Emerg rule
7/1/98

# Chapter HFS 119

## HEALTH INSURANCE RISK–SHARING PLAN



**Note: Chapter Ins 18 was renumbered ch. HFS 119 under s. 13.93 (2m) (b) 1., Stats., and corrections made under s. 13.93 (2m) (b) 6. and 7., Stats., Register, March, 1998, No. 507.**

Note: Many changes were made in the Health Insurance Risk–Sharing Plan by 1997 Wis. Act 27, including transfer of responsibility for operating the Plan from the office of the commissioner of insurance to the department of health and family services. On April 1, 1998 the revisor renumbered the implementing rules from ch. Ins 18 to ch. HFS 119 to make the chapter part of the department's series in the Wisconsin Administrative Code and to correct internal statutory references. Changes in how the Plan will be operated are now mainly set out in ch. 149, Stats., as created by Act 27. The related substantive changes to ch. HFS 119 will be made in a forthcoming revision of ch. HFS 119 through the regular rulemaking process.

**HFS 119.01 Purpose.** This chapter is intended to implement and interpret ch. 149, Stats., and s. 632.785, Stats., for the purpose of establishing procedures and requirements for a health insurance risk–sharing plan, in accordance with ss. 149.11 and 601.41 (3), Stats.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.

**HFS 119.02 Creation of plan and title.** In accordance with ss. 149.11 and 601.41 (3), 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.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.

**HFS 119.03 Scope.** This chapter shall apply to all insurers as defined in s. 149.10 (5), Stats.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.

**HFS 119.04 Definitions.** For the purpose of this chapter, the definition of terms used shall be those definitions set forth in s. 149.10, Stats.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.

**HFS 119.05 Eligibility.** Eligibility shall be determined in accordance with s. 149.12, Stats.

**(1)** CRITERIA. The administering carrier shall certify as eligible any resident as defined in s. 149.10 (9), Stats., upon written receipt from the plan applicant of evidence of any of the eligibility criteria set forth in s. 149.12 (1), Stats., or a physician certification meeting the requirements of sub. (2m) (b) that is accepted following the review process specified under s. 149.12 (2) (e) 2., Stats.

**(2)** NON–ELIGIBILITY. (a) Exclusions from eligibility for the plan shall be as set forth in s. 149.12 (2), 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 board determines that the failure to pay was not intentional.

**(2m)** 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) *Limited coverage under employer plan.* 1. 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.

2. The person has continued coverage under s. 632.897, Stats., or the federal consolidated omnibus budget reconciliation act of 1985, as amended.

(b) *Physician certification.* 1. An applicant for coverage under the plan who believes he or she is eligible under s. 149.12 (2) (e), Stats., shall submit with the application all of the following:

a. The name and address of the applicant's employer and the name and address of the insurer that provides the employer's small employer health insurance plan under subch. II of ch. 635, Stats.

b. A certification signed, not more than 30 days before the date of application, by a physician licensed under ch. 448, Stats., stating that the applicant has a severe and chronic or long–lasting physical or mental illness or disability.

2. a. Upon receipt of an application under subd. 1., the administering carrier shall notify the insurer named in subd. 1. a. that it has the right, under s. 149.123, Stats., to submit information contesting or supporting the physician's certification within 5 working days after receipt of the notice. Only the insurer named in subd. 1. a. has the right to support or contest the certification.

b. An insurer which does not respond within the time specified or notifies the administering carrier that it supports the physician's certification may not contest the certification. This does not limit the board's authority to review an application under s. 149.12 (2) (e) 2., Stats.

c. If the insurer contests the physician's certification, the administering carrier shall refer the application with the attached physician's certification and the insurer's written objection to the board.

d. The board shall make the final decision on the applicant's eligibility for the plan under s. 149.12 (2) (e), Stats. The board may delegate the authority to make the decision to the administering carrier, or may delegate the authority to make the initial decision subject to a right of the applicant or a contesting insurer to appeal an adverse decision to the board.

**(3)** BOARD REVIEW. Any person denied coverage under the plan or whose coverage is terminated by the administering carrier is entitled to a review under s. HFS 119.15. A request for review does not stay the plan's termination of coverage.

**(4)** DATE OF ELIGIBILITY. Except as provided in s. 149.14 (1) (b), Stats., coverage for a person certified as eligible for the plan begins on the date the plan receives the person's complete application. 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.

History: Cr. Register, December, 1980, No. 300, eff. 1–1–81; am. (3), Register, August, 1986, No. 368, eff. 9–1–86; r. and recr. (1), am. (3), Register, February, 1989, No. 398, eff. 3–1–89; (2) renum. (2) (a), cr. (2) (b), Register, April, 1991, No. 424, eff. 5–1–91; cr. (2) (c), Register, June, 1992, No. 438, eff. 7–1–92; am. (1), renum. (2) (c) to be (2m) (a) and am. (intro.), cr. (2m) (b), Register, November, 1993, No. 455, eff. 12–1–93; am. (2) (b) and (4), Register, June, 1994, No. 462, eff. 7–1–94; am. (3), Register, March, 1996, No. 483, eff. 4–1–96.

**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 (5), the board of governors 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 the form "Wisconsin health insurance risk–sharing plan assessment form," with its annual statement filing with the office of the commissioner of insurance.

**(3)** An insurer that makes an error in its 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 (1), 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 shall be granted for an error in an assessment form filed in any year prior to the previous calendar year.

Note: The form referenced in sub. (2), OCI 43–003, may be obtained from the Wisconsin Department of Health and Family Services, P. O. Box 309, Madison, WI 53701.

History: Cr. Register, December, 1980, No. 300, eff. 1–1–81; am. Register, June, 1992, No. 438, eff. 7–1–92; Ins 18.06 renum. to be Ins 18.06 (1), cr. (2), (3) and (4), Register, June, 1995, No. 474, eff. 7–1–95.

**HFS 119.07 Coverage.** Coverage shall conform with s. 149.14, Stats.

**(1)** LIMITATIONS ON COVERAGE OFFERED TO ELIGIBLE PERSONS ALSO ELIGIBLE FOR MEDICARE. Limitations on coverage offered shall conform with s. 149.14 (1), Stats. In accordance with s. 149.14 (2) (b), Stats., the plan shall offer an alternative to the major medical policy for individuals who are eligible for the plan and also eligible for medicare.

**(2)** MAJOR MEDICAL EXPENSE COVERAGE. Major medical expense coverage shall conform with s. 149.14 (2), Stats.

**(3)** COVERED EXPENSES. (a) Covered expenses shall be those services and articles enumerated in s. 149.14 (3), Stats. The formula for determining usual and customary charges shall be developed by the administering carrier and approved by the board.

(b) The plan shall cover services for a chronically mentally ill policyholder in a community support program under s. 149.14 (3) (c) 3., Stats., if the case management review under s. HFS 119.13 (3) (c) determines that the services are medically necessary, appropriate and cost effective.

**(4)** EXCLUSIONS. Exclusions from coverage shall conform with s. 149.14 (4), Stats.

(a) The formula for determining the prevailing charge in the locality where the service is provided shall be developed by the administering carrier and approved by the board.

(b) The medical necessity of the service shall be determined by the administering carrier.

**(5)** PREMIUMS, DEDUCTIBLES AND COINSURANCE. (a) Premiums, deductibles and coinsurance shall conform with ss. 149.14 (5), 149.165 and 149.17, Stats.

(b) The schedule of annual premiums for the period from July 1, 1996 to June 30, 1997, for persons not entitled to a premium reduction under s. 149.165, Stats., is as follows:

MAJOR MEDICAL PLAN – Males

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $1,680 | $1,512 | $1,344 |
| 19–24 | 1,680 | 1,512 | 1,344 |
| 25–29 | 1,728 | 1,560 | 1,380 |
| 30–34 | 1,968 | 1,776 | 1,572 |
| 35–39 | 2,184 | 1,968 | 1,752 |
| 40–44 | 2,640 | 2,376 | 2,112 |
| 45–49 | 3,276 | 2,952 | 2,616 |
| 50–54 | 4,284 | 3,852 | 3,432 |
| 55–59 | 5,616 | 5,052 | 4,488 |
| 60–64 | 6,852 | 6,168 | 5,484 |

MAJOR MEDICAL PLAN – Females

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $1,680 | $1,512 | $1,344 |
| 19–24 | 2,484 | 2,232 | 1,992 |
| 25–29 | 2,640 | 2,376 | 2,112 |
| 30–34 | 2,832 | 2,544 | 2,268 |
| 35–39 | 3,036 | 2,736 | 2,424 |
| 40–44 | 3,276 | 2,952 | 2,616 |
| 45–49 | 3,756 | 3,384 | 3,000 |
| 50–54 | 4,320 | 3,888 | 3,456 |
| 55–59 | 4,908 | 4,416 | 3,924 |
| 60–64 | 5,820 | 5,244 | 4,656 |

MEDICARE PLAN – Males

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $1,140 | $1,140 | $1,020 |
| 19–24 | 1,140 | 1,140 | 1,020 |
| 25–29 | 1,140 | 1,140 | 1,020 |
| 30–34 | 1,140 | 1,140 | 1,020 |
| 35–39 | 1,140 | 1,140 | 1,020 |
| 40–44 | 1,380 | 1,248 | 1,104 |
| 45–49 | 1,704 | 1,536 | 1,368 |
| 50–54 | 2,232 | 2,004 | 1,788 |
| 55–59 | 2,928 | 2,640 | 2,340 |
| 60–64 | 3,576 | 3,216 | 2,856 |

MEDICARE PLAN – Females

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $1,140 | $1,140 | $1,020 |
| 19–24 | 1,296 | 1,164 | 1,032 |
| 25–29 | 1,368 | 1,236 | 1,092 |
| 30–34 | 1,476 | 1,332 | 1,176 |
| 35–39 | 1,584 | 1,428 | 1,272 |
| 40–44 | 1,704 | 1,536 | 1,368 |
| 45–49 | 1,956 | 1,764 | 1,560 |
| 50–54 | 2,256 | 2,028 | 1,800 |

| | | | |
|---|---|---|---|
| 55–59 | 2,556 | 2,304 | 2,040 |
| 60–64 | 3,036 | 2,736 | 2,424 |

(bg) 1. The annual rates applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's major medical plan for the period from July 1, 1997, to June 30, 1998, are as follows:

MAJOR MEDICAL PLAN – Males
(Base for Reduced Rates)

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $948 | $852 | $756 |
| 19–24 | 948 | 852 | 756 |
| 25–29 | 972 | 876 | 780 |
| 30–34 | 1,092 | 984 | 876 |
| 35–39 | 1,224 | 1,104 | 972 |
| 40–44 | 1,488 | 1,332 | 1,188 |
| 45–49 | 1,836 | 1,656 | 1,476 |
| 50–54 | 2,376 | 2,148 | 1,908 |
| 55–59 | 3,108 | 2,796 | 2,484 |
| 60–64 | 3,804 | 3,432 | 3,048 |

MAJOR MEDICAL PLAN – Females
(Base for Reduced Rates)

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $948 | $852 | $756 |
| 19–24 | 1,320 | 1,188 | 1,056 |
| 25–29 | 1,380 | 1,248 | 1,104 |
| 30–34 | 1,524 | 1,368 | 1,212 |
| 35–39 | 1,644 | 1,476 | 1,320 |
| 40–44 | 1,800 | 1,620 | 1,440 |
| 45–49 | 2,076 | 1,872 | 1,656 |
| 50–54 | 2,364 | 2,124 | 1,884 |
| 55–59 | 2,688 | 2,424 | 2,148 |
| 60–64 | 3,180 | 2,856 | 2,544 |

2. The annual rates applicable to standard risks under individual policies providing substantially the same coverage and deductibles as the plan's medicare plan for the period from July 1, 1997, to June 30, 1998, are as follows:

MEDICARE PLAN – Males
(Base for Reduced Rates)

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $480 | $432 | $384 |
| 19–24 | 480 | 432 | 384 |
| 25–29 | 480 | 432 | 384 |
| 30–34 | 552 | 492 | 444 |
| 35–39 | 612 | 552 | 492 |
| 40–44 | 744 | 672 | 600 |
| 45–49 | 924 | 828 | 732 |
| 50–54 | 1,188 | 1,068 | 948 |
| 55–59 | 1,560 | 1,404 | 1,248 |
| 60–64 | 1,908 | 1,716 | 1,524 |

MEDICARE PLAN – Females
(Base for Reduced Rates)

| Age | Zone 1 | Zone 2 | Zone 3 |
|---|---|---|---|
| 0–18 | $480 | $432 | $384 |
| 19–24 | 660 | 600 | 528 |
| 25–29 | 696 | 624 | 552 |
| 30–34 | 756 | 684 | 612 |
| 35–39 | 816 | 744 | 660 |
| 40–44 | 900 | 804 | 720 |
| 45–49 | 1,044 | 936 | 828 |
| 50–54 | 1,176 | 1,068 | 948 |
| 55–59 | 1,344 | 1,212 | 1,080 |
| 60–64 | 1,584 | 1,428 | 1,272 |

(br) For the purposes of pars. (b) and (bg), Zone 1 shall contain all of the Wisconsin postal 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.

(c) The department shall have on file an actuarial report detailing the process by which rates were determined.

(d) 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) and (e).

**(6)** 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 administering carrier.

**(7)** COORDINATION OF BENEFITS. There shall be coordination of benefits as provided in s. 149.14 (7), Stats.

**(8)** RIGHT TO REVIEW. Any person whose claim is denied or reduced by the administering carrier is entitled to a review under s. HFS 119.15.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.; r. and recr. (5) (b), Register, June, 1982, No. 318, eff. 7–1–82; r. and recr. (5) (b), Register, December, 1983, No. 336, eff. 1–1–84; r. and recr. (5) (b) 1., Register, December, 1984, No. 348, eff. 1–1–85; am. (5) (b) 1., Register, December, 1985, No. 360, eff. 1–1–86; r. and recr. (5) (b) 1., Register, December, 1986, No. 372, eff. 1–1–87; r. and recr. (5) (b) 1. and 2., Register, May, 1990, No. 413, eff. 6–1–90; renum. (3) to be (3) (a), cr. (3) (b), r. and recr. (5) (b) 1. (schedule), Register, June, 1991, No. 426, eff. 7–1–91; emerg. r. and recr. (5) (b) 1. (schedule), eff. 7–1–91; r. and recr. (5) (b) 1. (schedule), Register, October, 1991, No. 430, eff. 11–1–91; emerg. am. (5) (a) and (c), renum. (5) (b) 1. and 2. to be (5) (b) (intro.) and (br) and am., cr. (5) (bg), eff. 1–1–92; am. (5) (d), Register, April, 1992, No. 436, eff. 5–1–92; am. (5) (a) and (c), renum. (5) (b) 1. and 2. to be (5) (b) (intro.) and (br) and am., r. and recr. (5) (b) schedule, cr. (5) (bg), Register, June, 1992, No. 438, eff. 7–1–92; emerg. am. (5) (b) and (bg) 1., eff. 4–20–93; r. and recr. (5) (b) and (bg) 1., Register, August, 1993, No. 452, eff. 9–1–93; r. and recr. (5) (b) and (bg) 1. and 2., Register, June, 1994, No. 462, eff. 7–1–94; r. and recr. (5) (b) and (bg) 1. and 2., Register, June, 1995, No. 474, eff. 7–1–95; am. (4) (b) and (6), cr. (8), Register, March, 1996, No. 483, eff. 4–1–96.; r. and recr. (5) (b), (bg) 1., 2., Register, June, 1996, No. 486, eff. 7–1–96; emerg. r. and recr. (5) (b), eff. 10–1–96; r. and recr. (5) (b), Register, April, 1997, No. 496, eff. 5–1–97; emerg. r. and recr. (5) (bg), eff. 7–1–97; r. and recr. (5) (bg), Register, October, 1997, No. 502, eff. 11–1–97; **emerg. am. (intro.), (5) (a) and (br), r. and recr., (5) (bm), eff. 1–1–98.**

**HFS 119.08 Board of governors.** The board shall be appointed and shall operate pursuant to s. 149.15, Stats.

**(1)** BOARD APPOINTMENTS. The board shall be appointed pursuant to s. 149.15 (1), Stats.

**(2)** ANNUAL REPORT. The board shall make an annual report to the members of the plan and to the chief clerk of each house of the legislature pursuant to s. 149.15 (2), Stats.

**(3)** BOARD FUNCTIONS. Board functions shall conform with s. 149.15 (3), (4) and (5), Stats.

(a) The board shall carry out the functions required in s. 149.15 (3), Stats.

(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 under the powers granted in s. 149.15 (5), Stats.

(d) The board may establish subcommittees and appoint members who do not serve on the board to these subcommittees in order to carry out its functions under s. 149.15, Stats.

(e) The board may hire consultants in order to carry out its functions under s. 149.15, Stats.

(f) The board shall contract with the administering carrier of the plan to provide those services enumerated in s. 149.16 (3), Stats., as well as any other functions enumerated in the contract between the board and the administering carrier, in order to carry out its functions under s. 149.15, Stats.

(g) The board may defer payment of administrative expenses to the administering carrier, in accordance with the terms set forth in the contract between the board and the administering carrier.

(h) The board shall develop a detailed written policy regarding confidentiality of records.

(i) The board may adopt and amend from time to time reasonable operating procedures which are not inconsistent with the statutory requirements and this chapter, for the management and operation of the plan.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81; am. (1), Register, December, 1983, No. 336, eff. 1–1–84; am. (2), Register, April, 1992, No. 436, eff. 5–1–92.

**HFS 119.09 Administering carrier.** The selection, term and functions of the administering carrier shall conform with s. 149.16, Stats.

**(1)** SELECTION. The board shall select an insurer through a competitive bidding process to administer the plan based on criteria established by the board which shall conform with the requirements of s. 149.16 (1), Stats.

**(2)** TERM SERVED AND SELECTION FOR SUCCEEDING PERIODS. The term served by the administering carrier and the selection of the administering carrier for succeeding periods shall conform with s. 149.16 (2), Stats.

**(3)** FUNCTIONS. The administering carrier shall perform the functions enumerated in s. 149.16 (3), Stats., and any other functions agreed to in the contract between the board and the administering carrier.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.

**HFS 119.10 Notice of mandatory risk–sharing plan.** Notice of the plan shall conform with s. 632.785, Stats.

**(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, of the existence of the plan, as well as the eligibility requirements and the method of applying for coverage under the plan, in accordance with s. 632.785 (1), Stats.

**(2)** FORM OF NOTICE REQUIRED. "Wisconsin HIRSP Health Insurance Risk–Sharing Plan," an informational pamphlet prepared by the office of the commissioner of insurance and endorsed by the board, shall satisfy the notice requirements set forth in s. 632.785 (1), Stats. Any other notice given in accordance with s. 632.785 (1), Stats., shall substantially conform to this pamphlet in type size and readability and shall be subject to the prior approval of the commissioner of insurance.

**(3)** STATEMENT OF REASONS FOR REJECTION, TERMINATION, CANCELLATION OR IMPOSITION OF UNDERWRITING RESTRICTIONS. The insurer's rejection, termination, cancellation or imposition of underwriting restrictions under s. 632.785 (1), Stats., shall, pursuant to s. 632.785 (2), Stats., state the specific medical reason for the insurer's action.

**Note:** The form referenced in sub. (2) may be obtained from the Wisconsin Department of Health and Family Services, P. O. Box 309, Madison, WI 53701.

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81; am. (2) and (3), Register, April, 1992, No. 436, eff. 5–1–92.

**HFS 119.11 Confidentiality and access to records.** **(1)** CONFIDENTIALITY. Information regarding plan applicants and plan participants shall be kept confidential by the administering carrier and the board. A detailed written policy regarding confidentiality shall be developed by the board pursuant to s. 149.15 (5), Stats., and s. HFS 119.08 (3) (h).

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

**History:** Cr. Register, December, 1980, No. 300, eff. 1–1–81.

**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 (2) 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., is set forth in s. HFS 119.07 (5) (bg) 1. and 2.

(b) The schedule of deductible reductions is set forth in s. 149.14 (5) (a), Stats.

(c) The board 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 board 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 board's decision.

(d) The availability of premium and deductible reductions is based on the availability of funds as appropriated under s. 20.435 (5) (ah) and (g), Stats.

**(4)** APPLICATION FOR PREMIUM AND DEDUCTIBLE REDUCTIONS. An application for premium and deductible reduction 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 administrator of the plan. 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 Blue Cross & Blue Shield United of Wisconsin, P.O. Box 3015, Milwaukee, Wisconsin 53201–3015 (414–223–4021 or 1–800–828–4777).

**(5)** APPLICATION DEADLINES, EFFECTIVE DATES OF REDUCTIONS, RE–ESTABLISHING ELIGIBILITY. (a) New plan applicants may establish eligibility for the reductions:

1. At the time of plan application. In this case, for purposes of the premium reduction, the administering carrier shall bill the applicant the reduced premium unless the first premium payment is submitted with the application. If the first premium payment is submitted with the application, the applicant shall receive a refund of the reduced portion of the premium. 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 administering carrier shall bill the policyholder 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) 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. 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. Deductible reductions under this paragraph take place on January 1 of the year following establishment of eligibility. Under this subsection, the administering carrier shall treat any individual who becomes a policyholder after March 31 as a new policyholder.

(c) Eligibility for the premium and deductible reductions shall be reestablished annually. Once eligibility is established, it is effective until the following July 1 at which time eligibility for the following year, from July 1 to June 30, shall have been established.

**(6)** An applicant who is denied a premium or deductible reduction is entitled to a review under s. HFS 119.15.

**History:** Cr. Register, August, 1986, No. 368, eff. 9–1–86; am. (1) to (5), cr. (5) (a) 2. b., Register, February, 1989, No. 398, eff. 3–1–89; emerg. am. (3), eff. 1–1–92; (5) (a) 1. and 2. (b), Register, April, 1992, No. 436, eff. 5–1–92; am. (3), Register, June, 1992, No. 438, eff. 7–1–92; am. (3), Register, June, 1994, No. 462, eff. 7–1–94; cr. (6), Register, March, 1996, No. 483, eff. 4–1–96.

**HFS 119.13 Cost containment services. (1)** PURPOSE. This section implements and interprets s. 149.17 (4) (a), Stats., by establishing cost containment provisions for the plan.

**(2)** DEFINITIONS. In this section:

(a) "Case management" means a review of the medical necessity and appropriateness of the treatment or procedures used in connection with specified medical conditions.

(b) "Preadmission and concurrent review of hospital admissions"means a review of the medical necessity and appropriateness of a hospital admission prior to and during a hospital stay.

(c) "Pretreatment and concurrent review of selected outpatient services" means a review of the medical necessity and appropriateness of a plan of treatment prior to and during the treatment.

**(3)** REQUIRED COST CONTAINMENT SERVICES. The plan shall include the following cost containment services:

(a) Preadmission and concurrent review of hospital admissions;

(b) Pretreatment and concurrent review of selected outpatient services; and

(c) Case management.

**(3m)** ADDITIONAL BENEFITS. The plan may cover expenses for a benefit not specified under s. 149.14 (3), Stats., if it is determined through case management that the provision of the benefit would be more cost effective than the provision of the benefit specified under s. 149.14 (3), Stats.

**(4)** WRITTEN DESCRIPTION OF COST CONTAINMENT SERVICES. When a new policy is issued, a new policyholder shall receive a written description of the plan's cost containment services and the procedures that the policyholder shall follow in order to comply with these cost containment services. Existing policyholders shall receive a written description of any change to the plan's cost containment services or the procedures that policyholders shall follow in order to comply with these cost containment services. The existing policyholders shall receive this written description at least 30 days before the change takes effect.

**(5)** PROVIDER NETWORK COST CONTAINMENT PROVISIONS. (a) The board may direct the plan administrator to contract with a network or networks of providers at discounts greater than those mandated by s. 149.15 (3) (e), Stats., and the board may establish different deductible amounts, a different coinsurance percentage, and different covered costs and deductible aggregate amounts from those specified in s. 149.14 (5) (a) to (c), Stats., for utilization of non–network providers.

(b) The board may establish a copayment schedule for services provided by non–network providers that is different from that established for network providers.

**History:** Cr. Register, February, 1989, No. 398, eff. 3–1–89; cr. (3m), Register, June, 1991, No. 426, eff. 7–1–91; emerg. cr. (5), eff. 1–8–96; cr. (5), Register, June, 1996, No. 486, eff. 7–1–96.

**HFS 119.14 Penalty for late assessment payment.** An insurer that violates s. 149.135 (1) (b), Stats., is subject to a penalty of $250. Each week the violation continues is a separate offense.

**History:** Cr. Register, April, 1992, No. 436, eff. 5–1–92.

**HFS 119.15 Grievance procedure. (1)** PURPOSE. This section implements s. 149.17 (3), Stats.

**(2)** REVIEW BY ADMINISTERING CARRIER. A person entitled under this chapter to a review of a determination by the administering carrier shall first request that the administering carrier review its determination. Upon receipt of a request, the administering carrier shall review the determination, either affirm, modify or rescind the original determination and provide the requester with a written response which includes the reason for its final determination.

**(3)** GRIEVANCE COMMITTEE REVIEW. (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. A request for review under this subsection shall clearly describe the reason the requester believes the administering carrier's decision is erroneous under of ch. 149, Stats., this chapter or the terms of the plan policy.

(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 administering carrier that adversely affect an applicant or policyholder entitled to a review under this chapter. The grievance committee shall conduct a review based on written submission by the administering carrier and the applicant or policyholder. No discovery is permitted. The grievance committee may invite or permit a representative of the administering carrier and the applicant or policyholder to appear and make an oral statement during the review. The grievance committee shall issue a written decision affirming, modifying or rescinding the decision of the administering carrier, stating the reason for the decision. The committee's decision shall be final.

(c) The grievance committee shall file a quarterly report with the board on all actions taken under par. (b).

**(4)** RESPONSIBILITY OF ADMINISTERING CARRIER. The administering carrier shall comply with the final decision of the grievance committee.

**History:** Cr. Register, March, 1996, No. 483, eff. 4–1–96.