:

SECTION 1. HFS 119.07 (6) (b) (intro.) and Medicare Plan tables are amended to read:

HFS 119.07(6)(b) (intro.) Annual premiums for major medical plan policies with standard deductible. The schedule of annual premiums beginning ~~July 1, 1998~~ July 1, 1999, for persons not entitled to a premium reduction under s. 149.165, Stats., is as follows:

MEDICARE PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~888~~1,008	$~~792~~924	$~~708~~816
19-24	~~888~~1,008	~~792~~924	~~708~~816
25-29	~~888~~1,032	~~792~~936	~~708~~828
30-34	~~1,020~~1,164	~~912~~1,056	~~816~~936
35-39	~~1,140~~1,332	~~1,020~~1,212	~~912~~1,068
40-44	~~1,380~~1,620	~~1,248~~1,440	~~1,092~~1,272
45-49	~~1,716~~2,040	~~1,536~~1,824	~~1,380~~1,632
50-54	~~2,208~~2,700	~~1,992~~2,424	~~1,764~~2,148
55-59	~~2,892~~3,504	~~2,616~~3,156	~~2,316~~2,808
60+	~~3,552~~4,308	~~3,192~~3,876	~~2,832~~3,444

MEDICARE PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~888~~1,008	$~~792~~924	$~~708~~816
19-24	~~1,224~~1,392	~~1,116~~1,272	~~972~~1,116
25-29	~~1,284~~1,500	~~1,152~~1,356	~~1,032~~1,188
30-34	~~1,404~~1,644	~~1,272~~1,488	~~1,128~~1,332
35-39	~~1,512~~1,788	~~1,368~~1,620	~~1,212~~1,428
40-44	~~1,680~~1,980	~~1,512~~1,800	~~1,332~~1,584
45-49	~~1,944~~2,340	~~1,752~~2,088	~~1,560~~1,872
50-54	~~2,184~~2,688	~~1,956~~2,400	~~1,752~~2,148
55-59	~~2,496~~3,072	~~2,244~~2,772	~~1,992~~2,436
60+	~~2,940~~3,600	~~2,640~~3,228	~~2,340~~2,880

SECTION 2. HFS 119.07 (6)(c)2. (intro.) and tables are amended to read:

HFS 119.07(6)(c) *Base rates for calculating premium reductions*. 2. (intro.) 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, 1998~~ July 1, 1999:

MEDICARE PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~588~~672	$~~528~~612	$~~468~~540
19-24	~~588~~672	~~528~~612	~~468~~540
25-29	~~588~~684	~~528~~624	~~468~~552
30-34	~~684~~780	~~612~~708	~~540~~624
35-39	~~756~~888	~~672~~804	~~600~~708
40-44	~~912~~1,068	~~828~~960	~~732~~852
45-49	~~1,140~~1,356	~~1,020~~1,212	~~912~~1,080
50-54	~~1,464~~1,788	~~1,320~~1,608	~~1,176~~1,428
55-59	~~1,932~~2,340	~~1,740~~2,100	~~1,536~~1,872
60+	~~2,364~~2,868	~~2,124~~2,580	~~1,884~~2,292

MEDICARE PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~588~~672	$~~528~~612	$~~468~~540
19-24	~~816~~924	~~732~~840	~~648~~744
25-29	~~852~~996	~~768~~900	~~684~~792
30-34	~~936~~1,092	~~840~~984	~~744~~876
35-39	~~1,008~~1,188	~~900~~1,068	~~804~~948
40-44	~~1,116~~1,320	~~996~~1,188	~~888~~1,056

45-49	~~1,284~~1,548	~~1,164~~1,392	~~1,032~~1,236
50-54	~~1,452~~1,788	~~1,308~~1,596	~~1,164~~1,428
55-59	~~1,656~~2,040	~~1,488~~1,836	~~1,332~~1,632
60+	~~1,956~~2,400	~~1,764~~2,160	~~1,560~~1,920

SECTION 3. HFS 119.15, as amended by emergency order effective January 1, 1999, is amended to read:

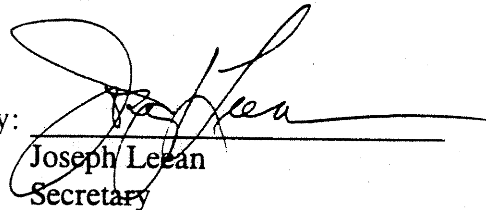
HFS 119.15 INSURER ASSESSMENTS AND PROVIDER PAYMENT RATES. (1) PURPOSE. This section implements s. 149.143 (2) (a) 3. and 4., Stats.

(2) INSURER ASSESSMENTS. The insurer assessments for the time period ~~January 1, 1999~~ July 1, 1999 through ~~June 30, 1999~~December 31, 1999 total ~~$4,043,589~~$2,975,605. The insurer assessments for the time period January 1, 2000 through June 30, 2000 total $3,055,065.

(3) PROVIDER PAYMENT RATES. The total adjustment to the provider payment rates for the time period ~~January 1, 1999~~July 1, 1999 through ~~June 30, 1999~~ December 31, 1999 is ~~$4,043,589~~$ 4,847,134. The total adjustment to the provider payment rates for the time period January 1, 2000 through June 30, 2000 is $ 4,926,594.

The rules contained in this order shall take effect as emergency rules on July 1, 1999.

Wisconsin Department of Health and Family Services



Dated: **June 16, 1999**

By: Joseph Leean
Secretary

SEAL:

1997 Session

LRB or Bill No./Adm. Rule No.
HFS 119.07(6)&119.15

Amendment No. if Applicable

FISCAL ESTIMATE
DOA-2048 N(R10/96)

☒ ORIGINAL ☐ UPDATED
☐ CORRECTED ☐ SUPPLEMENTAL

Subject

HEALTH INSURANCE RISK-SHARING PLAN (HIRSP)

Fiscal Effect

State: ☐ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☐ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected: ☐ Towns ☐ Villages ☐ Cities ☐ Counties ☐ Others ____ ☐ School Districts ☐ WTCS Districts

Fund Sources Affected
☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Ch. 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

This order updates Health Insurance Risk-Sharing Plan (HIRSP) premium rates effective July 1, 1999 for both unsubsidized and subsidized HIRSP policies that provide supplemental health insurance coverage for persons eligible for Medicare, and adjusts total HIRSP insurer assessments and the provider payment rate, first for the 6-month period beginning January 1, 1999, and then for the 6-month period beginning January 1, 2000.

To cover Plan costs, the Department is directed by s. 149.143 (2) (a) 2., 3. and 4., Stats., to set premium rates and total insurer assessments for each Plan year and to adjust the provider payment rate for each Plan year. That is being done through this order for the Plan year beginning July 1, 1999.

The rule changes will not by themselves affect the expenditures or revenues of state government or local governments. They adjust premiums, as expected under the program statute, to help offset program costs and adjust the total insurer assessments and the provider payment rate in accordance with a statute-specified methodology, also to offset program costs.

Long-Range Fiscal Implications

Agency/Prepared by: (Name & Phone No.)
H&FS/Randy McElhose, 267-7127

Authorized Signature/Telephone No.
John Kiesow, 266-9622

Date
6-16-99

ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
REPEALING AND RECREATING RULES

The Legislature in s. 9123 (4) of 1997 Wisconsin Act 27 permitted the Department to promulgate any rules that the Department is authorized or required to promulgate under ch. 149, Stats., as affected by Act 27, by using emergency rulemaking procedures except that the Department was specifically exempted from the requirement under s. 227.24 (1) and (3), Stats., that it make a finding of emergency. These are the rules.

Analysis Prepared by the Department of Health and Family Services

The State of Wisconsin in 1981 established a Health Insurance Risk Sharing Plan (HIRSP) for the purpose of making health insurance coverage available to medically uninsured residents of the state.

HIRSP provides a major medical type of coverage for persons not eligible for Medicare (Plan 1) and a Medicare supplemental type of coverage for persons eligible for Medicare (Plan 2). Plan 1 has a $1,000 deductible. Plan 2 has a $500 deductible. On December 31, 1997 there were 7,318 HIRSP policies in effect, 83% of them Plan 1 policies and 17% Plan 2 policies. HIRSP provides for a 20% coinsurance contribution by plan participants up to an annual out-of-pocket maximum of $2,000 (which includes the $1,000 deductible) per individual and $4,000 per family for major medical and $500 per individual for Medicare supplement. There is a lifetime limit of $1,000,000 per covered individual that HIRSP will pay for all illnesses.

There is provision under HIRSP for graduated premiums and reduced deductibles. Plan participants may be eligible for graduated premiums and reducted deductibles if their household income for the prior calendar year, based on standards for computation of the Wisconsin Homestead Credit, was less than $20,000.

The current Budget Act, 1997 Wisconsin Act 27, transferred responsibility for the Health Insurance Risk-Sharing Plan (HIRSP) from the Office of Commissioner of Insurance to the Department of Health and Family Services effective January 1, 1998. The transfer included the administrative rules that the Office of Commissioner of Insurance had promulgated for the administration of HIRSP. These were numbered ch. Ins 18, Wis. Adm. Code. The Department arranged for the rules to be renumbered ch. HFS 119, Wis. Adm. Code, effective April 1, 1998, and, at the same time, because the program statutes had been renumbered by Act 27, for statutory references in ch. HFS 119 to be changed from subch. II of ch. 619, Stats., to ch. 149, Stats.

Act 27 made several other changes in the operation of the Health Insurance Risk-Sharing Plan. The Department through this rulemaking order is amending ch. HFS 119 by repeal and re-creation mainly to make the related changes to the rules, but also to update annual premiums for HIRSP participants in accordance with authority set out in s. 149.143

(3) (a), Stats., under which the Department may increase premium rates during a plan year for the remainder of the plan year.

Major changes made in the rules to reflect changes made by Act 27 in the HIRSP program statute are the following:

-Transfer of plan administration responsibility from an "administering carrier" selected by the Board of Governors through a competitive negotiation process to Electronic Data Systems (EDS), the Department's fiscal agent for the Medical Assistance Program, called in the revised statute the "plan administrator";

-Deletion of a physician certification requirement in connection with applications of some persons for coverage;

-Addition of alternatives to when eligibility may begin, namely, 60 days after a complete application is received, if requested by the applicant, or on the date of termination of Medical Assistance coverage;

-Addition of a reference to how creditable coverage is aggregated, in relation to eligibility determination;

-Modification of the respective roles of the state agency, now the Department, and the Board of Governors;

-Clarification that the alternative plan for Medicare recipients reduces the benefits payable by the amounts paid by Medicare;

-Modification of cost containment provisions to add that for coverage services must be medically necessary, appropriate and cost-effective as determined by the plan administrator, and that HIRSP is permitted to use common and current methods employed by managed care programs and the Medical Assistance program to contain costs, such as prior authorization;

-Continuation of an alternative plan of health insurance that has a $2500 deductible (this was added by emergency order effective January 1, 1998);

-Addition of timelines to the grievance procedure for plan applicants and participants, and a provision to permit the Department Secretary to change a decision of the Board's Grievance Committee if in the best interests of the State; and

-Establishment of total insurer assessments and the total provider payment rate for the period July 1, 1998 to December 31, 1998.

ORDER

Pursuant to authority vested in the Department of Health and Family Services by 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., as affected by 1997 Wisconsin Act 27, and s. 9123 (4) of 1997 Wisconsin Act 27, the Department of Health and Family Services hereby repeals and recreates rules interpreting ch. 149, Stats., as affected by 1997 Wisconsin Act 27, as follows:

SECTION 1. Chapter HFS 119 is repealed and recreated to read:

Chapter HFS 119

HEALTH INSURANCE RISK-SHARING PLAN

HFS 119.01 Authority and purpose
HFS 119.02 Applicability
HFS 119.03 Establishment of plan and title
HFS 119.04 Definitions
HFS 119.05 Eligibility
HFS 119.06 Participation of insurers
HFS 119.07 Coverage
HFS 119.08 Board of governors
HFS 119.09 Plan administrator
HFS 119.10 Notification by insurers of availability of HIRSP
HFS 119.11 Confidentiality and access to records
HFS 119.12 Premium and deductible reductions for low-income policyholders
HFS 119.13 Cost containment provisions
HFS 119.14 Grievance procedure
HFS 119.15 Insurer assessments and provider payment rates

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.

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.

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", and shall be referred to in this chapter as the plan.

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 allowed amount 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, 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 insurerto 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) "Medicaid" means the medical assistance 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.

Note: The Department's fiscal agent (payer of claims) under s. 49.45 (2) (b) 2., Stats., for the Medical Assistance Program, currently Electronic Data Systems (EDS), serves also as the plan administrator for HIRSP.

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

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

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

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 (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.

(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 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 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.

(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).

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 when it is determined 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 Wisconsin Department of Health and Family Services, P.O. Box 309, Madison, WI 53701.

(3) An insurer who makes an error in the insurer's assessment form that results in an underpayment of assessments to the plan shall 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 shall, 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.

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, 1998, 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	$1,512	$1,368	$1,212
19-24	1,512	1,368	1,212
25-29	1,548	1,404	1,248
30-34	1,764	1,584	1,404
35-39	2,004	1,800	1,608
40-44	2,400	2,160	1,908
45-49	3,048	2,736	2,436
50-54	4,020	3,624	3,228
55-59	5,256	4,740	4,212
60+	6,468	5,820	5,172

MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,512	$1,368	$1,212
19-24	2,088	1,896	1,680
25-29	2,232	2,016	1,788
30-34	2,472	2,220	1,980
35-39	2,688	2,412	2,148
40-44	2,976	2,688	2,376
45-49	3,492	3,132	2,796
50-54	4,020	3,600	3,204
55-59	4,596	4,128	3,672
60+	5,400	4,860	4,320

MEDICARE PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$888	$792	$708
19-24	888	792	708
25-29	888	792	708
30-34	1,020	912	816
35-39	1,140	1,020	912
40-44	1,380	1,248	1,092
45-49	1,716	1,536	1,380
50-54	2,208	1,992	1,764
55-59	2,892	2,616	2,316
60+	3,552	3,192	2,832

MEDICARE PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$888	$792	$708
19-24	1,224	1,116	972
25-29	1,284	1,152	1,032
30-34	1,404	1,272	1,128
35-39	1,512	1,368	1,212
40-44	1,680	1,512	1,332
45-49	1,944	1,752	1,560
50-54	2,184	1,956	1,752
55-59	2,496	2,244	1,992
60+	2,940	2,640	2,340

(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, 1998:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,008	$912	$804
19-24	1,008	912	804
25-29	1,032	936	828
30-34	1,176	1,056	936
35-39	1,332	1,200	1,068
40-44	1,596	1,440	1,272
45-49	2,028	1,824	1,620
50-54	2,676	2,412	2,148
55-59	3,504	3,156	2,808
60+	4,308	3,876	3,444

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,008	$912	$804
19-24	1,392	1,260	1,116
25-29	1,488	1,344	1,188
30-34	1,644	1,476	1,320
35-39	1,788	1,608	1,428
40-44	1,980	1,788	1,584
45-49	2,328	2,088	1,860
50-54	2,676	2,400	2,136
55-59	3,060	2,748	2,448
60+	3,600	3,240	2,880

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, 1998:

MEDICARE PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$588	$528	$468
19-24	588	528	468
25-29	588	528	468
30-34	684	612	540
35-39	756	672	600
40-44	912	828	732
45-49	1,140	1,020	912
50-54	1,464	1,320	1,176
55-59	1,932	1,740	1,536
60+	2,364	2,124	1,884

MEDICARE PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$588	$528	$468
19-24	816	732	648
25-29	852	768	684
30-34	936	840	744
35-39	1,008	900	804
40-44	1,116	996	888
45-49	1,284	1,164	1,032
50-54	1,452	1,308	1,164
55-59	1,656	1,488	1,332
60+	1,956	1,764	1,560

(d) Annual premiums for major medical plan policies with $2500 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. The schedule of annual premiums for coverage under the alternative plan with a $2,500 deductible is as follows beginning July 1, 1998:

ALTERNATIVE MAJOR MEDICAL PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,092	$984	$876
19-24	1,092	984	876
25-29	1,116	1,008	900
30-34	1,272	1,140	1,008
35-39	1,440	1,296	1,152
40-44	1,728	1,560	1,368
45-49	2,196	1,968	1,752
50-54	2,892	2,604	2,328
55-59	3,780	3,408	3,036
60+	4,656	4,188	3,720

ALTERNATIVE MAJOR MEDICAL PLAN –
Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$1,092	$984	$876
19-24	1,500	1,368	1,212
25-29	1,608	1,452	1,284
30-34	1,776	1,596	1,428
35-39	1,932	1,740	1,548
40-44	2,148	1,932	1,716
45-49	2,520	2,256	2,016
50-54	2,892	2,592	2,304
55-59	3,312	2,976	2,640
60+	3,888	3,504	3,108

(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 and 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) 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).

(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.

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

(2) ANNUAL REPORT. The board shall make an annual report to plan participants and to the chief clerk of each house of the legislature pursuant to s. 149.15 (2), Stats., which summarizes the activities of the plan in the preceding calendar year.

(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 companies 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.

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.

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 EDS, Health Insurance Risk-Sharing Plan (HIRSP), Suite #18, 6406 Bridge Road, Madison, Wisconsin 53784-0018 (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 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.

HFS 119.11 CONFIDENTIALITY AND ACCESS TO RECORDS. (1) CONFIDENTIALITY. The plan administrator and the department shall keep information

about plan applicants and plan participants confidential, unless disclosure is otherwise permitted by law.

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

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.

(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 (5) (ah), 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 may also need to include a completed federal profit or loss from farming form, schedule F. 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 reductions at no charge from EDS, Health Insurance Risk-Sharing Plan (HIRSP), 6406 Bridge Road, Suite #18, Madison, Wisconsin 53784-0018 (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. 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 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 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) Under this subsection, the plan administrator shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(d) Reestablisment 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.

HFS 119.13 COST CONTAINMENT PROVISIONS. HIRSP may use common, current methods employed by managed care programs and the medicaid program to contain costs, including prior authorization and other limitations regarding healthcare 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.

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: EDS-HIRSP, 6406 Bridge Road, Suite #18, Madison, WI 53784-0018.

(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 deems 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.

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, 1998 through December 31, 1998 total $ 4,266,874.

(3) PROVIDER PAYMENT RATES. The total provider payment rate for the time period July 1, 1998 through December 31, 1998 is $ 4,266,874.

The rules contained in this order shall take effect as emergency rules on July 1, 1998.

Wisconsin Department of Health and
Family Services

Dated: June 25, 1998

By: ______________________
Joseph Leean
Secretary

SEAL:

			1997 Session
FISCAL ESTIMATE DOA-2048 N(R10/96)	☒ ORIGINAL ☐ CORRECTED	☐ UPDATED ☐ SUPPLEMENTAL	LRB or Bill No./Adm. Rule No. HFS 119 Amendment No. if Applicable

Subject

HEALTH INSURANCE RISK-SHARING PLAN (HIRSP)

Fiscal Effect

State: ☐ No State Fiscal Effect

Check columns below only if bill makes a direct appropriation or affects a sum sufficient appropriation.

☐ Increase Existing Appropriation ☐ Increase Existing Revenues
☐ Decrease Existing Appropriation ☐ Decrease Existing Revenues
☐ Create New Appropriation

☐ Increase Costs - May be possible to Absorb Within Agency's Budget ☐ Yes ☐ No

☐ Decrease Costs

Local: ☐ No local government costs

1. ☐ Increase Costs ☐ Permissive ☐ Mandatory
2. ☐ Decrease Costs ☐ Permissive ☐ Mandatory
3. ☐ Increase Revenues ☐ Permissive ☐ Mandatory
4. ☐ Decrease Revenues ☐ Permissive ☐ Mandatory
5. Types of Local Governmental Units Affected:
   ☐ Towns ☐ Villages ☐ Cities
   ☐ Counties ☐ Others _____
   ☐ School Districts ☐ WTCS Districts

Fund Sources Affected

☐ GPR ☐ FED ☐ PRO ☐ PRS ☐ SEG ☐ SEG-S

Affected Ch. 20 Appropriations

Assumptions Used in Arriving at Fiscal Estimate

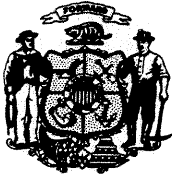
This order repeals and recreates the Department's rules for operation of the Health Insurance Risk-Sharing Plan (HIRSP) under ch.149, Stats., as renumbered from subch. II of ch. 619, Stats., and as otherwise affected by 1997 Wisconsin Act 27, to incorporate in the rules the statutory changes made in the program by Act 27, to carry out new directives added to the program statutes by Act 27, to update premiums for HIRSP participants in accordance with authority set out in s. 149.143 (3) (a), Stats., under which the Department may increase premium rates during a plan year for the remainder of the plan year and to bring the rules into approximately the same form as other rules of the Department following the transfer of responsibility for administering HIRSP from the Office of the Commissioner of Insurance to the Department effective January 1, 1998.

How HIRSP is to be financed is set out in s. 149.143, Stats., as created by Act 27. One of the new directives to the Department included in s. 149.143, Stats., is for the Department by rule to set the total insurer assessments and the provider payment rate for the new plan year. This has been done through this rulemaking order for the period July 1, 1998 to December 31, 1998, in accordance with the method specified in s. 149.143, Stats. The total insurer assessments is set at $4,266,874.

The rule changes will not by themselves affect the expenditures or revenues of state government or local governments. They make the rules conform to the amended statutes, adjust premiums as permitted under the program statute to help offset increased program costs and adjust the total of insurer assessments in accordance with a statute-specified methodology also to offset program costs. There is no local government involvement in the administration of HIRSP.

Long-Range Fiscal Implications

Agency/Prepared by: (Name & Phone No.)	Authorized Signature/Telephone No.	Date
H&FS/ Kathy Rogers, 264-7733	Richard W. Lorang, 266-9622	6-25-98



Legislative Fiscal Bureau

One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873

November 15, 2000

TO: Senator Judy Robson
Room 15 South, State Capitol

FROM: Rachel Carabell, Fiscal Analyst

SUBJECT: HIRSP Pharmacy Payments and Plan 2 Premiums

You requested the following information: (a) costs by service type for each of the plans offered under the health insurance risk sharing plan (HIRSP); (b) recent audit findings relating to HIRSP payment of pharmaceutical claims; (c) the impact of the audit findings on cost projections for plan year 2000-01; and (d) whether use of the surplus premium revenue to reduce Plan 2 rates proposed by the Department of Health and Family Services (DHFS) for plan year 2000-01 is allowable under current law. This memorandum responds to this request and provides additional information on HIRSP funding and enrollment.

Background

HIRSP was created in 1980 to provide comprehensive health insurance coverage for the state's medically uninsurable population. HIRSP is administered by DHFS under the guidance of the HIRSP Board of Governors.

HIRSP provides two health insurance plans. Plan 1 is a major medical plan that covers most major medical expenses, but not necessarily preventive services, for individuals that are not otherwise insurable. Persons enrolled in Plan 1 may choose a policy with either a $1,000 deductible or a $2,500 deductible. Plan 2 provides major medical coverage similar to Plan 1, but coverage is supplemental to coverage provided by Medicare.

HIRSP Funding. In April, 2000, Milliman & Robertson, Inc., actuaries for HIRSP, estimated that HIRSP benefit and administrative costs would total approximately $60.6 million for 2000-01. HIRSP is funded by policyholder premiums, assessments on health insurance companies, payment reductions for providers and state general purpose revenue (GPR). DHFS is budgeted $11.9 million GPR in 2000-01 to offset total costs for the program. Policyholder premiums (60%),

assessments on health insurance companies (20%) and payment reductions for providers (20%) pay the remainder of costs, $48.2 million, after accounting for interest and other miscellaneous income ($0.5 million). Despite this cost allocation, premiums for Plan 1 and 2 are established based on specific requirements in current law.

Plan 1 Premiums. Plan 1 has two options, Option A offers a $1,000 deductible. Option B offers a $2,500 deductible with lower premiums than Option A. Current law requires that HIRSP premiums for Plan 1 be established at a rate equal to at least 150% of the rate that an individual who is considered a standard risk would be charged under an individual health insurance policy providing substantially the same coverage and deductibles as HIRSP. Current law requires that premiums for Option B be set in proportion to Option A based on the percentage difference between an individual standard rate for policies providing substantially the same coverage and deductibles as provided in Option A and in Option B.

If the projected revenue from premiums based on 150% of the individual standard rate are not sufficient to pay 60% of HIRSP costs, then the Board must use any surplus premium revenue available from previous years to maintain the rates equivalent to 150% of the individual standard rate. If surplus premium revenue is not sufficient to cover 60% of HIRSP costs, then the Board may increase premiums to more than 150% of the individual standard rate, but not more than 200% of the individual standard rate. If this action is not sufficient to pay 60% of HIRSP costs, then the remainder of costs must be shared between insurers and providers.

Plan 2 Premiums. Plan 2 provides supplemental coverage for individuals in Medicare. Premiums for Plan 2 are established based on the following factors:

- A comparison between the average per capita expenditures in the previous calendar year for Plan 2 policyholders and the average per capita expenditures in the previous calendar year for Plan 1A policyholders;

- Plan 2 enrollment levels; and

- Other economic factors that DHFS and the Board consider relevant.

Surplus Premium Revenue. If, in any one plan year, DHFS receives premium revenue in excess of 60% of HIRSP costs, DHFS must keep a separate accounting for this revenue. This surplus may be used for two purposes: (a) to avoid increasing premiums for each plan above the amount established by a process prescribed by statute if the projected revenue from premiums would not meet 60% of projected plan costs; and (b) for other needs of HIRSP policyholders, with the approval of the HIRSP Board. As of December 31, 1999, the amount of surplus revenue available for these purposes was approximately $5.9 million. In 2000-01, premiums for Plan 1 have been established at 150% of the individual standard rate, based on an actuarial analysis. This analysis projects revenue from premiums to exceed 60% of HIRSP costs. Therefore, use of the

surplus revenue was not necessary to maintain premiums for Plan 1 at 150% of the individual standard rate.

HIRSP Enrollment. Most HIRSP enrollees are enrolled in Plan 1, Option A. As of June, 2000, there were 8,949 individuals enrolled in HIRSP, of which approximately 66% were enrolled in Plan 1, Option A. However, Plan 1, Option B has the fastest growing enrollment levels, from 739 policyholders in July, 1999 to 1,692 policyholders in June, 2000, an increase of more than 120%. This enrollment growth is attributable to its relatively recent availability. Option B was available to policyholders beginning in July, 1998.

Table 1 indicates enrollment in each HIRSP plan for the month of June in 1998, 1999 and 2000.

TABLE 1

HIRSP Policies in Force

	Plan 1			
Month	Option A	Option B	Plan 2	Total
June, 1998	6,014	N.A.	1,204	7,218
June, 1999	5,540	683	1,231	7,454
June, 2000	5,909	1,692	1,348	8,949

HIRSP Costs. Claims for types of services for HIRSP beneficiaries vary significantly by plan. Table 2 identifies the type of services for claims paid for HIRSP beneficiaries for calendar year 1999.

TABLE 2

HIRSP Claims
Calendar Year 1999

	Plan 1, Option A		Plan 1, Option B		Plan 2		Total	
	Expenditures	% of Total	Expenditures	% of Total	Expenditures	% of Total	Expenditures	% of Total
Pharmaceuticals	$6,500,000	23%	$53,000	7%	$6,000,000	71%	$12,553,000	34%
Physician	6,507,000	23	220,000	28	700,000	8	7,427,000	20
Outpatient Hospital	2,017,000	7	56,000	7	715,000	9	2,788,000	8
Durable Medical Equipment	790,000	3	10,000	1	160,000	2	960,000	3
Inpatient Hospital	12,007,500	43	450,000	57	730,000	9	13,187,500	36
Nursing Home	36,000	0	1,000	0	97,000	1	134,000	0
Totals	$27,857,500	100%	$790,000	100%	$8,402,000	100%	$37,049,500	100%

For 1999, approximately 75% of HIRSP claims are paid on behalf of policyholders in Plan 1, Option A. However, as the table indicates, pharmacy costs for HIRSP are shared almost equally between Plan 1, Option A and Plan 2. Pharmaceuticals represent a large portion of Plan 2 costs [71 % for Plan 2, versus 30% for Plan 1, Option A] because Plan 2 is a Medicare supplement plan and Medicare does not cover outpatient pharmaceuticals.

Audit Findings Related to Pharmaceuticals

On November 9, 2000, the Legislative Audit Bureau released its report on its 1998-99 audit of HIRSP. In that report, the Audit Bureau indicated that it determined that HIRSP had overpaid pharmacies for pharmaceuticals by approximately $1.7 million in 1998-98 and HIRSP had likely overpaid pharmacies by approximately $2.0 million in 1999-00. According to the Audit Bureau report, the overpayment resulted from DHFS suspending the plan administrator's controls in the claims systems that prohibit the plan administrator from paying more than the maximum allowed reimbursement rate.

Beginning in July, 1998, Electronic Data Systems, Inc. (EDS), the medical assistance (MA) fiscal agent, became the plan administrator for HIRSP. With this change in administration came a change in the way and the amount HIRSP reimbursed policyholders for pharmaceuticals. This change, according to the Audit Bureau, resulted in increasing confusion and difficulty for both policyholders and pharmacies. In order to address numerous complaints, DHFS modified the method used to reimburse policyholders for pharmaceutical costs. DHFS instructed pharmacies to charge HIRSP policyholders the maximum HIRSP reimbursement rate for pharmaceuticals at the point-of-sale, rather than at the pharmacies' usual and customary charges. At the same time, DHFS suspended the controls in the claims system that prohibited the claims system from paying more than the maximum reimbursement rate for pharmaceuticals.

The audit report indicates that these changes quickly addressed the complaints from pharmacies and policyholders. However, DHFS never reinstated the controls in the claims system and never monitored pharmaceuticals to determine if they were complying with the Department's billing instructions. Therefore, according to the Audit Bureau, more than 75% of the prescriptions tested in an Audit Bureau sampling of 1998-99 claims were found to have been paid in excess of the maximum reimbursement allowable. A complete review of HIRSP pharmaceutical claims in 1998-99 determined that HIRSP had overpaid pharmaceutical claims by $1.7 million.

Since being notified of the overpayment, DHFS has instructed EDS to reinstate the controls in the claim system and has notified pharmacies of the overpayments and its intent to recover the overpayments and sent a reminder to pharmacists of proper HIRSP billing procedures. Further, DHFS and the HIRSP Board are considering options to simplify the HIRSP pharmaceutical billing procedures for policyholders and pharmacies. Such changes could improve DHFS management and monitoring of HIRSP pharmaceutical costs.

Basis of Cost Projections for 2000-01

You specifically requested this office to verify that HIRSP 2000-01 cost projections were based on previous year claims for pharmaceuticals that included overpayments identified in the Audit Bureau report. Neither DHFS nor the Board were aware of the overpayments for HIRSP pharmaceuticals at the time the Board approved the premium rates for plan year 2000-01. According to its report, the Audit Bureau notified DHFS of the overpayments in May, 2000. The premium rates were approved by the Board in April, 2000. Therefore, 2000-01 premiums were established using projections based on costs that included the overpayments for pharmaceuticals. These inflated costs disproportionately affect cost projections for Plan 2 because pharmaceuticals represent 71% of Plan 2's costs compared to 30% for Plan 1, Option A, as identified in Table 2.

Use of Surplus Premium Revenue to Reduce Plan 2 Rates

You expressed interest in using the surplus premium revenue to reduce rates for Plan 2 premiums in order to offset the disproportionate effect of the overpayment for pharmaceuticals on Plan 2 premium rates. Specifically, you asked whether such a use of the surplus premium revenue was allowable.

Based on consultations with staff attorneys at the Legislative Council, it appears that use of the surplus premium revenue to reduce current premiums for Plan 2 policyholders is not an allowable use of the surplus under current law. When setting rates as prescribed in statute does not generate sufficient revenue to cover 60% of plan costs, only then can DHFS use the surplus revenue to meet 60% of plan costs. As stated earlier, surplus premium revenue can be used for the following purposes: (a) to avoid increasing premiums above the amount established by a statutorily-prescribed process, if the projected revenue from premiums set at these rates would not meet 60% of projected plan costs (after accounting for GPR budgeted for HIRSP); and (b) for other needs of HIRSP policyholders, with the approval of the Board. Because the rates set by the Board, following the process prescribed in statute, are projected to generate sufficient revenue to meet 60% of plan costs (after accounting for GPR budgeted for HIRSP), DHFS is not authorized to use the surplus revenue to reduce plan rates in this manner.

However, current law does authorize the use of the surplus premium revenue for the needs of HIRSP policyholders (other than to avoid increasing premiums to meet 60% of plan costs after accounting for GPR budgeted for the program). The approval of the HIRSP Board is required for the use of the surplus in this manner.

Please contact me if you require additional information on this matter.

RC/lah

SENATOR JUDITH B. ROBSON
CO-CHAIR

P.O. Box 7882
MADISON, WI 53707-7882
(608) 266-2253

REPRESENTATIVE GLENN GROTHMAN
CO-CHAIR

P.O. Box 8952
MADISON, WI 53708-8952
(608) 264-8486

JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

January 24, 2000

The Honorable Fred Risser
Senate President
State Capitol Building, Room 220 South
Madison, WI 53702

The Honorable Scott Jensen
Assembly Speaker
State Capitol Building, Room 211 West
Madison, WI 53702

Dear President Risser and Speaker Jensen:

The Joint Committee for the Review of Administrative Rules met in Executive Session on January 20, 2000 and adopted the following motions:

Emergency Rule HFS 119

Relating to: Health Insurance Risk-Sharing Plan (HIRSP) premium rates. Extension of this emergency rule by 35 days at the request of the Department of Health and Family Services.

Moved by Representative Grothman, seconded by Representative Gunderson that pursuant to Section 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective period of emergency rules HFS 119 by 35 days, at the request of the Department of Health and Family Services recommended, Ayes 10, Noes 0, Absent 0

Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

*voted by phone or paper ballot

Emergency Rule HFS 101 to 103 & 108

Relating to: the operation of BadgerCare. Extension of this emergency rule by 60 days at the request of the Department of Health and Family Services.

Moved by Representative Grothman, seconded by Representative Grothman that, pursuant to Section 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective period of emergency rules HFS 101 to 103 & 108 by 60 days, at the request of the Department of Health and Family Services recommended, Ayes 10, Noes 0, Absent 0

Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

*voted by phone or paper ballot

Emergency Rule HFS 106 & 108

Relating to: the discovery rights in contested case proceedings involving health care providers under the Medical Assistance.

Moved by Representative Grothman, seconded by Senator Robson that, pursuant to Section 227.26(2)(d), stats. And for the reason set forth in ss. 227.19(4)(d)1 that the Joint Committee for Review of Administrative Rules suspend HFS 106 and 108.

Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

*voted by phone or paper ballot

Emergency Rule CVRB 1

Relating to: the rights of crime victims. Extension of the effective period of this emergency rule by 60 days by the Crime Victims Rights Board.

Moved by Representative Grothman, seconded by Representative Gunderson, that pursuant to Section 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective period of emergency rules CVRB 1 by 60 days, at the request of the Crime Victims Rights Board recommended, Ayes 10, Noes 0, Absent 0

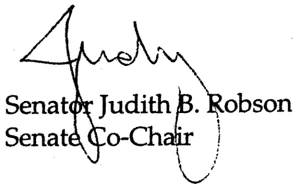
Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

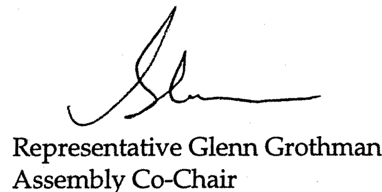
*voted by phone or paper ballot

Pursuant to s. 227.24(2)(c), stats., as treated by 1997 Wisconsin Act 185, please forward a copy of this notice to the chairperson of the standing committee in your respective house most likely to have jurisdiction over the Clearinghouse Rule corresponding to this emergency rule.

Sincerely,



Senator Judith B. Robson
Senate Co-Chair



Representative Glenn Grothman
Assembly Co-Chair

BW:GG:mjg

SENATOR JUDITH B. ROBSON
CO-CHAIR

P.O. BOX 7882
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REPRESENTATIVE GLENN GROTHMAN
CO-CHAIR

P.O. BOX 8952
MADISON, WI 53708-8952
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JOINT COMMITTEE FOR REVIEW OF ADMINISTRATIVE RULES

January 24, 2000

Joe Leann, Secretary
Department of Health and Family Services
1 West Wilson Street, Ste. 650
Madison, WI 53702

Dear Secretary Leann:

The Joint Committee for the Review of Administrative Rules met in Executive Session on January 20, 2000 and adopted the following motions:

Emergency Rule HFS 119

Relating to: Health Insurance Risk-Sharing Plan (HIRSP) premium rates. Extension of this emergency rule by 35 days at the request of the Department of Health and Family Services.

Moved by Representative Grothman, seconded by Representative Gunderson that pursuant to Section 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective period of emergency rules HFS 119 by 35 days, at the request of the Department of Health and Family Services recommended, Ayes 10, Noes 0, Absent 0

Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

*voted by phone or paper ballot

Emergency Rule HFS 101 to 103 & 108

Relating to: the operation of BadgerCare. Extension of this emergency rule by 60 days at the request of the Department of Health and Family Services.

Moved by Representative Grothman, seconded by Representative Grothman that, pursuant to Section 227.24(2)(a), Stats., the Joint Committee for Review of Administrative Rules extend the effective period of emergency rules HFS 101 to 103 & 108 by 60 days, at the request of the Department of Health and Family Services recommended, Ayes 10, Noes 0, Absent 0

Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

*voted by phone or paper ballot

Emergency Rule HFS 106 & 108

Relating to: the discovery rights in contested case proceedings involving health care providers under the Medical Assistance.

Moved by Representative Grothman, seconded by Senator Robson that, pursuant to Section 227.26(2)(d), stats. And for the reason set forth in ss. 227.19(4)(d)1 that the Joint Committee for Review of Administrative Rules suspend HFS 106 and 108.

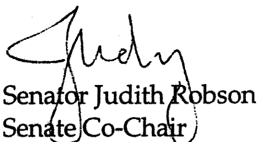
Ayes: (10) Representatives Grothman,Gunderson, Seratti, Kreuser, and Black; Senators Robson, Grobschmidt*, Shibilski*, Darling* and Welch.

Noes: (0)

*voted by phone or paper ballot

Pursuant to s. 227.24(2)(c) Stats, we are notifying the Secretary of State and the Revisor of Statutes of the Committee's action through copies of this letter.

Sincerely,



Senator Judith Robson
Senate Co-Chair

Representative Glenn Grothman
Assembly Co-Chair

JBR:GSG:mjg

cc: Secretary of State Doug LaFollette
Revisor of Statutes Gary Poulson

ORDER OF THE
DEPARTMENT OF HEALTH AND FAMILY SERVICES
AMENDING RULES

Section 149.143 (4), Stats., permits the Department to promulgate rules required under s. 149.143 (2) and (3), Stats., by using emergency rulemaking procedures, except that the Department is specifically exempted from the requirement under s. 227.24 (1) and (3), Stats., that it make a finding of emergency. These are the emergency rules. Department staff consulted with the Health Insurance Risk-Sharing Plan (HIRSP) Board of Governors on April 26, 2000 on the rules, as required by s. 149.20, Stats.

Analysis Prepared by the Department of Health and Family Services

The State of Wisconsin in 1981 established a Health Insurance Risk-Sharing Plan (HIRSP) for the purpose of making health insurance coverage available to medically uninsured residents of the state. HIRSP offers different types of medical care coverage plans for residents.

One type of medical coverage provided by HIRSP is the Major Medical Plan. This type of coverage is called Plan 1. Eighty-four percent of the 8,427 HIRSP policies in effect in March 2000, were of the Plan 1 type. Plan 1 has Option A ($1,000 deductible) or Option B ($2,500 deductible). The rate increases for Plan 1 contained in this rulemaking order increase an average of 12.4%. Rate increases for specific policyholders range from 3.5% to 15.0%, depending on a policyholder's age, gender, household income, deductible and zone of residence within Wisconsin. This increase reflects industry-wide premium increases and takes into account the increase in costs associated with Plan 1 claims. According to state law, HIRSP premiums cannot be less than 150% of the amount an individual would be charged for a comparable policy in the private market. The average 12.4% rate increase for Plan 1 is the minimum increase necessary to maintain premiums at the lowest level permitted by law.

A second type of medical coverage provided by HIRSP is supplemental coverage for persons eligible for Medicare. This type of coverage is called Plan 2. Plan 2 has a $500 deductible. Sixteen percent of the 8,427 HIRSP policies in effect in March 2000, were of the Plan 2 type. The rate increases for Plan 2 contained in this rulemaking order increase an average of 18.2%. Rate increases for specific policyholders range from 7.5% to 21%, depending on a policyholder's age, gender, household income and zone of residence within Wisconsin. These rate increases reflect industry-wide cost increases and adjust premiums to a level that more accurately reflects actual claim costs for Plan 2 policyholders.

The Department through this rulemaking order is amending ch. HFS 119 in order to update HIRSP premium rates in accordance with the authority and requirements set out in s. 149.143 (3) (a), Stats. The Department is required to set premium rates by rule. HIRSP premium rates must be calculated in accordance with generally accepted actuarial principles. Policyholders are to pay 60% of the costs of HIRSP.

The Department through this order is also adjusting the total HIRSP insurer assessments and provider payment rates in accordance with the authority and requirements set out in s. 149.143 (2) (a) 3. and 4., 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 1999. 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 calendar year are to be applied to the next plan year budget beginning July 1, 2000. The total annual contribution to the HIRSP budget provided by an adjustment to the provider payment rates is $10,119,482. The total annual contribution to the HIRSP budget provided by an assessment on insurers is $9,898,358. On April 26, 2000, the HIRSP Board of Governors approved the calendar year 1999 reconciliation process and the HIRSP budget for the plan year July 1, 2000 through June 30, 2001.

ORDER

Pursuant to authority vested in the Department of Health and Family Services by ss. 149.143 (2) (a) 2., 3. and 4., (3) and (4), Stats., the Department of Health and Family Services hereby amends rules interpreting s. 149.143, Stats., as follows:

SECTION 1. HFS 119.07 (6) (b) (intro.) and tables for medical plan policies with standard deductible are amended to read:

HFS 119.07 (6) (b) (intro.) *Annual premiums for major medical plan policies with standard deductible*. The schedule of annual premiums beginning ~~July 1, 1999~~July 1, 2000, 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	$~~1,512~~1,656	$~~1,368~~1,500	$~~1,212~~1,332
19-24	~~1,512~~1,656	~~1,368~~1,500	~~1,212~~1,332
25-29	~~1,548~~1,716	~~1,404~~1,548	~~1,248~~1,368
30-34	~~1,764~~1,932	~~1,584~~1,728	~~1,404~~1,536
35-39	~~2,004~~2,232	~~1,800~~2,016	~~1,608~~1,788
40-44	~~2,400~~2,664	~~2,160~~2,412	~~1,908~~2,148
45-49	~~3,048~~3,480	~~2,736~~3,132	~~2,436~~2,772
50-54	~~4,020~~4,560	~~3,624~~4,104	~~3,228~~3,660
55-59	~~5,256~~5,832	~~4,740~~5,256	~~4,212~~4,668
60+	~~6,468~~7,200	~~5,820~~6,480	~~5,172~~5,760

MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,512~~1,656	$~~1,368~~1,500	$~~1,212~~1,332
19-24	~~2,088~~2,184	~~1,896~~1,968	~~1,680~~1,752
25-29	~~2,232~~2,376	~~2,016~~2,148	~~1,788~~1,908
30-34	~~2,472~~2,652	~~2,220~~2,376	~~1,980~~2,112
35-39	~~2,688~~2,976	~~2,412~~2,688	~~2,148~~2,376
40-44	~~2,976~~3,384	~~2,688~~3,048	~~2,376~~2,700
45-49	~~3,492~~3,984	~~3,132~~3,588	~~2,796~~3,168
50-54	~~4,020~~4,596	~~3,600~~4,140	~~3,204~~3,672
55-59	~~4,596~~5,220	~~4,128~~4,704	~~3,672~~4,176
60+	~~5,400~~6,084	~~4,860~~5,472	~~4,320~~4,860

MEDICARE PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,008~~1,176	$~~924~~1,044	$~~816~~936
19-24	~~1,008~~1,176	~~924~~1,044	~~816~~936
25-29	~~1,032~~1,212	~~936~~1,080	~~828~~960
30-34	~~1,164~~1,356	~~1,056~~1,212	~~936~~1,080
35-39	~~1,332~~1,572	~~1,212~~1,428	~~1,068~~1,248
40-44	~~1,620~~1,872	~~1,440~~1,692	~~1,272~~1,500
45-49	~~2,040~~2,436	~~1,824~~2,196	~~1,632~~1,944
50-54	~~2,700~~3,192	~~2,424~~2,880	~~2,148~~2,556
55-59	~~3,504~~4,092	~~3,156~~3,696	~~2,808~~3,276
60+	~~4,308~~5,064	~~3,876~~4,536	~~3,444~~4,032

MEDICARE PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,008~~1,176	$~~924~~1,044	$~~816~~936
19-24	~~1,392~~1,536	~~1,272~~1,368	~~1,116~~1,224
25-29	~~1,500~~1,680	~~1,356~~1,500	~~1,188~~1,332
30-34	~~1,644~~1,860	~~1,488~~1,680	~~1,332~~1,476
35-39	~~1,788~~2,088	~~1,620~~1,872	~~1,428~~1,680
40-44	~~1,980~~2,376	~~1,800~~2,148	~~1,584~~1,896
45-49	~~2,340~~2,796	~~2,088~~2,520	~~1,872~~2,220
50-54	~~2,688~~3,228	~~2,400~~2,904	~~2,148~~2,580
55-59	~~3,072~~3,660	~~2,772~~3,300	~~2,436~~2,940
60+	~~3,600~~4,272	~~3,228~~3,840	~~2,880~~3,408

SECTION 2. HFS 119.07 (6) (c) 1. (intro.) and tables are amended to read:

HFS 119.07 (6) (c) *Base rates for calculating premium reductions.* 1. (intro.) 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, 1998~~July 1, 2000:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,008~~1,104	$~~912~~996	$~~804~~888
19-24	~~1,008~~1,104	~~912~~996	~~804~~888
25-29	~~1,032~~1,140	~~936~~1,032	~~828~~912
30-34	~~1,176~~1,284	~~1,056~~1,152	~~936~~1,020
35-39	~~1,332~~1,488	~~1,200~~1,344	~~1,068~~1,188
40-44	~~1,596~~1,776	~~1,440~~1,608	~~1,272~~1,428
45-49	~~2,028~~2,316	~~1,824~~2,088	~~1,620~~1,848
50-54	~~2,676~~3,036	~~2,412~~2,736	~~2,148~~2,436
55-59	~~3,504~~3,888	~~3,156~~3,504	~~2,808~~3,108
60+	~~4,308~~4,800	~~3,876~~4,320	~~3,444~~3,840

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,008~~1,104	$~~912~~996	$~~804~~888
19-24	~~1,392~~1,452	~~1,260~~1,308	~~1,116~~1,164
25-29	~~1,488~~1,584	~~1,344~~1,428	~~1,188~~1,272
30-34	~~1,644~~1,764	~~1,476~~1,584	~~1,320~~1,404
35-39	~~1,788~~1,980	~~1,608~~1,788	~~1,428~~1,584
40-44	~~1,980~~2,256	~~1,788~~2,028	~~1,584~~1,800
45-49	~~2,328~~2,652	~~2,088~~2,388	~~1,860~~2,112
50-54	~~2,676~~3,060	~~2,400~~2,760	~~2,136~~2,448
55-59	~~3,060~~3,480	~~2,748~~3,132	~~2,448~~2,784
60+	~~3,600~~4,056	~~3,240~~3,648	~~2,880~~3,240

SECTION 3. HFS 119.07 (6) (c) 2. (intro.) and tables are amended to read:

HFS 119.07 (6) (c) *Base rates for calculating premium reductions*. 2. (intro.) 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, 1999~~July 1, 2000:

MEDICARE PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~672~~780	$~~612~~696	$~~540~~624
19-24	~~672~~780	~~612~~696	~~540~~624
25-29	~~684~~804	~~624~~720	~~552~~636
30-34	~~780~~900	~~708~~804	~~624~~720
35-39	~~888~~1,044	~~804~~948	~~708~~828
40-44	~~1,068~~1,248	~~960~~1,128	~~852~~996
45-49	~~1,356~~1,620	~~1,212~~1,464	~~1,080~~1,296
50-54	~~1,788~~2,124	~~1,608~~1,920	~~1,428~~1,704
55-59	~~2,340~~2,724	~~2,100~~2,460	~~1,872~~2,184
60+	~~2,868~~3,372	~~2,580~~3,024	~~2,292~~2,688

MEDICARE PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~672~~780	$~~612~~696	$~~540~~624
19-24	~~924~~1,020	~~840~~912	~~744~~816
25-29	~~996~~1,116	~~900~~996	~~792~~888
30-34	~~1,092~~1,236	~~984~~1,116	~~876~~984
35-39	~~1,188~~1,392	~~1,068~~1,248	~~948~~1,116
40-44	~~1,320~~1,584	~~1,188~~1,428	~~1,056~~1,260
45-49	~~1,548~~1,860	~~1,392~~1,680	~~1,236~~1,476
50-54	~~1,788~~2,148	~~1,596~~1,932	~~1,428~~1,716
55-59	~~2,040~~2,436	~~1,836~~2,196	~~1,632~~1,956
60+	~~2,400~~2,844	~~2,160~~2,556	~~1,920~~2,268

SECTION 4. HFS 119.07 (6) (d) (intro.) and tables are amended to read:

HFS 119.07 (6) (d) *Annual premiums for major medical plan policies with a $2,500 deductible.* (intro.) 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 two 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, 1998~~July 1, 2000:

ALTERNATIVE MAJOR MEDICAL PLAN Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,092~~1,188	$~~984~~1,080	$~~876~~960
19-24	~~1,092~~1,188	~~984~~1,080	~~876~~960
25-29	~~1,116~~1,236	~~1,008~~1,116	~~900~~984
30-34	~~1,272~~1,392	~~1,140~~1,248	~~1,008~~1,104
35-39	~~1,440~~1,608	~~1,296~~1,452	~~1,152~~1,284
40-44	~~1,728~~1,920	~~1,560~~1,740	~~1,368~~1,548
45-49	~~2,196~~2,508	~~1,968~~2,256	~~1,752~~1,992
50-54	~~2,892~~3,288	~~2,604~~2,952	~~2,328~~2,640
55-59	~~3,780~~4,200	~~3,408~~3,780	~~3,036~~3,360
60+	~~4,656~~5,184	~~4,188~~4,668	~~3,720~~4,152

ALTERNATIVE MAJOR MEDICAL PLAN Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	$~~1,092~~1,188	$~~984~~1,080	$~~876~~960
19-24	~~1,500~~1,572	~~1,368~~1,416	~~1,212~~1,260
25-29	~~1,608~~1,716	~~1,452~~1,548	~~1,284~~1,368
30-34	~~1,776~~1,908	~~1,596~~1,716	~~1,428~~1,524
35-39	~~1,932~~2,148	~~1,740~~1,932	~~1,548~~1,716
40-44	~~2,148~~2,436	~~1,932~~2,196	~~1,716~~1,944
45-49	~~2,520~~2,868	~~2,256~~2,580	~~2,016~~2,280
50-54	~~2,892~~3,312	~~2,592~~2,976	~~2,304~~2,640
55-59	~~3,312~~3,756	~~2,976~~3,384	~~2,640~~3,012
60+	~~3,888~~4,380	~~3,504~~3,936	~~3,108~~3,504

SECTION 5. HFS 119.15 is amended to read:

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, 1999 through December 31, 1999 total $2,975,605. The insurer assessments for the time period January 1, 2000 through June 30, 2000 total $3,055,065.~~July 1, 2000 through June 30, 2001 total $9,898,358.

(3) PROVIDER PAYMENT RATES. The total adjustment to the provider payment rates for the time period ~~July 1, 1999 through December 31, 1999 is $4,847,134. The total adjustment to the provider payment rates for the time period January 1, 2000 through June 30, 2000 is $ 4,926,594.~~ July 1, 2000 through June 30, 2001 is $10,119,482.

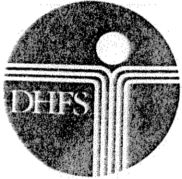
The rules contained in this order shall take effect as emergency rules on July 1, 2000.

Wisconsin Department of Health and Family Services

Dated: June 30, 2000

By:
Joseph Leean
Secretary

SEAL



State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

April 30, 1999

The Honorable Judy Robson, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 South, State Capitol
Madison, Wisconsin

Dear Senator Robson:

The Department of Health and Family Services has two emergency rulemaking orders in effect that will expire before the emergency rules are replaced by permanent rules unless the effective periods of the emergency rules are extended. Pursuant to s. 227.24(2), Stats., I ask the Joint Committee to extend the effective periods of the emergency rules by the number of days indicated below. The emergency rules are as follows:

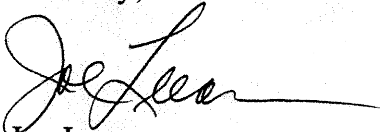
(1) Operation of the Health Insurance Risk-Sharing Plan (HIRSP). These emergency rules, amendments to HFS 119, were published to take effect on January 1, 1999, and will expire on May 31, 1999, unless extended. The order increases premium rates for policies that provide supplemental coverage for persons eligible for Medicare, and adjusts total insurer assessments and provider payment rates. The Department's authority to increase HIRSP premium rates and adjust total insurer assessments and the provider payment rate during a plan year is set out in s. 149.143 (3), Stats. The Department is authorized by s. 149.143 (4), Stats., to promulgate these rule changes by using emergency rulemaking procedures but without having to make a finding of emergency. Identical replacement permanent rules were sent to the Legislative Council for review on January 15, 1999, taken to public hearing on March 11, 1999, and submitted to the Legislature on April 27, 1999, for review by standing committees, but cannot be filed until mid-June 1999 for an August 1, 1999 effective date. Therefore, I request an extension of the effective period of the emergency rules by 60 days, through July 29, 1999.

(2) Neonatal Intensive Care Unit Training Grants. These emergency rules, HFS 114, were published on January 21, 1999, and will expire on June 20, 1999, unless extended. The order establishes criteria and procedures for awarding grants to hospitals with neonatal intensive care units to pay for specialized and on-site consultation and support of medical personnel of those units in the principles and practices of a training program called "developmentally supportive and family-centered care for high-risk infants and their families." Section 9122 (3ty) (c) of 1997 Wisconsin Act 237 directed the Department to promulgate rules for the grant program, and s. 9122 (3tz) of Act 237 authorized the Department to promulgate the rules by using emergency rulemaking procedures but without having to make a finding of emergency. Replacement permanent rules were sent to the Legislative Council for review on February 9, 1999, taken to

public hearing on April 7, 1999, and submitted to the Legislature on April 27, 1999, for review by standing committees, but cannot be filed until mid-June 1999 for an August 1, 1999 effective date. Therefore, I request an extension of the effective period of the emergency rules by 42 days, through July 31, 1999.

Copies of the emergency orders are attached to this letter. If you have any questions about the emergency rules relating to operation of HIRSP, you may contact Randy McElhose of the Department's Division of Health Care Financing at 267-7127. If you have any questions about the emergency rules relating to neonatal intensive care unit training grants, you may contact Laurie Tellier of the Department's Division of Public Health at 267-9662.

Sincerely,



Joe Leean
Secretary

Attachments

cc Representative Grothman

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

October 16, 2000

The Honorable Judy Robson, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Senator Robson:

Note: This request is a revision of a request the Department previously submitted on October 12, 2000. The Department has received a letter from Senator Moen dated October 12, 2000, requesting an extension of time to review CR 00-114 relating to the Health Insurance Risk-Sharing Plan. The Department previously requested a 3-day extension of the emergency rules. Given Senator Moen's request, the Department must delay filing its replacement permanent rules. Therefore, the Department requests a 60-day extension of the emergency rules.

The Department of Health and Family Services has an emergency rulemaking order in effect that will expire before the emergency rules are replaced by permanent rules unless the effective period of the emergency order is extended. Pursuant to s. 227.24 (2), Stats., I ask the Joint Committee to extend the effective periods of the emergency order by the number of days indicated below. The emergency rule is as follows:

Health Insurance Risk-Sharing Plan (HIRSP). The emergency rulemaking order amending ch. HFS 119 was published and effective on July 1, 2000. Section 149.143 (4), Stats., permits the Department to promulgate rules required under s. 149.143 (2) and (3), Stats., by using emergency rulemaking procedures, except that the Department is specifically exempted from the requirement under s. 227.24 (1) and (3), Stats., that it make a finding of emergency. The order amending ch. HFS 119, the Department's rules for administering the Health Insurance Risk-Sharing Plan, updated HIRSP premium rates in accordance with the authority and requirements set out in s. 149.143 (3) (a), Stats. The Department is required to set premium rates by rule. HIRSP premium rates must be calculated in accordance with generally accepted actuarial principles. Policyholders are to pay 60% of the costs of HIRSP.

The Department through this order also adjusted the total HIRSP insurer assessments and provider payment rates in accordance with the authority and requirements set out in s. 149.143 (2) (a) 3. and 4., 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 1999. 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 calendar year are to be applied to the next plan year budget beginning July 1, 2000. The total annual contribution to the HIRSP budget provided by an adjustment to the provider payment rates is $10,119,482. The total annual contribution to the

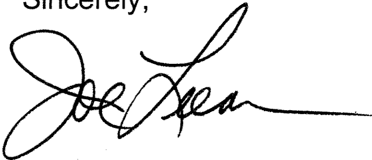
HIRSP budget provided by an assessment on insurers is $9,898,358. On April 26, 2000, the HIRSP Board of Governors approved the calendar year 1999 reconciliation process and the HIRSP budget for the plan year July 1, 2000 through June 30, 2001.

Replacement permanent rules were sent to the Legislative Council for review on July 13, 2000 and were the subject of a public hearing on August 29th of this year. The Department transmitted a Legislative Report to the Presiding Officers of the Senate and Assembly on September 12th.

Senator Moen has requested additional time to review the proposed permanent rules. Consequently, the Department cannot file the rules as it had planned for a December 1, 2000 effective date. Given that the emergency rules will expire after November 27, 2000, I therefore request an extension of the effective period of the emergency rules by **60 days**, through January 26, 2001. If the effective period of the emergency rules is not extended, the Department will not have the authority to assess the premiums specified in the emergency rules.

A copy of the emergency rulemaking order is attached to this letter. If you have any questions about the emergency rules relating to the health insurance risk-sharing program, you may contact Randy McElhose of the Department's Division of Health Care Financing at 267-7127.

Sincerely,



Joe Leean
Secretary

Attachments

cc Representative Grothman
Senator Risser
Representative Jensen

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

OCT 12 2000

October 12, 2000

The Honorable Judy Robson, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 South, State Capitol
P.O. Box 7882
Madison, Wisconsin 53707-7882

Dear Senator Robson:

The Department of Health and Family Services has an emergency rulemaking order in effect that will expire before the emergency rules are replaced by permanent rules unless the effective period of the emergency order is extended. Pursuant to s. 227.24 (2), Stats., I ask the Joint Committee to extend the effective periods of the emergency order by the number of days indicated below. The emergency rule is as follows:

Health Insurance Risk-Sharing Plan (HIRSP). The emergency rulemaking order amending ch. HFS 119 was published and effective on July 1, 2000. Section 149.143 (4), Stats., permits the Department to promulgate rules required under s. 149.143 (2) and (3), Stats., by using emergency rulemaking procedures, except that the Department is specifically exempted from the requirement under s. 227.24 (1) and (3), Stats., that it make a finding of emergency. The order amending ch. HFS 119, the Department's rules for administering the Health Insurance Risk-Sharing Plan, updated HIRSP premium rates in accordance with the authority and requirements set out in s. 149.143 (3) (a), Stats. The Department is required to set premium rates by rule. HIRSP premium rates must be calculated in accordance with generally accepted actuarial principles. Policyholders are to pay 60% of the costs of HIRSP.

The Department through this order also adjusted the total HIRSP insurer assessments and provider payment rates in accordance with the authority and requirements set out in s. 149.143 (2) (a) 3. and 4., 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 1999. 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 calendar year are to be applied to the next plan year budget beginning July 1, 2000. The total annual contribution to the HIRSP budget provided by an adjustment to the provider payment rates is $10,119,482. The total annual contribution to the HIRSP budget provided by an assessment on insurers is $9,898,358. On April 26, 2000, the HIRSP Board of Governors approved the calendar year 1999 reconciliation process and the HIRSP budget for the plan year July 1, 2000 through June 30, 2001.

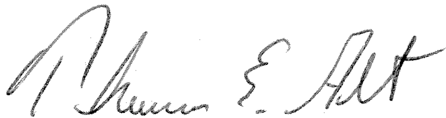
Replacement permanent rules were sent to the Legislative Council for review on July 13, 2000 and were the subject of a public hearing on August 29th of this year. The Department transmitted a Legislative Report to the Presiding Officers of the Senate and Assembly on September 12th.

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone (608) 266-9622 • www.dhfs.state.wi.us

Standing committees have not held any hearings on the proposed permanent rules. Consequently, the Department plans to file the rules on October 12, 2000 for a December 1, 2000 effective date. Given that the emergency rules will expire after November 27, 2000, I therefore request an extension of the effective period of the emergency rules by **3 days**, through November 30, 2000. If the effective period of the emergency rules is not extended, in the interim 3 day period, the Department will not have the authority to assess the premiums specified in the emergency rules.

A copy of the emergency rulemaking order is attached to this letter. If you have any questions about the emergency rules relating to the health insurance risk-sharing program, you may contact Randy McElhose of the Department's Division of Health Care Financing at 267-7127.

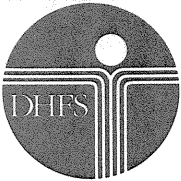
Sincerely,



for Joe Leean
Secretary

Attachments

cc Representative Grothman
Senator Risser
Representative Jensen



State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

January 4, 1999

The Honorable Judy Robson, Co-Chairperson
Joint Committee for Review of Administrative Rules
Room 15 South, State Capitol
Madison, Wisconsin

Dear Senator Robson:

The Department of Health and Family Services has two emergency rulemaking orders in effect that will expire before permanent rules replace the emergency rules unless the effective periods of the emergency rules are extended. Pursuant to s. 227.24(2), Stats., I ask the Joint Committee to extend the effective periods of these emergency rules by the number of days indicated below. The emergency rules are as follows:

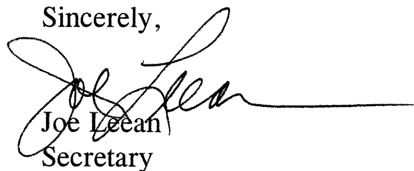
(1) **Operation of the Health Insurance Risk-Sharing Plan (HIRSP).** These emergency rules, HFS 119, will expire on January 27, 1999, before they are replaced by permanent rules unless the effective period of the emergency rules is extended. Responsibility for administration of HIRSP was transferred from the Office of Commissioner of Insurance to the Department in January 1998 by 1997 Wisconsin Act 27. Section 9123(4) of Act 27 permitted the Department to promulgate any rules that the HIRSP program statutes, as renumbered and amended by Act 27, authorized it or required it to promulgate, by using emergency rulemaking procedures but without having to make a finding of emergency. The Department repealed and recreated the rules for HIRSP in July 1998 to make necessary changes in the rules. The Joint Committee on November 11, 1998, extended the effective period of the emergency rules by 60 days. The replacement permanent rules were filed on December 10, 1998, and will take effect on February 1, 1999. I therefore ask that the effective period of the emergency rules be further extended by 5 days, through January 31, 1999.

(2) **Certification of Persons to Remove Lead-Based Paint or Otherwise Reduce Lead-Based Paint Hazards.** These emergency rules, amendments to HFS 163, were published on August 29, 1998, and will expire on January 27, 1999, unless extended. The rulemaking order made the Department's rules consistent with federal regulations published in August 1996, which was a condition for U.S. Environmental Protection Agency (EPA) approval of the Department's lead (Pb) training and certification program. EPA approval of the Department's program had to be obtained by August 30, 1998, or else EPA would have taken over the certification and training course accreditation activities with consequent uncertain enforcement and likely loss of related federal funding. Replacement permanent rules were sent to the Legislative Council for review on October 19, 1998, and were taken to public hearings in late November and early December 1998. They will be sent to the Legislature in January 1999 for review by standing committees which means that they will not likely be take effect until May 1, 1999. Therefore, I request an extension of the effective period of the emergency rules by 60 days, through March 27, 1999. If the emergency rules are not extended, the Department in the interim will be out of compliance with federal requirements for a state-operated lead (Pb) certification and training course accreditation program which could jeopardize continuation of the Department's program and mean less protection for residents of buildings in which lead-based paint activities are performed, an inadequate number of qualified lead (Pb) professionals to make inspections or

risk assessments under real estate disclosure regulations and loss of federal funding to local public health agencies for lead hazard reduction and lead poisoning prevention activities.

Copies of the emergency rule orders are attached to this letter. If you have any questions about the rules relating to operation of HIRSP, you may contact Kathy Rogers of the Department's Division of Health Care Financing at 264-7733, and if you have any questions about the rules relating to certification for removal of lead-based paint or other reduction of lead-based paint hazards, you may contact Gail Boushon of the Department's Division of Public Health at 267-2289.

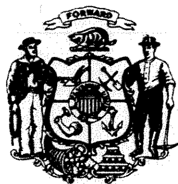
Sincerely,



Joe Leean
Secretary

Attachments

cc Representative Grothman



Judith B. Robson
Wisconsin State Senator

DATE: October 20, 1999

TO: Co-Chair Glenn Grothman
Members, JCRAR
Ron Sklansky, Legislative Council

FROM: Co-Chair Judy Robson

RE: Health Insurance Risk Sharing Plan (HIRSP)

On May 27, our committee did not approve extension of the HIRSP emergency rule relating to increasing premiums for Plan 2 non-subsidized policyholders. At that time we objected to the basis the department used for establishing the Plan 2 premiums.

Since that date, I have corresponded with DHFS Secretary Leean to resolve the discrepancy between the statutory requirements for establishing the Plan 2 premiums and the method used by DHFS.

I am pleased to report Secretary Leean has concurred with our position and has instructed the HIRSP actuary to construct a "standard rate" based on Medicare supplement policies that are offered in the state.

Attached, for your information, are copies of the letters related to this matter.

15 South, State Capitol, Post Office Box 7882, Madison, WI 53707-7882 • Telephone (608) 266-2253
District Address: 2411 East Ridge Road, Beloit, WI 53511
Toll-free 1-800-334-1468 • E-Mail: sen.robson@legis.state.wi.us
Printed on recycled paper.

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

October 15, 1999

The Honorable Judy Robson
Wisconsin State Senate
P. O. Box 7882
Madison, WI 53707-7882

Dear Senator Robson:

I am writing to provide you with an update regarding premiums for Plan 2 of the Health Insurance Risk Sharing Plan (HIRSP).

We have received the actuary's resource estimate I referenced in my last letter to you regarding this issue. We have instructed the HIRSP actuary to proceed with the analysis to construct a "standard rate" which could serve as the basis upon which HIRSP Plan 2 premiums are set.

At this time, we anticipate the actuary will complete this project within the next two months.

I will provide you with more information as soon as it is available.

Sincerely,

Joe Leean
Secretary

1 West Wilson Street • Post Office Box 7850 • Madison, WI 53707-7850 • Telephone (608) 266-9622

State of Wisconsin
Department of Health and Family Services

Tommy G. Thompson, Governor
Joe Leean, Secretary

August 19, 1999

The Honorable Judy Robson
Wisconsin State Senate
P.O. Box 7882
Madison, WI 53707-7882

Dear Senator Robson:

Thank you for your follow-up letter regarding Plan 2 premiums for the Health Insurance Risk Sharing Plan (HIRSP). I appreciate your commitment to keeping HIRSP premiums as low as possible.

Your letter raises some very appropriate questions concerning how Plan 2 premiums are established. Specifically, you question whether or not it would be possible to use "actuarial judgments" to achieve a standard plan for HIRSP Plan 2. This would allow Plan 2 premiums to be set in reference to a standard plan in a manner consistent with how Plan 1 premiums are set.

As you requested, I have enclosed a list of Medicare supplement policies. You also asked for an analysis of how these plans compare to HIRSP Plan 2. I have forwarded the list of Medicare supplement policies to our actuary to obtain an estimated cost and timeframe to complete this analysis. I will provide you with more information as soon as it is available.

As you know, State law requires that policyholder premiums fund 60 percent of HIRSP costs. Therefore, I would like to review the issue of Plan 2 premiums with the HIRSP Board as a part of our budget discussion as we review the overall HIRSP budget and evaluate the need to adjust policyholder premiums, provider payment rates, and insurer assessments. This will provide Board members with an opportunity to review the actuarial analysis of Plan 2 premiums and work with me to establish a HIRSP budget that meets all of the relevant statutory provisions.

I will contact you as soon as we receive information from the actuary. Please let me know if you have further questions at this time.

Sincerely,

Joe Leean
Secretary

Enclosure

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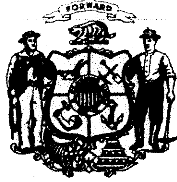


Judith B. Robson
Wisconsin State Senator

July 16, 1999

Secretary Joe Leean
Department of Health & Family Services
Room 650, 1 West Wilson Street
INTER-D

Dear Secretary Leean:

Thank you for your response to my questions relating to HIRSP. The information was helpful to better understand your position.

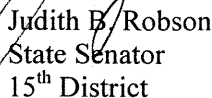
You said Plan 2 premiums are not set at the standard risk rate because the HIRSP actuary has determined "Plan 2 does not have a counterpart in the standard risk private market." The actuarial report does not include a comparison of the benefits offered by Medicare Supplement Insurance Policies and HIRSP.

I would appreciate a listing of the private market Medicare Supplement policies that are approved in Wisconsin, the benefits offered, including the optional benefits, the cost, and how these benefits compare to those offered by HIRSP. Also, please explain why none of the Medicare Supplement policies meet the statutory standard to provide "substantially the same coverage and deductibles."

The Methodology section of the actuarial report indicates that "actuarial judgments" are made to adjust the premium rates obtained from market-share leading carriers. The rates are adjusted "for plan design differences between their policy and those offered under HIRSP." Is it possible to use "actuarial judgments" to achieve a comparable in the private market for Plan 2?

I look forward to your response.

Sincerely,



Judith B. Robson
State Senator
15th District

JBR:kas

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