LCRC FORM 2

WISCONSIN LEGISLATIVE COUNCIL
RULES CLEARINGHOUSE

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CLEARINGHOUSE REPORT TO AGENCY

[THIS REPORT HAS BEEN PREPARED PURSUANT TO S. 227.15, STATS. THIS IS A REPORT ON A RULE AS ORIGINALLY PROPOSED BY THE AGENCY; THE REPORT MAY NOT REFLECT THE FINAL CONTENT OF THE RULE IN FINAL DRAFT FORM AS IT WILL BE SUBMITTED TO THE LEGISLATURE. THIS REPORT CONSTITUTES A REVIEW OF, BUT NOT APPROVAL OR DISAPPROVAL OF, THE SUBSTANTIVE CONTENT AND TECHNICAL ACCURACY OF THE RULE.]

CLEARINGHOUSE RULE **02-083**

AN ORDER to amend HFS 119.07 (6) (b) (intro.) and tables, (c) 1. (intro.) and tables and 2. (intro.) and tables, and (d) (intro.) and tables and 119.15 (2) and (3), relating to operation of the health insurance risk-sharing plan (HIRSP).

Submitted by **DEPARTMENT OF HEALTH AND FAMILY SERVICES**

06-11-2002 RECEIVED BY LEGISLATIVE COUNCIL.

07-03-2002 REPORT SENT TO AGENCY.

RS:JLK

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LEGISLATIVE COUNCIL RULES CLEARINGHOUSE REPORT

This rule has been reviewed by the Rules Clearinghouse. Based on that review, comments are reported as noted below:

1. STATUTORY AUTHORITY [s. 227.15 (2) (a)]

   Comment Attached YES ☑ NO ☐

2. FORM, STYLE AND PLACEMENT IN ADMINISTRATIVE CODE [s. 227.15 (2) (c)]

   Comment Attached YES ☑ NO ☐

3. CONFLICT WITH OR DUPLICATION OF EXISTING RULES [s. 227.15 (2) (d)]

   Comment Attached YES ☐ NO ☑

4. ADEQUACY OF REFERENCES TO RELATED STATUTES, RULES AND FORMS [s. 227.15 (2) (e)]

   Comment Attached YES ☑ NO ☐

5. CLARITY, GRAMMAR, PUNCTUATION AND USE OF PLAIN LANGUAGE [s. 227.15 (2) (f)]

   Comment Attached YES ☑ NO ☐

6. POTENTIAL CONFLICTS WITH, AND COMPARABILITY TO, RELATED FEDERAL REGULATIONS [s. 227.15 (2) (g)]

   Comment Attached YES ☐ NO ☑

7. COMPLIANCE WITH PERMIT ACTION DEADLINE REQUIREMENTS [s. 227.15 (2) (h)]

   Comment Attached YES ☐ NO ☑

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CLEARINGHOUSE RULE 02-083

Comments

[NOTE: All citations to "Manual" in the comments below are to the Administrative Rules Procedures Manual, prepared by the Revisor of Statutes Bureau and the Legislative Council Staff, dated September 1998.]

1. Statutory Authority

When discussing the premiums for the major medical plan (Plan 1) for both Option A ($1,000 deductible) and Option B ($2,500 deductible), the last sentence of the second paragraph of the analysis indicates that health insurance risk-sharing plan (HIRSP) premiums must fund 60% of plan costs and cannot be less than 150% of the amount an individual would be charged for a comparable policy in the private market. This statement is true for Plan 1, Option A according to s. 149.143 (1) (b) 1. c. and (2) (a) 2., Stats., although it would be useful to further indicate that the premium may not be more than 200% of that amount.

However, for Plan 1, Option B, the premium is established under s. 149.146 (2) (b), Stats., which indicates that the rates for coverage under the $2,500 choice of coverage plan must be set such that they differ from the rates of coverage under Plan 1, Option A by the same percentage as the percentage difference between the following: (1) the rate that a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under s. 149.14 (2) (a) and (5) (a), Stats.; and (2) the rate that a standard risk would be charged under an individual policy providing substantially the coverage and deductibles as the coverage offered under Plan 1, Option B. This is not explained in the analysis. Were the premiums for Plan 1, Option B determined on the basis set forth in s. 149.146 (2) (b), Stats.?

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2. Form, Style and Placement in Administrative Code

a. The analysis should include a statutes interpreted section, as well as a statutory authority section. [s. 1.02 (2) (a), Manual.]

b. SECTIONS 1, 2, 3, and 4 amend s. HFS 119.07 (6) (b) to (d). Because they are affected by the same treatment and are consecutively numbered, s. HFS 119.07 (6) (b) to (d) could be included in a single SECTION. [s. 1.04 (2) (a) 1., Manual.] Even if this is not done, the treatment clauses should be simplified because the tables are part of each paragraph. For example, SECTION 1 should indicate that "HFS 119.07 (6) (b) is amended to read:".

c. In s. HFS 119.07 (6) (b), "(intro.)" should be deleted. A similar comment applies to SECTIONS 2, 3, and 4.

d. In SECTIONS 2 and 3, the title to par. (c) in s. HFS 119.07 (6) (c) should not be shown. [s. 1.05 (3) (c), Manual.]

e. In s. HFS 119.07 (6) (d), the reference to "family with two or more" should be changed to "family with ~~two~~ 2 or more." [s. 1.01 (5), Manual.]

f. In s. HFS 119.15 (3), the two references to "Health Insurance Risk-Sharing Plan" should be changed to "HIRSP" which is a defined term in s. HFS 119.04 (7).

4. Adequacy of References to Related Statutes, Rules and Forms

The statutory authority section refers only to ss. 149.143 (2) (a) 2., 3., and 4., and (3) and 227.11 (2), Stats. However, other statutes provide authority for the promulgation of this rule, and consideration should be given to adding ss. 149.14 (8) (a), 149.142, 149.16 (2) (b), and 149.17 (4), Stats.

5. Clarity, Grammar, Punctuation and Use of Plain Language

a. In the statutory authority section of the transmittal and the first paragraph of the order, commas should be inserted in the subdivision of paragraphs in s. 149.143 (2) (a) 2., 3., and 4., Stats.

b. Section HFS 119.15 (3) indicates that HIRSP provider payment rates may not exceed "allowed charges" and, in the case of hospital outpatient services, indicates that payment rates are set at 59.93% of "allowed charges." "Allowed charges" is not a defined term in ch. HFS 119 or ch. HFS 149, Stats. Because the term is not defined, its meaning is unclear. Was the intent to refer to allowable charges under the Medicaid program as discussed in s. 149.142 (1) (a), Stats., or rates adjusted for the HIRSP program under ss. 149.143 and 149.144, Stats., as allowed under s. 149.142 (2), Stats.? This should be clarified.

c. Section HFS 119.15 (3) refers to "diagnosis related groups (DRGs)" and later refers to "DRG weights." First, it appears that the reference should have been to "diagnostically related groups" as that is the term used in s. HFS 149.142 (1) (a), Stats. Second, if an acronym is

used, it must be defined in the definitions section. [s. 1.01 (8), Manual.] As an alternative to using the acronym, the term could be repeated.

d. In the last sentence of s. HFS 119.15 (3), the phrase "including physicians, labs and therapies" should be set off by commas. Also, all of the occurrences of the word "per" should be replaced by the word "under."

DEPARTMENT OF HEALTH & FAMILY SERVICES
Office of Legal Counsel
OPB-140 (9/89)

STATE OF WISCONSIN

TRANSMITTAL TO LEGISLATIVE COUNCIL RULES CLEARINGHOUSE

PROPOSED RULES OF THE DEPARTMENT OF HEALTH AND FAMILY SERVICE

HFS 119, Wis. Adm. Code

Subject: **To amend HFS 119.07 (6) (b) (intro.) and tables, and (c) 1. (intro.) and tables, and (c) 2. (intro.) and tables, and (d) (intro.) and tables, and 119.15 (2) and (3) relating to operation of the health insurance risk-sharing plan (HIRSP).**

Statutory Authority: Sections 149.143 (2) (a) 2. 3. and 4., and (3) and 227.11 (2), Stats.

Analysis: Reason for Rules, Intended Effects, Requirements

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-eight percent of the 13,645 HIRSP policies in effect in March 2002, 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 25.4%. This produces policyholder premiums that are equivalent to 150% of the industry standard, the minimum allowed by statute. Rate increases for specific policyholders range from 19.2% to 27.8%, depending on a policyholder's age, gender, household income, deductible and zone of residence within Wisconsin. These rate increases reflect general and industry-wide premium increases and take into account the increase in costs associated with Plan 1 claims. For example, recent annual industry standard premium rates have increased by approximately 35%. HIRSP costs have risen by a smaller amount, hence the smaller rate increases for HIRSP, relative to the industry standard. According to state law, HIRSP premiums must fund 60% of plan costs and cannot be less than 150% of the amount an individual would be charged for a comparable policy in the private market.

A second type of medical coverage provided by HIRSP is for persons eligible for Medicare. This type of coverage is called Plan 2. Plan 2 has a $500 deductible. Twelve percent of the 13,645 HIRSP policies in effect in March 2002, were of the Plan 2 type. The rate increases for Plan 2 contained in this rulemaking order increase an average of 30.8%. Rate increases for specific policyholders range from 23.3% to 33.5%, depending on a policyholder's age, gender, household income and zone of residence within Wisconsin. These rate increases reflect general and industry-wide cost increases and adjust premiums to a level in accordance with the authority and requirements set out in s. 149.14(5m), Stats.

The Department through this rulemaking order proposes to amend ch. HFS 119 in order to update HIRSP premium rates in accordance with the authority and requirements set out in s. 149.143(2) (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.

The Department through this rulemaking order is also increasing total HIRSP insurer assessments and reducing 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 2001. 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.

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

To amend HFS 119.07 (6) (b) (intro.) and tables, and (c) 1. (intro.) and tables, and (c) 2. (intro.) and tables, and (d) (intro.) and tables, and 119.15 (2) and (3) relating to operation of the health insurance risk-sharing plan (HIRSP).

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-eight percent of the 13,645 HIRSP policies in effect in March 2002, 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 25.4%. This produces policyholder premiums that are equivalent to 150% of the industry standard, the minimum allowed by statute. Rate increases for specific policyholders range from 19.2% to 27.8%, depending on a policyholder's age, gender, household income, deductible and zone of residence within Wisconsin. These rate increases reflect general and industry-wide premium increases and take into account the increase in costs associated with Plan 1 claims. For example, recent annual industry standard premium rates have increased by approximately 35%. HIRSP costs have risen by a smaller amount, hence the smaller rate increases for HIRSP, relative to the industry standard. According to state law, HIRSP premiums must fund 60% of plan costs and cannot be less than 150% of the amount an individual would be charged for a comparable policy in the private market.

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The Department through this rulemaking order proposes to amend ch. HFS 119 in order to update HIRSP premium rates in accordance with the authority and requirements set out in s. 149.143(2) (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.

The Department through this rulemaking order is also increasing total HIRSP insurer assessments and reducing 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 2001. 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, 2002. The total annual contribution to the HIRSP budget provided by an adjustment to the provider payment rates is $24,750,178. The total annual contribution to the HIRSP budget provided by an assessment on insurers is $26,003,305. On April 17, 2002, the HIRSP Board of Governors approved the calendar year 2001 reconciliation process. The Board also approved the HIRSP budget for the plan year July 1, 2002 through June 30, 2003.

These proposed rules are identical to emergency rules issued by the Department that became effective July 1, 2002.

ORDER

Pursuant to authority vested in the Department of Health and Family Services by ss. 149.143 (2) (a) 2. 3. and 4., and (3), 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, 2001~~July 1, 2002, 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	~~$1,716~~2,088	~~$1,536~~1,872	~~$1,368~~1,680
19-24	~~1,716~~2,088	~~1,536~~1,872	~~1,368~~1,680
25-29	~~1,764~~2,184	~~1,584~~1,968	~~1,404~~1,752
30-34	~~1,968~~2,472	~~1,788~~2,220	~~1,584~~1,980
35-39	~~2,292~~2,868	~~2,076~~2,580	~~1,836~~2,292
40-44	~~2,736~~3,408	~~2,448~~3,060	~~2,184~~2,724
45-49	~~3,492~~4,308	~~3,132~~3,876	~~2,796~~3,444
50-54	~~4,644~~5,712	~~4,176~~5,136	~~3,732~~4,572
55-59	~~6,048~~7,560	~~5,436~~6,804	~~4,848~~6,048
60+	~~7,548~~9,612	~~6,792~~8,664	~~6,036~~7,692

MAJOR MEDICAL PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,716~~2,088	~~$1,536~~1,872	~~$1,368~~1,680
19-24	~~2,232~~2,688	~~2,016~~2,412	~~1,788~~2,148
25-29	~~2,448~~2,952	~~2,196~~2,664	~~1,944~~2,364
30-34	~~2,688~~3,276	~~2,412~~2,940	~~2,148~~2,616
35-39	~~3,060~~3,744	~~2,760~~3,384	~~2,448~~3,012
40-44	~~3,456~~4,236	~~3,120~~3,804	~~2,760~~3,384
45-49	~~3,984~~4,932	~~3,588~~4,452	~~3,192~~3,948
50-54	~~4,680~~5,856	~~4,212~~5,280	~~3,744~~4,680
55-59	~~5,424~~6,864	~~4,884~~6,180	~~4,344~~5,496
60+	~~6,360~~8,016	~~5,724~~7,224	~~5,076~~6,408

MEDICARE PLAN – Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,212~~1,536	~~$1,080~~1,368	~~$960~~1,224
19-24	~~1,212~~1,536	~~1,080~~1,368	~~960~~1,224
25-29	~~1,248~~1,608	~~1,116~~1,440	~~996~~1,284
30-34	~~1,368~~1,800	~~1,248~~1,620	~~1,116~~1,440
35-39	~~1,608~~2,088	~~1,464~~1,896	~~1,296~~1,680
40-44	~~1,932~~2,484	~~1,716~~2,232	~~1,536~~1,980
45-49	~~2,448~~3,156	~~2,196~~2,832	~~1,968~~2,520
50-54	~~3,264~~4,176	~~2,940~~3,744	~~2,616~~3,348
55-59	~~4,248~~5,532	~~3,816~~4,992	~~3,408~~4,428
60+	~~5,292~~7,044	~~4,752~~6,336	~~4,236~~5,616

MEDICARE PLAN – Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,212~~1,536	~~$1,080~~1,368	~~$960~~1,224
19-24	~~1,572~~1,968	~~1,428~~1,764	~~1,248~~1,572
25-29	~~1,716~~2,160	~~1,548~~1,944	~~1,368~~1,728
30-34	~~1,872~~2,400	~~1,692~~2,148	~~1,500~~1,908
35-39	~~2,148~~2,736	~~1,932~~2,484	~~1,716~~2,196
40-44	~~2,436~~3,096	~~2,184~~2,772	~~1,932~~2,484
45-49	~~2,796~~3,600	~~2,520~~3,264	~~2,232~~2,880
50-54	~~3,276~~4,284	~~2,952~~3,852	~~2,628~~3,420
55-59	~~3,804~~5,028	~~3,420~~4,524	~~3,048~~4,020
60+	~~4,464~~5,868	~~4,020~~5,280	~~3,564~~4,680

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, 2001~~July 1, 2002:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,140~~1,392	~~$1,020~~1,248	~~$912~~1,116
19-24	~~1,140~~1,392	~~1,020~~1,248	~~912~~1,116
25-29	~~1,176~~1,452	~~1,056~~1,308	~~936~~1,164
30-34	~~1,308~~1,644	~~1,188~~1,476	~~1,056~~1,320
35-39	~~1,524~~1,908	~~1,380~~1,716	~~1,224~~1,524
40-44	~~1,824~~2,268	~~1,632~~2,040	~~1,452~~1,812
45-49	~~2,328~~2,868	~~2,088~~2,580	~~1,860~~2,292
50-54	~~3,096~~3,804	~~2,784~~3,420	~~2,484~~3,048
55-59	~~4,032~~5,040	~~3,624~~4,536	~~3,228~~4,032
60+	~~5,028~~6,408	~~4,524~~5,772	~~4,020~~5,124

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,140~~1,392	~~$1,020~~1,248	~~$912~~1,116
19-24	~~1,488~~1,788	~~1,344~~1,608	~~1,188~~1,428
25-29	~~1,632~~1,968	~~1,464~~1,776	~~1,296~~1,572
30-34	~~1,788~~2,184	~~1,608~~1,956	~~1,428~~1,740
35-39	~~2,040~~2,496	~~1,836~~2,256	~~1,632~~2,004
40-44	~~2,304~~2,820	~~2,076~~2,532	~~1,836~~2,256
45-49	~~2,652~~3,288	~~2,388~~2,964	~~2,124~~2,628
50-54	~~3,120~~3,900	~~2,808~~3,516	~~2,496~~3,120
55-59	~~3,612~~4,572	~~3,252~~4,116	~~2,892~~3,660
60+	~~4,236~~5,340	~~3,816~~4,812	~~3,384~~4,272

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, 2001~~July 1, 2002:

MEDICARE PLAN – Males
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$804~~1,020	~~$720~~912	~~$636~~816
19-24	~~804~~1,020	~~720~~912	~~636~~816
25-29	~~828~~1,068	~~744~~960	~~660~~852
30-34	~~912~~1,200	~~828~~1,080	~~744~~960
35-39	~~1,068~~1,392	~~972~~1,260	~~864~~1,116
40-44	~~1,284~~1,656	~~1,140~~1,488	~~1,020~~1,320
45-49	~~1,632~~2,100	~~1,464~~1,884	~~1,308~~1,680
50-54	~~2,172~~2,784	~~1,956~~2,496	~~1,740~~2,232
55-59	~~2,832~~3,684	~~2,544~~3,324	~~2,268~~2,952
60+	~~3,528~~4,692	~~3,168~~4,224	~~2,820~~3,744

MEDICARE PLAN – Females
(Base for Reduced Rates)

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$804~~1,020	~~$720~~912	~~$636~~816
19-24	~~1,044~~1,308	~~948~~1,176	~~828~~1,044
25-29	~~1,140~~1,440	~~1,032~~1,296	~~912~~1,152
30-34	~~1,248~~1,596	~~1,128~~1,428	~~996~~1,272
35-39	~~1,428~~1,824	~~1,284~~1,656	~~1,140~~1,464
40-44	~~1,620~~2,064	~~1,452~~1,848	~~1,284~~1,656
45-49	~~1,860~~2,400	~~1,680~~2,172	~~1,488~~1,920
50-54	~~2,184~~2,856	~~1,968~~2,568	~~1,752~~2,280
55-59	~~2,532~~3,348	~~2,280~~3,012	~~2,028~~2,676
60+	~~2,976~~3,912	~~2,676~~3,516	~~2,376~~3,120

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, 2001~~July 1, 2002:

ALTERNATIVE MAJOR MEDICAL PLAN Males

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,236~~1,500	~~$1,104~~1,344	~~$984~~1,212
19-24	~~1,236~~1,500	~~1,104~~1,344	~~984~~1,212
25-29	~~1,272~~1,572	~~1,140~~1,416	~~1,008~~1,260
30-34	~~1,416~~1,776	~~1,284~~1,596	~~1,140~~1,428
35-39	~~1,656~~2,064	~~1,500~~1,860	~~1,320~~1,656
40-44	~~1,968~~2,448	~~1,764~~2,208	~~1,572~~1,956
45-49	~~2,520~~3,096	~~2,256~~2,796	~~2,016~~2,484
50-54	~~3,348~~4,116	~~3,012~~3,696	~~2,688~~3,288
55-59	~~4,356~~5,448	~~3,912~~4,896	~~3,492~~4,356
60+	~~5,436~~6,924	~~4,896~~6,240	~~4,344~~5,544

ALTERNATIVE MAJOR MEDICAL PLAN Females

Age Group	Zone 1	Zone 2	Zone 3
0-18	~~$1,236~~1,500	~~$1,104~~1,344	~~$984~~1,212
19-24	~~1,608~~1,932	~~1,452~~1,740	~~1,284~~1,548
25-29	~~1,764~~2,124	~~1,584~~1,920	~~1,404~~1,704
30-34	~~1,932~~2,364	~~1,740~~2,112	~~1,548~~1,884
35-39	~~2,208~~2,700	~~1,992~~2,436	~~1,764~~2,172
40-44	~~2,484~~3,048	~~2,244~~2,736	~~1,992~~2,436
45-49	~~2,868~~3,552	~~2,580~~3,204	~~2,304~~2,844
50-54	~~3,372~~4,212	~~3,036~~3,804	~~2,700~~3,372
55-59	~~3,900~~4,944	~~3,516~~4,452	~~3,132~~3,960
60+	~~4,584~~5,772	~~4,116~~5,196	~~3,660~~4,608

SECTION 5. HFS 119.15 (2) and (3) are amended to read:

(2) INSURER ASSESSMENTS. The insurer assessments for the time period ~~July 1, 2001 through June 30, 2002 total $19,617,772.~~ July 1, 2002 through June 30, 2003 total $26,003,305.

(3) PROVIDER PAYMENT RATES. The total adjustment to the provider payment rates for the time period ~~July 1, 2001 through June 30, 2002 is $19,982,024.~~ July 1, 2002 through June 30, 2003 is $24,750,178. Health Insurance Risk-Sharing Plan provider payment rates may not exceed allowed charges. Payment rates for prescription drugs are set per s.

49.46(2)(b)6.h., Stats. Payment rates for hospital inpatient services utilize hospital-specific inpatient rates established per s. 49.46(2)(b)6.e., Stats., Medicaid diagnosis related groups (DRGs),and Health Insurance Risk-Sharing Plan specific DRG weights. Payment rates for hospital outpatient services are set at 59.93% of allowed charges. Payment rates for other professional services including physicians, labs and therapies are set per s. 49.46(2)(b), Stats., including a 37.2% enhancement per s. 149.142(1)(a), Stats.

The rules contained in this order shall take effect on the first day of the month following publication in the Wisconsin Administrative Register, as provided in s. 227.22(2), Stats.

Wisconsin Department of Health and Family Services

Dated:

By: _____
Phyllis Dubé
Secretary

SEAL: