

1979 Senate Bill 400

Date published: May 17, 1980

**CHAPTER 313, Laws of 1979**  
(Vetoed in Part)

AN ACT to renumber 628.34 (3); to amend 613.03 (3); and to create 20.145 (7), 70.10 (6m), 70.11 (44) (c) 8 and (45), subchapter I (title) and subchapter II of chapter 619, 628.34 (3) (b) and 632.785 of the statutes, relating to a mandatory health insurance risk sharing plan, prohibiting discrimination in insurance coverage because of mental or physical disability, requiring employers who provide health insurance on a self-insurance basis to so indicate on income tax returns, requiring the department of revenue to compile and report that information, granting rule-making authority and making an appropriation.

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

SECTION 1. At the appropriate place in the schedule under section 20.005 of the statutes, insert the following amounts for the purposes indicated:

	1979-80	1980-81
<b>20.145 Insurance, office of the commissioner of</b>		
(7) HEALTH INSURANCE RISK SHARING		
PLAN ADMINISTRATION		
(a) General program operations	GPR C -0-	63,000

SECTION 2. 20.145 (7) of the statutes is created to read:

20.145 (7) HEALTH INSURANCE RISK SHARING PLAN ADMINISTRATION. (a) General program operations. As a continuing appropriation, the amounts in the schedule for the administration of subch. II of ch. 619.

(g) *Administration and benefits*. All moneys received under subch. II of ch. 619 for the administration of and benefits payable under subch. II of ch. 619.

SECTION 3. 71.10 (6m) of the statutes is created to read:

71.10 (6m) A person who is required to file an income tax return under this chapter and who is a self-insurer for the purposes of subch. II of ch. 619 shall indicate on the return that the person is such a self-insurer.

SECTION 4. 71.11 (44) (c) 8 and (45) of the statutes are created to read:

71.11 (44) (c) 8. The office of the commissioner of insurance with respect to information compiled under sub. (45).

(45) SELF-INSURERS. The department shall compile and maintain a current list of names and addresses of persons who indicate they are self-insurers as required by s. 71.10 (6m). The list shall be furnished to the office of the commissioner of insurance on request.

SECTION 5. 613.03 (3) of the statutes, as affected by chapter 102, laws of 1979, is amended to read:

613.03 (3) APPLICABILITY OF INSURANCE LAWS. Except as otherwise specifically provided, service insurance corporations organized or operating under this chapter are subject to subch. II of ch. 619 and ss. 610.01, 610.11, 610.21, 610.23, 610.24 and 610.46 and chs. 600, 601, 617, 620, 623, 625, 627, 628, 631, 632, 636 and 645 and to no other insurance laws.

SECTION 6. Subchapter I (title) of chapter 619 of the statutes is created to read:

CHAPTER 619  
SUBCHAPTER I  
GENERAL PROVISIONS  
(to precede s. 619.01)

SECTION 7. Subchapter II of chapter 619 of the statutes is created to read:

CHAPTER 619  
SUBCHAPTER II

MANDATORY HEALTH INSURANCE RISK SHARING PLAN

**619.10 Definitions.** In this subchapter: (1) "Administering carrier" means the insurer designated under s. 619.16.

(2) "Board" means the board of governors established under s. 619.15.

(3) "Eligible person" means a resident of this state who qualifies under s. 619.12 whether or not the person is legally responsible for the payment of medical expenses incurred on the person's behalf.

(4) "Health insurance" means surgical, medical, hospital, major medical and other health service coverage provided on an expense-incurred basis. "Health insurance" does not include ancillary coverages such as income continuation, short-term, accident only, fixed indemnity policies, credit insurance, automobile medical payment coverage, coverage issued as a supplement to liability coverage, loss of time or accident benefits.

(5) "Insurer" means any person or association of persons, including a health maintenance organization, offering or insuring health services on a prepaid basis, including, but not limited to, policies of health insurance issued by a currently licensed insurer ~~under subch. VII of ch. 632~~, nonprofit hospital or medical service plans under ch. 613, cooperative medical service plans under s. 185.981, or other entity whose primary function is to provide diagnostic, therapeutic or preventive services to a defined population in return for a premium paid on a periodic basis. "Insurer" includes any person providing health services coverage for ~~50 or more~~ individuals on a self-insurance basis without the intervention of other entities, as well as any person providing health insurance coverage under a medical reimbursement plan to ~~50 or more~~ persons. "Insurer" does not include a plan under ch. 613 which offers only dental care.

Vetoed  
in Part

(6) "Medical assistance" means health care benefits provided under ss. 49.45 to 49.47.

(7) "Medicare" means coverage under both part A and part B of Title XVIII of the federal social security act, 42 USC 1395 et seq., as amended.

(8) "Plan" means the health care insurance plan established under this subchapter.

(9) "Resident" means a person who has been legally domiciled in this state for a period of at least 30 days. For purposes of this subchapter, legal domicile is established by living in this state and obtaining a Wisconsin motor vehicle operator's license, registering

to vote in Wisconsin or filing a Wisconsin income tax return. A child is legally domiciled in this state if the child lives in this state and if at least one of the child's parents or the child's guardian is legally domiciled in this state. A person with a developmental disability or another disability which prevents the person from obtaining a Wisconsin motor vehicle operator's license, registering to vote in Wisconsin, or filing a Wisconsin income tax return, is legally domiciled in this state by living in this state for 30 days.

**619.11 Establishment of plan.** The commissioner shall promulgate rules establishing a plan of health insurance coverage for an eligible person which satisfies the requirements of this chapter.

**619.12 Eligibility determination.** (1) Except as provided in sub. (2), the board or administering carrier shall certify as eligible any person upon receipt of any of the following based wholly or partially on medical underwriting considerations within 6 months prior to making application for coverage by the plan:

- (a) A notice of rejection or cancellation of coverage from 2 or more insurers.
- (b) A notice of reduction or limitation of coverage, including restrictive riders, from an insurer if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.
- (c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies then in effect.
- (d) A notice of premium for a policy not yet in effect from 2 or more insurers which exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage provided by the plan.

(2) (a) No person who is currently receiving medical assistance benefits is eligible for coverage under the plan.

(b) No person who is covered under the plan and voluntarily terminates the coverage under the plan, is again eligible for coverage unless 12 months have elapsed since the person's latest voluntary termination of coverage under the plan.

(c) No person on whose behalf the plan has paid out \$250,000 or more is eligible for coverage under the plan.

(d) No person who is 65 years of age or older is eligible for coverage under the plan.

**619.13 Participation of insurers.** (1) (a) Every insurer shall participate in the cost of administering the plan.

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

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

(c) If assessments and other receipts by the commissioner, board or administering carrier exceed actual losses and administrative expenses of the plan, the excess shall be held at interest and used by the board to offset future losses or to reduce plan premiums. In this paragraph, "future losses" includes reserves for incurred but not reported claims.

(d) 1. Each insurer's proportion of participation in the plan shall be determined annually by the commissioner based on annual statements and other reports filed by the insurer with the commissioner.

2. If the commissioner finds that the commissioner's authority to require insurers to report under chs. 600 to 649 is not adequate to permit the commissioner or the board to carry out the commissioner's or the board's responsibilities under this subchapter, the commissioner may promulgate rules requiring insurers to report the information necessary for the commissioner and the board to make the determinations required under this subchapter.

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

**Vetoed in Part** **619.14 Coverage.** (1) ~~COVERAGE OFFERED.~~ (a) The plan shall offer in an annually renewable ~~standard or group policy form~~ the coverage specified in this section for each eligible person. If an eligible person is also eligible for medicare coverage, the plan shall not pay or reimburse any person for expenses paid for by medicare.

**Vetoed in Part** (b) ~~If any individual whose coverage under an individual or group health insurance policy or any other plan providing coverage similar to that under a health insurance policy, including medical assistance, is terminated for any reason other than failure to pay any required contribution applies for coverage under the plan within 45 days after the termination and is subsequently found to be eligible under s. 619.12, the effective date of coverage for the eligible person under the plan shall be the date of termination of the previous coverage.~~

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

(b) The plan shall provide an alternative policy for those persons eligible for medicare which reduces the benefits payable under par. (a) by the amounts paid under medicare.

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

(a) Hospital services.

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

(c) Outpatient treatment for alcoholism, drug abuse and mental and nervous disorders as required under s. 632.89 for group disability policies providing outpatient treatment coverage.

(d) Drugs requiring a physician's prescription.

(e) Services of a licensed skilled nursing facility for eligible persons eligible for medicare, for not more than 120 days during a policy year, if the services are of the type which would qualify as reimbursable services under medicare.

(f) Services of a home health agency, as defined in s. 150.001 (8), if the services are of the type which would qualify as reimbursable services under medicare.

(g) Use of radium or other radioactive materials.

(h) Oxygen.

(i) Anesthetics.

(j) Prostheses other than dental.

(k) Rental or purchase, as appropriate, of durable medical equipment other than eyeglasses and hearing aids.

(L) Diagnostic X-rays and laboratory tests.

(m) Oral surgery for partially or completely unerupted, impacted teeth and oral surgery with respect to tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(n) Services of a physical therapist.

(o) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition.

(p) Services of a licensed skilled nursing facility to the extent required by s. 632.78 (4).

(q) Any other health insurance coverage required under subch. VI of ch. 632.

(r) Processing charges for blood including, but not limited to, the cost of collecting, testing, fractionating and distributing blood.

(4) EXCLUSIONS. Covered expenses shall not include the following:

(a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect.

(b) Care which is primarily for custodial or domiciliary purposes which do not qualify as eligible services under medicare.

(c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician. If the institution does not have semiprivate rooms, its most common semiprivate room charge shall be 90% of its lowest private room charge.

(d) That part of any charge for services or articles rendered or prescribed by a physician, dentist or other health care personnel which exceeds the prevailing charge in the locality where the service is provided or any charge not medically necessary.

(e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles.

(f) Any expense incurred prior to the effective date of coverage under the plan for the person on whose behalf the expense is incurred.

(g) Dental care except as provided in sub. (2) (m).

(h) Eyeglasses and hearing aids.

(i) Routine physical examinations, including routine examinations to determine the need for eyeglasses and hearing aids.

(j) Illness or injury due to acts of war.

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

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(L) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.

(5) PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) ~~X~~ The plan shall offer a \$1,000 annual deductible in combination with appropriate premiums determined under this subchapter for major medical expense coverage required under this section. For coverage offered to those persons eligible for medicare, the plan shall offer a deductible equal to the deductible charged by part A of title XVIII of the federal social security act, as amended.

Vetoed  
in Part

The schedule of premiums and deductibles shall be promulgated by rule by the commissioner. The rating plan shall be designed to be self-sufficient, except that for the first 3 years of its operation, the rating plan shall not provide for rates greater than 130 % of the average of rates which a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under this section.

Vetoed  
in Part

~~2. The calculation of the base rate for a standard risk under subd. 1 shall be based on the arithmetic mean of rates charged for an individual policy providing substantially the same coverage and deductibles as provided under this section by the 10 insurers which write the largest volume of health insurance in this state.~~

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

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

Vetoed  
in Part

(6) PREEXISTING CONDITIONS. (a) ~~Except as provided in pars. (b),~~ no person who obtains coverage under the plan may be covered for any preexisting condition during the first 30 days of coverage under the plan if the condition first manifested itself and the person was diagnosed or treated for that condition during the 6 months immediately preceding the filing of an application with the plan.

Vetoed  
in Part

~~(b) This subsection does not apply if the condition was covered under medical assistance or a previous health insurance policy and coverage under the plan is obtained under sub. (1) (b) from the previous policy.~~

(c) Any waiting period required under par. (a) shall be reduced by any waiting period applied to the preexisting condition under the health insurance policy or other health insurance coverage, including medical assistance, most recently applicable to the eligible person.

(7) COORDINATION OF BENEFITS. (a) Covered expenses under the plan shall not include any charge for care for injury or disease for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, for which benefits are payable under a worker's compensation or similar law, or for which benefits are payable under another policy of health care insurance, medicare or any other governmental program, except as otherwise provided by law.

(b) The board has a cause of action against an eligible participant for the recovery of the amount of benefits paid which are not for covered expenses under the plan. Benefits under the plan may be reduced or refused as a setoff against any amount recoverable under this paragraph.

(c) The board is subrogated to the rights of an eligible person to recover special damages for illness or injury to the person caused by the act of a 3rd person to the extent that benefits are provided under the plan.

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

(2) Annually, the board shall make a report to the members of the plan and to the standing committees on health and insurance in each house of the legislature summarizing the activities of the plan in the preceding calendar year. The annual report shall define the cost burden imposed by the plan on all policyholders in this state.

(3) The board shall:

(a) Establish procedures under which applicants and participants may have grievances reviewed by an impartial body and reported to the board.

(b) Select an administering carrier in accordance with s. 619.16.

(c) Collect assessments from all insurers to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board. Assessment of the insurers shall occur at the end of each calendar year or other fiscal year end established by the board. Assessments are due and payable within 30 days of receipt by the insurer of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements and procedures for enrollment, and to maintain public awareness of the plan.

(4) The board may:

(a) Prepare and distribute certificate of eligibility forms and enrollment instruction forms to insurance solicitors, agents and brokers, and to the general public in this state.

(b) Provide for reinsurance of risks incurred by the plan, and may enter into reinsurance agreements with insurers to establish a reinsurance plan for risks of coverage described in the plan, or obtain commercial reinsurance to reduce the risk of loss through the pool.

(c) In addition to assessments imposed under sub. (3) (c), levy interim assessments to ensure the financial ability of the plan to cover claims expense and administrative expenses incurred or estimated to be incurred in the operation of the plan prior to the end of the calendar year end or other fiscal year end established by the board. Interim assessments shall be due and payable within 30 days of receipt by an insurer of an interim assessment notice. Interim assessments shall be credited against each insurer's annual assessment.

(5) The commissioner may, by rule, establish additional powers and duties of the board.

(6) If any provision of this subchapter conflicts with s. 625.11 or 625.12, this subchapter prevails.

**619.16 Administering carrier.** (1) The board shall select an insurer through a competitive bidding process to administer the plan. The board shall evaluate bids submitted under this subsection based on criteria established by the board which shall include:

- (a) The insurer's proven ability to handle large group accident and health insurance.
- (b) The efficiency of the insurer's claim paying procedures.
- (c) An estimate of total charges for administering the plan.

(2) (a) The administering carrier shall serve for a period of 3 years.

(b) At least one year prior to the expiration of each 3-year period of service by an administering carrier, the board shall invite all insurers, including the current administering carrier, to submit bids to serve as the administering carrier for the succeeding 3-year period. Selection of the administering carrier for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

(3) (a) The administering carrier shall perform all eligibility and administrative claims payment functions relating to the plan.

(b) The administering carrier shall establish a premium billing procedure for collection of premiums from insured persons. Bills shall be made on a periodic basis as determined by the board.

(c) The administering carrier shall perform all necessary functions to assure timely payment of benefits to covered persons under the plan, including:

- 1. Making available information relating to the proper manner of submitting a claim for benefits under the plan and distributing forms upon which submissions shall be made.
- 2. Evaluating the eligibility of each claim for payment under the plan.
- 3. Notifying each claimant within 30 ~~working~~ days after receiving a properly completed and executed proof of loss whether the claim is accepted, rejected or compromised.

Vetoed  
in Part

(d) The administering carrier shall submit regular reports to the board regarding the operation of the plan. The frequency, content and form of the report shall be as determined by the board.

(e) The administering carrier shall pay claims expenses from the premium payments received from or on behalf of covered persons under the plan. If the administering carrier's payments for claims expenses exceed the portion of premiums allocated by the board for payment of claims expenses, the board shall provide to the carrier additional funds for payment of claims expenses.

(f) 1. The administering carrier shall be paid as provided in the board's contract with the carrier for its direct and indirect expenses incurred in the performance of its services from the plan premiums.

2. In this paragraph "direct and indirect expenses" shall include that portion of the carrier's audited administrative costs, printing, claims administration, management, building overhead expenses, and other actual operating and administrative expenses approved by the board as allocable to the administration of the plan and included in the bid specifications.

**619.17 Contents of plan.** The plan shall include, but is not limited to, the following:

(1) A rating plan calculated in accordance with generally accepted actuarial principles. The rating plan shall be designed to be self-sufficient, except during the first 3 years of its operation the rating plan shall not provide for rates greater than 130% of the average of rates which a standard risk would be charged under an individual policy providing substantially the same coverage and deductibles as provided under the plan. The calculation of the base rate for a standard risk under this paragraph shall be based on the arithmetic mean of rates charged for an individual policy providing substantially the same coverage and deductibles as provided under this section by the 10 insurers which write the largest volume of health insurance in this state.

Vetoed  
in Part



(2) A schedule of premiums, deductibles and coinsurance payments which complies with all requirements of this subchapter.

(3) Procedures for applicants and participants to have grievances reviewed by an impartial body.

**619.18 Insurance code applicable.** Except as otherwise provided in this subchapter, the plan shall comply and be administered in compliance with chs. 600 to 645.

SECTION 8. 628.34 (3) of the statutes is renumbered 628.34 (3) (a).

SECTION 9. 628.34 (3) (b) of the statutes is created to read:

628.34 (3) (b) No insurer may refuse to insure or refuse to continue to insure, or limit the amount, extent or kind of coverage available to an individual, or charge an individual a different rate for the same coverage because of a mental or physical disability except when the refusal, limitation or rate differential is based on either sound actuarial principles supported by reliable data or actual or reasonably anticipated experience.

SECTION 10. 632.785 of the statutes is created to read:

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

(a) A notice of rejection or cancellation of coverage.

(b) A notice of reduction or limitation of coverage, including restrictive riders, if the effect of the reduction or limitation is to substantially reduce coverage compared to the coverage available to a person considered a standard risk for the type of coverage provided by the plan.

(c) A notice of increase in premium exceeding the premium then in effect for the insured person by 50% or more, unless the increase applies to substantially all of the insurer's health insurance policies then in effect.

(d) A notice of premium for a policy not yet in effect which exceeds the premium applicable to a person considered a standard risk by 50% or more for the types of coverage provided by the plan.

(2) Any notice issued under sub. (1) shall also state the reasons for the rejection, termination, cancellation or imposition of underwriting restrictions.

SECTION 11. **Positions authorized.** 2.0 full-time equivalent positions funded by the appropriation under section 20.145 (7) of the statutes, as created by this act, are authorized in the office of the commissioner of insurance for the purpose of administering subchapter II of chapter 619 of the statutes, as created by this act.

SECTION 12. **Rules.** The commissioner of insurance shall promulgate rules to implement subchapter II of chapter 619 of the statutes, as created by this act, within one year after the date of publication of this act.

SECTION 13. **Effective date.** Except as provided in SECTION 12 of this act, this act takes effect January 1, 1981.

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